Tobacco Use 27

Lead Agency:

Centers for Disease Control and Prevention

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Goal: Reduce illness, disability, and death related to tobacco use and exposure to secondhand smoke.

Introduction*

Tobacco use causes more than 440,000 deaths each year in the United States.[1] Of these, approximately 38,000 deaths result from secondhand smoke exposure. For every person who dies from a smoking-related disease, 20 more people suffer with at least one serious illness from smoking.[2] Since the release of the 1964 Surgeon General's report on smoking and health, more than 12 million Americans have died prematurely due to smoking. Currently, estimates of annual smoking-associated economic costs in the United States are more than $167 billion.[1]

Progress toward reaching objectives—especially for secondhand smoke, youth smoking rates, and youth exposure to tobacco advertising—is ongoing. The objective to reduce the proportion of nonsmokers exposed to environmental tobacco smoke was achieved, exceeding its targeted change at midcourse by 36 percent. If the current rate of decline since 1997 were maintained, the Nation could achieve its target for reducing high school smoking rates. However, recent findings suggest a slowing of this downward trend; less progress is being made in reducing overall adult tobacco use and tobacco-related disparities.

While positive trends are noted in eliminating tobacco-related disparities, continued and enhanced efforts across a broad spectrum of players, including the Federal Government, States, and the private sector, need to address tobacco use in racial and ethnic populations disproportionately affected by the health burdens of tobacco.[3, 4]

Progress to date is due, in part, to comprehensive tobacco control programs.[5, 6] Many effective evidence-based interventions exist and are detailed in the Centers for Disease Control and Prevention's (CDC's) *Best Practices for Comprehensive Tobacco Control Programs*; the U.S. Public Health Service Clinical Practice Guideline, *Treating Tobacco Use and Dependence;* and the *Guide to Community Preventive Services: Tobacco Use Prevention and Control*.[7, 8, 9] These publications present evidence for the effectiveness of comprehensive tobacco control programs that include the following:[7, 8, 9]

- Increasing tobacco prices.
- Sustained media campaigns.
- Smoke-free policies in workplaces and public places.
- Reduced out-of-pocket costs for cessation services.
- Telephone quitlines.
- Prompts to clinicians to provide evidence-based intervention counseling.
- Community mobilization combined with additional interventions.

Many of these components are reflected in Healthy People 2010 objectives.

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* Unless otherwise noted, data referenced in this focus area come from Healthy People 2010 and can be located at http://wonder.cdc.gov/data2010. See the section on DATA2010 in the Technical Appendix for more information.

Public health efforts continue to be partially offset by several factors that encourage smoking, such as lack of indoor air regulations, discounted tobacco prices, and smoking scenes in movies.[10] Significant countervailing forces include increased advertising and promotions by the tobacco industry.[11] In the time between the Master Settlement Agreement in 1998 and the year 2003, cigarette company marketing expenditures increased by more than 125 percent.[11] More than three-fourths of the total is for discount pricing or promotional allowances to retailers, which undercut the effect of tax increases.[11] In addition, the tobacco industry and smoker rights groups continue to oppose smoke-free indoor air policies and price increases through excise taxes and to promote preemptive State laws that block local nonsmoking ordinances.[12, 13]

Another factor, which may slow or even reverse these positive trends, is the loss of funding for State tobacco prevention programs and national countermarketing campaigns.[14] The amount that States are investing in tobacco control decreased 28 percent from 2002 to 2004.[14] In 2004, spending was less than 3 percent of the $20 billion that the States received from tobacco excise taxes and tobacco settlement money in 2004.[14] One recent finding shows an association between a large decline in State funding for an antitobacco media campaign in Minnesota and a subsequent 10 percentage point increase in the likelihood youth will engage in cigarette smoking.[15] Another example is the substantial decrease in funding in Massachusetts, which was followed by a 74 percent increase in retail outlet sales of cigarettes to minors.[5, 16]

Modifications to Objectives and Subobjectives

The following discussion highlights the modifications, including changes, additions, and deletions, to this focus area's objectives and subobjectives as a result of the midcourse review.

At the time of the midcourse review, four developmental objectives became measurable on the basis of newly available data sources that are nationally representative. These objectives were initiation of tobacco use (27-3), tobacco advertising and promotion targeting adolescents and young adults (27-16), tobacco control programs (27-18), and sales-weighted average level of toxic chemicals in tobacco products sold in the United States (27-20). Within these 4 objectives, 10 subobjectives were added to stratify and track the information. For smoke-free indoor air laws (27-13), a subobjective measuring smoke-free laws in bars (27-13i) was added to reflect growing State activity in this area. The language in this objective that allowed for "limited to separately ventilated areas" was deleted because ventilation was shown to be inadequate to protect nonsmokers' health. Worksite smoking policies (27-12) was similarly revised. For adolescent tobacco use (27-2), a subobjective that tracks use of bidis in the past month (27-2e) was added to track the growing popularity and use of bidis among teens and young adults.

One tobacco tax subobjective was reworded from "increase the average Federal and State tax on tobacco products" to "increase the average Federal and State tax on cigarettes and expand the number of States with higher smokeless tobacco taxes over the decade" (27-21b). This change was made to ensure that all applicable taxes were measured.

As stated in *Healthy People 2010*: "Most developmental objectives have a potential data source with a reasonable expectation of data points by the year 2004 to facilitate setting 2010 targets in the mid-decade review. Developmental objectives with no baseline at the midcourse will be dropped." At the midcourse review, two subobjectives were dropped from this focus area because nationally representative data

sources could not be identified: reduce use of other tobacco products (that is, use of something other than cigarettes, spit tobacco, or cigars) by adults (27-1d) and increase all insurance coverage of evidence-based treatment for nicotine dependency (27-8c). However, the U.S. Department of Health and Human Services and the agencies that serve as the leads for the Healthy People 2010 initiative will consider ways to ensure that these public health issues retain prominence despite their current lack of data.

Progress Toward Healthy People 2010 Targets

The following discussion highlights objectives that met or exceeded their 2010 targets; moved toward the targets, demonstrated no change, or moved away from the targets; and those that lacked data to assess progress. Progress is illustrated in the Progress Quotient bar chart (see Figure 27-1), which displays the percent of targeted change achieved for objectives and subobjectives with sufficient data to assess progress.

The review of progress toward the Healthy People 2010 smoking objectives showed that many objectives moved toward their targets. Exposure to environmental tobacco smoke (27-10) exceeded its target. Eight objectives and one subobjective moved toward their targets: adult tobacco use (27-1), adolescent tobacco use (27-2), smoking cessation by adults (27-5), smoke-free and tobacco-free schools (27-11), worksite smoking policies (27-12), smoke-free indoor air laws (27-13), enforcement of laws on tobacco sales to minors in the States and the District of Columbia (27-14a), adolescent disapproval of smoking (27-17), and tobacco tax (27-21). Smoking cessation by adolescents (27-7) moved away from its target, and mixed progress was observed for tobacco advertising and promotion targeting adolescents and young adults (27-16). The remaining nine objectives and three subobjectives lacked data necessary to assess progress. However, data are anticipated by the end of the decade.

Objectives that met or exceeded their targets. Between 1988–94 and 1999–2000, the proportion of nontobacco users aged 4 years and older exposed to environmental tobacco smoke (27-10) fell from 88 percent to 54 percent, achieving 136 percent of the targeted change. Exposure was measured by blood levels of cotinine, a marker for cigarette smoke exposure. The primary factors that produced the reduction in secondhand smoke exposure include recent increases in smoke-free policies, both legislated and voluntary, in workplaces and public places[17]; recent increases in smoke-free home rules[18]; and a gradual reduction in adult smoking.[19] The declines in exposure were not as great in select populations, such as children aged 4 through 11 years and the black non-Hispanic population. Levels of secondhand smoke exposure also remained high among certain types of workers, including blue collar and service workers, and especially among restaurant, bar, and gaming workers.[17]

In addition, public awareness grew regarding the health risks that secondhand smoke poses to nonsmokers.[20] Changes in public and employer policies and home rules both reflected and contributed to changes in social norms regarding the social acceptability of smoking.[21, 22, 23] Changes in norms then led to further reductions in smoking and secondhand smoke exposure.[19]

Objectives that moved toward their targets. Tobacco use, including the use of cigarettes, spit tobacco, and cigars, among persons aged 18 years and older (27-1) made progress from its 1998 baseline. Cigarette smoking rates among persons aged 18 years and older (27-1a) declined from a 1998 baseline of 24 percent to a 2003 level of 21 percent of that population. Rates for spit tobacco use (27-1b) and cigar smoking (27-1c) among persons aged 18 years of age and older progressed toward their targets more slowly than cigarette smoking.

