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Tobacco Control and Prevention

American College of Physicians

A Policy Monograph

2010

ACP American College of Physicians℠
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Tobacco Control and Prevention

Summary of Policy Monograph Approved by the ACP Board of Regents, April 2010

What Does Tobacco Control and Prevention Involve?

Tobacco use is the leading cause of preventable death and disease in the United States. While significant progress has been made over the last 50 years to reduce tobacco use, it remains a daunting problem. Twenty-one percent of adults currently smoke cigarettes, and 20% of high school students report having smoked cigarettes in the past 30 days. Therefore, it remains important that stakeholders aggressively work to reduce tobacco use rates. Doing so will ensure that a new generation does not succumb to a lifetime of harmful addiction, disease, and untimely death.

The tobacco problem cannot be curbed by piecemeal action. Effective tobacco control occurs when a concerted effort is made to establish and financially maintain comprehensive tobacco control initiatives by increasing tobacco excise taxes, prohibiting smoking in public places, preventing tobacco use among young people, facilitating smoking cessation programs, and banning tobacco additives such as menthol flavoring. In 2009, the FDA was given the authority to regulate tobacco products. This important step signals promise that tobacco use can be greatly reduced, but regulation alone is not sufficient.

Why is Controlling and Preventing the Use of Tobacco Important?

Though anti-tobacco use efforts have been remarkably successful, tobacco use remains high. Each year, cigarette smoking is the cause of over 440,000 deaths, nearly 50,000 of which are attributed to exposure to secondhand smoke. The 2004 Surgeon General's report concluded that smoking affects nearly every organ in the human body. Tobacco and its smoke contain over 4,000 chemicals, including 60 known carcinogens.

Further, tobacco users are not the only individuals exposed to the harmful effects of smoking. Tens of thousands of nonsmoking Americans die each year from illness attributed to secondhand smoke. Smoking also has a harmful effect on the nation's economy and health care system due to such factors as lost worker productivity, increased medical costs, health effects of smoking during pregnancy, and smoking-related fires.

Key Findings and Recommendations from the Paper

ACP recommends the following:

- All states, with assistance from the federal government, should establish and adequately fund comprehensive tobacco control efforts to prevent smoking and other tobacco product use among young people; provide objective information about the dangers of cigarette, cigar, pipe, smokeless, and other tobacco products, minimize exposure to secondhand smoke; and help tobacco users quit.
- Public and private insurers, as well as state, community, and employer-based entities, should provide effective comprehensive tobacco cessation and treatment benefits –

including counseling and medication – to all qualifying individuals. Physicians should help their patients quit.

- All states should commit to funding tobacco control efforts at CDC-recommended levels. All states should establish requirements that an appropriate portion of tobacco-generated revenue be directed toward tobacco control efforts. Local governments should be permitted to implement tobacco excise taxes beyond state levels.
- Youth tobacco education and prevention efforts, such as antismoking media campaigns and school-based interventions, must be enhanced and properly funded. Information and interventions related to cigars, pipes, smokeless tobaccos, and other cigarette alternatives should be incorporated into youth and antismoking efforts.
- The FDA should implement a ban on menthol flavoring in all tobacco products, as it has done with other flavors in cigarettes.
- State and local governments should take necessary action to establish comprehensive smoke-free laws banning smoking in all nonresidential indoor areas, including workplaces, restaurants, and bars. State and local governments should work to control smoking in residential areas, such as apartment and condominium buildings.
- Comprehensive tobacco control efforts should seek to reduce use of cigars and pipes in addition to cigarettes, particularly among young people and cigarette smokers.
- The FDA should be authorized to regulate electronic cigarettes until convincing evidence develops that they are not addictive or harmful.
- Smoking and tobacco use in movies and television should be discouraged, and the media industry should take responsibility to emphasize the dangers of tobacco use, particularly to young people.

For More Information

This issue brief is a summary of *Tobacco Control and Prevention*. The full paper is available at http://www.acponline.org/pressroom/control_tobacco.pdf.

Tobacco Control and Prevention

A Policy Monograph of the
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Introduction

Tobacco use is the leading cause of preventable death in the United States. Over the past 50 years, government, public health advocates, grassroots organizations, and others have worked to stem the rates of smoking and tobacco-related disease and death. These efforts have been remarkably successful. Following the release of the Surgeon General's 1964 report that named smoking as the cause of lung and other cancers, smoking rates have dropped precipitously. Per capita annual adult cigarette consumption rates dropped from 4,345 cigarettes in 1963 to 1,979 in 2002.[1] This decrease in tobacco use has justifiably been called one of the 20th century's great public health triumphs.

Unfortunately, tobacco use remains high. Twenty-one percent of adults currently smoke cigarettes, and 20% of high school students report having smoked cigarettes in the past 30 days.[2] The Healthy People 2010 report from the Centers for Disease Control and Prevention (CDC) established a goal of reducing smoking rates to 12% of the population, spit tobacco use to 0.4%, and cigar use to 1.2%.[3] While progress has been made, it is doubtful that these goals have been met. Therefore, it remains important that stakeholders aggressively work to reduce tobacco use rates. Doing so will ensure that a new generation does not succumb to a lifetime of harmful addiction, disease, and untimely death.

The American College of Physicians – the largest medical specialty society in the United States with over 129,000 members – has long advocated for efforts to reduce tobacco use in the United States. ACP has supported authorizing the Food and Drug Administration (FDA) to regulate tobacco products and efforts to facilitate access to effective smoking cessation aids and has advocated for a comprehensive antismoking legislative agenda. Given physicians' prominent role in counseling and treating patients who smoke, the College has an important role to play in helping tackle the tobacco problem. This paper updates the College's policies on tobacco, while reaffirming those that remain relevant.

The tobacco problem cannot be curbed by piecemeal action. Effective tobacco control occurs when a concerted effort is made to establish and financially maintain comprehensive tobacco control initiatives by increasing tobacco excise taxes, prohibiting smoking in public places, preventing tobacco use among young people, facilitating smoking cessation programs, and banning tobacco additives such as menthol flavoring. In 2009, the FDA was given the authority to regulate tobacco products. This important step signals promise that tobacco use can be greatly reduced, but regulation alone is not sufficient.

