



EXECUTIVE SUMMARY REPORT

Ending Cigarette Use By Adults In A Generation Is Possible

The Views Of 120 Leaders In Tobacco Control

Michael Terry, John Seffrin, Ph.D.,
K. Michael Cummings, Ph.D.,
Allan Erickson, and
Donald Shopland; Authors
Core Team on Tobacco Control

March 2017

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THE VIEWS OF 120 LEADERS IN TOBACCO CONTROL



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Core Team on Tobacco Control

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Dedicated to the Memory of Charles Aubrey (Mickey) LeMaistre, M.D.

- A Tobacco Control Pioneer -

Public health and smoking control lost one of its most ardent supporters on Saturday, January 18, 2017 with the death of Charles “Mickey” LeMaistre at age 92.

“Extraordinary” is the only word that adequately describes Mickey’s long career dedicated to improving the health of this nation. In 1962, at the age of 38, he was the youngest member appointed to serve on Surgeon General Luther Terry’s Advisory Committee on Smoking and Health that issued its landmark report linking cigarette smoking to lung cancer, heart and lung issues. Mickey was the last surviving member of the Advisory Committee.

Mickey served as a Chancellor of the University of Texas System for seven years (1971-1978) where he directed a significant expansion of the UT System, including new medical schools in Houston and San Antonio, and new Universities in Dallas, Odessa and San Antonio before becoming President of MD Anderson Cancer Center. During 18 years as the second full-time President of MD Anderson, Mickey led the institution through the period of substantial growth in programs, personnel, facilities, private philanthropy and reputation.

Smoking control was an important and ongoing part of his life-long cancer prevention message. He chaired the National Conference on Smoking OR Health in 1981, the International Summit of Smoking Control Leaders in 1985, and he served as President of the American Cancer Society in 1987; he also chaired the Society’s National Committee on Tobacco and Cancer for two years.

In recognition of his life-time commitment to cancer prevention and control, the ACS presented Dr. Charles LeMaistre with its highest tribute, the Medal of Honor.



“The Executive Summary Report provides the three essential interventions that must be enhanced and given the highest priority if we are to accelerate the dramatic reduction in cigarette smoking in adults achieved over the last five decades.

This landmark Report represents a consensus of the opinions of those who led the highly successful past efforts toward a society free from cigarettes”.

Mickey LeMaistre – November 6, 2016

Disclaimer: Opinions expressed in this Executive Summary Report are those of the authors and do not necessarily reflect the views of any organization for which they work or are associated.

“Too many Americans falsely believe that tobacco hazards are under control. THEY ARE WRONG!!!

Adult smoking remains the greatest preventable cause of fatal sickness and premature death. In 1962, the Surgeon General’s Advisory Committee Report launched a national campaign to reduce smoking. But, the campaign was only half successful. What is desperately needed today is the launching of another potent campaign to awaken the American public and public health policy to combat the still virulent epidemic of tobacco use.

This is what the remarkable ‘Clarion Call to Action’ represents: the combined wisdom and passion of the most authoritative tobacco control leaders as produced. It is as worthy of broad attention as the original Surgeon General’s Report”

Michael Pertschuk, Former Chairman, Federal Trade Commission

“It is absolutely vital that we do whatever is necessary to inject new passion, urgency and excitement into tobacco control efforts to reach adults who smoke cigarettes, ensure that we put fresh ideas out front, and place a new generation of tobacco control advocates on the front line”.

“We need to get a wide variety of people on board to commit to advocating for cessation and the end of combustion at every level, particularly state and community levels”.

“Unfortunately, we have allowed the prevention-only leaders to dominate the discussion of what tobacco control is all about. We agree on a lot ... raise taxes on cigarettes, put clean indoor-air policies in place to protect non-smokers, make it hard to market cigarettes ... especially to kids. Where we disagree is getting serious about helping addicted adult smokers and recognizing that tobacco harm reduction is a major part of the effective formula”.

“Addressing tobacco use in adults will (has in the past) aid the de-normalization of combustible tobacco among kids and adults. With the evolving market of products, which appear to have strong consumer acceptance among smokers, there is an opportunity to dramatically lower death rates from smoking and see cigarettes go the way of the spittoon. This is why we need to push loudly beyond the prevention-only model some leaders seem to be stuck on”.

- Respondents to Tobacco Control Stakeholder Survey, 2016 -

Clarion Call to Action

Chronic exposure to tobacco smoke is the single largest cause of preventable illness and premature death in the United States today. In spite of significant progress in tobacco control over the last half century, tobacco use is still the cause of nearly one in every four deaths daily in America.

Unlike 50 years ago, we now know the things we need to do to prevent addiction to tobacco, and to help adults quit smoking. Thus, most of the tobacco-induced illnesses and deaths could be avoided, if we as a nation chose to make that happen.

Because tobacco-induced illnesses and deaths almost always strike people in the prime of life, their negative economic impact on the nation is huge, due to lost productivity and extraordinary health care costs.

If the United States is to be competitive in the global marketplace in the future, and eventually become the healthiest nation, then tobacco control must become the top public health priority for the nation.

Toward that end, we call for action now to reignite the nation's tobacco control efforts, and we urge the public sector to work with the private sector and the social sector in eliminating tobacco use in America at the earliest possible time.

— Core Team for Tobacco Control —

Michael Terry

Corporate CEO; Son of Former U.S. Surgeon U.S. Surgeon General, Luther Terry, M.D.

John Seffrin, Ph.D.

Former CEO, American Cancer Society; Professor of Practice, Indiana University

Allan Erickson

Former Vice President for Public Education/Tobacco Control, American Cancer Society

Donald Shopland

Former Director, Office on Smoking and Health, US Public Health Service

K. Michael Cummings, Ph.D.

Professor, Department of Psychiatry & Behavioral Sciences, Medical University of South Carolina & Co-leader, Tobacco Research Program, Hollings Cancer Center

Disclosure Statement

This Report is an analysis and interpretation of the input and recommendations received from a group of key tobacco control leaders who responded to our survey. It does not purport to be a consensus document of the tobacco control leadership community. Rather, it is a reflection of the Core Team's best efforts to glean the most important and relevant recommendations made by the 120 respondents after assessing their 446 proposed priority actions to reduce adult smoking.

To assure transparency, and given the uniqueness and importance of this Report, we will make the raw responses from all respondents available in a de-identified format upon request. Requests and follow-up questions should be directed to Allan Erickson via AllanCErickson@aol.com.