Each day in the United States, approximately 4,000 youth aged 12 to 17 years try their first cigarette.[24] Although the percentage of high school students who smoke declined in recent years, rates for all populations remained higher than their targets. In 2003, 22 percent of students in grades 9 through 12 reported using cigarettes within the past month (27-2b); 7 percent reported using spit tobacco (27-2c) during the same timeframe. Fifteen percent of students in grades 9 through 12 reported smoking cigars, cigarillos, or little cigars (27-2d) in the past month. Overall, the proportion of students in grades 9 through 12 who reported using any tobacco product over the past month (27-2a) achieved 68 percent of the targeted change.

Prevailing attitudes about smoking play an important role in influencing adolescents and young adults to quit or avoid tobacco products altogether.[25] Disapproval of smoking by 8th, 10th, and 12th graders (27-17a, b, and c) all moved toward their respective targets. The disapproval of smoking by adolescents provided an indication of the decreases in youth tobacco use.[26]

Some progress was made in the enforcement of laws on tobacco sales to minors in the States and the District of Columbia (27-14a). In 2003, one State had reduced the illegal sales rate, compared with no States in 1998. The target for this objective is 50 States and the District of Columbia.

Between 1998 and 2003, students reported a decrease in perceived availability of cigarettes.[27] For example, in 1998, 88.1 percent of 10th graders reported that cigarettes were easy to access, compared with 80.7 percent in 2003.

In 2000, 45 percent of schools reported smoke-free and tobacco-free school policies (27-11), up from 37 percent in 1994 but less than the target. In addition, 45.5 percent of school districts and 13 States reported having such policies.[28]

States are also working toward making workplaces and public places smoke free. The seven measurable subobjectives for smoke-free indoor air laws (27-13) moved toward their targets of 50 States and the District of Columbia. In 2003, the subobjective measuring smoke-free laws in bars (27-13i) was the farthest from the target, with only two States prohibiting smoking in these establishments. Private workplaces (27-13a) and restaurants (27-13c) were smoke free in five States. Policies establishing smoke-free environments are the most effective method in protecting both workers and patrons from secondhand smoke exposure.[29] Restrictions on where smoking is allowed are associated with decreased cigarette consumption and possibly with increased cessation rates among workers and the public.[29, 30]

More than 70 percent of smokers want to quit, though success rates for quitting without treatment are low.[19, 30] This proportion underscores the importance of increased availability of evidence-based treatments. Between 1998 and 2003, smoking cessation attempts by smokers aged 18 years and older (27-5) increased from 41 percent to 43 percent, representing 6 percent of the targeted change toward the target of 75 percent.

Since 2000, a major advance in providing assistance to smokers who want to quit has been the increased availability of quitline services and the implementation of the National Network of Quitlines in 2004.[31] Through the network, a national access number for tobacco cessation electronically transfers callers to their State quitline. Forty-nine States, the District of Columbia, and five jurisdictions have been supported by CDC to initiate or expand quitline services. All States are anticipated to have a quitline by the end of the decade.

Other smoking cessation tools are available. A smoking cessation website, www.smokefree.gov, offers tools, information, and support in helping smokers quit. Individuals can use the updated *Pathways to Freedom: Winning the Fight Against Tobacco*, a comprehensive self-help manual for adult cessation with recommendations by and for the black non-Hispanic population.[32] The U.S. Public Health Service Clinical Practice Guideline, *Treating Tobacco Use and Dependence,* provides implementation strategies for tobacco-use treatment.[8] The document contains sections on cessation strategies for clinicians, health care systems, and communities.

Increases in the price of cigarettes through excise taxes (27-21a) had an impact on the smoking population.[16, 30, 33, 34] These increases influenced all populations, but particularly younger smokers and lower income populations. Price hikes also increased cessation and decreased initiation, aiding in the attainment of the respective targets.[30, 34] Between 1998 and 2002, the combined Federal and average State tax on cigarettes (27-21a) increased from 59 cents per pack to $1 per pack, moving toward the target of $2 per pack.[35] Three States—Michigan, New Jersey, and Rhode Island—have excise taxes that are at or over $2, thus meeting the target. Three States—Colorado, Montana, and Oklahoma—successfully raised the tobacco tax through ballot measures. Virginia raised its cigarette tax from 2.5 cents to 20 cents per pack—the first increase since 1960. Significant cigarette tax increases motivated smokers to quit and prevented youth from starting.[9, 34] In addition, 21 States increased their taxes on smokeless tobacco products between 2000 and 2004 (27-21b). The target is increased taxes in all 50 States and the District of Columbia.

Objectives that demonstrated mixed movement toward or away from their targets.
Progress was mixed regarding exposure to tobacco advertising for students in grades 9 through 12 (27-16). Advertising in magazines and newspapers (27-16b) targeted primarily to adolescents decreased by 4 percentage points between 2000 and 2002. In 2000, 74 percent of students in grades 9 through 12 reported exposure to tobacco advertising and promotions in magazines and newspapers. In 2002, that number dropped to 70 percent, moving toward the target of 67 percent. However, advertising via the Internet (27-16a) increased. Tobacco advertising exposure rates for high school students increased from 28 percent in 2000 to 38 percent in 2002. Because the Internet has become an integral source of news, information, and communication among younger populations, much work needs to be done to achieve this objective. In 2003, tobacco companies' advertising expenditures represented more than 23 times what States spend on tobacco prevention and control.[11] The tobacco industry has increased its expenditures for advertising and promotions.[11] In 2003, cigarette companies spent $15.15 billion on advertising and promotions, the most ever reported to the Federal Trade Commission.[11]

Objectives that moved away from their targets. While progress was made in smoking cessation attempts among adults aged 18 years and older, cessation attempts among students in grades 9 through 12 (27-7) did not improve. From a baseline of 61 percent of smokers in this age group attempting to quit, the most current measurement (2003) was 60 percent.

Objectives that could not be assessed. Trend data were not available for nine objectives: initiation of tobacco use (27-3), age at first tobacco use (27-4), smoking cessation during pregnancy (27-6), insurance coverage of cessation treatment (27-8), exposure to tobacco smoke at home among children (27-9), retail license suspension for sales to minors (27-15), evidence-based tobacco control programs (27-18), preemptive tobacco control laws (27-19), and sales-weighted average levels of toxic chemicals in tobacco products sold in the United States (27-20). Thus, progress for these objectives could not be assessed. However, additional data are expected to be available before the end of the decade.

Data to assess progress toward enforcement of illegal tobacco sales to minors by Territories (27-14b) were not available. In addition, smoke-free indoor air laws for Tribes and Territories (27-13g and h) remained developmental.

No nationally representative data source was available for 27-1d and 27-8c, and these subobjectives were dropped for this reason.

Progress Toward Elimination of Health Disparities

The following discussion highlights progress toward the elimination of health disparities. The disparities are illustrated in the Disparities Table (see Figure 27-2), which displays information about disparities among select populations for which data were available for assessment. The discussion of disparities is constrained by the data available for various populations. Limited data were available regarding disparities between ethnic and racial populations and in disability status.

Disparity exhibited a mixed pattern among racial and ethnic populations. The black non-Hispanic population had the best rates for 5 of the 13 objectives with significant racial and ethnic disparities (or disparities of 10 percent or more). The Hispanic population had the best rates for four of these objectives and the white non-Hispanic for three objectives. The Asian or Pacific Islander population had the best rate of working in worksites that prohibit smoking (27-12). Females had better rates than males for seven of the eight objectives with significant gender-specific disparities. Persons with at least some college had the best rates for the four objectives and subobjectives with significant education disparities, whereas middle/high-income persons had the best rates for the four objectives and subobjectives with significant income disparities. Finally, persons without disabilities had better rates of tobacco use (27-1a, b, and c) than persons with disabilities. Persons with disabilities had a better rate of smoking cessation attempts (27-5).

An example of success in reducing a disparity in adult tobacco use (27-1) was the reduction of the disparity between proportions of the black non-Hispanic and white non-Hispanic populations that smoked, which occurred between 1950 and 2000. The black non-Hispanic adult population smoked at higher levels than the white non-Hispanic population since the 1950s, but by 2001 smoking rates were equal among these two populations.[3, 36, 37] Several factors may have contributed to this decline among the black non-Hispanic population, including the increased price of cigarettes,[5, 33] media campaigns to raise awareness about the dangers of smoking,[25, 26] and comprehensive community programs. In addition, the disparity reduction was augmented by development of targeted cessation materials, diversification of the tobacco control movement, and the increased program capacity and infrastructure initially promoted by the American Stop Smoking Intervention Study (ASSIST),[38] the Robert Wood Johnson Foundation, and CDC.[39]

In contrast, an example of lack of progress toward the elimination of disparities was the consistently high use of tobacco products among the American Indian or Alaska Native population. In 2003, the proportion of the American Indian or Alaska Native population aged 18 years and older who smoked cigarettes (27-1a) was more than twice that of the Hispanic (best) population. Tribal support centers and a national network to facilitate capacity and infrastructure development within this community address this disparity.[40] Through the network, research and culturally appropriate cessation protocols and other interventions have been developed to reduce the high tobacco-use rates.

