

Delaware's Comprehensive Tobacco Control Program

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Policy and program development is messy. It is sometimes an uncomfortable mix of Politics, Epidemiology, Ethics, Economics and Law (PEEEL). This paper is intended to shed some light on current tobacco control initiatives in Delaware using the PEEEL framework, developed by Dru Bhattacharya.¹

Politics

It will come as no surprise that tobacco control is perhaps the most politicized issue in public health history. Delaware is not immune to these politics as, for example, policy makers make budget decisions and weigh civil liberties against population-based approaches to health. In addition, the political activity of the tobacco industry is significant and to some extent the health burden from tobacco is directly attributed to their success.

Epidemiology

While we saw improvements in the first decade of this century, Delaware data show that our adult smoking prevalence has remained stagnant for the past few years. Cigarette smoking is the number one preventable killer in Delaware and the United States. During the time period of 2007-2011, lung cancer accounted for nearly one third (29.9 percent) of all cancer deaths in Delaware. During the 2006-2010 time period, Delaware women ranked fourth highest in the nation for lung cancer mortality, and Delaware men ranked twelfth highest for lung cancer mortality. Approximately one in five Delawareans die of a tobacco-related disease. While lung cancer is the disease most associated with tobacco use, tobacco is also responsible for many deaths from heart disease, respiratory diseases and other cancers. With more than 157,500 Delaware adults and high school students smoking regularly, tobacco use is a persistent and serious public health problem.²

The epidemic of tobacco use is also changing because of political and economic forces. For example, e-cigarettes have been marketed as a healthier alternative to smoking. E-cigarettes contain nicotine and numerous other chemicals including: ultrafine particles; toxic metals; and a number of carcinogens. There has been an alarming increase in their use.³

Ethics

The impact of tobacco use is not distributed evenly throughout the population. The prevalence of smoking is higher among those who have a low income and lower education level, identify as lesbian, bi-sexual, gay or transsexual (LBGT), have disabilities, or who have mental health or substance abuse disorders. There are disparities in access to cessation services which also creates disadvantages in some populations. These differences and others create health inequities.⁴

Another consideration is the conflict between two ethical principles of public health. On one hand, there is the obligation to address fundamental causes of disease and requirements for health. On the other, we strive to achieve health in a way that respects the rights of individuals in the community.⁵

Often, this conflict manifests in arguments for or against policies that restrict the use of tobacco. In some cases, such as exposure to second-hand smoke, the harmful effects of tobacco are not a choice.

Economics

The critical nature of funding is highlighted in a study published in the *Journal of Contemporary Economic Policy*. The study found that adequately funded state tobacco-prevention programs could save up to 20 times the cost of implementing them. Analyzing data from 1991 through 2007, the researchers found that state tobacco control programs that met the established threshold have a sustained impact on the demand for tobacco, and reduced disease and health-care costs.⁶

This study reinforces the need for sustained funding for tobacco prevention and control efforts in Delaware. The annual health care costs directly attributed to smoking use in Delaware is estimated to be \$532 million. Of this, \$95.6 million is state Medicaid expenditures. Another way to look at this is that each Delaware household pays \$953 annually in state and federal taxes for smoking-caused government expenditures.⁷

Other economic considerations must include the long-term outlook for the state's funding of the tobacco control program, which is largely dependent on revenue from the Master Settlement Agreement. This is an accord reached in 1998 between the state Attorneys General of forty-six states (including Delaware) and the five largest tobacco companies in America. The formula of this agreement has and will likely continue to reduce the revenue to states over time.

Law

The political, epidemiologic, ethical, and economic environment in Delaware has shaped our public policy as manifested by the laws passed by the General Assembly and signed by our governors. For example,

- In 2002 our state became the second to pass a statewide Clean Indoor Air Act (CIAA);
- This year we were the fourth state to include e-cigarettes in our CIAA; and
- In 2003, Delaware's tax on a pack of cigarettes was 55 cents. It was increased in 2007 to \$1.15 and to \$1.60 in 2009, where it remains. This is the same amount as Pennsylvania, but less than New Jersey (\$2.70), Maryland (\$2.00), and DC (\$2.50).⁸

Numerous economic studies in peer-reviewed journals have documented that cigarette tax or price increases reduce both adult and underage smoking. The general consensus is that every 10 percent increase in the real price of cigarettes reduces overall cigarette consumption by approximately three to five percent; reduces the number of young-adult smokers by 3.5 percent; and reduces the number of youth who smoke by six or seven percent.⁹

Based on science and emerging trends, policy makers and advocates may soon need to address new policy initiatives such as:

- Prohibiting smoking (including e-cigarettes) in any vehicle with a minor present;
- Prohibiting smoking (including e-cigarettes) in individual units of multi-unit housing;

- Increasing the cost to vendors to purchase a license to sell tobacco and e-cigarettes;
- Prohibiting the sale of tobacco in places where prescription medications are sold, following the CVS pharmacy chain example;
- Raising the tobacco purchase age to 21;
- Creating tax equity for other tobacco products to be equal to the unit cost of cigarettes; and
- Further increasing the tax on cigarettes

Programs

Politics, ethics, epidemiology, economics and law also shape the programs that we implement. Delaware has been using the best available evidence for well over a decade to implement a comprehensive approach to control tobacco usage. The Centers for Disease Control and Prevention (CDC) recommends the following components of a comprehensive approach: state and community interventions; mass-reach health communication; cessation interventions; surveillance and evaluation; and infrastructure.¹⁰ Here is what this looks like in our state.

