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Smoking Isn't Cool Anymore: The Success and Continuing Challenge of Public Health Efforts to Reduce Smoking

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The six tobacco related papers in this issue of JPHMP will remind readers of both the tremendous progress that has been made over the past half century in reducing cigarette use and the continuing challenges that remain to be addressed to accelerate a decline in the health consequences of cigarette smoking (1–6). The 1964 report of the Surgeon General's Advisory Committee marked the beginning of a sea-change in public attitudes about smoking that have continued evolve up to this day (7). For those of us who are old enough to remember there was a time when smoking was permitted nearly everywhere: smokers could light up at work, in hospitals, in school buildings, in bars, in restaurants, and even on buses, trains and planes. It was common to see doctors, athletes, and celebrities smoking and advertising cigarettes. So common was cigarette advertising that a 1967 Federal Trade Commission report observed that it was "impossible for Americans of almost any age to avoid cigarette advertising" (8).

How things for changed. Once a sign of class and glamour, smoking is no longer sexy, cool, or even normal. The shift in public perceptions is important because perception and the social pressure that comes along with it have been the driving force behind the decline of smoking over the last half century. Once consider a rite of passage into adulthood, the majority of teenagers today have never smoked and don't intend to. In 1965, 42% of adults were current smokers while the latest figures from CDC show smoking rates having fallen to 15% (9, 10).

While the success of comprehensive tobacco control policies and programming is now irrefutable (11, 12), the paper by Roeseler and colleagues (1) document that the implementation of evidence based tobacco control policies and programs is suboptimal in all states, with huge variations across states and regions. The good news is many states are making slow and steady progress in implementing smoke-free policies, hiking cigarette taxes, and adopting policies to discourage smoking by young people.

The paper by Neuberger and LeClair (2) provide yet another demonstration that the public is way out ahead of the policy makers when it comes to tobacco control (13). In 2010, Kansas legislators passed the Kansas Clean Indoor Air Act which effectively banned smoking in indoor workplaces and public spaces restaurants and bars. Opponents of the law challenged its enforceability and public support, but the evidence presented in this paper shows that

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compliance with the law was outstanding with few violations of the law reported (i.e. 1.47 per 100,000), and only a handful of fines or sanctions issued over a two year period. As the authors note in their conclusion, “if a socially conservative state such as Kansas with a keen interest in individual liberties can create, observe, and maintain such a law, the other 26 states without such a law (or the United States as a whole) could surely do the same” (2).

The paper by Mamudu and colleagues (3), describe some of challenges associated with implementing another type of tobacco-free policy – i.e., tobacco free campuses. Tobacco free campuses policies represent an effort to extend tobacco free elementary and secondary school policies to young adults, who often gravitate towards cigarette smoking when they get to college. College campuses have always been a hotbed of tobacco marketing activity for manufacturers who recognize if they fail to get someone smoking by age 25, chances are they will never take up smoking (14). So far about 15% of US colleges/universities have implemented tobacco free campus policies and more are likely to join this movement as the appeal of smoking continues to wane among young people (3). Tobacco free campus policies will also likely become easier to implement as more states and localities increase the legal age for the purchase of tobacco from 18 to 21 years, as recently recommended by the Institute of Medicine (15, 16).

While addressing tobacco use by college students may become easier overtime, a more challenging problem facing tobacco control is how to address tobacco use among the poor and disenfranchised segments of society. Over 25% of people living below the poverty line smoke and smoking is more common among those with mental health and substance abuse diagnoses (17, 18). Stress due to economic insecurity and social and medical problems can not only lead people into smoking, but can it make it harder to quit (19). Making matters worse, cigarette companies often target low income neighborhoods with their advertising and price promotions to ensure a steady stream of customers (14, 20).

The paper by Xu et al. (4) describes consumer participation in some of the price marketing schemes that cigarette makers have devised to keep people smoking. What is apparent from the findings of this study is that cigarette companies have employed a wide array of sophisticated price marketing strategies to appeal to different segments of the smoking market. Persuading government officials to adopt policies that keep cigarette prices high and reduce price differentials among brands would prevent smoking initiation and encourage more smokers to quit (21). Not surprisingly, tobacco companies fight the hardest when it comes to policies that threaten to increase the purchase price of their products, which is justification enough for public health officials to keep pushing for ways to raise tobacco prices whether it be it through excise taxes, minimum pricing laws, improved track and tracing methods to prevent tax evasion, and/or policies that prohibit price promotions such as couponing and promotional allowances to retailers and wholesalers (22, 23).