Spit tobacco use (27-1b) continued to demonstrate disparity across different education levels. Compared with the best group rate of persons with at least some college education, the rate for high school graduates differed by 50 percent to 99 percent. The rate for persons with less than a high school education differed by 100 percent or more.

Exposure to tobacco smoke at home among children (27-9) showed persistent disparities by race and ethnicity and by income level. The Hispanic population had the best rate in 1998, with half as many Hispanic children aged 6 years and under exposed to tobacco smoke as black non-Hispanic and white non-Hispanic children were. Among populations by income, children in poor and near-poor families were twice as likely to be exposed to tobacco smoke as children in middle/high-income families were. During the period 1988–94 and 1999–2000, the disparity in nonsmokers' exposure to environmental tobacco smoke (27-10) between the black non-Hispanic and the Hispanic (best) populations increased by 50 to 99 percentage points.

Several changes in disparity were observed in high school students' disapproval of smoking (27-17). Racial and ethnic disparities among 12th graders (27-17c) decreased between the Hispanic and black populations as well as between the white population and the best group. Disparity between black and white 10th graders (27-17b) also declined. However, disparity increased between Hispanic and black 10th graders (27-17b) and between black and white 8th graders (27-17a). Increases in disparities between males and females were also seen among 8th and 12th graders (27-17a and c).

Emerging Issues

Monitoring emerging tobacco control issues is important because information is continually being acquired to explain the link between use and behavior, exposure, and multiple adverse health outcomes. Research on tobacco product toxicity and the subsequent health effects increases the understanding of individual and population risks of tobacco use as well as overall patterns of use of tobacco products.

Use of and risks from potentially reduced exposure products (PREPs) that purportedly deliver lower amounts of toxic, carcinogenic, or addictive agents to the user compared with conventional products is an emerging issue.[41] PREPs are increasingly appearing on the market. Accordingly, there is a growing need to study them.[41] Little is known about the impact of PREPS on individual or population risk. Of concern, these products may discourage smokers from quitting or encourage youth to start.[41] Some PREPs are promoted with explicit or implicit claims that they are less harmful or less addictive.[42, 43] However, the scientific evidence is insufficient to evaluate whether these products reduce exposure to toxins or risk for tobacco-related diseases.[41] These products are not yet in wide use. Information on their toxicity is limited, and many questions remain about their potential appeal to current or former smokers and youth. Monitoring patterns of initiation, use, and quitting in response to PREPs will improve understanding of these products.

Smokeless tobacco is another emerging issue. Use of smokeless tobacco, a known human carcinogen, can lead to addiction and other serious health consequences, as can use of other products such as cigars and bidis.[44, 45, 46, 47, 48] Hookah (water-pipe) smoking is a growing practice among smokers, particularly in urban areas and around college campuses.[49] Little research has been done on its health consequences, its toxicity compared with smoking conventional cigarettes, or its potential for addiction. Preliminary data indicate these products have high levels of nicotine and potential to cause significant exposure to toxins.[50, 51]

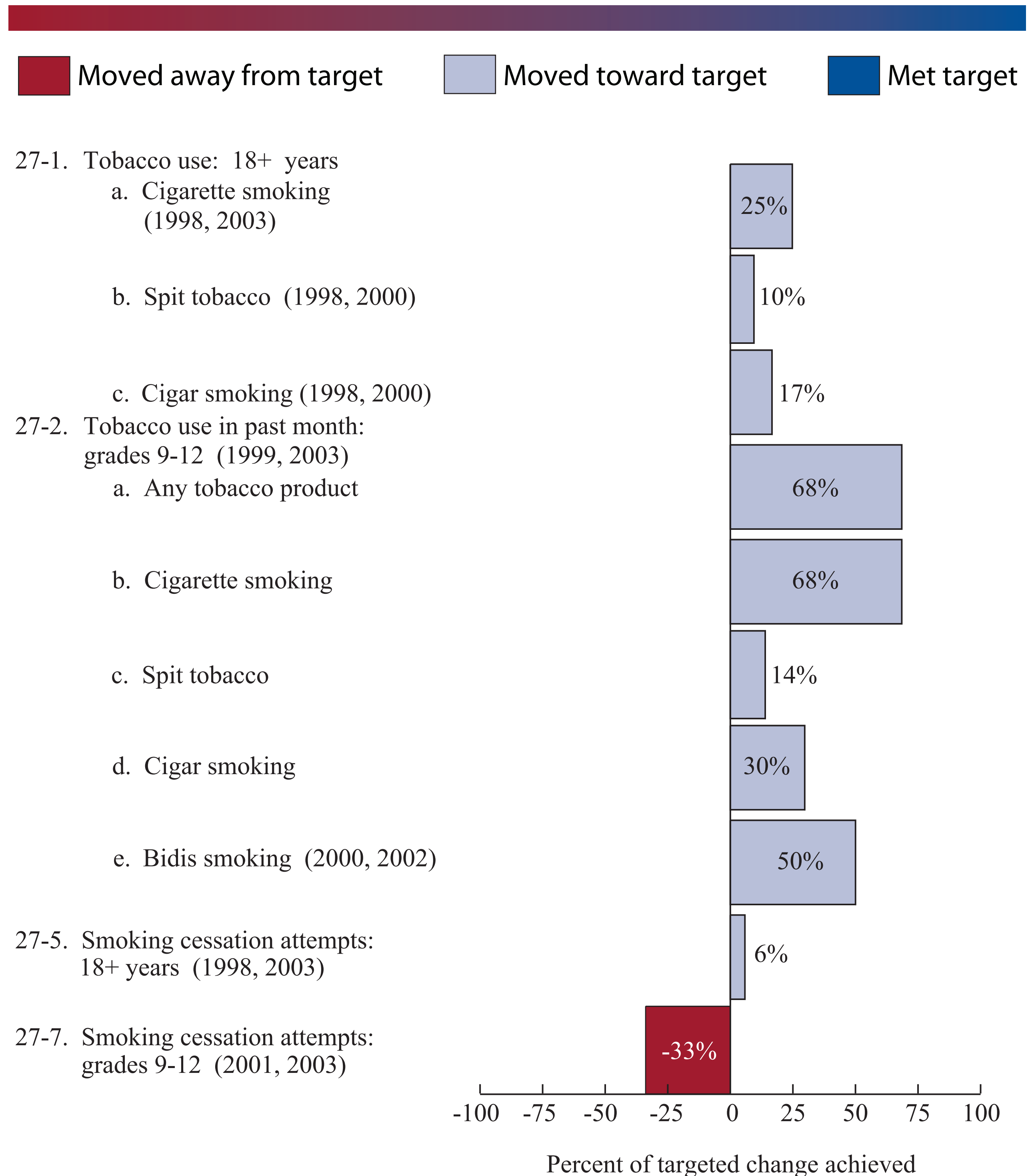
Expanded research is also needed to link information on toxic or addictive chemicals in smoke and tobacco products with the presence of such chemicals in humans. Identifying these biomarkers will allow for improved documentation of the actual exposure that tobacco users experience. This information will be critical to understanding the biological effects of a variety of tobacco products.

Internet sale of tobacco products has emerged as an issue of increasing concern, especially as it applies to youth. Internet vendors have weak or nonexistent age verification mechanisms, potentially allowing underage youth to access cigarettes and other tobacco products.[52, 53] Such access may mitigate successful efforts to reduce sales of tobacco products to youth in traditional retail outlets.

Finally, as youth access to retail sources of tobacco declines,[54, 55, 56] access to tobacco products through other sources is emerging as an issue. Recent surveys[57, 58] indicate that youth report most commonly obtaining tobacco from other sources, including friends and family.[56] Current knowledge on effective strategies to reduce access to tobacco through social sources is limited.