ACP recommends the following:

1. **All states, with assistance from the federal government, should establish and adequately fund comprehensive tobacco control efforts to prevent smoking and other tobacco product use among young people; provide objective information about the dangers of cigarette, cigar, pipe, smokeless, and other tobacco products; minimize exposure to secondhand smoke; and help tobacco users quit.**

2. **Public and private insurers, as well as state, community, and employer-based entities, should provide effective comprehensive tobacco cessation and treatment benefits – including counseling and medication – to all qualifying individuals. Physicians should help their patients quit.**

3. **All states should commit to funding tobacco control efforts at CDC-recommended levels. All states should establish requirements that an appropriate portion of tobacco-generated revenue be directed toward tobacco control efforts. Local governments should be permitted to implement tobacco excise taxes beyond state levels.**

4. **Youth tobacco education and prevention efforts, such as antismoking media campaigns and school-based interventions, must be enhanced and properly funded. Information and interventions related to cigars, pipes, smokeless tobaccos, and other cigarette alternatives should be incorporated into youth antismoking efforts.**

5. **The FDA should implement a ban on menthol flavoring in all tobacco products, as it has done with other flavors in cigarettes.**

6. **State and local governments should take necessary action to establish comprehensive smoke-free laws banning smoking in all nonresidential indoor areas, including workplaces, restaurants, and bars. State and local governments should work to control smoking in residential areas, such as apartment and condominium buildings.**

7. **Comprehensive tobacco control efforts should seek to reduce use of cigars and pipes in addition to cigarettes, particularly among young people and cigarette smokers.**

8. **The FDA should be authorized to regulate electronic cigarettes until convincing evidence develops that they are not addictive.**

9. **Smoking and tobacco use in movies and television should be discouraged, and the media industry should take responsibility to emphasize the dangers of tobacco use, particularly to young people.**

Background

Tobacco use is the leading cause of preventable death and disease in the United States.[4] Each year, cigarette smoking is the cause of over 440,000 deaths, nearly 50,000 of which are attributed to exposure to secondhand smoke.[5] The World Health Organization estimates that one billion people worldwide could die from tobacco-related illness by the end of the 21st century if current rates of tobacco use continue unabated.[6] Each day, nearly 4,000 young people aged 12 to 17 smoke their first cigarette, 25% of whom will become regular smokers.[7] According to the Institute of Medicine (IOM), smoking-related deaths "account for more deaths than AIDS, alcohol, cocaine, heroin, homicide, suicide, motor vehicle crashes, and fires combined."[8] Tobacco use peaked in the mid-1960s when over half of adult men and about 35% of adult women smoked.[9] Over the past 40 years tobacco consumption rates have declined significantly, a trend described as 1 of the 10 greatest public health achievements of the 20th century.[10] The steady decline in smoking, particularly from the mid-1960s to the mid-1990s, can be attributed to a number of events, including public education campaigns highlighting the dangers of smoking, prohibitions on smoking in public places, improvements in the availability and efficacy of smoking cessation aids and pharmaceuticals, limitations on marketing of tobacco products, and

stigmatization of tobacco use.[11] The rate of decline in tobacco use has slowed over the past 20 years and in 2005, tobacco use rates remained about the same as the previous year.[12,13] In 2000, the U.S. Department of Health and Human Services released Healthy People 2010, which provided a framework for tackling public health challenges over the decade. The report established a number of goals aimed at decreasing tobacco use, including cutting cigarette smoking rates in half, to 12% of the adult population, over the decade. In a 2006 report evaluation, the data indicated substantial progress on limiting exposure to environmental tobacco smoke and some progress on reducing adult and adolescent tobacco use rates, increasing smoking cessation participation by adults, and tobacco tax increases among others.[14] However, the report concluded that more needed to be done to reduce the use of tobacco, to increase funding for anti-tobacco information campaigns, and to counter factors that may promote smoking, such as discounted prices for certain tobacco products, increased efforts to market tobacco products to youths, and the depiction of smoking in movies.[15]

Health Consequences of Tobacco Use

While the landmark 1964 U.S. Surgeon General's report raised awareness of the dangers related to smoking by presenting evidence that smoking is a cause of lung cancer, the 2004 Surgeon General's report concluded that smoking affects nearly every organ in the human body. The report found that in addition to lung cancer, smoking is a cause of cancer of the bladder, cervix, esophagus, and kidneys, among others. Further, the report outlined the causal relationship between smoking and stroke, heart disease, various respiratory diseases, fetal death and stillbirths, low birth weight, cataracts, lower bone density, and others.[16] Cigarette smoking remains one of the leading causes of cancer, accounting for 30% of cancer deaths, including 9 out of 10 lung cancer deaths.[17] Tobacco and its smoke contain over 4,000 chemicals, including 60 known carcinogens.[18] The nicotine contained in tobacco is highly addictive and affects the brain in ways similar to that of heroin and cocaine.[19,20] Symptoms associated with nicotine withdrawal include anxiety, weight gain, depression, and irritability.[21] In the 1990s, tobacco industry whistleblowers admitted that nicotine was added to cigarette tobacco to make the user even more dependent on the product.[22]

Despite tobacco industry attempts to market certain cigarettes as safer than others by applying filters, offering "low-tar" or "light" cigarettes, and promoting brands as having lower nicotine yields, among other gimmicks, no cigarette is safe. A monograph of the National Cancer Institute (NCI) determined that cigarettes marketed as "low-tar," "mild," or "light" offer no health advantages over regular cigarettes. Smokers of such products often compensate for the lower nicotine yields by smoking more or adjusting their method of smoking, thereby exposing themselves to similar amounts of nicotine, tar, and other harmful compounds found in products with higher levels of nefarious substances. Despite evidence that machine-measured amounts of tar and nicotine have declined in cigarettes, rates of lung cancer have not decreased as a result of changes in cigarette design.[23] Not surprisingly, the NCI recommends that health professionals not urge patients to switch to lower-yield cigarettes as it may delay or prevent smokers from attempting to quit and may reduce their chances of success in quitting.[24]

Cigarettes are not the only tobacco product associated with negative health consequences. Smokeless tobacco is perceived by some as a safe alternative to cigarettes and is used by some smokers as a smoking cessation aid. Products such as snuff (dry, fine tobacco that is inhaled or moist, fine tobacco pressed between the lip and gums) and plug tobacco (brick-like tobacco also squeezed

between the lip and gum), are related to adverse health effects.[25] Like cigarettes, smokeless tobacco products contain nicotine and are addictive. Additionally, smokeless tobacco products contain a range of carcinogens and have been linked to oral and other cancers as well as precancerous oral lesions. [26,27,28] A 1986 report by the U.S. Surgeon General concluded that smokeless tobacco products pose a significant health risk and that they are not safe alternatives to cigarettes.[29]