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Executive Summary

Each year, cigarette smoking directly kills 480,000 Americans. It also harms many millions more through secondary effects. The economic toll is enormous and costly, with an annual medical bill of over \$170 billion. Yet, the public and media's focus has largely shifted to other health issues. Mainstream tobacco control largely centers on measures to slow youth uptake, which *will* yield mortality and health gains, but will only reach its full impact 50 years from now.

There is an urgent need to accelerate progress to end cigarette smoking in adults. That requires fully implementing historically-validated tobacco control measures — especially tobacco taxes — and integrating new science-based reduced-risk products into tobacco control. Simultaneously, we need to pursue a long-term approach to nicotine that is coherent with, and proportionate to, the risks associated with other public health measures required to address psychoactive substances.

We consulted 120 key tobacco control leaders across the United States (U.S.). They represent a broad swath of tobacco control experience and expertise, ranging from researchers and academics, to advocates, state and urban tobacco control staff, government officials, and local front-line workers. Their input is integrated into a proposed strategy to achieve the goal of reducing cigarette smoking in adults to less than 10 percent in all communities nationwide by 2024.

This is *not* a consensus report. We considered all inputs, and focus here on what represents the needed balance between what has worked to reduce smoking in the U.S., and additional steps that are now needed. These steps draw upon advances in technology and deeper insights into what drives behavior change.

Three (3) specific actions are proposed for immediate, accelerated implementation:

Action 1:

Increase excise taxes at the federal level and in many states with four (4) goals: lower smoking rates, harmonize taxes across state borders to reduce illicit trade, cover the costs of smoking-related disease, and encourage a shift from cigarettes to reduced-risk products and complete cessation.

Action 2:

Encourage health and life insurers, employers, and health professionals to actively promote smoking cessation measures supported by the U.S. Preventive Services Task Force and the 2014 U.S. Surgeon General's Report.

Action 3:

Establish a more rational tobacco, nicotine, and alternative products regulatory framework based on their relative risks, and that is adaptable to the increased speed of innovation in new technology development.

These three (3) actions need to be underpinned by heightened lay and professional media advocacy for adult tobacco cessation. It also must include continued support for expanded voluntary and legislated ways of providing smoke-free areas to all. Each of the actions should address social class, race, geographic, and other correlates of cigarette smoking-related inequalities.

Proposed Strategy to Accelerate the Decline in Adult Smoking

Introduction

Tobacco control is losing priority in social, political, and health agendas, and public awareness of smoking as a continued public health threat has waned. Obesity, opioid abuse, marijuana legalization, and inequalities in access to healthcare all receive wider media coverage and professional attention. Nonetheless, tobacco use remains the leading cause of preventable death in the United States (U.S.) — cigarette smoking alone kills an estimated 480,000 Americans a year — and is a major source of race, class, and education disparities.¹ About 40 million current adult smokers in the U.S. face immediate risks to their health and well-being, just as the health system grapples with the high and rising costs of healthcare that are required to treat tobacco-related disease. The toll of tobacco is enormous and costly, with an annual medical bill of over \$170 billion.

A stronger, concerted effort on adult smoking cessation — well documented as a highly cost-effective intervention — is needed to reach the short-term national goal of reducing the prevalence of cigarette smoking in adults to less than 10 percent in all communities nationwide by 2024. We continue to see substantial gains over the last two decades from many collaborative efforts to reduce youth smoking initiation. The same drive is now needed to reach the 40 million current adult smokers and ensure that accelerated declines in smoking occur.

Building Priorities Based on the Input of Leaders in Tobacco Control

This unique report draws upon the experience and input from 120 carefully-selected tobacco control leaders. It includes their perspectives on priorities for tackling adult smoking cessation. These leaders believe we can, and must, do more to confront the challenge of tobacco smoking cessation. This can be achieved by making a special effort to activate new partners outside of tobacco control to fully implement traditional tobacco control policies, and by positioning the field to embrace recent technological advances. We believe it is time to raise our ambitions about what is desirable and possible to prevent millions of tobacco-related deaths in this country in the coming decades.

¹ Centers for Disease Control and Prevention. “Burden of Tobacco Use.” May 2016.

We propose a strategy based on three (3) principles that emerged from stakeholders' input. First, traditional, science-based tobacco control approaches must remain at the core of efforts to reduce adult smoking. Second, these policies must be adapted to meet the specific needs of individuals with low-socioeconomic status, racial and ethnic minorities, and individuals with comorbid mental health and substance use disorders. Third, we need to separate the harms of tobacco from the addiction caused by nicotine in future policy development.

The emergence of reduced-risk products is the subject of intense scrutiny in this effort, and we argue that embracing harm-reduction products makes sense. This will involve contextualizing nicotine use and its risks within drug and addiction policy, alongside other psychoactive substances, such as prescription opioids and heroin, alcohol, and marijuana. The 2016 Surgeon General's Report on Addiction explicitly includes harm-reduction approaches as core to public health plans to address opioids and alcohol. Now is the time to apply that logic to tobacco control. An important principle for policy on all psychoactive substances is that regulations must be proportionate to human risk.

Three (3) Priority Actions to Accelerate Decline in Adult Smoking

Traditional, science-based tobacco control approaches will continue to be at the core of efforts to reduce adult smoking. These approaches enjoy widespread public and stakeholder support. We compared the submitted proposed priority actions against a comprehensive framework for tobacco control — the World Health Organization's Framework Convention on Tobacco Control (WHO FCTC) — and found that four of the top areas for action identified by respondents mapped directly to these historically and internationally-validated tobacco control measures. These interventions — price and tax measures to reduce demand for tobacco, cessation support measures to reduce dependence on tobacco, protection from exposure to tobacco smoke, and communication, media, and public awareness — accounted for more than half of the recommendations extracted from the solicited input. Several priority actions emerged for the field in these areas. Each requires intensive focus.

Already substantial progress has been made across the U.S. in implementing smoke-free areas using a combination of voluntary and legislative approaches. These efforts are unstoppable and accepted as a new social norm. Recent data indicate that over 80% of U.S. indoor workers have smoke-free workplaces, and even a greater percentage of adults live in smoke-free homes. Similarly, progress has been made in implementing media campaigns to better address quitting and the dangers of tobacco. These need to be both continued and strengthened.

