



Responses to Questions Following PTT Meeting on December 8, 2008

1. *Who do Quitlines currently serve?*

The large variation in funding for state smoking cessation quitlines means that they differ in terms of the populations they are able to serve as well as the scope of the benefit. However, it is clear that they reach a broad diversity of smokers, including the Medicaid and uninsured populations.

Current funding for quitlines comes from a range of sources, including federal and state governments, and CDC does not collect any information about who is served through the state quitline. Free & Clear, one of the largest quitline service providers in the U.S., collects caller demographic data from the quitlines the company administers in seventeen states. Recent data from Free & Clear demonstrates the diversity of smokers served by the quitlines. From July of 2007 through June of 2008, Free & Clear fielded more than 120,000 calls from tobacco users during this time period.

- Fifty-four percent of callers to these state quitlines were either Medicaid enrollees or uninsured (17.5 percent and 36.5 percent, respectively), while 10 percent were covered by Medicare and 32 percent by commercial insurance.
- Fifty-five percent of the quitline callers had a high school education or less. Twenty-eight percent had some college, and 13 percent had a college degree or higher.
- Whites and Blacks/African Americans are represented roughly proportionately among quitline callers. Seventy-five percent of callers to quitlines in these seventeen states were white, and 12 percent were black. Nationally, 82 percent of smokers are white, and 13 percent are Black/African American. More than six percent of callers to quitlines in these seventeen states were Hispanic and 9.5 percent of smokers are Hispanic.

The attached data from Free and Clear provide a full profile of the quitline callers. Also attached is a factsheet on Quitlines that provides a summary of how they work and data on their effectiveness.

2. *What are best examples of state and community based programs and what are essential components?*

Comprehensive tobacco prevention and cessation programs both prevent kids from starting to smoke and encourage and help adult smokers to quit. They are instrumental in raising public awareness about the tobacco problem, countering the marketing efforts of the tobacco companies, and engaging community members in the issue, thereby creating a social and cultural environment that is more conducive to healthy behavior.

Recommendations for comprehensive tobacco prevention and cessation programs are detailed in the Center for Disease Control and Prevention's *Best Practices for Comprehensive Tobacco Control Programs*.¹

The empirical evidence regarding the effectiveness of comprehensive tobacco prevention and cessation programs is vast and growing. The best evidence on the effectiveness of these programs comes from national studies that look across states and control for as many of the relevant confounding factors as possible. These studies consistently show effects of tobacco prevention and cessation programs.² In addition, data from numerous states that have implemented programs consistent with CDC guidelines show significant reductions in youth and adult smoking.

Program Success – New York

New York began implementing a comprehensive state tobacco control program in 2000. As the data below demonstrate, New York's comprehensive approach is working. While declines in youth smoking nationally have slowed, New York's rates continue to decline steadily.

- Between 2000 and 2006, smoking among middle school students declined by 61 percent, (from 10.5 percent to 4.1 percent), and smoking among high school students declined by 40 percent, (from 27.1 percent to 16.3 percent).³



- Between 2000 and 2006, adult smoking declined by 15 percent, from 21.6 percent to 18.3 percent.⁴

Program Success – California

California launched its Tobacco Control Program in 1990. Despite increased levels of tobacco marketing and promotion, a major cigarette price cut in 1993, tobacco company interference with the program, and periodic cuts in funding, the program has still reduced tobacco use and its attendant devastation substantially.

- California's comprehensive approach has reduced adult smoking significantly. Adult smoking declined by 43 percent from 1988 to 2007, from 24.2 percent to 13.8 percent.⁵ If every state had California's current smoking rate, there would be more than 16 million fewer smokers in the United States.
- Between 1988 and 2001, lung and bronchus cancer rates in California declined at three times the rate of decline as the rest of the U.S.⁶ Surveillance, Epidemiology, and End Results (SEER) data associated lower lung cancer incidence with California's program.⁷

Program Success – Maine

In 1997, Maine established a comprehensive tobacco prevention program known as the Partnership for a Tobacco-Free Maine. Prior to launching this effort, Maine had one of the highest youth smoking rates in the country. Now, it has one of the lowest.

- Smoking among Maine's high school students declined a dramatic 64 percent between 1997 and 2007, falling from 39.2 percent to 14 percent. Smoking among Maine's middle school students declined by 71 percent, from 21 percent to 6 percent, over the same time period.⁸
- The Maine Department of Health (DOH) has calculated that, as a result of these declines, there are now more than 26,000 fewer youth smokers in Maine and more than 14,000 youth will be saved from premature, smoking-caused deaths. Based on estimates that smokers, on average, have \$16,000 more in lifetime health care costs than non-smokers, the DOH calculated that these declines will save Maine more than \$416 million in long-term health care costs.