Cigars and pipes also pose a health risk, particularly if the smoke is inhaled.[30] Even if the smoker does not inhale, nicotine, carcinogens, and other toxins can be absorbed through the mouth and other parts of the body. Since cigars often contain more tobacco than cigarettes, the smoke of larger cigars may contain the same amount of nicotine as a pack or more of cigarettes.[31] Evidence also suggests that cigar and pipe smoking reduce the user's lung function and increases airflow obstruction compared with those who have never smoked. Long-term pipe and/or cigar use may increase risk for chronic obstructive pulmonary disease.[32] Further, cigar smoke may be more toxic than cigarette smoke.[33]

Tobacco users are not the only individuals exposed to the harmful effects of smoking. Tens of thousands of nonsmoking Americans die each year from illness attributed to secondhand smoke. Exposure to secondhand smoke has been linked to such illnesses as cardiovascular disease, sudden infant death syndrome, and lung cancer.[34] Secondhand and sidestream smoke (smoke from the burning end of a tobacco product) contain over 50 carcinogens.[35,36] According to the IOM, secondhand smoke exposure increases the risk for cardiovascular disease by 25% to 30%.[37] The 2006 Surgeon General's report on the health effects of smoking also concluded that secondhand smoke exposure contributes to premature death among nonsmokers (or involuntary smokers), particularly children.[38] Additionally, the report found that there is no safe level of exposure.

Economic Consequences of Smoking

Smoking also has a harmful effect on the nation's economy and health care system due to such factors as lost worker productivity, increased medical costs, health effects of smoking during pregnancy, and smoking-related fires.[39] The CDC estimates that from 2001-2004, the total economic burden of smoking on the nation's economy was $193 billion a year.[40] Tobacco-attributed work productivity losses total nearly $100 billion annually, and smokers miss 50% more work days than nonsmokers.[41,42] Additionally, treating tobacco-related illness costs the health care system a total of $100 billion a year.[43] The average spending on health care services per person for current and past smokers is 21% higher than for nonsmokers, and the cost of medications for such individuals is 28% to 30% higher.[44] Further, smokers are subject to an additional $15,000 to $17,000 in lifetime health care costs compared with nonsmokers.[45] Medicare spends over $27 billion a year on treatment related to smoking, and federal and state Medicaid contributions for such services total over $30 billion annually.[46]

Brief History of Tobacco Regulation and Control in the United States: 1950s-2000s

Despite the efforts of antitobacco movements in the late 1800s and early part of the twentieth century to curb tobacco use, cigarette use exploded from the 1920s to the 1960s after manufacturing improvements made cigarettes cheaper and simpler to use.[47] Cigarettes were included in rations of American military personnel during the First and Second World Wars, establishing a significant customer base for tobacco companies as soldiers returned to civilian life. The early 20th century saw more women taking up smoking, and tobacco companies responded with extensive marketing campaigns aimed at persuading women to smoke.[48] By the 1950s, any stigma attached to cigarette smoking had largely receded and smoking became a more socially acceptable practice.[49] Tobacco advertising often focused on the supposed health benefits of smoking a particular brand. In the 1930s, Kool brand menthol cigarettes were marketed as being "easier on the throat" than nonmentholated varieties and Lucky Strike cigarettes were promoted to diet-conscious women as a healthy alternative to sweets.[50]

By mid-century, evidence began to accumulate suggesting that smoking posed a health risk; a 1952 *Reader's Digest* article titled "Cancer by the Carton" annunciated findings that smoking caused lung cancer, leading to a temporary drop in overall smoking consumption.[51] Tobacco companies responded to the evidence by offering filter-tipped cigarettes as being safer than nonfiltered cigarettes and establishing the Tobacco Industry Research Council (later known as the Council for Tobacco Research) to provide counterevidence to claims that smoking had a deleterious effect on health.[52,53] Tobacco company marketing efforts were ramped up as well. Advertisements by tobacco company R.J. Reynolds claimed that their Camel brand was preferred by physicians and scientists.[54] The major turning point was the landmark 1964 Surgeon General's report, Smoking and Health: Report of the Advisory Committee to the Surgeon General, which concluded that smoking increased the risk for lung cancer and other diseases. The report had a significant impact of public perception of the health effects of smoking; in 1958, 44% of Americans believed smoking caused cancer. By 1968, that number rose to 78%.[55] The report also helped initiate a wave of regulatory efforts over the next 40 years. Shortly after the release of the Surgeon General's report, the Federal Cigarette Labeling and Advertising Act of 1965 was passed, requiring that cigarette packaging display a label warning of smoking's negative health effects.[56] In the late 60s, the Federal Communications Commission intervened and established the Fairness Doctrine, requiring broadcasters to air one antismoking public service announcement for every three cigarette commercials shown.[57,58] In 1969, Congress passed a law banning all cigarette advertising from television and radio. Tobacco companies acquiesced to the broadcast ban, possibly because the antismoking messages were neutralizing the messages of their cigarette commercials.[59] However, not all antismoking efforts were successful. In the mid-1970s, Congress prohibited the Consumer Product Safety Commission from attaining the authority to regulate and ban tobacco products and in the 1980s Congress blocked efforts to prohibit smoking during some airline travel.[60]

To undermine the fallout after the release of the 1964 Surgeon General's report, the tobacco industry sought to position the issue as one of protecting individual liberty and First Amendment rights. A 1995 report by the Advocacy Institute outlined the tobacco industry's strategy for "ensuring the continued use of tobacco," which included legal, economic, and personal intimidation; alliances with like-minded interests; lobbying and campaign contributions to

sympathetic legislators and political organizations; establishment of front groups, such as the Michigan Citizens for Fair Taxes and the National Smokers Alliance; charitable giving to a variety of organizations; and buying the expertise of outside economists, medical researchers, and others.[61]

As evidence emerged in the 1970s about the harmful effects of secondhand smoke, state and local governments began placing restrictions on smoking in public places. Starting with a 1973 Arizona law limiting smoking in some public places, efforts by regulators, businesses, and legislators at various levels sought to control secondhand smoke exposure, chiefly by separating smokers from nonsmokers or prohibiting smoking altogether.[62] Indoor-air laws addressing smoking in enclosed spaces were facilitated by a growing movement of nonsmoker advocates motivated by growing evidence of the harmful effects of secondhand smoke. A rising grassroots effort by antismoking advocates led to the Great American Smokeout and more aggressive efforts by established health advocates, such as the American Lung Association, to educate the public about the harmful effects of smoking to smokers and nonsmokers alike.[63,64] The 1980s saw a number of other landmark changes. In 1982, the federal excise tax on cigarettes was doubled, and in 1986, Surgeon General C. Everett Koop released a report concluding that secondhand smoke posed a serious public health threat, further buttressing the antismoking movement's arguments.[65] By 1983, yearly per capita consumption of cigarettes had declined 20% from the 1963 level.[66]