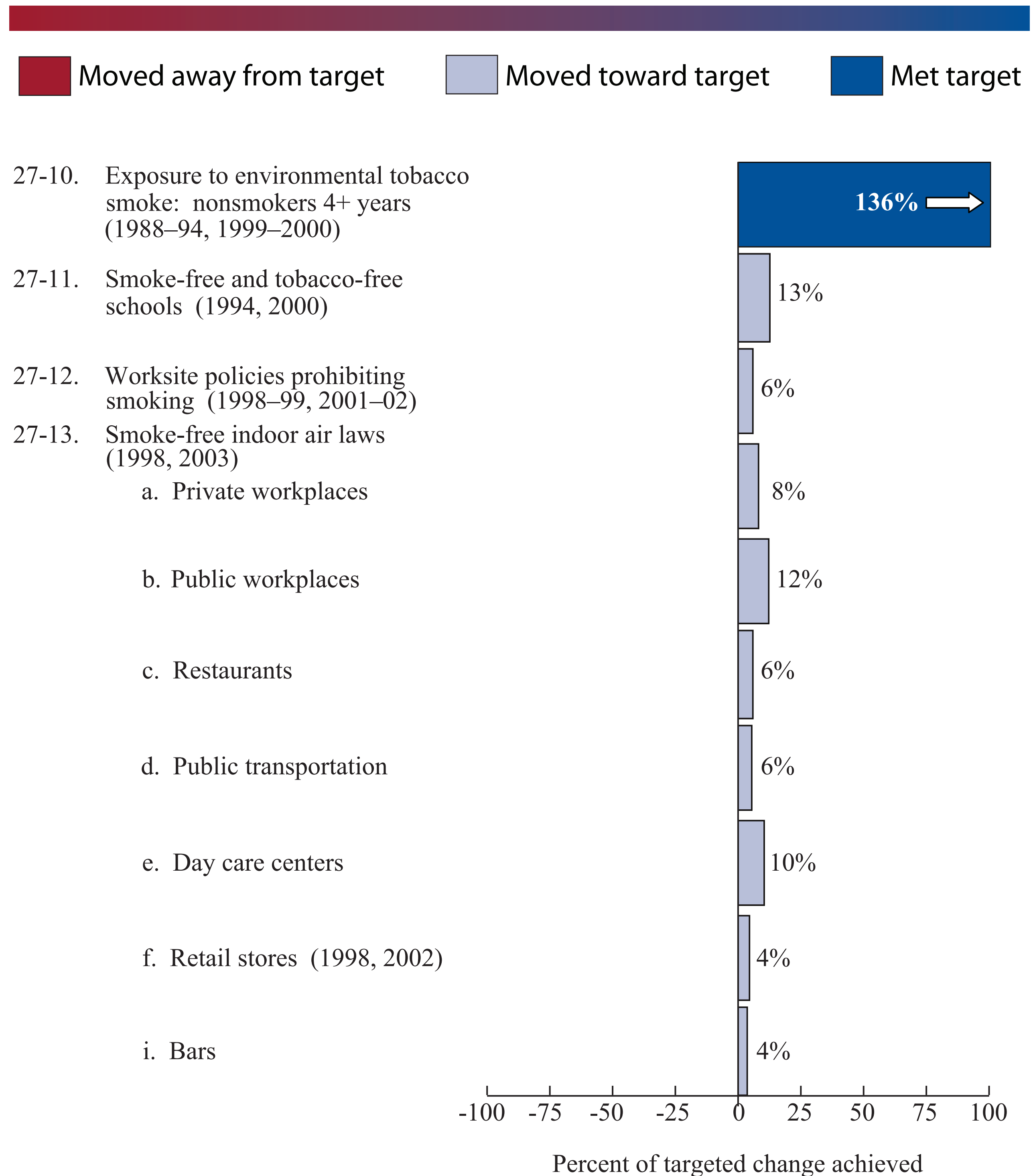
In conclusion, a majority of the objectives made progress toward their targets. Most of the objectives that are not currently measurable are expected to have data by the end of the decade. Focusing on youth smoking is a key aspect in achieving the Healthy People 2010 goal to reduce illness, disability, and death related to tobacco use and exposure to secondhand smoke. Analyses of CDC's national Youth Risk Behavior Surveys show that lifetime, current, and current frequent cigarette use among high school students was stable or increased during the late 1990s and then decreased significantly from the late 1990s to 2003. However, decreases in State funding and the increase in tobacco advertising and promotional expenditures will likely have a negative impact on many of the objectives, including a potential deceleration of the rate of decline in cigarette use among high school students over the past several years.[11, 59, 60]

Figure 27-1. Progress Quotient Chart for Focus Area 27: Tobacco Use



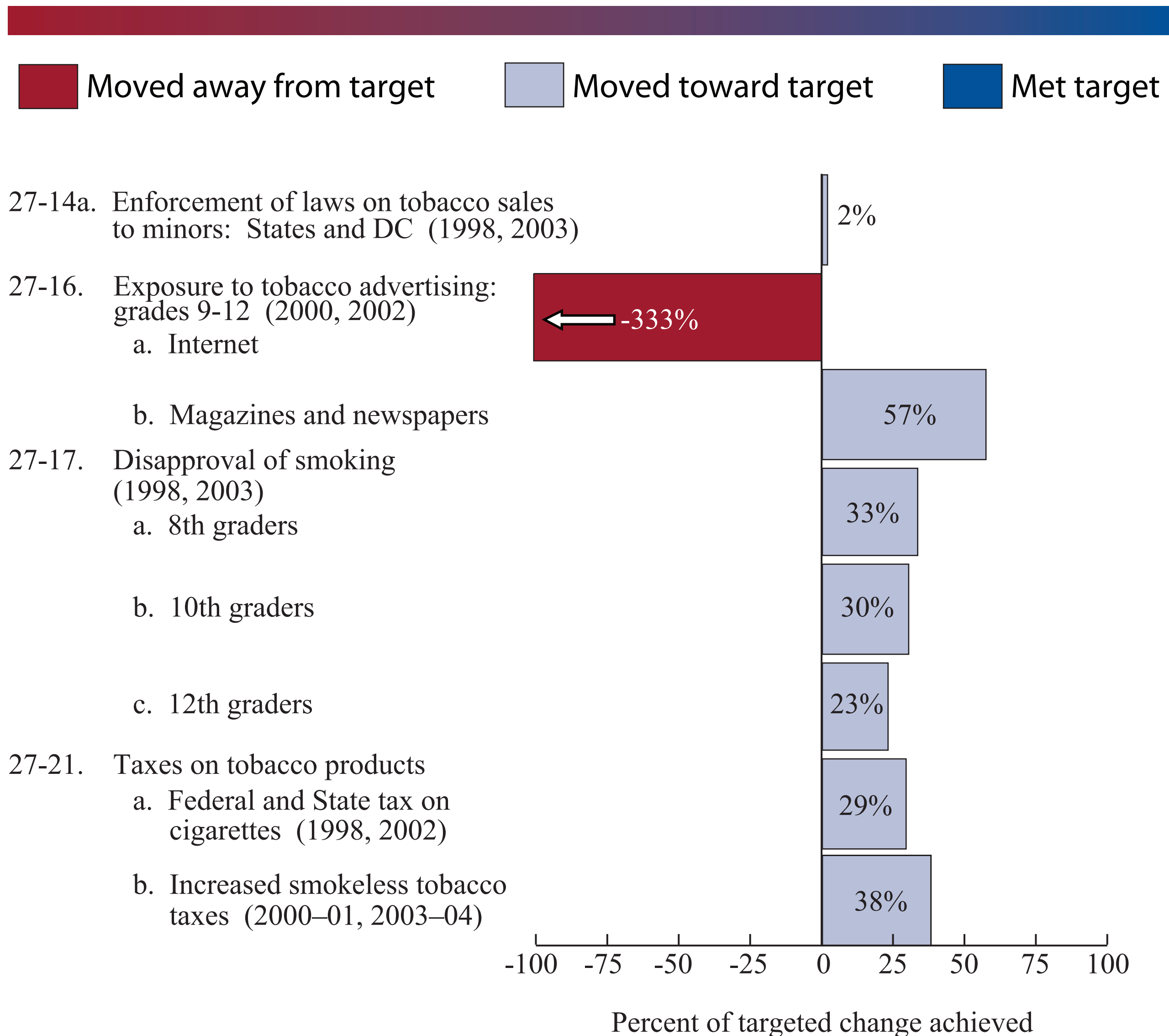
See notes at end of chart. *(continued)*

Figure 27-1. *(continued)*



See notes at end of chart. *(continued)*

Figure 27-1. *(continued)*



Notes: Tracking data for objectives 27-3a and b, 27-4a and b, 27-6, 27-8a and b, 27-9, 27-13g and h, 27-14b, 27-15, 27-18a, b, and c, 27-19, and 27-20a, b, and c are unavailable. Objectives 27-1d and 27-8c were deleted at the midcourse.

Years in parentheses represent the baseline data year and the most recent data year used to compute the percent of the Healthy People 2010 target achieved.

$$\text{Percent of targeted change achieved} = \left(\frac{\text{Most recent value} - \text{baseline value}}{\text{Year 2010 target} - \text{baseline value}}\right) \times 100$$

Figure 27-2. Disparities Table for Focus Area 27: Tobacco Use

Disparities from the best group rate for each characteristic at the most recent data point and changes in disparity from the baseline to the most recent data point.

