Tobacco Control in the Obama Era — Substantial Progress, Remaining Challenges

Michael C. Fiore, M.D., M.P.H., M.B.A.

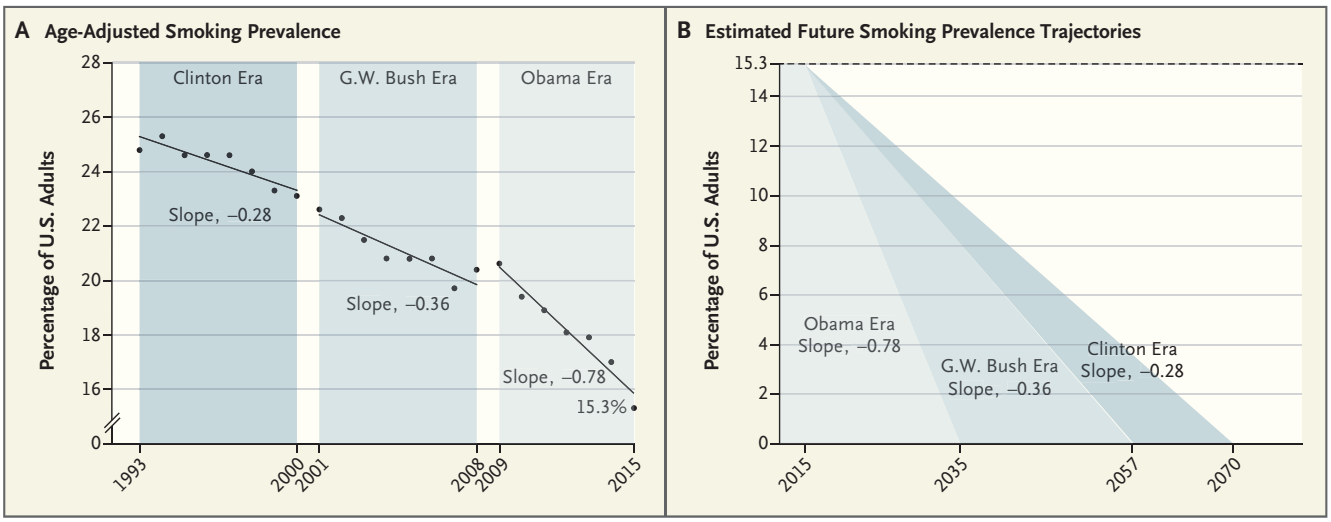
The steady decline in smoking rates among U.S. adults that began in the early 1960s has accelerated substantially during the 7 years of the Barack Obama presidency. Since 2009, the prevalence of cigarette smoking in the United States has fallen at a rate of about 0.78 percentage points per year[1] — more than double the rates observed during the administrations of Bill Clinton and George W. Bush (mean decreases of 0.28 and 0.36 percentage points per year, respectively; see graphs). If the current rate of decline were to continue, the prevalence of smoking among U.S. adults would fall from its current level of 15.3% to zero by around 2035. In contrast, at the slower rates of decline observed during the Clinton and Bush years, smoking would not reach zero until approximately 2070 and 2057, respectively (see graphs). (Although cigarettes account for most of the combustible tobacco products sold in the United States,[2] sales of noncigarette tobacco products such as cigars have not decreased at the same rates.)

The recent accelerated decrease in cigarette smoking has not occurred in a vacuum. The striking decline since 2009 is most likely due to the implementation of an array of tobacco-control interventions at the federal, state, nonprofit, and private-sector levels.

These interventions, particularly those at the federal level, were highly intentional, well planned, and well organized. During the first 2 years of the Obama era, several legislative acts provided both the foundation and the essential tools for concerted action on tobacco control. Three of these new laws were particularly influential: the Children's Health Insurance Program Reauthorization Act of 2009, which increased the federal cigarette excise tax rate from $0.39 to $1.01 per pack; the Family Smoking Prevention and Tobacco Control Act passed in June 2009, which gave the Food and Drug Administration (FDA) the authority to comprehensively regulate thousands of tobacco products for the first time; and the Affordable Care Act (ACA) passed in March 2010, which mandated insurance coverage of evidence-based smoking-cessation counseling and medications without barriers or copayments[3] and expanded Medicare and Medicaid coverage for smoking-cessation treatments. The ACA also established the National Prevention Council and the Prevention and Public Health Fund. Other legislation that contributed included the American Recovery and Reinvestment Act (ARRA), the Prevent All Cigarette Trafficking Act, and the Health Information Technology for Economic and Clinical Health Act; these provided research funding, levied taxes on Internet sales of tobacco products, helped to reduce such sales to children, and incorporated assessment of tobacco use into "meaningful use" requirements for health information technology.