In 1992, Congress enacted the Synar amendment that sought to reduce the sale of tobacco to young people. In 1996, the FDA began regulating the sale of tobacco products to young people and established monetary fines on merchants who sold tobacco products to minors; however, the U.S. Supreme Court later ruled that the agency did not have such authority and the program was eliminated.[67] A major victory for antismoking interests occurred in 1998, when 46 state attorneys general settled lawsuits with tobacco companies over smoking-related Medicaid expenditures.[68] The Master Settlement Agreement required tobacco companies to pay states $206 billion over 25 years.[69] Around the same time, the U.S. Department of Justice sued the tobacco industry under the Racketeer Influenced and Corrupt Organizations Act for a record $280 billion, arguing that the industry had purposely misled the public about the dangers of smoking.[70]

Nearly a decade after the Supreme Court ruled that the FDA did not have the authority to regulate tobacco, President Obama signed into law the Family Smoking Prevention and Tobacco Control Act (FSPTCA). On June 22, 2009, the FDA was finally granted the authority to regulate tobacco products. Once fully implemented, the legislation will prohibit cigarettes from containing candy, fruit, and other flavors; require tobacco companies to submit information on ingredients and additives found in tobacco products; reissue the FDA's 1996 regulation on curbing youth tobacco use; prevent tobacco manufacturers from labeling or advertising their products as "low," "mild," or "light," unless allowed by the FDA; and strengthen warning labels on cigarettes and smokeless tobacco products.[71] The legislation does not, however, grant the FDA the authority to ban tobacco products outright because the agency feared that the health care system would be overwhelmed by 40 million smokers seeking treatment for nicotine withdrawal.[72] Despite some concerns that the legislation will face numerous legal challenges and may provide a legal shield for tobacco companies, the Congressional Budget Office predicts that the legislation will reduce youth smoking by 11% over the next decade.[73]

It took decades of scientific research, regulation, legislative intervention, grassroots activity, and litigation to reach the conclusion that, as stated by Judge

Gladys Kessler, "(o)ver the course of more than 50 years, [tobacco industry] defendants lied, misrepresented, deceived the American public…suppressed research, destroyed documents, and manipulated the use of nicotine."[74] Despite changing public perception and attitudes toward smoking and tobacco use, more needs to be done to ensure that future generations do not replace those who have suffered and died because of tobacco addiction.

Recommendations

1. **All states, with assistance from the federal government, should establish and adequately fund comprehensive tobacco control efforts to prevent smoking and other tobacco product use among young people; provide objective information about the dangers of cigarette, cigar, pipe, smokeless, and other tobacco products; minimize exposure to secondhand smoke; and help tobacco users quit.**

In 2007, the IOM released the report Ending the Tobacco Problem: A Blueprint for the Nation, which outlined a comprehensive framework for reducing tobacco use. Among the recommendations, the IOM urged stakeholders to adjust tobacco excise taxes, restrict youth access to tobacco with proper enforcement, strengthen prevention efforts directed toward young people, establish smoking restrictions, improve and fund smoking cessation programs, and authorize the FDA to regulate tobacco.[75] With passage of the FSPTCA, the federal government was authorized to regulate tobacco products, as recommended by the IOM and other public health advocates. Additionally, federal tobacco excise taxes were raised to offset the cost of expanding the Children's Health Insurance Program in 2009.[76]

State efforts to discourage tobacco use, however, vary significantly. Those states that have established and maintained comprehensive tobacco control efforts often see significant reductions in the rates of tobacco use and related disease. California pioneered the multipronged approach by raising tobacco excise taxes in the late 1980s and devoting a significant portion of the revenue to reducing tobacco use. The state partnered with philanthropic organizations, community groups, and others to establish the California Tobacco Control Program (CTCP). The program focused efforts on public information campaigns, cessation, changing "social norms among adults," and other initiatives.[77,78] Funding for CTCP fluctuated throughout the 1990s and 2000s, and by 2002 the state ranked 20th in tobacco-control program spending.[79] Evidence suggests that the CTCP has been very successful. One study concluded that between 1989 and 2004, personal health expenditure savings totaled $86 billion.[80] California's initiative may have also had a positive effect on cancer rates in the state. The CDC determined that from 1988, when CTCP was established, to 1999, age-adjusted lung cancer rates in the state declined considerably compared with a number of other states and metropolitan areas reviewed by the agency.[81]

Substantial funding is required to implement and maintain tobacco-control efforts. Evidence shows that smoking rates correlate with comprehensive tobacco control program funding – as program resources dwindle, smoking rates increase.[82] There is consensus on what needs to be done to reduce smoking and tobacco use in the United States, but these measures take resources and sustained interest for proper implementation. If done correctly, the IOM estimates that comprehensive tobacco control efforts could reduce current adult smoking rates in half by 2025.[83]

2. Public and private insurers, as well as state, community, and employer-based entities, should provide all effective comprehensive tobacco cessation and treatment benefits – including counseling and medication – to all qualifying individuals. Physicians should help their patients quit.

Nicotine is highly addictive. If cigarettes were introduced into the marketplace today, according to the IOM they would qualify as a Schedule 1 drug under the Controlled Substances Act, alongside illicit drugs like heroin and LSD, because of their potential for abuse and lack of medical benefit.[84] Despite the addictive nature of nicotine, a 2008 CDC survey reported that of the 94 million people who had smoked at least 100 cigarettes in their lifetime, 51% had quit at the time of the interview.[85]

Smoking cessation programs are essential to reducing smoking-related preventable death. While an in-depth review of smoking cessation methods are outside the scope of this paper, typical effective treatments include a combination of counseling and FDA-approved medications, such as nicotine replacement gums, nasal sprays, and patches, as well as prescriptions that assist in cessation.[86,87] Without the help of smoking cessation programs, quit rates are very low – only about 4% to7% of smokers are able to quit without medication or other assistance; when smoking cessation medications are used, 25% to 33% of smokers are able to quit for at least 6 months.[88] According to the Surgeon General's 1988 report on nicotine addiction, "Tobacco use is a disorder which can be remedied through medical attention; therefore, it should be approached by physicians and other health care professionals just as other substance-use disorders are approached: with knowledge, understanding, and persistence."[89]

