NACCHO
National Association of County & City Health Officials

13-12

STATEMENT OF POLICY

Comprehensive Tobacco Prevention and Control at the Local Level

Policy

The National Association of County and City Health Officials (NACCHO) supports national, state, and local public health approaches that enhance local health department capacity to prevent tobacco use initiation, promote tobacco cessation, eliminate exposure to secondhand smoke, and identify and eliminate tobacco-related disparities.

NACCHO supports policies and actions aligned with National Prevention Strategy strategic directions and priorities, recommendations from the Guide to Community Preventive Services recommendations, and the Centers for Disease Prevention and Control's (CDC's) Best Practices for Comprehensive Tobacco Programs, which include the following:[1,2,3,4]

- Federal, state, and non-governmental funding at or above levels recommended by the CDC to implement comprehensive local tobacco control programs.
- Comprehensive local programming that includes community interventions; health communications interventions; cessation interventions; disease, sales, and use surveillance and evaluation; and program administration and management functions.
- Proven programs and policies, such as those outlined in the Guide to Community Preventive Services, to prevent tobacco use and reduce exposure to secondhand smoke, including smoke-free workplaces, city and county buildings, and other public places.
- Increases in the price of tobacco products through increased excise taxes, particularly if funds are used to enhance revenue for proven tobacco control and prevention programs.
- Smoke-free and tobacco-free policies for indoor environments (e.g., restaurants, bars, casinos, multiunit housing) and outdoor environments (e.g., public parks, recreation areas, beaches).
- Expansion of services to help smokers quit, including promotion of toll-free telephone quit lines, individual and group counseling, and greater use of cessation benefits available through many health plans.
- Mass media campaigns to convey health risks of tobacco use, encourage smokers to quit, decrease social acceptability of tobacco use, and build public support for tobacco control policies.
- Epidemiologic data collection and analysis to identify emerging issues in tobacco control.
- Policies and programs that reduce youth access to tobacco products.
- Policies and programs that promote health equity in tobacco prevention and control, including joint efforts with local anti-tobacco coalitions who represent communities most impacted and data collection inclusive of subpopulations.
- Policies and programs that include and are accessible to people with disabilities to reduce and prevent smoking among people with disabilities.

- Collaboration with the Food and Drug Administration (FDA) to ensure full implementation of the 2009 Family Smoking Prevention and Tobacco Control Act (Tobacco Control Act), the landmark law that for the first time grants the FDA authority to regulate the manufacture, distribution, and marketing of tobacco products.

NACCHO encourages local health departments to enforce regulations established in the Tobacco Control Act at the local level and implement additional necessary regulations to address any gaps or shortcomings in the federal legislation. Specifically, NACCHO supports local health department efforts to address use of non-cigarette tobacco products, including electronic cigarettes, hookah, and smokeless and emerging tobacco products. (See NACCHO policy statements on Regulation of Electronic Cigarettes, Supporting Local Legislation to Ban Hookah Smoking, and Regulation of Smokeless and Emerging Tobacco Products.)

NACCHO encourages local health departments to support programs and policies to identify and eliminate tobacco-related disparities.

NACCHO encourages local health departments to call upon the FDA to prohibit menthol as a characterizing flavor and, until then, take action at the local level to address menthol cigarettes, which despite their minty flavor, were exempted from the Tobacco Control Act's flavor prohibition.

Justification

In the United States, tobacco use is the leading preventable cause of death, disability, and disease. Each year, 443,000 people die prematurely from smoking or exposure to secondhand smoke, and another 8.6 million suffer from serious illness caused by smoking.[5] Each day, more than 3,800 young people under age 18 years of age smoke their first cigarette, and more than 1,000 become daily cigarette smokers.[6]

An estimated 88 million nonsmoking Americans, including 54 percent of children aged 3 to 11 years, are exposed to secondhand smoke. Secondhand smoke exposure causes serious disease and death, including heart disease and lung cancer in nonsmoking adults and sudden infant death syndrome, acute respiratory infections, ear problems, and more frequent and severe asthma attacks in children. Each year, primarily due to secondhand smoke exposure, 3,000 nonsmoking Americans die of lung cancer, more than 46,000 die of heart disease, and about 150,000 to 300,000 children younger than 18 months have lower respiratory tract infections.[7] Although secondhand smoke exposure has declined overall since the 1986 Surgeon General's Report on involuntary smoking, the 2006 report on the same topic found that secondhand smoke exposure continues in restaurants, bars, casinos, gaming halls (areas often exempted by current smoke-free air laws) and that homes and workplaces are major locations for secondhand smoke exposure.[8] In multiunit housing, secondhand smoke exposure poses a concern even for residents who have chosen to make their own units smoke-free. Almost 50 percent of multiunit housing residents report having experienced secondhand smoke infiltrating their unit.[9]

During 2000–2004, cigarette smoking cost the United States $193 billion in annual health-related economic losses— nearly $96 billion in direct medical costs and $97 billion in lost productivity. Annual costs of secondhand smoke exposure reach $10 billion per year.[10] Due to the funding of public health insurance programs and treating the uninsured, state and local governments bear a substantial burden of these excess costs. Local health departments are on the front lines of public health and play an essential role in limiting the burden of tobacco use.

Non-cigarette tobacco products are growing in popularity, including electronic cigarettes (e-cigarettes) and other emerging products, such as orbs, sticks, strips, and dissolvables. These products are often used not in place of cigarettes, but in addition to them. For example, about 21 percent of adult smokers had used e-cigarettes in 2011, up from about 10 percent in 2010; overall, the percentage of all adults who had ever tried e-cigarettes (6%) nearly doubled during this time period.[11] Similarly, a 2013 CDC study found a doubling in the numbers of high-school and middle-school aged youth who had experimented with e-cigarettes, from 4.7% and 1.4 %, respectively, in 2011, to 10% and 2.7% in 2013.[12] Meanwhile, a 2012 study showed a 30 percent dual use rate (the use of cigarettes in conjunction with one or more other tobacco products) among current tobacco users and showed that 64 percent of individuals who use other tobacco products smoke cigarettes concurrently.[13]

An ongoing challenge is the lack of secure funding for tobacco prevention and control programs and activities. Local health departments are often the frontline for regulation, awareness, and education about emerging products. However, federal and state budget cuts significantly impact local health department capacity to provide clinical services and population-primary prevention services, including those aimed at prevention and reduction of tobacco use. Therefore, it is imperative that local health departments educate decision makers about the importance of dedicated funding for tobacco prevention and control. Diverse resources and funding opportunities should enable local health departments to maintain a sufficient budget and implement evidence-based programs that are cost-effective and sustainable.

State and local public health practitioners, healthcare providers, and policymakers recognize that the tobacco industry's promotion practices often target women, youth, and communities of color. As a result, rates of tobacco use are disproportionately higher among these populations. For example, 47.7 percent of adolescent (age 12–17) smokers report menthol cigarette use compared to 40.8 percent of young adult smokers (age 18–25) and 31.5 percent of older adult smokers (age 26 or older). Menthol cigarettes are also used at disproportionately higher rates by racial and ethnic minority smokers, including African-Americans (82.6%), Native Hawaiian or Pacific Islanders (53.2%), Hispanics or Latinos (32.3%), and Asian Americans (31.2%), relative to White smokers (23.8%).[14] Cigarette smoking is significantly higher among adults with a disability (25.4%) compared to adults without a disability (17.3%).[15] Tobacco use is also correlated with income level and education and is higher in populations with lower education and socioeconomic status.[16] As a result, some population subgroups experience disproportionately higher morbidity and mortality rates associated with tobacco use than others.

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