Population-based objectives	Characteristics: Race and ethnicity								Gender		Education				Income				Disability	
	American Indian or Alaska Native	Asian	Native Hawaiian or other Pacific Islander	Two or more races	Hispanic or Latino	Black non-Hispanic	White non-Hispanic	**Summary index**	Female	Male	Less than high school	High school graduate	At least some college	**Summary index**	Poor	Near poor	Middle/high income	**Summary index**	Persons with disabilities	Persons without disabilities
27-1a. Cigarette smoking: 18+ years (1998, 2003) * [1]		b			B				B				B				B			B
27-1b. Spit tobacco use: 18+ years (1998, 2000) * [2]													B			b	B			B
27-1c. Cigar smoking: 18+ years (1998, 2000) * [2]												B								B
27-2a. Use of any tobacco products in past month: grades 9-12 (1999, 2003) *						B			B											
27-2b. Cigarette smoking in past month: grades 9-12 (1999, 2003) *						B				B										
27-2c. Spit tobacco in past month: grades 9-12 (1999, 2003) *																				
27-2d. Cigar smoking in past month: grades 9-12 (1999, 2003) *					B															
27-2e. Bidis smoking in past month: grades 9-12 (2000, 2002) *																				
27-3a. Initiation of cigarette use: 12-17 years (2002) *						B				B										
27-3b. Initiation of cigarette use: 18-25 years (2002) *																				
27-4a. Age at first tobacco use: 12-17 years (2002) *						B			B											
27-4b. Age at first tobacco use: 18-25 years (2002) *						B			B											
27-5. Smoking cessation attempts: 18+ years (1998, 2003) * [1]				b		B			B				B		B				B	
27-6. Smoking cessation during pregnancy: females 18-49 years (1998) *												B					B			
27-7. Smoking cessation attempts: grades 9-12 (2001, 2003) *							B		B											
27-9. Exposure to tobacco smoke at home: < 7 years (1998) *					B				B								B			
27-10. Exposure to environmental tobacco smoke: nonsmokers 4+ years (1988-94, 1999-2000) *					B[3]	↑↑		↑												
27-12. Worksite policies prohibiting smoking (1998-99, 2001-02) †		B[4]							B				B				B			
27-16a. Exposure to tobacco advertising on the Internet: grades 9-12 (2000, 2002) *							B			B										
27-16b. Exposure to tobacco advertising in newspapers and magazines: grades 9-12 (2000, 2002) *	B									B										

(continued)

Figure 27-2. *(continued)*

Population-based objectives	American Indian or Alaska Native	Asian	Native Hawaiian or other Pacific Islander	Two or more races	Hispanic or Latino	Black non-Hispanic	White non-Hispanic	**Summary index**	Female	Male	Less than high school	High school graduate	At least some college	**Summary index**	Poor	Near poor	Middle/high income	**Summary index**	Persons with disabilities	Persons without disabilities
	Characteristics																			
	Race and ethnicity								**Gender**		**Education**				**Income**				**Disability**	
27-17a. Disapproval of smoking: 8th graders (1998, 2003) †						↑[5]	B[5]		B	↑										
27-17b. Disapproval of smoking: 10th graders (1998, 2003) †					↑	B[5]	↓[5]		B											
27-17c. Disapproval of smoking: 12th graders (1998, 2003) †					B ↓[6]	5	↓[5]	↓	B	↑										

Notes: Data for objectives 27-8a and b, 28-11, 27-13a through i, 27-14a and b, 27-15, 27-18a, b, and c, 27-19, 27-20a, b, and c, and 27-21a and b are unavailable or not applicable. Objectives 27-1d and 27-8c were deleted at the midcourse.

Years in parentheses represent the baseline data year and the most recent data year (if available).

Disparity from the best group rate is defined as the percent difference between the best group rate and each of the other group rates for a characteristic (for example, race and ethnicity). The summary index is the average of these percent differences for a characteristic. Change in disparity is estimated by subtracting the disparity at baseline from the disparity at the most recent data point. Change in the summary index is estimated by subtracting the summary index at baseline from the summary index at the most recent data point. See Technical Appendix for more information.

The **best group rate** at the most recent data point.
- B — The group with the best rate for specified characteristic.
- b — Most favorable group rate for specified characteristic, but reliability criterion not met.
- (blank box) — Best group rate reliability criterion not met.

Disparity from the best group rate at the most recent data point.

Percent difference from the best group rate
- Less than 10 percent or not statistically significant
- 10-49 percent
- 50-99 percent
- 100 percent or more

Changes in disparity over time are shown when the change is greater than or equal to 10 percentage points and statistically significant, or when the change is greater than or equal to 10 percentage points and estimates of variability were not available.

Increase in disparity (percentage points)
- ↑ 10-49
- ↑↑ 50-99
- ↑↑↑ 100 or more

Decrease in disparity (percentage points)
- ↓ 10-49
- ↓↓ 50-99
- ↓↓↓ 100 or more

Availability of data.
- Data not available.
- Characteristic not selected for this objective.

* The variability of best group rates was assessed, and disparities of $\geq 10\%$ are statistically significant at the 0.05 level. Changes in disparity over time, noted with arrows, are statistically significant at the 0.05 level. See Technical Appendix.

† Measures of variability were not available. Thus, the variability of best group rates was not assessed, and the statistical significance of disparities and changes in disparity over time could not be tested. See Technical Appendix.

1 Baseline data by race and ethnicity are for 1999.

2 Baseline data by race and ethnicity are for 2000.

3 Data are for Mexican Americans.

4 Data are for Asians or Pacific Islanders.

5 Data include persons of Hispanic origin.

6 Disparity declined for Hispanics relative to blacks, the group with the best rate at baseline.

Objectives and Subobjectives for Focus Area 27: Tobacco Use

Goal: Reduce illness, disability, and death related to tobacco use and exposure to secondhand smoke.

As a result of the Healthy People 2010 Midcourse Review, changes were made to the Healthy People 2010 objectives and subobjectives. These changes are specific to the following situations:

- Changes in the wording of an objective to more accurately describe what is being measured.
- Changes to reflect a different data source or new science.
- Changes resulting from the establishment of a baseline and a target (that is, when a formerly developmental objective or subobjective became measurable).
- Deletion of an objective or subobjective that lacked a data source.
- Correction of errors and omissions in *Healthy People 2010.*

Revised baselines and targets for measurable objectives and subobjectives do not fall into any of the above categories and, thus, are not considered a midcourse review change.[1]

When changes were made to an objective, three sections are displayed:

1. In the Original Objective section, the objective as published in *Healthy People 2010* in 2000 is shown.
2. In the Objective With Revisions section, strikethrough indicates text deleted, and underlining is used to show new text.
3. In the Revised Objective section, the objective appears as revised as a result of the midcourse review.

Details of the objectives and subobjectives in this focus area, including any changes made at the midcourse, appear on the following pages.

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[1] See Technical Appendix for more information on baseline and target revisions.

Tobacco Use in Population Groups

ORIGINAL OBJECTIVE

27-1. Reduce tobacco use by adults.

Target and baseline:

Objective	Reduction in Tobacco Use by Adults Aged 18 Years and Older	1998 Baseline*	2010 Target
		Percent	
27-1a.	Cigarette smoking	24	12
27-1b.	Spit tobacco	2.6	0.4
27-1c.	Cigars	2.5	1.2
27-1d.	Other products	Developmental	

*Age adjusted to the year 2000 standard population.

Target setting method: Better than the best.

Data source: National Health Interview Survey (NHIS), CDC, NCHS.

OBJECTIVE WITH REVISIONS (Including subobjective deleted)

27-1. Reduce tobacco use by adults.

Target and baseline:

Objective*	Reduction in Tobacco Use by Adults Aged 18 Years and Older	1998 Baseline†	2010 Target
		Percent	
27-1a.	Cigarette smoking	24	12
27-1b.	Spit tobacco	~~2.6~~ 2.5[1]	0.4
27-1c.	Cigars	~~2.5~~ 2.4[2]	1.2
~~**27-1d.**~~	*(Subobjective deleted due to unreliable data source)** ~~Other products~~	~~Developmental~~	

* For data control purposes, subobjectives are not renumbered.
† Age adjusted to the year 2000 standard population.

Target setting method: Better than the best.

Data source: National Health Interview Survey (NHIS), CDC, NCHS.

[1] Baseline revised from 2.6 after November 2000 publication.
[2] Baseline revised from 2.5 after November 2000 publication.

REVISED OBJECTIVE

27-1. Reduce tobacco use by adults.

Target and baseline:

Objective*	Reduction in Tobacco Use by Adults Aged 18 Years and Older	1998 Baseline†	2010 Target
		Percent	
27-1a.	Cigarette smoking	24	12
27-1b.	Spit tobacco	2.5[1]	0.4
27-1c.	Cigars	2.4[2]	1.2

* For data control purposes, subobjectives are not renumbered.
† Age adjusted to the year 2000 standard population.