Program Success – Washington State

The Washington State Tobacco Prevention and Control program was implemented in 1999. According to a recent study in CDC's peer-reviewed journal, *Preventing Chronic Disease*, although Washington made progress in implementing tobacco control policies between 1990 and 2000, smoking prevalence did not decline significantly until after substantial investment was made in the state's comprehensive tobacco control program.⁹ As the data below demonstrate, Washington's comprehensive program is working.

- Since the program began, Washington's tobacco prevention efforts have cut smoking by 60 percent among sixth graders, 58 percent among eighth graders, 40 percent among tenth graders, and 43 percent among twelfth graders. Because of these declines, there are 65,000 fewer youth smokers in Washington.¹⁰
- Since the tobacco control program was implemented, adult smoking has declined by 24 percent, from 22.4 percent in 1999 to 16.5 percent in 2007, one of the lowest smoking rates in the country.¹¹ Washington's dramatic decline in adult smoking translates to more than 240,000 fewer smokers in the state, saving about \$2.1 billion in future health care costs.¹²

Core Components of Comprehensive Tobacco Prevention and Cessation Program

As noted previously, CDC has provided guidance regarding the essential elements of a comprehensive tobacco prevention and cessation program. CDC recommends that states establish tobacco control programs comprised of three core components: public education efforts, community-based interventions, and cessation programs.

Public Education Efforts: Research has demonstrated that tobacco industry marketing increases the number of kids who try smoking and become regular smokers. One of the best ways to reduce the power of tobacco marketing is an intense campaign to counter these pro-smoking messages. Health communication campaigns prevent smoking initiation, promote cessation and change social norms related to tobacco use. These efforts



include multiple paid media (TV, radio, print, web-based, etc.), earned media (press releases, local events and promotions), and other efforts.

Community-based programs are the foundation of any statewide tobacco control program. State tobacco control programs advance and achieve their goals by working with and funding community-based programs that conduct community education and outreach, provide cessation assistance, sponsor events and generate earned media to influence the knowledge, attitudes and behaviors of tobacco users and nonusers. A significant portion of a state's tobacco control funding should be provided to diverse groups at the local level, including local government entities, community organizations, local businesses, and other community partners.

State tobacco control programs that have included a strong community-based component in their efforts have achieved enormous success in reducing tobacco use rates among adults and youth. Adequately funded state tobacco control programs, such as California, Maine, New York and Washington, fund community-based programs to perform the following activities, in addition to others:

- Educate smokers about the health risks of smoking and the benefits of quitting
- Educate their communities about the tobacco industry's manipulative and deceptive marketing practices
- Reach populations disproportionately impacted by tobacco use right where they live, work, play and worship with messages and programs aimed at preventing initiation and providing cessation assistance. For example, Washington's tobacco control program funds Vietnamese community leaders to communicate anti-tobacco messages to the Vietnamese community which has very high rates of smoking.
- Raise awareness of resources to help smokers quit, such as the state Quitline
- Educate health care providers about the importance of treating tobacco dependence
- Work with health care systems and provider groups to implement effective systems to prompt providers to screen for tobacco use and advise smokers to quit
- Provide education and cessation services to populations most impacted by tobacco use
- Support schools seeking to develop, implement and enforce tobacco-free schools policies
- Educate local school boards about the importance of youth prevention and educate school nurses about the Public Health Service guidelines for cessation
- Involve youth in activities to educate each other about the harms of tobacco use and tobacco company marketing practices

Helping Smokers Quit (Cessation): A comprehensive tobacco control program should not only encourage smokers to quit but also help them do so. Most smokers want to quit but have a very difficult time because nicotine is so powerfully addictive. State programs make evidence based treatments available to smokers who would otherwise not have access to assistance. These interventions include counseling via telephone (quitlines), in-person sessions, and the web. Helping adult smokers quit not only achieves immediate reductions in disease, death, and healthcare costs; it also creates an environment in which kids are less likely to smoke.

For additional information on comprehensive tobacco prevention and cessation programs, please see the attached factsheet, "*Comprehensive Tobacco Prevention and Cessation Programs Effectively Reduce Tobacco Use*".

3. What should NIH be spending on tobacco-related research?

We have a large body of evidence to inform tobacco control policy and program interventions but there is still much to learn about prevention and cessation interventions as well as tobacco product design issues.

It is critical that research drive the policies and programs designed to address tobacco use – the leading preventable cause of death in the country and the direct cause of nearly \$100 billion in health care costs each year. Given the lack of attention in recent years to tobacco control research at the NIH it is clear that a greater investment is needed. We suggest that the new administration engage the relevant federal agencies (NIH, CDC, and FDA if the agency is given jurisdiction over tobacco products) and tobacco control community to determine what the



research needs are on tobacco and what it would take to address them. This will inform the investment in tobacco-related research but will also foster further coordination among the various agencies engaged in this research.