Three (3) actions that together will accelerate progress towards ending the use of combustible tobacco products in adult Americans are needed, as follows:

Action 1 Increase excise taxes at the federal level and in many states with four goals: lower smoking rates, harmonize taxes across state borders to reduce illicit trade, cover the costs of smoking-related disease, and encourage a shift from cigarettes to reduced-risk products and complete cessation.

There are disparities among states in the implementation of proven tobacco control measures, with tobacco excise tax rates ranging from less than \$0.20 to \$4.35 per pack. These gradients create incentives for illicit trade and limit health gains. Stakeholders prioritized filling these gaps, either by raising tobacco excise taxes in states with the lowest rates, or by raising the federal excise tax to set a meaningful national floor. Some stakeholders envisioned distributing increased federal excise tax revenues to offset falling revenues in states that adopt more aggressive tobacco control policies.

The Congressional Budget Office (CBO) has called to raise the federal excise tax and done the legwork to enable serious consideration of this proposal by the U.S. Congress.² Similar efforts should be undertaken by the appropriate state agencies to facilitate change at a state level. Tobacco control leaders must step up support for the CBO's proposal, and modes of action at the state level. Internationally, public support for tobacco taxes is highest when the public is assured that part of the tax will target the costs of associated disease and fund effective prevention and control programs.

It was noted by stakeholders that adjusting excise taxes proportionate to the risk of the product would accelerate the shift towards use of less-risky nicotine products, and do so most effectively among the groups with the highest prevalence of smoking — the poorest, least educated, and those with mental health and addictive disorders. Further, these market signals would encourage companies to innovate and shift out of combustible product markets faster.

² Congressional Budget Office. "Raising the Excise Tax on Cigarettes: Effects on Health and the Federal Budget." June 13, 2012.

Action 2 Encourage health and life insurers, employers, and health professionals to actively promote smoking cessation measures supported by the U.S. Preventive Services Task Force and the 2014 U.S. Surgeon General’s Report.

More must be done to shore up smoking cessation support measures to reduce dependence on tobacco. While some stakeholder input concerned expanding state quitlines and increasing the availability of nicotine replacement therapies in retail locations, most stakeholders focused on the role played by insurers, employers, and health professionals in improving the financing and delivery of high-quality cessation support measures.

Stakeholders described opportunities under the Affordable Care Act (ACA) and other health reform legislation that they perceived as yet to be fully utilized for tobacco control. We describe each in succession.

First, regardless of whether the ACA is retained, modified, or repealed, it is critical that the prevention provisions — especially those related to cigarette smoking — be retained in some form. Specifically, the ACA’s guarantee of free preventive services to consumers, including tobacco use screening and cessation interventions, should be incorporated into health reform going forward, and used to connect more smokers to cessation support. Insurers, employers, and health providers’ professional associations must join tobacco control officers in protecting the integrity of such programs that address smoking cessation for adults. They will yield health gains in a cost-effective manner, and if fully applied, have the potential to reach the poorest and most marginalized adult smokers. Their success will also reduce Medicare costs in the future.

Second, the 2008 federal Mental Health Parity and Addiction Equity law’s requirement that insurers cover addiction benefits on par with general medical benefits should be used to expand financial access to intensive, individualized therapy for smoking cessation, and reduce hurdles to use of these benefits.

Third, the introduction of financial incentives for medical providers to improve population health, characteristic of ACA and recent Medicare payment reforms as well as private sector demonstrations, should be used to encourage providers to provide high-quality, science-based cessation support that includes reduced-risk products.

Fourth, the option to incentivize smoking cessation via insurance premium ratings and workplace wellness, which was codified under the ACA, should be retained and extended to reward use of less-harmful forms of nicotine. This will require developing new screening tests that distinguish between tobacco use versus nicotine use.

We must look to insurers and health professionals to comply with requirements under health reform and report violations. We also must look to private employers to innovate around new permissions, such as developing effective workplace programs for smoking cessation. Such incentive programs can be successful when behavioral economics principles are applied.³ The tobacco control field should focus on activating and supporting these actors as agents for improving cessation support.

Action 3 Establish a more rational tobacco, nicotine, and alternative products regulatory framework that is based on their relative risks, and that is adaptable to the increased speed of innovation in new technology development.

Consumer use of alternative nicotine delivery systems has increased dramatically in the U.S. and globally, outpacing development of policy around them as a potential tool for tobacco control. These products, which now include electronic cigarettes, heat-not-burn tobacco products, snus, and vapor products, reduce user exposure to the toxins associated with combusted tobacco, while maintaining nicotine content close to levels in traditional cigarettes. These technological advances spotlight a neglected policy option to support addicted smokers in making substantially less-harmful choices for their health. Such harm-reduction approaches have gained a foothold in other areas of drug and addiction policy in the U.S., and in tobacco control in the United Kingdom and Sweden.

Stakeholders broadly supported development and regulation of all tobacco products, including alternative nicotine delivery systems. There was strong support for product standards on all such products that was coherent with a nicotine regulatory strategy. It should be noted that harm reduction is integral to the core definition of tobacco control in the WHO FCTC preamble.

³ Halpern SD, French B, Small DS, Saulsgiver K, Harhay MO, Adurain-McGovern J, Loewenstein G, Brennan TA, Asch DA, Volpp KG. Randomized Trial of Four Financial-Incentive Programs for Smoking Cessation. *N Engl J Med* 2015; 372:2108-2117. doi:10.1056/NEJMoa1414293

The range of specific actions recommended by stakeholders emphasized the need for additional research on the long-term and public health impacts of alternative nicotine delivery systems, clarification and implementation of regulatory standards promulgated by the Food and Drug Administration (FDA), continuing product development and innovation by manufacturers, and careful targeting of the products toward adult users of combustible cigarettes.

These recommendations reflect a growing sense of urgency to position nicotine products for use in tobacco control in the U.S. To that end, a genuine debate is needed on the relative risks and gains to health that a shift towards these products could bring. Attorney General Thomas Miller of Iowa, a veteran in legal battles with tobacco companies, called for such a debate in recent remarks at the Food and Drug Law Institute.⁴ This debate, he suggested, should not be rooted in rhetoric or ideology, but based on the available evidence.

There is a near-term need to reduce the burden manufacturers independently bear as they pursue steps to verify their products as reduced-risk with the FDA. Specifically, respondents called for clarification and standardization of FDA product standards for e-cigarettes and other alternative nicotine delivery systems to ease the uncertainty and duplicative work associated with individual product authorizations. In support of this goal, there is a need to find a formula by which the research insights from the tobacco and e-cigarette industries can be placed in the public domain in ways that have been addressed for pharmaceutical companies.