Physicians and other health care professionals play a crucial role in helping smokers quit, but not all smokers receive such guidance from their doctors. In the mid-1990s, about 48% of smokers were told to quit smoking by their physician or health provider; by the mid-2000s, reported advice rates increased to 61%.[90] However, only about 28% of smokers received smoking cessation assistance in the form of medications or other methods from their health care provider. If 90% of smokers received advice and assistance to quit smoking, 42,000 lives could be saved each year.[91] In 2000, the federal government recommended that physicians and other health care professionals use "the five A's" when treating nicotine-addicted patients, recommending that physicians *ask* patients of their smoking habits, *advise* them to quit, *assess* patient's willingness to quit, assist the patient in their attempts to quit, and *arrange* for follow-up contact.[92]

States and community efforts play an important role in tobacco control programs. Maine's Tobacco Treatment Initiative supports smokers trying to quit by providing telephone counseling services ("Helpline"), vouchers for nicotine replacement products, and training for health professions in effective tobacco cessation treatments. The Helpline services have proved successful, as 21% of smokers who had received assistance from the Helpline remained tobacco-free for 6 months.[93] New York City successfully implemented a comprehensive tobacco control effort that included physician outreach and education, cessation clinics, and wide distribution of nicotine-replacement aides, leading to a marked decrease in smoking rates.[94] Preliminary evidence shows that Massachusetts' Tobacco Cessation and Prevention Program has dramatically lowered smoking rates among Medicaid beneficiaries by making antismoking medications available at very low cost.[95] Employers can also play a role in assisting employees' attempts to quit using tobacco. Smoking cessation programs improve employee

health and result in short-term costs savings for the employer due to reduced medical and life insurance costs.[96] Novartis Pharmaceuticals implemented a tobacco cessation program, partnering with a pharmacy benefit manager and a number of telephone-based counseling services to help employees quit using tobacco. The program helped initiate a change in corporate culture that promoted healthy living rather than reactive health care.[97]

Public and private insurance should also improve access to tobacco cessation treatments. Medicare currently covers smoking cessation, including counseling and medication therapy, but the benefit is limited only to beneficiaries with a condition or medication regimen adversely affected by smoking or tobacco use.[98] Smoking cessation is especially important for the Medicaid population, since the smoking rate among Medicaid beneficiaries and other low-income people is significantly higher than that of the general population.[99] Medicaid coverage of smoking cessation treatments varies throughout the nation. Eighty-four percent of Medicaid programs offer some form of smoking cessation coverage, but only six programs offer comprehensive treatment that includes all effective counseling and medication services.[100] Further, the level of coverage may depend on the type of Medicaid coverage (fee-for-service versus managed care) and may only be available to pregnant women.

Providing smoking cessation services is cost-effective. The Congressional Budget Office has stated that the federal government would generate cost savings if Medicaid provided coverage of smoking cessation services to eligible pregnant woman.[101] In March 2010, President Obama signed into law the Patient Protection and Affordable Care Act, which would require Medicaid programs to offer smoking cessation services to eligible pregnant women.

Tobacco cessation coverage varies in the private insurance market as well. Seven states have a law or mandate requiring that private insurers cover smoking cessation services, but the level of coverage varies and may only apply to certain insurance markets.[102] National surveys report that coverage of smoking cessation services is highest among employer-based HMOs, but only 20% of employer-provided plans offer such coverage.[103]

Effective, comprehensive tobacco cessation programs that include counseling and medication therapies have been shown to be significantly effective in reducing tobacco-related disease and death. It is imperative that insurers cover comprehensive cessation services as recommended by the U.S. Public Health Service.[104]

3. All states should commit to funding tobacco control efforts at CDC-recommended levels. All states should establish requirements that an appropriate portion of tobacco-generated revenue be directed toward tobacco control efforts. Local governments should be permitted to implement tobacco excise taxes beyond state levels.

While tobacco products are taxed in a number of ways at the federal, state, and local level, the excise tax and the general sales tax are the most significant.[105] In April 2009, the largest increase in the federal cigarette excise tax went into effect, bringing the total (combined with average state excise tax) to $2.21 per pack.[106] The tax increase fulfills the CDC's Healthy People 2010 recommendation that average combined federal and state cigarette excise taxes be a minimum of $2.00 per pack.

The benefits of increased tobacco excise taxes are two-fold. Not only do tobacco excise taxes raise revenue, they also reduce smoking rates as price-sensitive smokers respond by limiting or quitting smoking. The effect is more

profound among adolescents; for every 10% increase in the price of cigarettes, 7% fewer teenagers will smoke.[107] Excise taxes have been shown to reduce smoking rates, but they are most effective as part of a comprehensive effort to eliminate tobacco use.[108] In the early 1990s, Massachusetts raised the state excise tax on tobacco and initiated an antismoking campaign leading to a significant reduction in smoking rates. The tobacco industry responded to the tax hikes in Massachusetts and other states by deeply discounting their products.[109] Despite the industry-initiated price reductions, the CDC estimates that Massachusetts' excise tax increase helped lower per capita smoking rates because it was part of a comprehensive antismoking campaign.[110] Tobacco excise taxes are traditionally considered to be regressive, since most smokers are low-income and yield more of their income in tobacco-related taxes than higher-income individuals.[111] Thus, it is crucial that comprehensive tobacco control efforts be directed toward low-socioeconomic-status individuals to mitigate any undue burden.

State excise taxes vary widely throughout the country. The per-pack tax on cigarettes is lowest in South Carolina at 7 cents and highest in New York at $2.75.[112] Given the wealth of evidence that shows smoking rates are reduced as excise taxes are raised, especially when they are part of a comprehensive antismoking campaign, it is imperative that states increase tobacco excise taxes to combat smoking and fund tobacco control efforts. At a minimum, all states should maintain tobacco excise taxes at a combined federal and state rate of $2.

