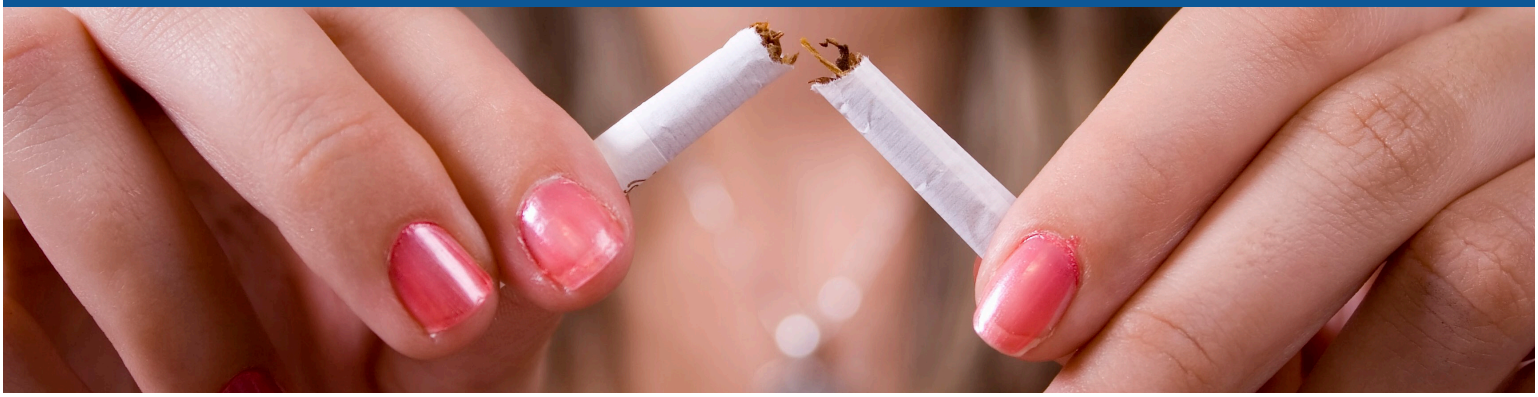
MULTI-SECTOR APPROACHES FOR TOBACCO PREVENTION

RECOMMENDATIONS FOR HEALTH SYSTEMS

Oregon Health Authority



THE PROBLEM

Tobacco imposes a considerable burden on society, including disease, lives lost, health care costs, and lost productivity. Smoking is the leading cause of premature death and preventable disease in Oregon and is responsible for about 7,000 deaths each year. Addressing tobacco use can save lives, improve health outcomes, and reduce health care and lost-productivity costs.

MULTI-SECTOR APPROACH TO ADDRESSING TOBACCO WITH EVIDENCE-BASED HEALTH PRACTICES

Conducting simultaneous multi-sector interventions maximizes the health and economic benefits of addressing tobacco use. Every dollar spent on coordinated, evidence-based tobacco control efforts can yield a savings of $55.[i] Coordinated efforts are effective across racial and ethnic groups, education levels, and socioeconomic status.[ii]

All of the following recommendations for prioritization of tobacco prevention in health spending are informed by *The Community Guide*, unless otherwise noted. *The Community Guide* is the official collection of Community Preventive Services Task Force findings and the systematic reviews on which they are based. These recommendations translate this evidence for Oregon health systems within the state's current tobacco control and prevention environment.

1. **Provide leadership for development of smoke-free policies in workplaces and public spaces.**
   Like other employers, health systems can provide leadership for tobacco-related efforts in the communities they serve by establishing smoke-free campuses through workplace policies and contracts. They can also lend a persuasive voice to efforts to develop public-sector regulations that prohibit tobacco use in public areas.

   Evidence: *Smoke-free policies reduce tobacco use and exposure to second-hand smoke, and increase the number of tobacco users who quit. They also keep young people from initiating tobacco use and reduce acute cardiovascular events and other adverse tobacco-related health issues. Smoke-free policies can substantially reduce health care costs without adverse economic impact on businesses.*

2. **Educate policy makers about the positive effects of raising the per-unit price of tobacco products.**
   Raising the price of tobacco products increases the number of tobacco users who quit and reduces tobacco use, youth initiation, and negative health effects. The medical community is uniquely positioned to provide a persuasive perspective on what these population level effects mean for patients and their families.

   Evidence: *Health effects of raising the price of tobacco are proportional to the size of the price increase and the scale of implementation. Increasing the unit price for tobacco products by 20% has been shown to reduce consumption by 10.4%, prevalence of adult use by 3.6%, and youth initiation of tobacco use by young people by 8.6%. Raising tobacco prices substantially reduces healthcare costs, reduces tobacco-related disparities among income groups, and may reduce disparities by race and ethnicity.*

For more information on Oregon Quitline materials or fax referrals visit: *smokefreeoregon.com/quitresources*

3. **Implement mass-reach communication interventions** to inform individual and public attitudes about tobacco use and secondhand smoke. Communication interventions should be coordinated with a statewide media strategy, and may include broadcast, print, and digital media and out-of-home placements (e.g., billboards, movie theaters, point of sale). Health system communications that promote tobacco cessation may be evaluated for effectiveness by tracking quit line call volumes and tobacco use prevalence. Clear communication of cessation benefits to both tobacco users and healthcare providers increases use and impact of cessation interventions.

   Evidence: *Strong evidence indicates that mass communication interventions decrease prevalence of tobacco use, increase cessation and use of cessation services, and prevent young people from initiating tobacco use. Mass-reach health communication interventions are cost-effective, with a benefit-to-cost ratio of 7:1 to 74:1. Savings from averted healthcare costs exceed intervention costs.*

4. **Community engagement via local public health authorities** to promote tobacco cessation, create tobacco-free community places, and identify and eliminate tobacco-related disparities. While Oregon's local health authorities are uniquely positioned to coordinate local and regional tobacco prevention initiatives, they receive one-quarter of the funding recommended by the Centers for Disease Control and Prevention. Additionally, Oregon ranks 46th in the country for state investment into the public health system overall. Support provided by health systems should be tailored to the needs of local communities.

   Evidence: *Coordinated statewide and local approaches to tobacco prevention and education are demonstrated to reduce initiation of tobacco use and secondhand smoke exposure, and to increase cessation. States that invest in coordinated tobacco control programs show greater reductions in tobacco consumption compared to states that do not.*[ii]

EXAMPLE OF EFFECTIVENESS OF A MULTI-SECTOR APPROACH.

From 2001 to 2010, the New York State Tobacco Control Program reported declines in the prevalence of smoking among adults and youth that outpaced declines nationally.[iii] New York's multi-sector approach included establishing the country's highest state cigarette excise tax, passing a statewide smoke-free air law, running an intensive health communications campaign, engaging community coalitions in decision maker education and ensuring all New Yorkers had access to cessation services. As a result, smoking-attributable personal health care expenditures in New York in 2010 were $4.1 billion less than they would have been had the prevalence of smoking remained at 2001 levels.[iv]

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[i] *Lightwood J, Glantz SA. The effect of the California tobacco control program on smoking prevalence, cigarette consumption, and healthcare costs: 1989-2008. PLoS One 2013; 8(2):e47145.*

[ii] *Guide to Community Preventive Services. Reducing tobacco use and secondhand smoke exposure. www.thecommunityguide.org/tobacco/index.html. Last updated: 8/31/2015.*

[iii] *RTI International. 2011 Independent Evaluation Report of the New York Tobacco Control Program. Albany, NY: New York State Department of Health, 2011.*

[iv] *Centers for Disease Control and Prevention. Best Practices for Comprehensive Tobacco Control Programs—2014. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2014*