The Obama administration also advanced tobacco control through its leadership choices for the Department of Health and Human Services (HHS), including many senior appointees with extensive tobacco-control experience, such as Deputy Secretary of Health William Corr, Centers for Disease Control and Prevention (CDC) Director Tom Frieden, FDA Center for Tobacco Products (CTP) Director Mitch Zeller, and Assistant Secretary for Health Howard Koh. All these appointees focused attention and energy on tobacco control. Koh, for instance, led the effort to develop the first HHS comprehensive strategic plan to confront tobacco use in America[4] and created the HHS Tobacco Control Steering Committee, which brought together key HHS agencies each month to coordinate departmental actions designed to reduce tobacco use.

The HHS agencies involved (including the National Cancer Institute, the National Institute on Drug Abuse, the Centers for Medicare and Medicaid Services, and the Substance Abuse and Mental Health Services Administration) capitalized on the tools and opportunities made possible by the new legislation to greatly increase tobacco-control interventions. HHS directed $200 million from ARRA to launch Communities Putting Prevention to Work, a program that encouraged 22 cities and counties to implement evidence-based strategies to reduce tobacco use. In September 2011, the CDC



Trends in Smoking Prevalence among U.S. Adults.

Panel A shows age-adjusted prevalence by year, from 1993 through 2015. Data are from the National Health Interview Survey.[1] Panel B shows the estimated trajectories, which are based on the slopes from relevant past periods, from 2015 forward.

awarded more than $100 million in prevention funding through a new program called Community Transformation Grants to aid states, communities, and tribes throughout the country in implementing tobacco-control programs. Both of these programs provided much needed funds as state and local tobacco-control funding was being reduced.

In March 2012, the CDC launched the first paid national tobacco-education campaign, "Tips from Former Smokers," which features compelling stories of former smokers living with smoking-related diseases and disabilities. The CDC estimates that the Tips campaign has helped at least 400,000 smokers quit smoking for good since 2012 and is projected to help prevent at least 17,000 premature deaths.[4]

The FDA's CTP has been central to federal efforts including banning the manufacture and sale of fruit- or candy-flavored cigarettes; prohibiting the use of misleading claims such as "low," "light," and "mild"; issuing a final "deeming" regulation that extends its authority over tobacco products to include e-cigarettes, cigars, and pipe and hookah tobacco; conducting more than 600,000 retailer inspections to ensure compliance with laws restricting sales of tobacco products to young people, and issuing warning letters, monetary penalties, and prohibitions of tobacco sales for violations; requiring tobacco manufacturers to report the ingredients and levels of harmful and potentially harmful constituents in their products; and launching "The Real Cost" and other information campaigns warning young people of the dangers of tobacco products.

The cumulative effects of these legislative, regulatory, and policy actions may have resulted in a snowball effect — a decline in smoking that has accelerated over the Obama years (see graphs). This progress has made the total elimination of tobacco use in the United States seem possible, rather than merely aspirational.

Capitalizing on this progress, the 50th-anniversary Surgeon General's report, *The Health Consequences of Smoking* (2014), outlined a series of specific and feasible steps for eliminating tobacco use in America.[5] The progress already made does not argue for future passivity; it argues for continued actions, ranging from sustaining national media campaigns to expanding the provision of tobacco-use counseling and medication treatments (see Actions to Further Reduce Smoking Rates in the United States).