While much progress has been made in reducing smoking in American, a careful analysis of what has been driving down smoking prevalence rates over the past 20 years reveals that much of the decline is the result of fewer young people taking up smoking, not so much the outflow of adult smokers quitting and remaining smoke-free (23). The reason for this is obvious, but still not very well appreciated; nicotine addiction is hard to overcome (19). It is

important to recognize that the cigarette manufacturers have worked hard to engineer their cigarettes in ways that make them difficult for people to stop using (19, 23–26). The paper by Dube and colleagues (5) reinforces what tobacco companies have known for decades ago, most adult smokers would quit if they could (27). The problem as Daube et al (5) point out is that the current array of tobacco cessation treatments are poor substitutes for cigarettes, since they are costly and inconvenient to acquire and use.

While we've had clinical practice guidelines for treating nicotine addiction for over a decade, the guidelines have never been fully translated into practice (28, 29). The sad reality is that the treatment of nicotine addiction is severely under-resourced which is why tobacco cessation treatment interventions have had relatively little impact on reducing smoking prevalence rates. Policies do matter. The paper by Athar and colleagues (6) provide an analysis of what would happen if states were to adopt policies to expand Medicaid the coverage and delivery of nicotine replacement therapies to smokers. The results are predictable, make it easier for smokers to get treatment for their nicotine addiction, smoking rates will go down, and the states and taxpayers will realize a net cost savings by reducing medical expenditures from treating costly smoking related diseases (6).

Fiscal conservatives should embrace smoking cessation since there are relatively few clinical interventions that are comparable in terms of cost-effective and that offer the potential to stem skyrocketing health care costs. Unfortunately, most states today would get an "F-grade" when it comes to delivery tobacco cessation support to smokers (30). Unfortunately, the US health system is set up to reward the treatment of acute health problems, not prevent problems from happening in the first place. Even in places where reimbursement barriers for smoking cessation have been theoretically been eliminated, getting smoking cessation treatments reimbursed is often difficult. Not surprisingly many patients and clinician simply give up. The tobacco control movement needs to do better job advocating for policies that will make it easier for smokers to get effective treatments (both pharmacologic and behavioral) to help them overcome their nicotine addiction. Here are a few suggestions of what might be done:

1. Eliminate where possible the bureaucratic barriers that impede the delivery (e.g., prior authorizations and co-pays) and delay reimbursement of smoking cessation treatments provided in health care settings.

2. Incentivize health care institutions to do a much better job delivering tobacco cessation support to their patients. For example, as a condition of receiving a license to operate, hospitals should be required to offer evidence based tobacco cessation treatment to all smokers as the Joint Commission recommended in 2012 (31). Smokers, of course, would be free to *opt out* of treatment, but evidence shows that most will happily accept treatment if provided.

3. Promote policies that improve the training of clinicians in how to effectively treat nicotine addiction. Clinician of all disciplines need to have a better understanding of nicotine addiction, as many still approach cigarette addiction as a character flaw rather than as a medical condition that requires treatment. Tobacco and nicotine addiction and treatment needs to be consistently taught in medical schools, nursing

schools, and other ancillary schools. Questions about tobacco and nicotine dependence and treatment need to be included certification exams.

4. Promote policies that encourage companies to develop and market cost-competitive evidence based harm reduction substitutes for cigarettes.

5. Stop corporate welfare for tobacco companies allowing them to collect the profits from selling cigarettes while passing off the downstream health care costs of treating nicotine addiction and the associated diseases onto taxpayers. Raising tobacco taxes to a level that reimburses states for their health care expenses and earmarking funds to cover the costs of smoking cessation services would be a start (1).

6. Finally it is well past time for the cigarette industry be held accountable for the consequences of manufacturing and promoting a product that causes so much disease and death. State and federal laws that have shielded cigarette manufacturers from liability for selling defective products need to be changed (32).

In summary, the tobacco related articles in this issue of JPHMP remind us that the decline in smoking prevalence that has taken place over the past 50 years has come about not just because of greater public understanding of the health risks of tobacco, but also because cigarette smoking is simply increasingly less socially accepted as it once was and that public health efforts to control tobacco in the future need to keep it that way.

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