The CDC has issued recommendations on funding levels for state tobacco control efforts, proposing that each state spend $15 to $20 per capita on such initiatives, depending on the state's demographics, smoking prevalence, and other factors.[113] In addition to excise tax revenue, a portion of funds from the Master Settlement Agreement (MSA) should be directed to antismoking programs. States are not required to allocate MSA funds to tobacco control efforts, and many have used the money to fund activities unrelated to tobacco initiatives or health improvement.[114] To ensure that an appropriate level of funding is used for antismoking efforts, some states have passed ballot initiatives designating that a portion of MSA funds be used on tobacco prevention and control. Arkansas, for instance, passed a ballot initiative in 2000 requiring that just over 31% of MSA settlement funds be devoted to CDC-recommended tobacco-control activities.[115] Although states received $203 billion in tobacco-generated revenue (including excise tax revenue and funds from the Master Settlement Agreement) from 2000-2009, only 3% of these funds were directed toward comprehensive tobacco control efforts.[116] CDC-recommended funding levels would be met if 15% of funds from tobacco-generated revenues were devoted to tobacco prevention and control programs across all states.[117] In 2009, only North Dakota funded its tobacco control programs at the level recommended by the CDC, the result of a ballot initiative that required an allocation for such activities.[118]

4. Youth tobacco education and prevention efforts, such as antismoking media campaigns and school-based interventions, must be enhanced and properly funded. Information and interventions related to cigars, pipes, smokeless tobaccos, and other cigarette alternatives should be incorporated into youth antismoking efforts.

The vast majority of smokers and tobacco users start as adolescents. In 1995, FDA Commissioner David Kessler labeled tobacco use and addiction a "pediatric disease."[119] Every day, 4,000 young people aged 12 to 17 smoke their first cigarette and 14% of youths have smoked a whole cigarette before the age of 13.[120,121] According to a survey conducted by the CDC, 20% of high school

students surveyed had smoked a cigarette on at least 1 day in the 30 days prior to the survey.[122] The same survey found that 8% of high school students had used smokeless tobacco at least 1 day in the 30 days prior to the survey.[123] The earlier people start smoking, the more likely they will become heavy smokers and develop a long-term addiction to nicotine.[124] Among adolescents who currently smoke, about half have tried to quit.[125] Smoking can hinder physical development in adolescents. Active cigarette smoking during adolescence reduces lung growth and function and facilitates the development of risk factors related to heart disease.[126] Peer pressure, potential for stress relief, facilitation of social interaction, positive perceptions of smoking, and inability to appreciate the risks of tobacco use are among the factors that contribute to smoking initiation and regular use among adolescents.[127,128,129]

These social and behavioral factors that contribute to tobacco initiation and use have long been exploited and manipulated by the tobacco industry. Despite the fact that tobacco sales are prohibited to anyone under age 18, evidence exists that the tobacco industry deliberately markets to young people to ensure that new customers replace those who die or quit. Such nefarious activity became apparent as thousands of pages of internal tobacco industry documents were made public as a result of litigation against tobacco companies. One such document stated, "(t)he fragile, developing self-image of the young person needs all of the support and enhancement it can get. Smoking may appear to enhance that self-image in a variety of ways. This self-image enhancement effect has traditionally been a strong promotional theme for cigarette brands."[130] One of the more notorious examples of tobacco industry attempts to capture the youth market was R.J. Reynolds' use of marketing cartoon mascot Joe Camel in the mid-1980s, as a cosmopolitan, urban-dwelling camel. Joe Camel became ubiquitous, appearing in print advertisements and promotions that may have been ostensibly directed toward adults but strongly appealed to young people. The onslaught proved effective: A 1991 study found that 91% of 6-year old children surveyed were able to associate Joe Camel with cigarettes and 30% of 3-year olds were able to make the same association.[131] Despite efforts to limit tobacco advertising over the past 40 years, tobacco industry marketing and promotion continues to profoundly influence young people and is among the factors that contribute to youth smoking initiation and use.[132] Further, the most-advertised cigarette brands (Marlboro, Newport, and Camel) are favored by 81% of young smokers aged 12 to 17.[133]

When implemented, the FSPTCA would prohibit youth-oriented marketing activities by barring tobacco companies from sponsoring or displaying brand names or logos at sporting and entertainment events, prevent offers of tobacco-related promotional items such as clothing, and prohibit distribution of free cigarette samples (although smokeless tobacco samples can be distributed at adult-only facilities).[134] Further, the bill would restrict billboards and other outdoor advertising from being displayed close to schools or playgrounds; limit advertising in publications with high levels of youth readership to a black and white, text-only format; and restrict advertising presented in audio and video formats.[135] Marketing expenditures of the top 5 tobacco companies have increased by nearly $6 billion since the Master Settlement Agreement.[136] In Tennessee, for instance, the ratio of tobacco industry marketing expenditures compared with state tobacco prevention spending is 274 to 1.[137] States and other stakeholders must invest more funds into youth smoking prevention and reduction to help counter tobacco industry messaging. Studies show that proper investment and implementation can reduce the adolescent smoking rate as well as the number of cigarettes smoked.[138,139] Florida's youth tobacco prevention pro-

gram, a unique mix of youth-oriented media campaigns, school-based interventions, and wide distribution of antismoking information, has been shown to reduce smoking rates and perception of tobacco use among targeted youths.[140] As suggested by the CDC, youth prevention efforts must be comprehensive and encourage prevention and/or cessation, incorporate mass media education campaigns, school-based interventions, and community engagement.[141] Further, the IOM recommends that medical societies, including ACP, encourage members to urge parents to keep a smoke-free home, educate their children about the dangers of smoking, impart that their children should not smoke, and monitor their children's tobacco use.[142]

5. The FDA should implement a ban on menthol as a flavoring in all tobacco products, as it has done with other flavors in cigarettes.

The FSPTCA prohibits use of candy, fruit, and other flavors in cigarettes. Despite urging from legislators and public health advocates, the legislation does not ban the use of menthol as a flavoring in cigarettes and other tobacco products.[143] The FDA is authorized to study the effects of mentholated tobacco products on children, African Americans, and other minority groups and to use its authority to ban or limit menthol.[144] Menthol cigarettes account for 25% of the domestic cigarette market, and Newport, a mentholated cigarette brand, is one of the highest-selling cigarette brands.[145,146] Menthol cigarettes are particularly popular with African-American smokers; 80% of African Americans prefer menthol cigarettes compared with one quarter of white smokers.[147] Young smokers also prefer menthol cigarettes at significantly higher rates than adult smokers.[148] In 2008, the rate of young smokers aged 12-17 who reported using menthol cigarettes increased to 48% from 44% in 2004.[149] Internal tobacco industry documents provide evidence that the industry has long manipulated menthol levels to make these cigarettes more attractive to young smokers.[150] Newport, one of the most preferred brands among young and adolescent smokers, has the lowest level of menthol compared with other popular menthol brands, such as Kool and Salem, providing evidence that younger smokers prefer milder cigarettes with lower levels of menthol.[151] Although total sales of cigarettes declined between 2000 and 2005, sales of menthol cigarettes remained stable.[152]

There is evidence that menthol cigarettes are particularly harmful. Studies show that menthol cigarettes may be more addictive than nonmentholated varieties because they mask the harshness of cigarette smoke, making it easier to inhale more nicotine and more difficult to quit.[153,154] Further, higher levels of cotinine (the primary proximate metabolite of nicotine) have been found in African Americans who smoke menthol cigarettes.[155] Such smokers often have more brief periods of quitting than those who smoke nonmentholated cigarettes.[156] Menthol cigarettes often have higher levels of nicotine and tar than other varieties. African-American smokers have higher rates of lung cancer than whites, despite smoking fewer cigarettes and initiating smoking later in life, a disparity potentially correlated to higher rates of menthol cigarette use.[157] However, some evidence shows that the causal relationship between menthol cigarette use and higher rates of tobacco-related disease is inconclusive.[158] Despite the tobacco industry's message to the contrary, menthol cigarettes are not healthier than regular cigarettes.