Target setting method: Better than the best.

Data source: National Health Interview Survey (NHIS), CDC, NCHS.

[1] Baseline revised from 2.6 after November 2000 publication.
[2] Baseline revised from 2.5 after November 2000 publication.

ORIGINAL OBJECTIVE

27-2. Reduce tobacco use by adolescents.

Target and baseline:

Objective	Reduction in Tobacco Use by Students in Grades 9 Through 12	1999 Baseline	2010 Target
		Percent	
27-2a.	Tobacco products (past month)	40	21
27-2b.	Cigarettes (past month)	35	16
27-2c.	Spit tobacco (past month)	8	1
27-2d.	Cigars (past month)	18	8

Target setting method: Better than the best.

Data source: Youth Risk Behavior Surveillance System (YRBSS), CDC, NCCDPHP.

OBJECTIVE WITH REVISIONS

27-2. Reduce tobacco use by adolescents.

Target and baseline:

Objective	Reduction in Tobacco Use by Students in Grades 9 Through 12	1999 Baseline (unless noted)	2010 Target

OBJECTIVE WITH REVISIONS *(continued)*

		Percent	
27-2a.	Tobacco products (past month)	40	21
27-2b.	Cigarettes (past month)	35	16
27-2c.	Spit tobacco (past month)	8	1
27-2d.	Cigars (past month)	18	8
27-2e.	Bidis (past month)	4 (2000)	2

Target setting method: Better than the best.

Data sources: Youth Risk Behavior Surveillance System (YRBSS), CDC, NCCDPHP; National Youth Tobacco Survey (NYTS), American Legacy Foundation and CDC.

REVISED OBJECTIVE

27-2. Reduce tobacco use by adolescents.

Target and baseline:

Objective	Reduction in Tobacco Use by Students in Grades 9 Through 12	1999 Baseline (unless noted)	2010 Target
		Percent	
27-2a.	Tobacco products (past month)	40	21
27-2b.	Cigarettes (past month)	35	16
27-2c.	Spit tobacco (past month)	8	1
27-2d.	Cigars (past month)	18	8
27-2e.	Bidis (past month)	4 (2000)	2

Target setting method: Better than the best.

Data sources: Youth Risk Behavior Surveillance System (YRBSS), CDC, NCCDPHP; National Youth Tobacco Survey (NYTS), American Legacy Foundation and CDC.

ORIGINAL OBJECTIVE

27-3. (Developmental) Reduce the initiation of tobacco use among children and adolescents.

Potential data source: National Household Survey on Drug Abuse (NHSDA), SAMHSA.

OBJECTIVE WITH REVISIONS

27-3. ~~(Developmental)~~ Reduce the initiation of tobacco use among children, ~~and~~ adolescents, and young adults.

Target and baseline:

Objective	Reduction in Cigarette Initiation	2002 Baseline	2010 Target
		Rate per 1,000 Person-Years Exposure	
27-3a.	Children and adolescents aged 12 to 17 years	100.1	81.2
27-3b.	Young adults aged 18 to 25 years	59.6	48.1

Target setting method: Better than the best.

~~Potential d~~Data source: National ~~Household~~ Survey on Drug Use and Health~~Abuse~~ (NH~~S~~DUH~~DA~~), SAMHSA.

REVISED OBJECTIVE

27-3. Reduce the initiation of tobacco use among children, adolescents, and young adults.

Target and baseline:

Objective	Reduction in Cigarette Initiation	2002 Baseline	2010 Target
		Rate per 1,000 Person-Years Exposure	
27-3a.	Children and adolescents aged 12 to 17 years	100.1	81.2
27-3b.	Young adults aged 18 to 25 years	59.6	48.1

Target setting method: Better than the best.

Data source: National Survey on Drug Use and Health (NSDUH), SAMHSA.

NO CHANGE IN OBJECTIVE
(Data updated and footnoted)

27-4. Increase the average age of first use of tobacco products by adolescents and young adults.

Target and baseline:

Objective	Increase in Average Age of First Tobacco Use	2002[1] Baseline	2010 Target

NO CHANGE IN OBJECTIVE *(continued)*
(Data updated and footnoted)

		Average Age of First Cigarette Use, in Years	
27-4a.	Adolescents aged 12 to 17 years	12	14
27-4b.	Young adults aged 18 to 25 years	14[2]	16[3]

Target setting method: Better than the best.

Data source: National Survey on Drug Use and Health (NSDUH), SAMHSA.

[1] Baseline year revised from 1997 after November 2000 publication.
[2] Baseline revised from 15 after November 2000 publication.
[3] Target revised from 17 because of baseline revision after November 2000 publication.

Cessation and Treatment

NO CHANGE IN OBJECTIVE

27-5. Increase smoking cessation attempts by adult smokers.

Target: 75 percent.

Baseline: 41 percent of adult smokers aged 18 years and older stopped smoking for 1 day or longer because they were trying to quit in 1998 (age adjusted to the year 2000 standard population).

Target setting method: Better than the best.

Data source: National Health Interview Survey (NHIS), CDC, NCHS.

NO CHANGE IN OBJECTIVE

27-6. Increase smoking cessation during pregnancy.

Target: 30 percent.

Baseline: 14 percent of females aged 18 to 49 years stopped smoking during the first trimester of their pregnancy in 1998.

Target setting method: Better than the best.

Data source: National Health Interview Survey (NHIS), CDC, NCHS.

NO CHANGE IN OBJECTIVE
(Data updated and footnoted)

27-7. Increase tobacco use cessation attempts by adolescent smokers.

Target: 64[1] percent.

Baseline: 61[2] percent of smokers in grades 9 through 12 who ever smoked at least one cigarette every day for 30 days tried to quit smoking in 2001.[2]

Target setting method: Better than the best.

Data source: Youth Risk Behavior Surveillance System (YRBSS), CDC, NCCDPHP.

[1] Target revised from 84 because of baseline revision after November 2000 publication.
[2] Baseline and baseline year revised from 76 and 1999 after November 2000 publication.

ORIGINAL OBJECTIVE

27-8. Increase insurance coverage of evidence-based treatment for nicotine dependency.

Target and baseline:

Objective	Increase in Insurance Coverage of Evidence-Based Treatment for Nicotine Dependency	1998 Baseline (unless noted)	2010 Target
		Percent	
27-8a.	Managed care organizations	75 (1997–98)	100
		Number	
27-8b.	Medicaid programs in States and the District of Columbia	24	51
27-8c.	All insurance	Developmental	

Target setting method: Total coverage of FDA-approved pharmacotherapies and behavioral therapies.

Data sources: Addressing Tobacco in Managed Care Survey, Robert Wood Johnson Foundation; (Medicaid data) Health Policy Tracking Service, National Conference of State Legislators.

OBJECTIVE WITH REVISIONS
(Including subobjective deleted)

27-8. Increase insurance coverage of evidence-based treatment for nicotine dependency.

OBJECTIVE WITH REVISIONS *(continued)*
(Including subobjective deleted)

Target and baseline:

Objective*	Increase in Insurance Coverage of Evidence-Based Treatment for Nicotine Dependency	1998 Baseline (unless noted)	2010 Target
		Percent	
27-8a.	Managed care organizations	75 (1997–98)	100
		Number	
27-8b.	Medicaid programs in States and the District of Columbia	24	51
~~**27-8c.**~~	*(Subobjective deleted due to unreliable data source)*† ~~All insurance~~	~~Developmental~~	

* For data control purposes, subobjectives are not renumbered.

Target setting method: Total coverage of FDA-approved pharmacotherapies and behavioral therapies.

Data sources: Addressing Tobacco in Managed Care Survey (managed care data), Robert Wood Johnson Foundation; ~~(Medicaid data)~~ Health Policy Tracking Service (Medicaid data), National Conference of State Legislators.

REVISED OBJECTIVE

27-8. Increase insurance coverage of evidence-based treatment for nicotine dependency.

Target and baseline:

Objective*	Increase in Insurance Coverage of Evidence-Based Treatment for Nicotine Dependency	1998 Baseline (unless noted)	2010 Target
		Percent	
27-8a.	Managed care organizations	75 (1997–98)	100
		Number	
27-8b.	Medicaid programs in States and the District of Columbia	24	51

* For data control purposes, subobjectives are not renumbered.

Target setting method: Total coverage of FDA-approved pharmacotherapies and behavioral therapies.

REVISED OBJECTIVE *(continued)*

Data sources: Addressing Tobacco in Managed Care Survey (managed care data), Robert Wood Johnson Foundation; Health Policy Tracking Service (Medicaid data), National Conference of State Legislators.

Exposure to Secondhand Smoke

NO CHANGE IN OBJECTIVE
(Data updated and footnoted)

27-9. Reduce the proportion of children who are regularly exposed to tobacco smoke at home.

