

## Achieving the Implausible in the Next Decade's Tobacco Control Objectives

In this issue of the *Journal*, Mendez and Warner take issue with the target-setting process in the *Healthy People 2010* objectives for the nation.<sup>1</sup> They question the wisdom of setting a 2010 objective of 13% for the prevalence of smoking among adults when we know we will miss the 15% target set (in 1990) for 2000 by nearly 10 percentage points.<sup>1</sup> They present a strong statistical case and a compelling demographic argument for the rates we

should expect. Even in their best-case scenario, we could not expect to reach the 2010 target of 13%.<sup>2</sup>

[The target of 13% smoking prevalence for 2010 was set in a draft that has since been revised; the final published version will appear after the publication of this editorial. As a result of the clearance process for vetting the government document, the 2010 target for smoking prevalence has been changed to 12%.]

Our purpose is not to second-guess the data or the analysis of Mendez and Warner but rather to offer a reflection on the rationale and implications of setting goals and targets that challenge the status quo and defy the forces of statistical gravity.

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*Editor's Note.* See related article by Mendez and Warner (p 401) in this issue.

## The Good News and the Bad

The good news from Mendez and Warner is that their projections dispel the clouds forming around the recent reports in *Morbidity and Mortality Weekly Report* on the apparent plateau in adult smoking prevalence. The National Health Interview Survey data show that the declines of the previous 30 years decelerated and flattened in the 1990s.<sup>3</sup> Mendez and Warner suggest that the rates will again begin to decline because of the aging population and age-related patterns of smoking cessation. The bad news is that when these declining prevalence rates are projected to the year 2010, even under Mendez and Warner's most optimistic assumptions about prevention of adolescent uptake of smoking and cessation of adult smoking, the best-fitting curves cross the year 2010 well above the 13% population prevalence mark.

The question then becomes whether, if we apply more effectively what we know today (the usual assumption on which the expert committees that set objectives are asked to base their targets), we can accelerate the projected declines in the prevalence of smoking. Given no major new scientific breakthroughs, can a more intensive, extensive, evidence-based, culturally sensitive set of programs and services produce an increased rate of cessation and a slower rate of uptake? Therefore, we focus on the assumptions Mendez and Warner make in setting their best-case projections.

But before conceding that the authors are correct in judging as a "blunder" the 15% smoking prevalence rate that was set as a *Healthy People 2000* target, we would recall that this target was based on optimism born of the rapid declines in smoking during the 1980s. That optimism was tempered in the 1990s by the success of the tobacco industry's counterstrategies in maintaining addiction in current smokers and recruiting new smokers among young people. The failure to reach 15% by 2000 is less a mistaken goal than it is a failure of political will during the 1990s to pass more widely the public policies that were advocated from knowledge accumulated during the 1980s. By the end of the 1990s, however, we had numerous new reasons—some political, some judicial, and some scientific—to revive our optimism.

## Reasons for Optimism and Stretch in Setting the 2010 Goal

When setting goals for 2010, the target-setting committees typically considered the levels already achieved by some states or by

some population groups. Utah, with an adult smoking prevalence of 14.2%, has already surpassed the year 2000 objective of 15%.<sup>4</sup> So have some population groups (e.g., people with more than 16 years of education, 11.6%; people older than 65 years, 12.0%; and Hispanic women, 14.3%)<sup>5</sup> and recipients of comprehensive, intensive, and targeted programs.<sup>5</sup>

A second basis for setting objectives for the nation was a straight-line projection of rates in those jurisdictions that have carried out the most effective implementation of "best practices" in preventing and controlling tobacco use. California, Massachusetts, and Oregon are heading toward the 13% mark faster than states that have not had the advantage of taking a portion of the revenue from increased excise taxes on cigarettes and dedicating it to comprehensive tobacco control programs. Now that the remaining states have the opportunity to take advantage of increased funding from the Master Settlement Agreement, we can reasonably expect that more states will follow suit and accelerate their implementation of the best practices.