The tobacco industry has deliberately and aggressively targeted the African-American community and other minority groups. Between 1998 and 2002, *Ebony* magazine, an African-American–interest publication, was almost 10 times

more likely than *People* magazine to contain advertisements for menthol cigarettes.[159] R.J. Reynolds even prepared to release an African-American–focused cigarette brand called Uptown, which contained nearly as much nicotine as unfiltered Camels, but withdrew the project after protests from public interest groups.[160,161]

While the link between menthol cigarettes and higher rates of tobacco-related disease may be unclear and warrants further research, evidence suggests that menthol cigarettes are more addictive and make it more difficult to quit than other varieties. Prior to passage of the FSPTCA, a bipartisan group of anti-smoking advocates, including seven former U.S. HHS/HEW Secretaries, sent a letter to congressional legislators stating that, "by failing to ban menthol, the bill caves to the financial interests of tobacco companies and discriminates against African Americans—the segment of our population at greatest risk for the killing and crippling smoking-related diseases…(m)enthol should be banned so that it no longer serves as a product the tobacco companies can use to lure African American children."[162] Given their appeal to minority groups and young smokers – probably the result of decades of aggressive marketing campaigns by the tobacco industry – ACP supports efforts to ban menthol in cigarettes and other tobacco products.

6. State and local governments should take necessary action to establish comprehensive smoke-free laws banning smoking in all non-residential indoor areas, including workplaces, restaurants, and bars. State and local governments should work to control smoking in residential areas, such as apartment and condominium buildings.

As the harm of secondhand smoke exposure has become more evident, a number of jurisdictions have established bans on smoking in workplaces, restaurants, and/or bars. As of January 2010, 19 states, as well as Puerto Rico and the District of Columbia, had in effect laws banning smoking in workplaces, restaurants, and bars, and many more have restricted smoking in one or more of these places.[163] Seventy-four percent of the U.S. population is covered by some form of smoke-free provision.[164]

The Surgeon General has stated that there is no risk-free level of exposure to secondhand smoke.[165] Eliminating secondhand smoke exposure indoors is the only way to protect nonsmokers from the harm associated with involuntary smoking. Merely separating smokers and nonsmokers in an open indoor area does not eliminate exposure risk.[166] Ample evidence shows immense benefits to establishing smoke-free laws and ordinances. From 1988 to 2002, for instance, nonsmoker exposure levels to serum cotinine have been greatly reduced among most populations, the likely result of restrictions on indoor smoking.[167]

The benefits of laws that ban smoking become apparent shortly after implementation. One study found that secondhand smoke exposure and tobacco use among Finnish workers declined 1 year after implementation of a nationwide ban on workplace smoking and that legislative restrictions were far more effective than voluntary workplace smoking bans.[168] Smoke-free bans have a particularly significant benefit for those who are exposed to high levels of secondhand smoke. A study of San Francisco bartenders found that symptoms of respiratory and sensory irritation declined substantially after smoke-free workplace bans were in effect.[169] In March 2006, Scotland enacted a ban on smoking in enclosed public places, including bars. Prior to the ban, 79% of bar workers reported experiencing respiratory or sensory irritation; 2 months after the ban, only about 47% reported any such symptoms.[170] Further, an IOM report on second-

hand smoke and cardiovascular disease found that smoking bans lead to a decrease in heart attacks.[171] Smoke-free policies benefit smoking cessation efforts since smoking bans at home and the workplace may motivate more smokers to attempt to quit and stay smoke-free for at least 6 months.[172] Despite claims that smoking bans would be detrimental to restaurant and bar revenue, evidence shows that such laws have had neither positive nor negative effects.[173] Further, attempts to mitigate secondhand smoke exposure by installing ventilation systems have proven to be ineffective in eliminating secondhand smoke risk.[174]

ACP supports efforts to ban smoking in workplaces, restaurants, bars, and other public areas. Such smoke-free policies have been shown to greatly reduce harmful secondhand smoke exposure, exposure-related disease rates, reinforce smokers' attempts to quit, and solidify nonsmoking as a social norm.[175] However, efforts also must be made to encourage smoke-free policies in residential areas, such as multiunit apartment buildings. Residents of apartment buildings, for instance, are exposed to secondhand smoke in common areas and through ventilation systems. Children are most likely to be exposed to secondhand smoke in the home and one quarter of children aged 3-11 live with at least one smoker.[176] Smoke-free policies have been slow to reach residential areas, but some localities have enacted smoking restrictions on multiunit apartment buildings. In 2007, Temecula, California, adopted a law requiring landlords of larger apartment buildings to designate a percentage of units as smoke-free.[177] Additionally, at least 165 local public housing authorities have established restrictions on resident smoking.[178] Landlords and residential associations should be encouraged to designate smoke-free apartment units and common areas, and smoking-related rules should be included in leases and housing agreements.[179] Antismoking advocates have facilitated the process of matching smoke-free housing with potential tenants. In Maine, potential tenants can access a Web-based registry listing smoke-free dwellings.[180] Physicians should remind patients of the harm caused by secondhand smoke and maintain that patients should stop smoking at home and in other enclosed areas as part of their comprehensive smoking cessation effort.

7. Comprehensive tobacco control efforts should seek to reduce use of cigars and pipes in addition to cigarettes, particularly among young people and cigarette smokers.

