Tobacco Policy Update: 6 Trends to Follow in 2017

Population Health Sciences

Date Posted:

Mar 13, 2017

Each day in our practices, we come across children and families exposed to cigarette smoke. Parents tell us that they want to quit, but they need help. Pediatric clinicians are uniquely positioned to provide that support. We can provide extra motivation for parents by framing quitting as a way to help protect their children and leverage our role as trusted education resources to start tobacco treatment, provide medications and connect parents to additional resources.

While there are so many challenges in U.S. health care and public health, cigarette smoking *remains* the leading cause of preventable disease and death in this country. Each year, approximately 480,000 deaths are attributable to smoking, making it responsible for one of every five deaths and one of every three cancer deaths in the U.S.

Furthermore, there is no safe level of tobacco exposure. Exposure to secondhand smoke (SHS) from burning tobacco, in particular, harms children their entire lives. SHS exposure affects 58 million U.S. nonsmokers – one-quarter of nonsmokers - causing more than 41,000 deaths among nonsmoking adults and 400 deaths in infants each year.

For those that care for these affected children and parents, there is hope. New policies and technologies can empower pediatric clinicians and pediatric health care systems to help parent smokers quit. Fortunately, new policies outside of the health care setting may help prevent smoking initiation, as well as improve cessation treatments. Below are six important policy and practice trends to watch in tobacco control efforts. For more information on these policies, be sure to read my recent review article in *Academic Pediatrics*.

1. The rise in e-cigarette use among youth is creating the need to reexamine tobacco control policies.

As of 2015, more youth reported using e-cigarettes than any other tobacco product, with substantial increases in their use among middle and high school students over the past five years. In fact, the rise of e-cigarettes halted long-term declines of tobacco use among youth between 2011 to 2015. Moreover, there are potential health harms to nonusers from e-cigarettes because of the toxicants, including nicotine, carcinogens and metal particles, found in the secondhand and thirdhand aerosol (residual nicotine and other chemicals left on surfaces). Several longitudinal studies of U.S. adolescents and young adults have added further evidence to a strong association between use of e-cigarettes and progression to traditional cigarette smoking, strengthening the argument to limit e-cigarette sales and decrease their appeal to protect public health. See the recent American Academy of Pediatrics and Surgeon General reports for these evidence-based reviews.

2. Federal policies currently in place are expanding physicians' ability to help parents quit smoking.

Currently, tobacco cessation efforts, including medications and behavioral interventions, are provided at no cost under most types of health insurance plans. In practice, however, there is no single definition of “tobacco cessation”, and the scope of coverage varies by state, insurance and insurance provider. As the U.S. health system continues to focus on population health and value-based care, insurance companies, accountable care organizations and Medicaid, in particular, can contribute to improving health and reducing health costs by paying for tobacco cessation efforts that have been shown to help smokers quit. While the future and shape of the Affordable Care Act (ACA) will be debated and considered over the next year, legislatures should maintain progress and expand access and use of tobacco prevention and treatment services across health care settings.

3. Researchers are developing new pediatric practice policies and interventions to help parents quit smoking.

As I’ve discussed before on this blog, when parents quit smoking, they not only increase their own life expectancy by an average of 10 years and eliminate the majority of their children’s SHS exposure, they also decrease the likelihood of their children becoming smokers later in life. Pediatricians are favorably positioned to help parents quit smoking by working through their children, but evidence-based treatment options are significantly underutilized. Clinical decision support tools embedded in electronic health records seamlessly fit within the physician workflow to help them efficiently ask, counsel, prescribe appropriate medications and electronically connect families to additional smoking treatment (such as telephone-based counseling, called Smoker Quitlines). Currently, the Pennsylvania Free Quitline is working with Children’s Hospital of Philadelphia to connect parents to their services, an acknowledgement of the important role pediatricians play in helping parents quit smoking.

4. The Food and Drug Administration (FDA) is increasingly regulating production and marketing of tobacco products.

The Family Smoking Prevention and Tobacco Control Act, signed into law by President Obama in 2009, expanded the FDA’s charge to protect consumers and enhance public health by giving the agency the authority to regulate tobacco products and minimize risk associated with those products. In August 2016, the FDA finalized a rule that extends its regulatory authority to all tobacco products, including e-cigarettes, cigars, hookah and pipe tobacco, affecting how these products are manufactured, marketed and sold. The implementation and enforcement of these approaches, in coordination with fully funded and sustained comprehensive state tobacco control programs, has the potential to reduce all forms of tobacco use among youths, including e-cigarettes. As the FDA brings more tobacco products under its regulatory authority in the coming years, pediatricians, tobacco control researchers and pediatric health policy experts can support and ensure that the FDA’s approach is grounded in science and uses the full power of the law to protect public health.

5. More and more cities and states are considering policies that increase the purchasing age of tobacco products.

Tobacco use and addiction almost always starts in childhood or adolescence, a period when the brain has heightened susceptibility to nicotine addiction. Among adults who become daily smokers, 80 percent report first using cigarettes as a teenager. Additionally, nearly everyone who buys cigarettes for minors in the U.S. is under 21 years of age. Thus, increasing the minimum age of purchase from 18 to 21 years – an effort called Tobacco 21 – is a simple but effective method to prevent smoking initiation and the subsequent pathway toward nicotine and tobacco addiction. A recent National Academy of Medicine report estimated that increasing the minimum age to 21 across the nation would lead to a 12 percent decrease in smoking rates. Because of the effectiveness of this approach, as of the time of publication, two states, California and Hawaii, several major cities, including New York City, and over 212 municipalities and counties have passed Tobacco 21 laws.

6. An increasing number of multiunit residences are implementing smoke-free policies.

Multiunit housing, such as apartments, represents a potential source of involuntary SHS exposure for a large portion of U.S. children and adults. Smoking in one unit involuntarily exposes those in nearby units. Among multiunit housing residents, surveys suggest strong support for bans on smoking in building areas, including individual units, with increased support among individuals who reside with children. Based on wide support, private-based initiatives are gaining traction throughout the U.S. On November 30, 2016, the U.S. Department of Housing and Urban Development (HUD) announced new regulations to require more than 3,100 public housing agencies across the country to implement smoke-free policies in their developments within 18 months. Questions remain about how the ban in public housing will be enforced. At this time, no studies have evaluated the impact on these policies on smoking behaviors and health outcomes.

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