With the expectation of new nicotine products being verified as reduced-risk, the tobacco control field must revisit and tweak traditional policies such that less-risky products will not be subject to the same barriers to use as are combustible cigarettes. In particular, it was recommended that excise tax rates be set based on the relative risks posed by tobacco and nicotine products, and public health communications should educate the public and health professionals about the harms of tobacco versus nicotine. Stakeholders argued that the already strong incentives to stop smoking would be more effective if more and easier pathways from smoking to not smoking were available, known, and supported; not opposed.

Moving Forward With the Proposed Strategy

⁴ Miller T. "E-Cigarettes: A Harm Reduction Tool to Save Millions of Lives." October 27, 2016. Remarks, Food and Drug Law Institute Conference on Tobacco.

The success of the three (3) actions demands that media advocacy for tobacco control is substantially increased and sustained, and that all actions are carefully designed to reduce inequalities by social class, race, geography, and underlying health risks (such as mental health status). Concurrently, there is a need for modeling to estimate the combined impact of accelerated implementation of the recommended classic tobacco control measures and switching to reduced-risk products on mortality over the next decades. This is a key input into moving these priority actions to the top of the political agenda for immediate, urgent implementation.

Annex A: History and Aims of Core Team and Support Group

In October 2013, a group of representatives from the leading non-profit organizations fighting the tobacco epidemic met in Washington, D.C. to discuss their respective plans and opportunities around the 50th Anniversary celebration of the historic Report of the Surgeon General's Advisory Committee on Smoking & Health scheduled for January 14, 2014. This meeting was organized and facilitated by the Legacy Foundation (now the Truth Initiative) and the Robert Wood Johnson Foundation.

At this meeting, the interagency group established the 10-year goal of reducing the prevalence of adults who smoke to 10% by 2024. This was subsequently adjusted to 10% in all communities nationwide. At a National Press Conference at the National Press Club on January 14, the following seven (7) national organizations called for a new national commitment and bold action across the major sectors to achieve the (10-in-10) goal: ACS, AHA, ALA, APA, the Truth Initiative, CTFK and ANR. The goal was later formally adopted by these and other organizations. CDC-OSH embraced the goal in the 2014 Surgeon General's Report, which also identified priorities and new directions for the federal agencies to reduce smoking among adults.

Each of these organizations and OSH developed, funded and executed their respective related national plans; however, no effort was made to formulate a cohesive collaborative and coordinated national plan, strategy and timeline for achieving the bold 2024 goal.

Michael Terry, son of SG Luther Terry, was invited to participate in the October 2013 meeting, and he invited Allan Erickson, former ACS National Vice President for Public Education/Tobacco Control, to join him in these discussions. Earlier, Michael had asked Allan to keep him and the Terry family posted on all related tobacco control activities going forward. Michael and Allan worked very productively together in 1999 to develop the prestigious ACS-sponsored Luther Terry Global Leadership Awards in Tobacco Control, which now has the status of the Nobel Peace prize for tobacco control worldwide. Since 2000, 41 individuals or organizations from 24 different nations have received this high award, including 10 in the U.S.

In May of 2014, Michael and Allan elected to form a Core Team for Tobacco Control in Adults of carefully-chosen exemplary senior tobacco control leaders. These mostly-retired individuals committed to serve as volunteer 'catalysts' to ensure that greater emphasis is given to reaching the 40 million current adult smokers, and to encourage the tobacco control community to work more closely together in pursuit of the 2024 goal.

Enlisted for the Core Team, were Donald Shopland, former Director of the Office on Smoking & Health; John Seffrin, Ph.D., recently-retired CEO of the ACS and currently Professor of Practice, School of Public Health, Indiana University; and, Mike Cumming, Ph.D., now a Professor and Co-leader of the Tobacco Research Program at the Hollings Cancer Center, Medical University of South Carolina.

Five (5) other distinguished and successful senior tobacco control leaders were selected to provide special expertise and guidance to the Core Team including: Charles LeMaistre, M.D., former head of MD Anderson Comprehensive Cancer Center, and the only surviving member of the original 1964 Surgeon General's Advisory Committee; Tom Glynn, Ph.D., Consulting Professor, School of Medicine, Stanford University; Scott Ballin, Health Policy Consultant to the Morven Dialogue, University of Virginia; Michael Eriksen, Ph.D., Dean, School of Public Health, Georgia State University; and, Derek Yach, Chief Health Officer, the Vitality Group (Global), and former head of the Tobacco-Free Initiative and the key WHO official for its Framework Convention on Tobacco Control in Geneva, Switzerland.

These two (2) inter-related groups are composed of experts in the epidemiology of tobacco use and tobacco risks, public health policy and practice, and in strategy, planning and organizational development.

The Core Team and Support Group seek to achieve three (3) main aims related to the 2024 adult smoking goal:

- Help steer the attention of the tobacco control community toward reaching the 40 million adult smokers in the U.S.;
- Provide the first-ever opportunity for tobacco control leaders, across the nation, major sectors and relevant disciplines, to provide input into the national priority-setting processes related to smoking cessation for adults; and,
- Help to 'jumpstart' a re-energized and greatly-expanded tobacco control effort laser-focused on implementing the highest-ranked priority actions with the greatest potential impact in reducing adult smoking over the next 7 years. Once this nationwide effort is fully operational and firing on all cylinders, the Core Team and Support Group will step aside and support the lifesaving effort going forward as 'cheerleaders' on the sidelines.

To prepare this report, Core Team members interacted on a regular basis by telephone and email. They also met several times and participated in conference calls with Support Group members.

The two groups collaborated in developing the strategy and processes for providing a carefully-chosen group of key tobacco control leaders from across the nation the first-ever opportunity to help determine national priorities for significantly reducing the prevalence of adult smoking. Over 150 stakeholders were given a chance to participate in the study, with 120 individuals (80 percent of the original group) returning their respective proposed priority actions. Allan Erickson managed the execution of this special effort and interacted with each of the 120 participants over the May through August 2016 period of the information-gathering initiative.

Derek Yach supervised the overall development of the Executive Summary Report, with the support of Kelsey Berry, a health policy researcher and doctoral candidate at Harvard University's Interdisciplinary Program in Health Policy. She carried out the data analysis, synthesis and processing of the respondent feedback, as well as the preparation of the draft Report. Support for her work was provided through a special restricted gift from Michael Terry through a contractual agreement arranged with Georgia State University (GSU), facilitated by Michael Eriksen and internally by Fred Grant of GSU.