The Tobacco Control Research Branch (TCRB) at the National Cancer Institute (NCI) and the National Institute on Drug Abuse each spend an estimated \$50 million annually on tobacco-related research. This research ranges from the genetics of tobacco addiction to tobacco product research to behavioral research. Other Institutes at NIH spend research dollars on tobacco-related disease and treatment research, but little of this is directly related to preventing tobacco use among kids or helping smokers quit. At \$50 million, the TCRB Research Budget represents just one percent of NCI's total budget. This is despite the fact that tobacco use causes 30 percent of all cancer deaths in the U.S. The National Heart, Lung and Blood Institute spends an insignificant amount on tobacco despite tobacco causing 20 percent of all heart disease deaths.

The need for more spending on tobacco research is compounded by the continuing efforts of the tobacco companies to recruit new youth smokers and keep adults as addicted customers. They are also developing new products at a dizzying pace, and we have to better understand the role of product design in addicting kids and keeping smokers hooked. This is especially true if legislation is finally passed giving the Food and Drug Administration the authority to regulate the marketing, sale, and manufacture of new and existing tobacco products. The FDA will need the best science not only on the products themselves but on the marketing of these products and how consumers react to new products. The tobacco companies certainly understand the importance of this type of research. Philip Morris alone has recently invested \$350 million on a new research and development facility in Richmond. The tobacco companies cannot continue to have a monopoly on the information regarding product design and its impact on consumers.

¹ Centers for Disease Control and Prevention (CDC), *Best Practices for Comprehensive Tobacco Control Programs*, Atlanta, GA: U.S. Department of Health and Human Services (HHS), October 2007.

² Farrelly, MC, et al., "The Impact of Tobacco Control Programs on Adult Smoking," *American Journal of Public Health* 98:304-309, February 2008. See also, Tauras, JA, et al., "State Tobacco Control Spending and Youth Smoking," *American Journal of Public Health* 95:338-344, February 2005; Farrelly, MC, et al., "The Impact of Tobacco Control Program Expenditures on Aggregate Cigarette Sales: 1981-2000," *Journal of Health Economics* 22:843-859, 2003.

³ Youth Tobacco Surveillance in New York State, 2006. NY State Department of Health. http://www.nyhealth.gov/prevention/tobacco_control/youth_tobacco_survey.htm

⁴ CDC, *Behavioral Risk Factor Surveillance System (BRFSS)*, <http://apps.nccd.cdc.gov/brfss/list.asp?cat=TU&yr=2006&qkey=4396&state=All>.

⁵ Adult Smoking Prevalence, California Department of Health Services, Tobacco Control Section, 2007 <http://www.dhs.ca.gov/tobacco>. See also, Overview of Evaluation in the California Tobacco Control Program; Warner, Kenneth E, et al., "Tobacco Control Success vs Demographic Destiny: Examining the Causes of the Low Smoking Prevalence in California," *Am J Public Health* 98: 268-269, February 2008.

⁶ Cowling DW, et al., "Declines in lung cancer rates: California, 1988-1997," *Morbidity and Mortality Weekly Report (MMWR)* 49:1066-1069, 2000, updated data included. See also, California Department of Health Services, Tobacco Control Section, California Tobacco Control Update, 2004, <http://www.dhs.ca.gov/tobacco/documents/pubs/2004TCSupdate.pdf>.

⁷ Cancer Surveillance Section, California Department of Health Services. Unpublished data. See also, California Department of Health Services, Tobacco Control Section, California Tobacco Control Update, 2004, <http://www.dhs.ca.gov/tobacco/documents/pubs/2004TCSupdate.pdf>.

⁸ *Maine 2007 Youth Risk Behavior Survey*, Maine Department of Human Services, 2008.

⁹ Dilley JA, et al., "Effective tobacco control in Washington State: A smart investment for healthy futures," *Preventing Chronic Disease* 4(3), July 3, 2007, http://www.cdc.gov/pcd/issues/2007/jul/06_0109.htm.

¹⁰ Washington State Department of Health, Tobacco Prevention and Control Program, Progress Report, March 2007. Data are from 2006 Healthy Youth Survey, <http://www.doh.wa.gov/Tobacco/program/reports/tpcp07progprpt.pdf>.

¹¹ CDC, *Behavioral Risk Factor Surveillance System (BRFSS)*, <http://apps.nccd.cdc.gov/brfss/display.asp?cat=TU&yr=2006&qkey=4396&state=WA>.

¹² Dilley JA, et al., "Effective tobacco control in Washington State: A smart investment for healthy futures," *Preventing Chronic Disease* 4(3), July 3, 2007. See also, Washington State Department of Health, Tobacco Prevention and Control Program, Progress Report, March 2007. See also, Behavioral Risk Factor Surveillance System for adult smoking rates.