The path followed to reduce smoking rates during the Obama era provides a road map for the elimination of smoking in the United States. The past 7 years have seen substantial progress, which suggests that the policies and programs implemented over this period have meaningfully reduced smoking prevalence. Obviously, there is no incontrovertible evidence linking the observed decreases in smoking with the administration's actions and policies. However, other secular trends, such as economic changes and

Actions to Further Reduce Smoking Rates in the United States

- Raise cigarette excise taxes at the state and federal levels
- Sustain high-impact national media campaigns such as "Tips" and "Real Cost"
- Target populations with high smoking prevalence, including the poor, the least educated, and people with mental health and substance abuse diagnoses
- Implement ACA provisions to provide all smokers visiting health care settings with barrier-free access to proven tobacco-use counseling and medication treatments
- Implement the FDA's authority for tobacco-product regulation to reduce harmfulness, including its authority to reduce the nicotine content of cigarettes to nonaddictive levels
- Mandate the inclusion of graphic warning labels on all tobacco products
- Release a final Housing and Urban Development regulation mandating that all publicly owned housing units be smoke-free
- Enact federal legislation to prohibit the sale of any tobacco product to persons younger than 21 years of age
- Expand tobacco-control and prevention research efforts to increase understanding of the ever-changing tobacco-control landscape
- Fully fund comprehensive statewide tobacco-control programs at CDC-recommended levels
- Extend comprehensive smoke-free indoor-air protections to all Americans

use of alternative tobacco products such as electronic nicotine delivery systems, do not seem substantial enough to account for the pronounced changes observed in cigarette smoking.[5]

Despite this great progress, tobacco use continues to cause substantial harm in the United States, with about 15% of adults, or more than 36 million Americans, continuing to smoke. About half these people will die prematurely unless they can stop smoking.[5] Although an end to tobacco use in the United States now appears achievable, it will be realized only if we expand on the successful actions begun during the Obama era.

Disclosure forms provided by the author are available at NEJM.org.

From the Center for Tobacco Research and Intervention, University of Wisconsin School of Medicine and Public Health, Madison.

This article was published on August 17, 2016, at NEJM.org.

1. Ward BW, Clarke TC, Nugent CN, Schiller JS. Early release of selected estimates based on data from the 2015 National Health Interview Survey. Hyattsville, MD: National Center for Health Statistics, May 2016 (http://www.cdc.gov/nchs/nhis.htm).
2. Consumption of cigarettes and combustible tobacco — United States, 2000–2011. MMWR Morb Mortal Wkly Rep 2012;61:565-9.
3. McAfee T, Babb S, McNabb S, Fiore MC. Helping smokers quit — opportunities created by the Affordable Care Act. N Engl J Med 2015;372:5-7.
4. Department of Health and Human Services. Ending the tobacco epidemic: a tobacco control strategic action plan for the U.S. Department of Health and Human Services. Washington, DC: Office of the Assistant Secretary for Health, November 2010 (http://www.hhs.gov/ash/initiatives/tobacco/tobaccostrategicplan2010.pdf).
5. The health consequences of smoking — 50 years of progress: a report of the Surgeon General. Rockville, MD: Public Health Service, 2014 (http://www.surgeongeneral.gov/library/reports/50-years-of-progress/full-report.pdf).

DOI: 10.1056/NEJMp1607850

Hearing without Listening

Jeffrey M. Drazen, M.D.

It is 06:30, and the ICU is quiet as I make "pre-rounds" with other senior ICU physicians. We go from patient to patient, and today we can have meaningful verbal interactions with 3 of our 10 patients. In each of the 10 cases, the nurses who have been on duty overnight fill us in on events, assist with the exam, and help create an image of that patient on that morning. There are no computers in these interactions. Our connection with the nurses is real and human. They look us in the eye, and we give them our full attention during our brief interactions. We learn a lot from them. By 08:00 we are ready for work rounds.

Work rounds involve a large group: attending physician, ICU fellow, senior residents, interns, medical students, pharmacists, nutritionists, respiratory therapists, continuing care representatives, and outside each room, the patient's nurse. Most of these people have their own computer, a workstation on wheels — a WOW. Our flock of WOWs moves from room to room. When we stop at a room, we review events from overnight, and since the relevant people have already examined the patient, we exchange information and make decisions.

How do our flock of WOWs and their operators deal with the task at hand? Thanks to the WOWs, we each have all the information in front of us. At the touch of the right keys, we can access vital signs, ventilator data, laboratory test results, imaging,