## The Intent to Reduce Disparities

The federal guidelines and departmental mandate for the *Healthy People* objectives demanded that the target-setting committees factor in the need to narrow the gaps between population groups. This emphasis on disparities as part of the *Healthy People 2010* planning was an extension of the emphasis in *Healthy People 2000*,<sup>6</sup> and both were in response to criticism that the first round of the 1990 objectives seemed to ignore such disparities.<sup>7</sup> The knowledge base for reaching lower-socioeconomic-status groups and racial and ethnic minority communities will continue to grow with the current emphasis given to these issues by federal health research and demonstration programs, among others.<sup>8</sup> Better understanding of culturally sensitive and effective approaches to specific population groups will accelerate the decline in the prevalence of smoking within these groups and consequently within the population as a whole.

The surgeon general specifically challenged the framers of the 2010 objectives to go for better than the best rates. By this, he meant that the improved average rates for the population should reduce disparities, not by regression to the mean but by bringing all groups to rates that equal or exceed those enjoyed by the healthiest population groups.

## Getting to the Implausible

The main hope of reaching the 13% prevalence rate by 2010, as acknowledged by Mendez and Warner, is a near-quadrupling of smoking cessation rates. Whether this increase can be achieved will depend partly on improved effectiveness for each attempt to quit, partly on increased numbers of smokers who attempt to quit, and partly on increased frequency of smokers' attempts to quit. We believe that all 3 of these developments are plausible for the 70% of smokers who say they would like to quit completely—and even for some of the 30% who now claim they have no intention of quitting. The most scientifically well-grounded basis for the plausibility of multiplying the cessation rate is the gap between the known efficacy of the best practices in smoking cessation and the current record of applying that knowledge. These developments are made even more plausible by the unprecedented current and emerging challenges to the societal status quo of norms, policies, enforcement, and programs and the synergism these challenges will produce on all fronts in the tobacco wars, for both the manufacturers and the users of tobacco products.

Most recent efforts on the state and national fronts have been directed at preventing smoking among youth. There has never been a full-blown, comprehensive, national cessation effort beyond the annual one-day "Great American Smokeout." Of the 32 million American smokers who tried to quit in any given recent year, 69% tried without the help of any pharmacological treatment (nicotine replacement therapy or non-nicotine pharmacotherapy) or behavioral counseling. Such "self-help" quit attempts have a 6-month efficacy rate of only 3% to 8%,<sup>9,10</sup> compared with rates as high as 14% for nicotine replacement therapy, 18% to 24% for behavioral counseling, and even higher rates for combinations of the two, according to systematic reviews and meta-analyses such as those conducted by the Cochrane Group and the Agency for Health Care Policy and Research (now called the Agency for Healthcare Research and Quality).<sup>10,11</sup>

Clearly, more extensive use of effective methods could more than triple the overall average annual cessation rate of less than 6%, as estimated by Mendez and Warner. These methods have been shown to gain wider use and lead to increased population cessation rates with mass media promotion, telephone help lines, insurance coverage of therapy, and encouragement by health care plans and practitioners. These methods could also be made more accessible and could be more widely

applied, for example, if the clinical practice guidelines of the Agency for Health Care Policy and Research<sup>10</sup> were adopted by health plans and if insurance reimbursement schedules were tied to the delivery of evidence-based interventions.

These more effective cessation methods will be greatly enhanced in their reach if their promotion is borne on the potential tidal wave of Master Settlement Agreement dollars that could be released through state programs and through the American Legacy Foundation's national programs. They will also benefit from the price increases imposed by many states, the tobacco industry itself, and the federal government; from the spread of smoke-free environments and the strengthening of no-smoking regulations; from the outcomes of pending judicial actions; and from other societal trends toward denormalization of smoking and reduced exposure to nicotine.

We agree with Mendez and Warner that "goals ought to be attainable," but the way to attain them is not to set them to fit projections from past performance alone. The 2010 smoking prevalence goals should be—and are—challenging goals that can be accomplished through a more aggressive public health response that treats the tobacco menace commensurately with the harm it causes. This public health challenge is well articulated in the other tobacco control objectives that would lead to a prevalence rate of 13% or lower—an end point in a causal chain of changes, each of which has a

challenging objective of its own. We cannot accept the assertion that "even heroic public health efforts will be preordained to fail" because of ambitious goals. If we commit ourselves as a nation to reaching these objectives through a comprehensive approach that includes a combination of aggressive price increases, regulatory authority and other policy changes, and program implementation, we can achieve the objectives set out in *Healthy People 2010*. □

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