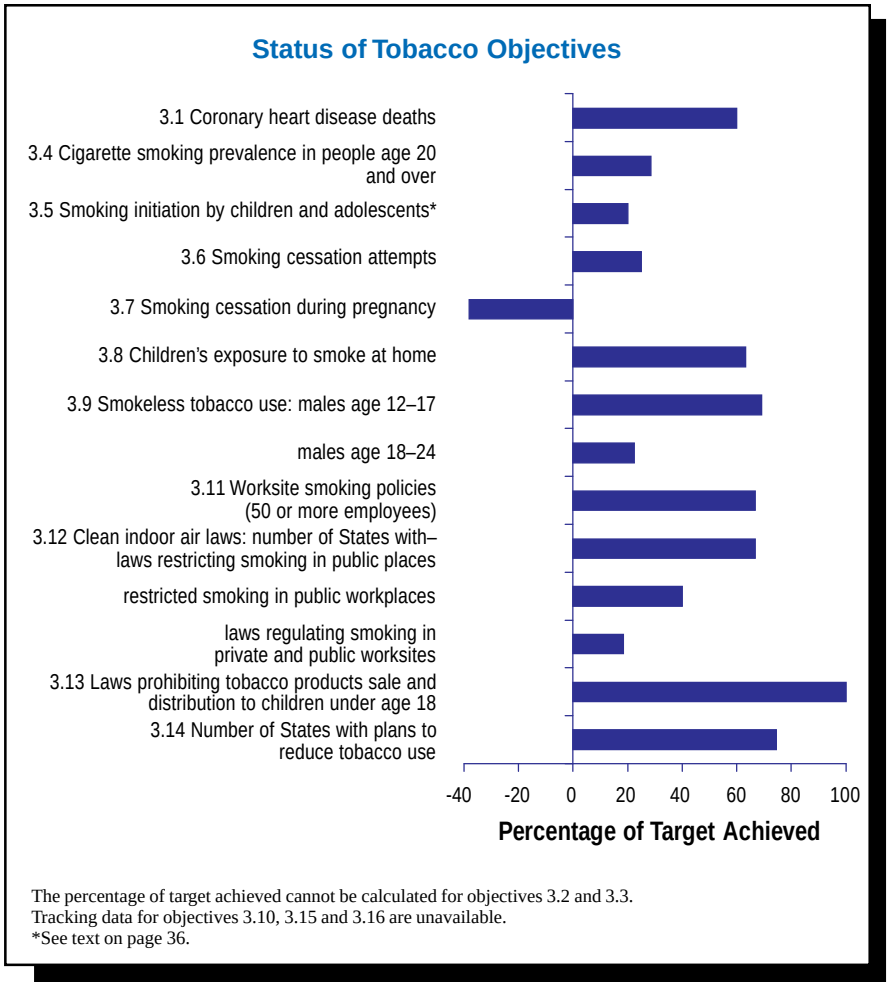
3 Tobacco



The percentage of target achieved cannot be calculated for objectives 3.2 and 3.3.
Tracking data for objectives 3.10, 3.15 and 3.16 are unavailable.
*See text on page 36.

Lead Agency: ***Centers for Disease Control and Prevention***

TOBACCO

Use of tobacco products is the leading preventable cause of death in the United States, accounting for more than 400,000 deaths each year or about one out of every five deaths.[1] Smoking substantially increases the risk of cardiovascular disease, accounts for about 30 percent of all cancer deaths,[2] is the leading cause of chronic lung disease, and contributes significantly to low birthweight. Furthermore, exposure to environmental tobacco smoke (ETS) is responsible for approximately 3,000 lung cancer deaths per year among nonsmokers.[3]

The overwhelming evidence of the addictive nature of nicotine necessitates a continued commitment to preventing tobacco use among young people through enforcement of youth access laws, effective prevention education programs in the schools and community, and media campaigns targeted at youth. With the passage of the Pro-Children Act of 1994 as part of the GOALS 2000: Educate America Act, federally funded facilities providing children's services, including schools and libraries, must be smokefree.