Target: 6[1] percent.

Baseline: 20[2] percent of children aged 6 years and under lived in a household where someone smoked inside the house at least 4 days per week in 1998.[2]

Target setting method: Better than the best.

Data source: National Health Interview Survey (NHIS), CDC, NCHS.

[1] Target revised from 10 because of baseline revision after November 2000 publication.
[2] Baseline and baseline year revised from 27 and 1994 after November 2000 publication.

NO CHANGE IN OBJECTIVE
(Data updated and footnoted)

27-10. Reduce the proportion of nonsmokers exposed to environmental tobacco smoke.

Target: 63[1] percent.

Baseline: 88[2] percent of nonsmokers aged 4 years and older had a serum cotinine level above 0.10 ng/mL in 1988–94 (age adjusted to the year 2000 standard population).

Target setting method: Better than the best.

Data source: National Health and Nutrition Examination Survey (NHANES), CDC, NCHS.

[1] Target revised from 45 because of baseline revision after November 2000 publication.
[2] Baseline revised from 65 after November 2000 publication.

NO CHANGE IN OBJECTIVE

27-11. Increase smoke-free and tobacco-free environments in schools, including all school facilities, property, vehicles, and school events.

Target: 100 percent.

Baseline: 37 percent of middle, junior high, and senior high schools were smoke-free and tobacco-free in 1994.

Target setting method: Retain year 2000 target.

Data source: School Health Policies and Programs Study (SHPPS), CDC, NCCDPHP.

ORIGINAL OBJECTIVE

27-12. Increase the proportion of worksites with formal smoking policies that prohibit smoking or limit it to separately ventilated areas.

Target: 100 percent.

Baseline: 79 percent of worksites with 50 or more employees had formal smoking policies that prohibited or limited smoking to separately ventilated areas in 1998–99.

Target setting method: Retain year 2000 target.

Data source: National Worksite Health Promotion Survey, Association for Worksite Health Promotion (AWHP).

OBJECTIVE WITH REVISIONS

27-12. Increase the proportion of ~~worksites with formal smoking policies that prohibit smoking or limit it to separately ventilated areas~~ persons covered by indoor worksite policies that prohibit smoking.

Target: 100 percent.

Baseline: ~~79~~69 percent of persons were covered by~~worksites with 50 or more employees had formal~~ indoor worksite smoking policies that prohibited ~~or limited~~ smoking ~~to separately ventilated areas~~ in 1998–99.

Target setting method: ~~Retain year 2000 target~~ Total coverage.

Data source: ~~National Worksite Health Promotion Survey, Association for Worksite Health Promotion (AWHP)~~Current Population Survey (CPS), U.S. Bureau of the Census and U.S. Bureau of Labor Statistics.

REVISED OBJECTIVE

27-12. Increase the proportion of persons covered by indoor worksite policies that prohibit smoking.

Target: 100 percent.

Baseline: 69 percent of persons were covered by indoor worksite smoking policies that prohibited smoking in 1998–99.

Target setting method: Total coverage.

Data source: Current Population Survey (CPS), U.S. Bureau of the Census and U.S. Bureau of Labor Statistics.

ORIGINAL OBJECTIVE

27-13. Establish laws on smoke-free indoor air that prohibit smoking or limit it to separately ventilated areas in public places and worksites.

Target and baseline:

Objective	Jurisdictions With Laws on Smoke-Free Air	1998 Baseline	2010 Target
		Number	
	States and the District of Columbia		
27-13a.	Private workplaces	1	51
27-13b.	Public workplaces	13	51
27-13c.	Restaurants	3	51
27-13d.	Public transportation	16	51
27-13e.	Day care centers	22	51
27-13f.	Retail stores	4	51
27-13g.	**Tribes**	Developmental	
27-13h.	**Territories**	Developmental	

Target setting method: Retain year 2000 target.

Data source: State Tobacco Activities Tracking and Evaluation System (STATE System), CDC, NCCDPHP, OSH.

OBJECTIVE WITH REVISIONS

27-13. Establish laws on smoke-free indoor air that prohibit smoking ~~or limit it to separately ventilated areas~~ in public places and worksites.

OBJECTIVE WITH REVISIONS *(continued)*

Target and baseline:

Objective*	Jurisdictions With Laws on Smoke-Free Air	1998 Baseline	2010 Target
		Number	
	States and the District of Columbia		
27-13a.	Private workplaces	1	51
27-13b.	Public workplaces	13	51
27-13c.	Restaurants	3	51
27-13d.	Public transportation	16	51
27-13e.	Day care centers	22	51
27-13f.	Retail stores	4	51
27-13g.	**Tribes**	Developmental	
27-13h.	**Territories**	Developmental	
27-13i.*	Bars	0	51

* For data control purposes, subobjectives are not renumbered.

Target setting method: ~~Retain year 2000 target~~Total coverage.

Data source: State Tobacco Activities Tracking and Evaluation System (STATE System), CDC, NCCDPHP, OSH.

REVISED OBJECTIVE

27-13. Establish laws on smoke-free indoor air that prohibit smoking in public places and worksites.

Target and baseline:

Objective*	Jurisdictions With Laws on Smoke-Free Air	1998 Baseline	2010 Target
		Number	
	States and the District of Columbia		
27-13a.	Private workplaces	1	51
27-13b.	Public workplaces	10	51
27-13c.	Restaurants	2	51
27-13d.	Public transportation	15	51
27-13e.	Day care centers	22	51
27-13f.	Retail stores	16	51
27-13g.	**Tribes**	Developmental	

REVISED OBJECTIVE *(continued)*

27-13h.	**Territories**	Developmental	
27-13i.*	Bars	0	51

* For data control purposes, subobjectives are not renumbered.

Target setting method: Total coverage.

Data source: State Tobacco Activities Tracking and Evaluation System (STATE System), CDC, NCCDPHP, OSH.

Social and Environmental Changes

NO CHANGE IN OBJECTIVE

27-14. Reduce the illegal sales rate to minors through enforcement of laws prohibiting the sale of tobacco products to minors.

Target and baseline:

Objective	Jurisdictions With a 5 Percent or Less Illegal Sales Rate to Minors	1998 Baseline	2010 Target
		Number	
27-14a.	States and the District of Columbia	0	51
27-14b.	Territories	0	All

Target setting method: Based on published literature and expert opinion.

Data source: State Synar Enforcement Reporting, SAMHSA, CSAP.

NO CHANGE IN OBJECTIVE

27-15. Increase the number of States and the District of Columbia that suspend or revoke State retail licenses for violations of laws prohibiting the sale of tobacco to minors.

Target: All States and the District of Columbia.

Baseline: 34 States with some form of retail licensure could suspend or revoke the license for violation of minors' access laws in 1998.

Target setting method: Total coverage.

Data source: State Tobacco Activities Tracking and Evaluation System (STATE System), CDC, NCCDPHP, OSH.

ORIGINAL OBJECTIVE

27-16. (Developmental) Eliminate tobacco advertising and promotions that influence adolescents and young adults.

Potential data source: American Legacy Foundation and National Association of Attorneys General.

OBJECTIVE WITH REVISIONS

27-16. ~~(Developmental) Eliminate~~Reduce the proportion of adolescents and young adults who are exposed to tobacco advertising and promotion~~s that influence adolescents and young adults~~.

Target and baseline:

Objective	Reduction in the Proportion of Adolescents in Grades 6 Through 12 Exposed to Tobacco Advertising and Promotion	2000 Baseline	2010 Target
		Percent	
27-16a.	Internet advertising and promotion	28	25
27-16b.	Magazine and newspaper advertising and promotion	74	67

Target setting method: Better than the best.

~~Potential d~~Data source: ~~American Legacy Foundation and National Association of Attorneys General.~~National Youth Tobacco Survey (NYTS), American Legacy Foundation and CDC.

REVISED OBJECTIVE

27-16. Reduce the proportion of adolescents and young adults who are exposed to tobacco advertising and promotion.

Target and baseline:

Objective	Reduction in the Proportion of Adolescents in Grades 6 Through 12 Exposed to Tobacco Advertising and Promotion	2000 Baseline	2010 Target
		Percent	
27-16a.	Internet advertising and promotion	28	25
27-16b.	Magazine and newspaper advertising and promotion	74	67

Target setting method: Better than the best.

REVISED OBJECTIVE *(continued)*

Data source: National Youth Tobacco Survey (NYTS), American Legacy Foundation and CDC.

NO CHANGE IN OBJECTIVE

27-17. Increase adolescents' disapproval of smoking.

Target and baseline:

Objective	Increase in Adolescents' Disapproval of Smoking	1998 Baseline	2010 Target
		Percent	
27-17a.	8th grade	80	95
27-17b.	10th grade	75	95
27-17c.	12th grade	69	95

Target setting method: Retain year 2000 target.