- **State and community-based programs:** In Delaware, the Division of Public Health (DPH) offers mini-grants to help tobacco prevention efforts reach the grassroots community. The total amount of grant funding this year is \$213,176 and grant amounts range from \$1,389 to \$12,000. The purpose of the mini-grants is to help us better target specific populations and benefit from the expertise of local nonprofit organizations.
- **Mass-reach health communication:** Mass-reach health communication interventions are powerful tools for preventing the initiation of tobacco use, promoting and facilitating cessation, and shaping social norms related to tobacco use. The Community Preventive Services Task Force¹¹ recommends mass-reach health communication interventions on the basis of strong evidence of effectiveness in decreasing the prevalence of tobacco use, increasing cessation efforts, and decreasing initiation of tobacco use among young people.

Approximately \$815,000 from the Delaware Health Fund is being used this fiscal year to support mass-reach health communication related to tobacco. By comparison, the tobacco industry invests about \$52 million annually in social marketing efforts in Delaware.¹²

DPH uses CDC guidelines and research and Delaware-specific data to develop social marketing campaigns. An effective state mass-reach health communication intervention delivers strategic, culturally appropriate, and high-impact messages via sustained and adequately funded campaigns that are integrated into a comprehensive state tobacco control program effort. To counter the tobacco industry's investments in social marketing in Delaware, we use data from a variety of sources to inform targeted population marketing and messaging. We select appropriate media or methods to target specific populations in conjunction with our media contractor, using media survey data, focus groups, and Nielsen segmentation data.

- **Cessation interventions** - Most smokers who smoke want to quit. Promoting and supporting cessation is a core component of a comprehensive state tobacco control program's efforts to reduce tobacco use. Encouraging and helping tobacco

users to quit is effective in reducing tobacco-related disease, death, and health care costs. Population-wide interventions that change societal environments and norms related to tobacco use — including increases in the unit price of tobacco products, comprehensive smoke-free policies, and hard-hitting media campaigns — increase tobacco cessation by motivating tobacco users to quit and making it easier for them to do so. The Delaware Quitline¹³ provides over-the-phone and in-person counselling. The Quitsupport website provides supportive cessation information. This year we are spending a little more than one million dollars for the Delaware Quitline and Quitsupport website.

- **Surveillance and Evaluation** - Publicly financed programs need to have accountability and demonstrate effectiveness, as well as have access to timely data that can be used for to inform program and policy direction. Therefore, a critical infrastructure component of any comprehensive tobacco control program is a surveillance and evaluation system that can monitor and document key short-term, intermediate, and long-term outcomes within populations. Our data are obtained for youth from two primary sources, the Youth Risk Behavior Survey¹⁴ and the Youth Tobacco Survey.¹⁵ For adults the data are obtained from the Behavioral Risk Factor Survey¹⁶ and the Adult Tobacco Survey.¹⁷

Conclusion

Politics, ethics, economics, epidemiology and law have shaped Delaware’s tobacco control strategy. DPH is continuously open to input from our partners and uses the latest and best science and data to do the “right stuff.” However, given that our adult smoking prevalence has remained stable at around 20 percent for the past few years, we need to ask if we are doing enough of the “right stuff.” Our eyes are focused on achieving the Surgeon General’s challenge to be a tobacco free state in 50 years. In order to accomplish this, we must continue to learn, evolve and change our strategy and tactics based on the best available information. We must work together to align our efforts and leverage resources. And we must make sure we are doing enough of what we need to in order to make this goal a reality.

References

1. Bhattacharya, D. (2013). *Public Health Policy: Issues, Theories, and Advocacy*. Jossey-Bass/Wiley & Sons, Inc.
2. Division of Public Health - <https://dhss.delaware.gov/dhss/dph/index.html>
3. <http://www.cdc.gov/tobacco/stateandcommunity/pdfs/ends-keyfacts2015.pdf>
4. http://www.cdc.gov/tobacco/data_statistics/fact_sheets/adult_data/cig_smoking/
- 5 The Public Health Leadership Society. *Principles of the Ethical Practice of Public Health*, 2002.
6. Chattopadhyay, S., & Pieper, D. (2012). Does spending more on tobacco control programs make economic sense? An incremental benefit-cost analysis using panel data. *Contemporary Economic Policy*, 30(3), 430–447. <https://doi.org/10.1111/j.1465-7287.2011.00302.x>
- 7 CDC, *Best Practices for Comprehensive Tobacco Control Programs*, 2014

- 8 Orzechowski & Walker, Tax Burden on Tobacco, 2014
9. Reducing Tobacco Use. A Report of the Surgeon General, Atlanta, Georgia: HHS, CDC, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2000
- 10 CDC, Best Practices for Comprehensive Tobacco Control Programs, 2014
11. <http://www.thecommunityguide.org/index.html>
- 12 U.S. Federal Trade Commission (FTC). Cigarette Report for 2012
13. <http://dhss.delaware.gov/dph/dpc/quitline.html>
14. <http://www.cdc.gov/healthyyouth/data/yrbs/index.htm>
15. http://www.cdc.gov/tobacco/data_statistics/surveys/yts/
16. <http://www.cdc.gov/brfss/>
17. http://www.cdc.gov/tobacco/data_statistics/surveys/nats/

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