The HEALTHY PEOPLE 2000 objectives, as updated by this midcourse review, cover the majority of the six core components of tobacco control: preventing tobacco use, treating nicotine addiction, protecting nonsmokers from ETS exposure, limiting the effect of tobacco advertising and promotion on young people, increasing the price of tobacco products, and regulating tobacco products. The combined efforts of the Federal Government, the States, and the private sector will help continue progress toward meeting the HEALTHY PEOPLE 2000 objectives.

Review of Progress

An August 1994 progress review with the Assistant Secretary for Health examined the comprehensive public health strategy to reduce tobacco use (the previous progress review took place April 1992). The 1993 data indicate that adult cigarette smoking prevalence has dropped to 25 percent. For certain population groups, particularly American Indians/Alaska Natives, blue-collar workers, and military personnel, the rates of smoking prevalence are considerably higher than those for the population as a whole. Limited progress has been made in reducing the proportion of people aged 20–24 who have begun to smoke cigarettes, a proxy measure of youth initiation. The rate dropped from 30 percent in 1987 to 27 percent in 1993. Among lower socioeconomic status youth the proportion declined from 40 percent in 1987 to 38 percent in 1993. Another survey, the 1994 Monitoring the Future Survey, indicated that there has been no decline in smoking prevalence among high school seniors over the last decade and an increase in smoking prevalence since 1991. The percentage of adult cigarette smokers who stopped smoking for at least 1 day during the preceding year increased from 34 percent in 1986 to 38 percent in 1993. However, among female cigarette smokers, the percentage who quit during pregnancy is moving away from the year 2000 target of 60 percent; in 1985, 39 percent quit, compared with 31 percent in 1991. Among women with less than a high school

education, 28 percent quit in 1985, compared with 21 percent in 1991. For males aged 12–17, smokeless tobacco use has declined from 6.6 percent in 1988 to 3.9 percent in 1993. Among males aged 18–24, a decrease from 8.9 percent in 1987 to 7.8 percent in 1993 has occurred. For American Indian/Alaska Native males, the comparability and small sample size of the data on smokeless tobacco makes identifying trends difficult.

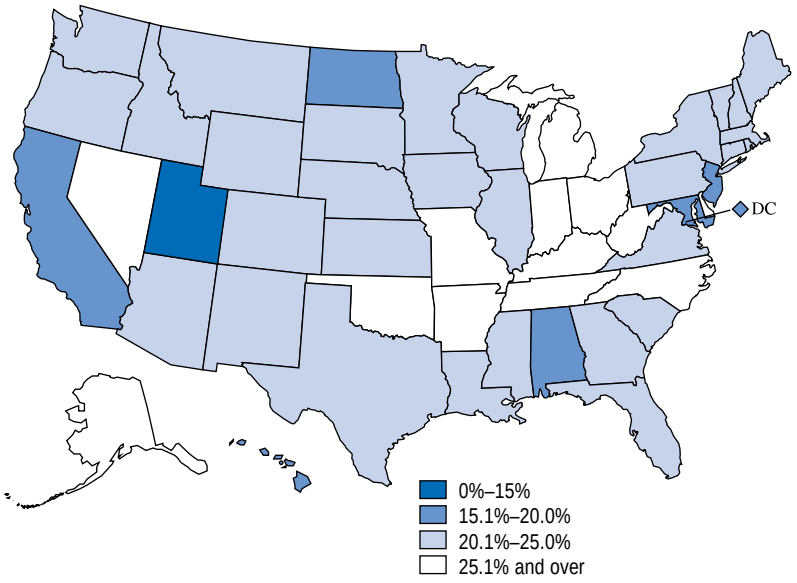
The number of children aged 6 and younger who are regularly exposed to tobacco smoke at home declined from 39 percent in 1986 to 27 percent in 1993. The Pro-Children Act of 1994, requiring federally funded schools to be smokefree, promotes the elimination of children's exposure to tobacco smoke in schools. In 1994 the District of Columbia and 41 States had plans to reduce tobacco use, particularly among young people.