The College supports the Surgeon General's emphatic message that there is no safe tobacco product and advocates for initiatives to reduce the use of cigarettes, smokeless tobacco, cigars, and other tobacco products. Comprehensive tobacco control efforts should devote attention to reducing use of cigarettes, cigars, pipes, and smokeless tobacco products given their deleterious effects on health. This is of particular concern because some cigarette users, faced with increasing cigarette costs and health concerns, may switch to other tobacco products because of their lower price and misconception that they are a healthy alternative to cigarettes.[181,182] A study of smokers in four countries, including the United States, found that 25% believed that pipes, cigars, or roll-your-own cigarettes were safer than factory-manufactured cigarettes.[183] Such beliefs are particularly dangerous for cigarette smokers who switch to cigars or pipes, as they typically continue to inhale the smoke of the alternate product, exposing themselves to elevated levels of toxins and carcinogens.[184]

An increasing number of young people are smoking cigars.[185] A focus group conducted by the HHS Office of Inspector General found that young people

believed cigars to be more socially acceptable and easier to purchase than cigarettes.[186] A survey of African-American college students found that users preferred small cigars because of their pleasant taste and smell, positive image, and potential for stress relief, among other reasons.[187] Small cigars are a growing segment of the tobacco market: From 1998 to 2006, large cigar consumption increased 45% while consumption of small cigars increased 154%.[188] Flavored small cigars are also growing in popularity. Although the FSPTCA bans the sale of flavored cigarettes and loose tobacco intended for roll-your-own cigarettes, it does not prohibit the sale of flavored cigars or smokeless or pipe tobacco. The FDA, however, is permitted to study and regulate the products as necessary.[189] Given flavored tobacco's strong appeal to youth, all types of flavored tobaccos should be prohibited. Currently, Maine is the only state that prohibits sale of flavored tobaccos.[190]

It is important to deploy public education campaigns that strongly insist that no form of tobacco is risk-free. Public information campaigns may be part of the reason fewer smokers in the United States (compared with those in three other countries surveyed) believe that alternative tobacco products are less harmful than cigarettes.[191] Additionally, excise taxes on cigars and other tobacco products should be raised to a level that discourages price-sensitive cigarette smokers from substituting cheaper alternative tobacco products and keeps young people from using.[192]

In 2003, U.S. Surgeon General Richard Carmona stated that, "Smokers who have taken the courageous step of trying to quit should *not* trade one carcinogenic product for another, but instead could use Food and Drug Administration-approved methods such as nicotine gum, nicotine patches, or counseling."[193] To counter the growing popularity of cigarette alternatives, such as flavored small cigars, stakeholders should apply effective comprehensive tobacco control methods used to confront cigarette smoking to all tobacco products.

8. The FDA should be authorized to regulate electronic cigarettes until convincing evidence develops that they are not addictive.

Recently, a number of companies have marketed tobacco-free electronic cigarettes, also known as e-cigarettes, which typically resemble a regular cigarette, cigar, or pipe. The user inhales and activates a heating mechanism within the device that vaporizes the synthetic liquid nicotine and creates water vapor that looks like tobacco smoke when exhaled.[194] Although users of such products are not exposed to the types of carcinogens found in tobacco and its smoke, FDA chemical analysis suggests that e-cigarettes contain a number of carcinogens and that one product tested by the agency contained ethylene glycol, a toxic chemical.[195] E-cigarettes are often marketed as an "alternative" to traditional tobacco products, although industry representatives maintain that they are not marketed as a safe alternative to smoking cigarettes or other products.[196] However, the FDA has raised concern that e-cigarettes are being used by smokers as a smoking cessation aid and should be regulated by the agency as a drug-delivery device. Further, since the products are available without age restrictions, public health officials are concerned that e-cigarettes could readily be acquired by young people.[197] In January 2010, a U.S. District Court judge ruled that e-cigarettes could not be regulated as a drug-delivery device because they are the functional equivalent of a traditional tobacco product; the FDA has appealed the decision.[198,199]

E-cigarettes often contain nicotine, a highly addictive drug. Additionally, the FDA has found evidence that some e-cigarettes contain carcinogens and

toxic chemicals found in antifreeze. Such products are unregulated and are not subject to the stringent age and marketing restrictions that limit promotion and sale to young people. Thomas P. Houston, MD, chair of the American Academy of Family Physicians' tobacco cessation advisory committee has stated, "These devices may not be marketed for cessation, but anecdotally, that's what the public is using them for. We still don't know the quality control, so somebody needs to be able to set standards for safety for whatever ingredients might be added and to understand what these do for the smoker in the short and the long term. Someone has to be accountable."[200] ACP believes that since e-cigarettes deliver nicotine and may contain a host of dangerous carcinogens and chemicals, they should be aggressively reviewed and regulated by the FDA.

9. Smoking and tobacco use in movies and television should be discouraged, and the media industry should take responsibility to emphasize the dangers of tobacco use, particularly to young people.

A number of studies have concluded that depicting smoking in movies and television may influence young people to start smoking.[201] Despite decreases since the 1990s, youth exposure to smoking in the media remains a problem, and films targeted toward the youth market – those rated G, PG, or PG-13 – often depict smoking.[202] Evidence shows that reducing smoking in movies may be correlated to a reduction in teen smoking rates.[203] In an effort to curb exposure to smoking images in film, some antismoking advocates, notably the AMA and World Health Organization, have recommended that films depicting smoking be rated R, restricting viewing to older people.[204,205] Other advocates have called for a prohibition on tobacco product placement in films and have suggested that strong antitobacco advertisements be shown prior to films that depict smoking.[206] The College reaffirms its position that glamorizing smoking on television and in movies influences young persons to smoke, and this tends to reverse the trend of declining tobacco use. ACP, therefore, discourages this practice and encourages efforts to effect a more responsible attitude from the media and to emphasize the importance of education on the hazards of smoking.

Conclusion

The immense progress in reducing tobacco use has justifiably been called one of the great public health achievements of the 20th century. While smoking and tobacco use rates have declined considerably over the past 40 years, a comprehensive tobacco control and prevention effort must be undertaken and consistently maintained to ensure that a new generation of smokers does not replace those who have quit or died because of their addiction. A combination of higher excise taxes on tobacco products, better coverage and funding of smoking/tobacco cessation services, improved youth prevention efforts, prohibition on tobacco additives such as menthol, stronger restrictions on public smoking, and steady funding of comprehensive tobacco control efforts will lead to a reduction in smoking rates. There is consensus on what needs to be done to reduce the tobacco problem, but stakeholders must work to ensure that comprehensive tobacco control efforts receive the attention they need to succeed.

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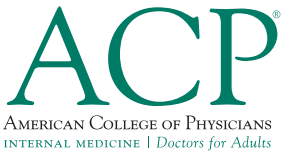

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