Annex B: Input Gathering Methods

B.1 Input-Gathering Procedures

Two (2) main input-gathering efforts were carried out to inform the development of priorities for reducing the prevalence of smoking among adults; the first, a one-day workshop with 18 invited tobacco control leaders, mostly from the Atlanta area; and the second, a qualitative survey fielded to 150 tobacco control leaders and stakeholders across multiple levels and disciplines across the public, private and voluntary sectors. These efforts were carried out in accordance with guiding principles to ensure the fair representation of a diversity of views and increase the legitimacy of resultant conclusions about priorities, specifically: inclusiveness (inclusion of multiple stakeholders from across sectors and disciplines), impartiality (all inputs afforded equal weight), and transparency (via publication of analysis approach and detailed findings; opportunities provided to comment on findings reported here).

The one-day workshop took place on September 3, 2015 at the Commerce Club in Atlanta, Georgia. The School of Public Health at Georgia State University hosted the meeting and covered related expenses. Eighteen (18) tobacco control leaders from OSH, ANR, ACS, Legacy (Truth), SSM, GSU, UCSF and CTFK joined the Core Team in these discussions.

Key outputs included reaching consensus to (1) launch a re-energized and focused tobacco control movement with cooperation across public, private and voluntary sectors; (2) elevate the importance of tobacco control for adult smokers; (3) generate public fervor and impatience about the 40 million adults who continue to smoke and that one in four of all deaths are caused by tobacco use; and, (4) increase the acquisition and investment of funds for tobacco control.

This workshop illuminated the need to involve more stakeholders across the tobacco control movement in priority-setting efforts, and motivated the Core Team to develop and conduct a qualitative survey as the second-stage of the input gathering process.

A survey instrument was designed with open-ended response categories to elicit stakeholder views about the highest priority actions to reduce the rate of tobacco use among adults. Specifically, stakeholders were asked to name the two actions that would have the greatest impact on reducing adult consumption of tobacco products in the immediate term, and two actions for impact in the longer term. The survey was administered via telephone and email to a group of stakeholders in tobacco control.

Target participants were identified by members of the Core Team and Support Group, whose positions gave them first-hand knowledge of key individuals engaged in tobacco control.

Participants were purposively selected to maximize the diversity of professional experiences and history of involvement in the tobacco control movement. Additionally, names were added from snowball sampling during correspondence with participants. These recommendations resulted in a convenience sample ($n = 150$) of stakeholders to engage from the public (federal, state, and local levels), private and voluntary sectors. The survey was fielded in the summer of 2016. The purpose of this process was not to conduct an exhaustive consultation with a representative sample of tobacco control leaders, but to solicit a range of ideas and attitudes to help frame deliberation on priorities to reduce adult smoking prevalence.

A total of 120 stakeholders completed the survey, yielding a response rate of 80%, which greatly exceeds that of other similar initiatives. In some instances, stakeholders recruited from the same national/regional organization consulted with one another and jointly returned a single response document. These groups are RWJF, AHA, ACS, ACS-CAN, the Truth Initiative, OSH, ANR, MD Anderson Cancer Center, UCSF and GSU. The overall effort yielded 91 usable responses encompassing the perspectives of 120 stakeholders from multiple levels of government, private and voluntary sectors.

B.2 Analysis Approach

An independent research consultant (Kelsey Berry) was contracted to analyze and synthesize response data. The purpose of this analysis was to explore the diversity of views on the tobacco control efforts that would have maximum impact on reducing smoking among adults, identify dominant strategies and cross-cutting themes in priorities detailed by respondents, and describe the current state of thinking around adult cessation in the tobacco control community. A qualitative analysis was suited to these goals.

The use of open-ended response categories in the survey produced rich and varied response text suitable for qualitative content analysis. Content analysis methods enable researchers to examine language intensely to classify large amounts of text into an efficient number of categories that represent similar interpretations.^{5, 6} Our aim was to

⁵ Hsieh H and Shannon SE. 2005. Three Approaches to Qualitative Content Analysis. *Qualitative Health Research*. 15(9): 1277-1288.

⁶ Weber RP. 1990. *Basic content analysis*. Beverly Hills, CA: Sage.

investigate the range and diversity of views presented in the response data regarding priority actions for reducing smoking among adults. Analysis proceeded in two complementary ways through directed (deductive) and conventional (inductive) content analysis, to systematically organize text and facilitate discovery of patterns and themes among responses.⁷

In the directed content analysis, response text was categorized according to previously established categories of action for tobacco control derived from the World Health Organization's Framework Convention on Tobacco Control (WHO FCTC). This document represents internationally-agreed standards and recommendations for evidence-based measures to reduce the demand, supply, and harms of tobacco use, adopted by all WHO Member States, including the U.S.

Researchers developed definitions of categories for action for tobacco control based on the articles of the WHO FCTC (e.g., price and tax measures to reduce the demand for tobacco; tobacco product regulation; protection from exposure to tobacco smoke). All response text was carefully reviewed, and text indicating an action or recommendation for reducing smoking among adults was highlighted. All highlighted text was coded using the predetermined categories for action wherever possible. Highlighted text that could not be coded into one of these categories was coded with another label that captured the type of action expressed in the recommendation, and these labels were re-examined to describe new categories for action.

We proceeded in this manner primarily to ensure that the initial categorization of recommendations in the response text aligned with concepts and groupings characteristic of the tobacco control field. This approach to data organization also enabled us to explore the coherence of recommendations with a previously established framework for tobacco control actions, and to identify areas in which the recommendations deviated from this framework. It was hypothesized that any such deviations would favor measures perceived as being related to adult smoking cessation, and disfavor measures targeted towards youth, in virtue of the specific question asked of respondents. This approach produced a matrix of response text organized according to categories for action. All text falling within a particular category was read vertically to identify subcategories, and open-coding was used to describe the range and diversity of recommendations and commentary within each category for action.