Data source: Monitoring the Future Study (MTF), NIH, NIDA.

ORIGINAL OBJECTIVE

27-18. (Developmental) Increase the number of Tribes, Territories, and States and the District of Columbia with comprehensive, evidence-based tobacco control programs.

Potential data sources: State Tobacco Activities Tracking and Evaluation System (STATE System), CDC, NCCDPHP, OSH; IHS.

OBJECTIVE WITH REVISIONS

27-18. ~~(Developmental)~~ Increase the number of ~~Tribes, Territories, and~~ States and the District of Columbia, Territories, and Tribes with sustainable and comprehensive evidence-based tobacco control programs.

Target and baseline:

Objective	Increase in Sustainable and Comprehensive Evidence-Based Tobacco Control Programs	2002 Baseline	2010 Target
		Number	
27-18a.	States and the District of Columbia	5	51
27-18b.	Territories	Developmental	
27-18c.	Tribes	Developmental	

OBJECTIVE WITH REVISIONS *(continued)*

Target setting method: Total coverage.

~~**Potential d**~~**Data sources:** State Tobacco Activities Tracking and Evaluation System (STATE System), CDC, NCCDPHP, OSH; IHS.

REVISED OBJECTIVE

27-18. Increase the number of States and the District of Columbia, Territories, and Tribes with sustainable and comprehensive evidence-based tobacco control programs.

Objective	Increase in Sustainable and Comprehensive Evidence-Based Tobacco Control Programs	2002 Baseline	2010 Target
		Number	
27-18a.	States and the District of Columbia	5	51
27-18b.	Territories	Developmental	
27-18c.	Tribes	Developmental	

Target setting method: Total coverage.

Data source: State Tobacco Activities Tracking and Evaluation System (STATE System), CDC, NCCDPHP, OSH; IHS.

NO CHANGE IN OBJECTIVE

27-19. Eliminate laws that preempt stronger tobacco control laws.

Target: Zero States.

Baseline: 30 States had preemptive tobacco control laws in the areas of clean indoor air, minors' access laws, or marketing in 1998.

Target setting method: Retain year 2000 target.

Data source: State Tobacco Activities Tracking and Evaluation System (STATE System), CDC, NCCDPHP, OSH.

ORIGINAL OBJECTIVE

27-20. (Developmental) Reduce the toxicity of tobacco products by establishing a regulatory structure to monitor toxicity.

Potential data source: FDA.

OBJECTIVE WITH REVISIONS

27-20. ~~**(Developmental)**~~ **Reduce** ~~**the toxicity of**~~**the sales-weighted average level of toxic chemicals in tobacco products** ~~**by establishing a regulatory structure to monitor toxicity**~~**sold in the United States.**

Target and baseline:

Objective	Reduction in Sales-Weighted Average Levels of Toxic Chemicals in the Smoke of Cigarettes Sold in the United States	2003 Baseline (unless noted)	2010 Target
		Nanograms per Cigarette	
27-20a.	Tobacco-specific nitrosamines	121.5	109.4
27-20b.	Polyaromatic hydrocarbon compounds (PAHs)	993.7	894.3
		Micrograms per Cigarette	
27-20c.	Volatile organic compounds (VOCs)	707.0 (2002)	636.3

Target setting method: 10 percent improvement.

~~**Potential d**~~**Data sources:** ~~FDA.~~ CDC, NCCDPHP, OSH; NCEH, Division of Laboratory Sciences.

REVISED OBJECTIVE

27-20. Reduce the sales-weighted average level of toxic chemicals in tobacco products sold in the United States.

Target and baseline:

Objective	Reduction in Sales-Weighted Average Levels of Toxic Chemicals in the Smoke of Cigarettes Sold in the United States	2003 Baseline (unless noted)	2010 Target
		Nanograms per Cigarette	
27-20a.	Tobacco-specific nitrosamines	121.5	109.4
27-20b.	Polyaromatic hydrocarbon compounds (PAHs)	993.7	894.3
		Micrograms per Cigarette	
27-20c.	Volatile organic compounds (VOCs)	707.0 (2002)	636.3

Target setting method: 10 percent improvement.

Data sources: CDC, NCCDPHP, OSH; NCEH, Division of Laboratory Sciences.

ORIGINAL OBJECTIVE

27-21. Increase the average Federal and State tax on tobacco products.

Target and baseline:

Objective	Increase in Combined Federal and Average State Tax	1998 Baseline	2010 Target
27-21a.	Cigarettes	$0.63*	$2.00
27-21b.	Spit tobacco	Developmental†	

* 24 cent Federal tax; 38.9 cent average State tax in 1998.
† 2.7 cent Federal tax in 1999; 7 States and the District of Columbia did not tax smokeless tobacco products in 1999.

Target setting method: Expert opinion; comparison to international tax rates.

Data source: The Tax Burden on Tobacco, The Tobacco Institute.

OBJECTIVE WITH REVISIONS

27-21. Increase the average Federal and State tax on ~~tobacco products~~cigarettes and expand the number of States with higher smokeless tobacco taxes over the decade.

Target and baseline:

Objective	Increase in Combined Federal and Average State Tax and in the Number of States With Higher Smokeless Tobacco Taxes	1998 Baseline (unless noted)	2010 Target
		Dollars per Standard U.S. Package of Cigarettes	
27-21a.	Cigarettes	~~$0.63*~~ $0.59[1]	$2.00
		Number of States and the District of Columbia	
27-21b.	~~Spit~~ Smokeless tobacco[2]	3[3] (2000–2001)[3] ~~Developmental~~	51*

* 2.7 cent Federal tax in 1999; 7 States and the District of Columbia did not tax smokeless tobacco products in 1999.

Target setting method: ~~E~~For 27-21a, expert opinion; ~~comparison to international tax rates.~~for 27-21b, total coverage.

Data source: ~~The Tax Burden on Tobacco, The Tobacco Institute;~~ State Tobacco Activities Tracking and Evaluation System (STATE System), CDC, NCCDPHP, OSH.

OBJECTIVE WITH REVISIONS *(continued)*

[1] Baseline revised from $0.63 after November 2000 publication.
[2] Smokeless tobacco now used instead of spit tobacco.
[3] Number of States that have increased taxes on smokeless tobacco.

REVISED OBJECTIVE

27-21. Increase the average Federal and State tax on cigarettes and expand the number of States with higher smokeless tobacco taxes over the decade.

Target and baseline:

Objective	Increase in Combined Federal and Average State Tax and in the Number of States With Higher Smokeless Tobacco Taxes	1998 Baseline (unless noted)	2010 Target
		Dollars per Standard U.S. Package of Cigarettes	
27-21a.	Cigarettes	$0.59[1]	$2.00
		Number of States and the District of Columbia	
27-21b.	Smokeless tobacco[2]	3 (2000–2001)	51*

* 2.7 cent Federal tax in 1999; 7 States and the District of Columbia did not tax smokeless tobacco products in 1999.

Target setting method: For 27-21a, expert opinion; for 27-21b, total coverage.

Data source: State Tobacco Activities Tracking and Evaluation System (STATE System), CDC, NCCDPHP, OSH.

[1] Baseline revised from $0.63 after November 2000 publication.
[2] Smokeless tobacco now used instead of spit tobacco.

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Related Objectives From Other Focus Areas

1. Access to Quality Health Services

1-3. Counseling about health behaviors

3. Cancer

3-1. Overall cancer deaths
3-2. Lung cancer deaths
3-4. Cervical cancer deaths
3-6. Oropharyngeal cancer deaths

7. Educational and Community-Based Programs

7-5. Worksite health promotion programs
7-6. Participation in employer-sponsored health promotion activities
7-10. Community health promotion programs
7-11. Culturally appropriate and linguistically competent community health promotion programs
7-12. Older adult participation in community health promotion activities

8. Environmental Health

8-18. Homes tested for radon
8-19. Radon-resistant new home construction
8-29. Global burden of disease

12. Heart Disease and Stroke

12-1. Coronary heart disease (CHD) deaths
12-7. Stroke deaths

16. Maternal, Infant, and Child Health

16-1. Fetal and infant deaths
16-6. Prenatal care
16-10. Low birth weight and very low birth weight
16-11. Preterm births
16-17. Prenatal substance exposure

21. Oral Health

21-6. Early detection of oral and pharyngeal cancers
21-7. Annual examinations for oral and pharyngeal cancers

23. Public Health Infrastructure

23-4. Data for all population groups

24. Respiratory Diseases

24-1. Deaths from asthma
24-2. Hospitalizations for asthma
24-3. Hospital emergency department visits for asthma

26. Substance Abuse

- 26-9. Substance-free youth
- 26-16. Peer disapproval of substance abuse
- 26-17. Perception of risk associated with substance abuse