Data for tracking objective 3.15 regarding tobacco product advertising targeted to youth are unavailable. However, continued attention must be paid to the effects of tobacco advertising and promotions on youth, particularly due to the recent finding that youth are more likely than adults to smoke the most advertised cigarette brands.[4]

A 1992 survey of employers with 50 or more employees found that 59 percent had policies in place either prohibiting or severely restricting smoking. In 1994 the District of Columbia and 41 States had laws restricting smoking in public places; 38 States and the District of Columbia had laws and/or executive orders restricting smoking in public workplaces; and 18 States and the District of Columbia had laws regulating smoking in private worksites. All 50 States and the District of Columbia have enacted laws prohibiting the sale and distribution of tobacco to youth under age 18. Although progress has been made toward achieving the year 2000 target for tobacco on the State level, many of these laws contain preemption clauses that prohibit local governments from enacting more stringent policies.

A 1992 Primary Care Providers Survey found that 33 percent of pediatricians routinely inquired about tobacco use, while 19 percent provided cessation counseling. Among

Objective 3.4: *Reduce cigarette smoking to a prevalence of no more than 15 percent among people aged 18 and older*



Source: CDC, BRFSS, 1993

internists, 75 percent routinely inquired about tobacco use; whereas 50 percent discussed strategies for quitting.

Mortality data demonstrate the results of decreased tobacco use. The coronary heart disease death rate has been reduced from 135 per 100,000 population in 1987 to 114 in 1992. The rate for blacks declined from 168 per 100,000 population in 1987 to 151 in 1992, but this decline is not sufficient to narrow the gap with the total population. The lung cancer death rate has risen slightly from 38.5 per 100,000 population in 1987 to 39.3 in 1992. The chronic obstructive pulmonary disease death rates have increased slightly from 18.9 per 100,000 population in 1987 to 19.9 in 1992.

1995 Revisions

Among the four new objectives added to the Tobacco priority area, one seeks to increase the average (State and Federal combined) tobacco excise tax to 50 percent of the retail price. Another seeks to increase to 100 percent the proportion of health plans that cover treatment of nicotine addiction. There is a new objective to reduce the number of States with clean indoor air laws that preempt stronger clean indoor air laws on the local level. Another new objective was added to supplement objective 3.13 to increase the number of States with laws restricting youth access to tobacco vending machines.

Special population targets have been added to objective 3.2 for females and black males to address the disparity in lung cancer deaths. For objective 3.4, reducing smoking prevalence, the age range was lowered from 20 to 18 years to focus attention on smoking at an earlier age. The language in objective 3.12 has been revised to specify that smokefree indoor air laws either ban or limit smoking to separately ventilated areas. New language has been added to objective 3.13 to measure the enforcement of laws prohibiting the sale and distribution of tobacco products to youths. The District of Columbia was added to the jurisdictions in which legislative action is sought in several objectives (objectives 3.12, 3.13, and 3.14).

Several objectives from other priority areas have been added as shared objectives to the Tobacco priority area. These objectives address the average age of first use of cigarettes by adolescents aged 12–17, oral cancer deaths, and stroke deaths. Because cigarettes have been added to the list of substances in three objectives in the Substance Abuse: Alcohol and Other Drugs priority area (use in the past month, perception of social disapproval, and perception of harm), these objectives are being added as shared objectives to the Tobacco priority area.

References

1. Centers for Disease Control and Prevention. Cigarette smoking-attributable mortality and years of potential life lost—United States 1990. *MMWR* 42(33):645–49. 1993.

2. U.S. Department of Health and Human Services, Public Health Service, Centers for Disease Control, Center for Chronic Disease Prevention and Health Promotion; 1989. *Reducing the Health Consequences of Smoking: 25 Years of Progress. A Report of the Surgeon General.* DHHS Publication (CDC) 898411.

3. Environmental Protection Agency, Office of Research and Development, Office of Air and Radiation. *Respiratory Health Effects of Passive Smoking: Lung Cancer and Other Disorders.* EPA/600/6-90, 1992.

4. Changes in the cigarette brand preferences of adolescent smokers—United States, 1989–1993. *MMWR* 43(32):577–81. 1994.