⁷ Mayring P. 2000. Qualitative content analysis. Forum: Qualitative Social Research, 1(2). Retrieved August 2016, from <http://www.qualitative-research.net/fqs-texte/2-00/02-00mayring-e.htm>

In the conventional content analysis, response text was read horizontally across categories for action in order to derive cross-cutting themes regarding priorities for adult smoking cessation directly from the data. The advantage of the conventional approach to content analysis is gaining direct information from participants without imposing preconceived categories or theoretical perspectives.⁸ An initial coding frame was developed based on a close read of 10% of the response text, and the remaining data were coded according to this frame. If new codes emerged, the coding frame was updated and the data were reread according to the new structure. Codes were grouped into emergent categories and linked to produce themes that reflect strategies and considerations relevant to the task of reducing smoking among adults. Counter-cases were analyzed to assess the coverage and comprehensiveness of the resultant themes.

B.3 Limitations

This input-gathering process is subject to three limitations. First, the collection of open-ended data via writing on questionnaires for most of the respondents made probing or extending responses impossible.

Second, inherent in any qualitative research is the potential for bias in analysis of the data. Our methods relied on data structuring, analysis and synthesis by a neutral research consultant to limit stakeholder bias. A Support Group member who was responsible for developing the original WHO FCTC reviewed the operational definitions used to categorize response text in the directed content analysis, in order to ensure the accuracy of predetermined categories. Consensus resolution and discussion of negative cases with this Support Group member were used to extract inductive themes in a reliable manner.

Third, our findings should not be interpreted as representative of the views of the tobacco control field. Our sampling technique was designed to maximize the diversity of expert perspectives on efforts to reduce smoking among adults, and our analysis techniques were structured primarily to capture that complexity rather than to describe characteristic attitudes in the tobacco control field. Offsetting strengths of this study include the nuance and depth of data, which we were able to describe in some detail using complementary deductive and inductive approaches. This input-gathering process provides the first evidence of themes in stakeholder recommendations for tobacco control priorities to greatly reduce smoking among adults.

⁸ Hsieh & Shannon 2005

Annex C: Input Gathering Complete Findings

Findings are presented in two sections, detailing specific interventions, and cross-cutting themes reflecting strategies and considerations relevant to the task of reducing smoking among adults.

C.1 Recommended Interventions

Respondents identified a total of 446 proposed top priority actions that they believed would have the greatest impact on reducing adult consumption of tobacco products. In the initial analysis, recommended actions were grouped together based on types of interventions set forth in the WHO FCTC. Table 1 summarizes the incidence of recommended actions that corresponded to each WHO FCTC intervention, and the incidence of actions identified that did not correspond to an intervention derived from the WHO FCTC. There was no difference in the relative ranking of interventions when recommended actions were analyzed separately based on whether they had been indicated by respondents for immediate versus long-term impact on reducing adult consumption of tobacco products (not shown).

Table 1: Recommended Tobacco Control Interventions to Reduce Smoking Among Adults

Tobacco Control Interventions	Incidence of actions corresponding to interventions; count (%)
Interventions derived from WHO FCTC	390 (87.4)
Price and tax measures to reduce the demand for tobacco	82 (18.3)
Protection from exposure to tobacco smoke	59 (13.2)
Regulation of tobacco products (general); regulation of the contents of tobacco products (specific)	68 (15.3)
Regulation of tobacco product disclosures	0 (0)
Packaging and labelling of tobacco products	7 (1.6)
Education, communication, training and public awareness	52 (11.7)

Restriction of tobacco advertising, promotion and sponsorship	25 (5.6)
Cessation support measures to reduce dependence on tobacco products	65 (14.6)
Reduction of illicit trade in tobacco products	0 (0)
Restriction of sales of tobacco products to and by minors	14 (3.1)
Provision of support for economically viable alternative activities to tobacco production and sales	1 (0.2)
Liability	2 (0.4)
Research, surveillance, exchange of information and cooperation in provision of scientific, technical and legal expertise	10 (2.2)
Protection of public health policies with respect to tobacco control from commercial and other vested interests of the tobacco industry	5 (1.1)
Newly identified interventions	56 (12.6)
Development and regulation of reduced-risk products	49 (11)
Coordination with tobacco industry	5 (1.1)
Link tobacco control and marijuana control	2 (0.4)
Total	446 (100)

Finding 1: Price and tax measures, tobacco product regulation, cessation support measures, smoke-free policies, and communication and public awareness are top recommended interventions from WHO FCTC for reducing adult smoking prevalence.

Five interventions account for nearly three-fourths (73.1%) of the recommendations extracted from the response text.

- Price and tax measures to reduce demand for tobacco (18.3% of recommended actions)

Among recommendations for this intervention, there was widespread support for raising state or federal excise taxes on tobacco products (mentioned 55 times). Other recommended actions included differentiating tax rates on tobacco and nicotine

products based on their risks and relative risks (mentioned 20 times), and adopting price measures for tobacco products like setting minimum prices and prohibiting cost-based promotional marketing (mentioned 6 times).

- Tobacco product regulation (15.3% of recommended actions)

Recommended actions emphasized the need for improvements and advancements in tobacco product regulation by the FDA. Though tobacco product regulation is generally consistent with the WHO FCTC interventions, and is described as such in Figure 1, two points bear mention about the recommended actions in this group. First, about one-third of the recommendations did not fully specify the envisioned content of regulatory action. These recommendations focused more generally on improving coordination between the Center for Tobacco Products and Center for Drug Evaluation and Research, and ensuring the FDA uses its full authority under the Family Smoking Prevention and Tobacco Control Act. Second, nearly one half of the recommendations called for types of regulatory action that, while they pertain to product regulation, do not map exactly onto guidelines for this intervention in the WHO FCTC.

One type of action (mentioned by respondents 10 times) involved setting product regulations based on the risks, relative risks, and intended uses of all tobacco and nicotine products. The other type of action (mentioned 20 times) involved regulating nicotine content to reduce the dependence liability of tobacco products. The parties to the FCTC have not yet issued guidelines around regulation of dependence liability of tobacco cigarettes, and do not comment on the role of risk in product regulation. The remaining recommended actions clustered around banning menthol flavoring and increasing the pH of cigarettes to reduce their attractiveness (mentioned 16 times), and ensuring non-cigarette combustible tobacco products were subject to similar regulations to prevent substitution.

- Cessation support measures to reduce dependence on tobacco products (14.6% of recommended actions)

Recommendations were fairly evenly spread across population-level and individual-care-focused interventions available through the health system. Recommendations for population-level interventions included improving quit lines; increasing the use of tobacco use screening, recording and brief advice; developing and disseminating comprehensive tobacco dependence treatment guidelines; and training health providers on principles and options for harm reduction. Recommendations intended to fix gaps in individual care included improving financial risk protection and provider payment for intensive behavioral support and medication coverage, and improving the delivery of

cessation services through care coordination and provider accountability mechanisms and the use of new digital and mobile technologies. Some recommendations emphasized the need for better targeting within health systems to reach populations with high prevalence of tobacco use, for example, by mobilizing providers in the behavioral health community to provide cessation support to their patients. The remaining recommendations dealt with cessation support measures that could be taken by non-health system actors, including employers incentivizing a smoke-free lifestyle or a transition from combustible tobacco to reduced-risk products, tobacco companies contributing funds into a cessation support pool, and retailers increasing the penetration of cessation products in all establishments where combustible tobacco products are sold.

- Protection from exposure to tobacco smoke (13.2% of recommended actions)

Recommendations related to protection from exposure to tobacco smoke predominantly clustered around extending the geographic coverage of clean indoor-air policies to new states and localities, and targeting certain sites for smoke-free policies (i.e., workplaces, casinos and bars, multi-unit conjoined housing, private homes and vehicles, outdoor gathering places). A small number of recommendations prioritized including vapor products (i.e., electronic cigarettes) in smoke-free laws; others prioritized differentially applying smoke-free laws to tobacco and vapor products based on the health risks posed by their emissions.

- Education, communication, training and public awareness (11.7% of recommended actions)

Within the category of education, communication, training and public awareness, clusters of recommendations emerged around sustaining a decade-long, year-round media campaign modeled on OSH TIPS (mentioned 14 times), and engaging in public education regarding the risks, relative risks and intended uses of products in the marketplace (mentioned 11 times). The remaining recommendations were spread fairly evenly across running media campaigns to highlight the dangers of second-hand smoke, the benefits of healthy lifestyles, harmful practices of the tobacco industry, and the tobacco endgame; and folding new media platforms (e.g., social and digital media) into communication strategies.

Finding 2: Development and regulation of reduced-risk products is a top intervention, though not included in the WHO FCTC. The range of recommendations can be characterized as differentially emphasizing the need for additional research, clarification

and implementation of regulatory standards, product development and innovation, and careful targeting of the products to adult users of combustible tobacco products.

The next most frequently recommended intervention included actions not explicitly stated in the WHO FCTC, related to the development and regulation of reduced-risk products (11% of recommended actions). This intervention type exhibited a great deal of heterogeneity in its associated recommendations, reflecting contrasting perspectives on how alternative nicotine delivery systems ought to be treated in regulatory policy.

For example, a narrow set of respondents resisted characterizing the new alternative nicotine delivery systems as reduced-risk products at this stage, calling for additional research on the opportunities and threats posed by these products to individual and public health. Other recommendations were oriented toward action that would facilitate markets in alternative nicotine delivery systems. For example, respondents called for a viable pathway to marketing authorization through standard-setting at the FDA that would ease the uncertainty and potential burdens associated with individual product authorizations. Respondents cautioned that an opaque or restrictive regulatory regime would inappropriately stifle market competition and innovation in development of alternative nicotine delivery systems. Related suggestions included providing incentives to manufacturers to continue to develop reduced-risk products as regulations are implemented. These respondents emphasized the importance of adopting a regulatory regime that would treat alternative nicotine delivery systems commensurate with the harms they cause, and of placing the burden of ascertaining those harms on the entities best able to bear it — for example, the FDA.

Another cluster of recommendations sought to improve the targeting of alternative nicotine delivery systems to specific populations. These respondents called for action to limit access and use of alternative nicotine delivery systems by youth and non-tobacco users while making them readily available to current users of tobacco products. Related suggestions included establishing a counter-marketing campaign for electronic cigarettes, promoting age-based restrictions on sales and promotions of alternative nicotine delivery systems, and channeling support for use of these products primarily through individual health care interactions. Finally, a clear tension emerged regarding whether actions should be taken to maximize the attractiveness of reduced-risk products to increase the likelihood that users of combustible tobacco products would switch to them (for example, by optimizing nicotine delivery and sensory appeal of reduced-risk products), or whether actions should be taken to limit the attractiveness of these products (for example, by banning flavorings) so as to diminish the likelihood of non-tobacco users taking them up.

Stakeholder input in this category also illuminated an important barrier to advancing public debate about the risks and relative risks of nicotine products. Whereas small manufacturers were initially the sole purveyors of alternative nicotine delivery systems, increasingly international tobacco companies have invested in research and development and realigned business models to expand their presence in these markets. These shifts have been accompanied by a split in the tobacco control community between those fearful that the tobacco industry's involvement is simply another misdirection in the manner of low-tar and filtered cigarettes, and those who see a chance to exploit market forces to end the use of harmful tobacco cigarettes. Despite a rapidly expanding literature on the risk profile of these products, this ambivalence and deep-seated distrust of market players hinders appraisal of the new products based on available evidence.

Finding 3: Some respondents break with the FCTC in recommending communication and collaboration with the tobacco industry.

A small number of other recommendations also diverged from the WHO FCTC categories. These included calls for collaboration with the tobacco industry to pursue harm-reduction measures (1.1% of recommended actions). Specifically, respondents suggested opening channels of communication with tobacco companies that have invested in the research and development of reduced-risk products, and negotiating publicly with tobacco companies to trade public health support for their reduced-risk product portfolios with their agreement to end production and sales of combustible tobacco products. Actions falling within this “collaboration” category warrant additional reflection, as this set of recommendations is not only absent from the WHO FCTC, but may also conflict with FCTC-recommended actions to protect public health policies from commercial and other vested interests of the tobacco industry.

C.2 Emergent Strategies, Barriers and Facilitators for Reducing Adult Smoking

In the second analysis, we analyzed response text inductively to identify emergent themes which cut across specific recommended interventions. Three themes surfaced that reflect overarching strategies for accelerating progress in adult smoking cessation, and three themes surfaced regarding forces seen as barriers and facilitators to achieving the 2024 goal. For each theme, we note the core content, and present language excerpted from responses that illustrates the theme. While this presentation does not portray all comments from respondents, it reflects the most prominent themes.

Finding 4: Respondents chiefly recommended tackling smoking cessation by (a) addressing geographic disparities in the implementation of historically-validated tobacco

control measures, and (b) integrating reduced-risk products in a comprehensive harm reduction-paradigm that would span regulatory, tax, and education policy. A smaller, but still substantial group emphasized the need to proceed by (c) reshaping tobacco control measures to engage with and prioritize the needs of low SES and special population groups.

- Tackle Geographic Disparities

Respondents located the challenge in reducing adult smoking as overcoming geographic disparities in the implementation of historically-validated tobacco control measures. In light of this, they called for a renewed effort at the state level to facilitate adoption of higher excise taxes, and at the local level to adopt smoke-free laws, for example:

“... There are currently a number of localities with campaigns in progress that have the potential to win and become smoke-free municipalities. It is far more challenging to adopt laws at the state level.”

Respondents also saw a route to reduce geographic disparities through a greater role for the federal government. Many viewed the federal government as a force for consistency, and anticipated that political will for action was more present at the federal versus the state level.

“Given the now slower progress at the state/local level, I believe it is time to think differently. Thus, my first highest-priority action is to create a more coherent, comprehensive, and adequately-funded national approach to tobacco control.”

“The problem... is the lack of will on the part of [state] politicians, and the lack of resources to get to the areas where policy change is most difficult.”

“...We should move state-driven quitlines to one national quitline so that services are not dependent on state funding levels or political will.”

- Strengthen Harm Reduction

Respondents located the challenge in reducing adult smoking to the lack of a comprehensive approach to harm reduction in tobacco control. They recommended separating nicotine from tobacco control policy in a way that would permit intensification of the current public health stance towards harmful combustible tobacco products, while expanding options for addicted smokers to use nicotine in less harmful forms.

“...From where I sit, the mainstream U.S. tobacco control movement looks locked into a counter-productive abstinence-only paradigm... Even the WHO’s FCTC identifies harm reduction as a key plank of tobacco control.”

“We need to be tightening the noose around cigarettes while making lower-risk science-based regulated products more available.”

Respondents perceived newer alternative nicotine delivery systems as playing a key role in this strategy. They primarily called for product regulation that would validate them as safe, reduced-risk alternatives to combustible tobacco products, and easing marketing authorization for less-risky products. The widespread support for accelerating this kind of assessment reflected a real openness to public debate about the products’ role in tobacco control. Several stakeholders noted that the field would be wrong to characterize alternative nicotine delivery systems as *no* risk at this point, since their long-term impact on individual and public health is not yet certain. However, others cautioned that it would be equally, if not more disingenuous, to assert or imply equivalence in the health risks posed by nicotine products and traditional tobacco cigarettes.

“...Truthful and non-misleading statements from the authorities on the relative risk of vapor products and smokeless tobacco (as with the Royal College of Physicians) are essential. First, do no harm and; make sure you tell the truth. CDC should be measured on alignment of public risk perception with best available scientific assessment.”

Stakeholders also suggested differentiating tax rates for combustible cigarettes and reduced-risk products, and mounting a campaign to educate the public and health professionals on the risks, relative risks and intended uses of products in the marketplace. This strategy was variably described as increasing chances that other tobacco control policies would work for smoking cessation, and as a means of side-stepping concerns that have been raised about traditional tobacco control policies.

“The incentives to stop smoking are already very strong, but will be more effective if more and easier pathways from smoking to not-smoking are available and supported, not opposed.”

“The key policy is to engineer a pro-health ‘taxation structure’, rather than press for ever higher tax levels – which are regressive, painful and ultimately promote black markets.

It was acknowledged that adult smokers would be the clear beneficiaries of such a strategy, and that concurrent actions may need to be taken to insulate other groups from any side-effects of this approach.

“...Focus on serving a key at-risk group – adult smokers >30 – with safer alternatives, rather than trying to micro-manage youth risk behavior.”

“For youth and non-users of nicotine, policy should be designed to discourage use of any nicotine products.”

- Address Group Disparities

Respondents located the challenge in reducing adult smoking in inadequate attention to groups with elevated smoking prevalence. They called for directing attention toward three priority groups: those with low socioeconomic status, racial/ethnic minorities, and those with mental health and substance use disorders. Improved targeting of these groups was seen not only as an imperative of social justice, but also as an efficient means to reduce aggregate rates of adult smoking due to the elevated smoking rates in these population subgroups.

“All tobacco control efforts should be framed within the health equity lens and ensure they do not lead to more or continued disparities.”

Rather than reaching consensus on needed equity-based modifications to each specific tobacco control policy, stakeholders overwhelmingly recommended inviting members and advocates from priority groups to the table as partners in order to ensure smoke-free laws, cessation support services, and media campaigns were responsive to their needs.

“Develop an investment to a ‘marginalized’ community ‘pool’... building the capacity for communities engaged in tobacco policy, and train[ing] the next generation of advocates.”

With regard to individuals with co-morbid mental health and substance use disorders, it was widely suggested to mobilize their health providers (via relevant professional associations) to connect their patients with appropriate cessation services.

Finding 5: Facilitators and barriers to reducing adult smoking include recent health laws, energy for tobacco control action, and the tobacco industry.

- Health reform and systems are seen as facilitators for improving access to high quality cessation support measures.

Respondents perceived a significant opportunity to embed smoking cessation efforts in the implementation of existing policies, such as the Affordable Care Act (ACA), the Mental Health Parity and Addiction Equity Act (MHPAEA), and Health Information Technology for Economic and Clinical Health Act (HITECH Act). Specifically, the ACA's guarantee of free preventive services, including tobacco use screening and cessation interventions, and the MHPAEA's requirement that insurers cover addiction benefits (e.g., intensive therapy for smoking cessation) on a par with general medical benefits, were identified as facilitators for expanding financial access to smoking cessation services. It was also suggested that financial incentives would improve provider engagement with cessation support, via accountable care under the ACA; and increase consistency in the use of tobacco screening and brief advice, through meaningful use of electronic health records required by the HITECH Act. Taking advantage of these opportunities, it was noted, would require the tobacco control field to take an active interest in the implementation and enforcement of these laws with regard to services for smoking cessation.

“[We need] \$0 out-of-pocket costs for patients for any of [preventive tobacco use and cessation] services. The ACA law... mandates most of this. If certain insurers don't cooperate with the law, then this needs to be exposed and confronted and/or to use litigation for compliance with ACA.”

Recent health reform laws were not the only means through which respondents saw an opportunity to take advantage of checks and balances in the health system. It was also suggested that accreditation mechanisms and medical malpractice systems could be exploited to improve the quality of smoking cessation services, by integrating standards for cessation support services into Joint Commission on Accreditation for Health Care Organizations accreditation, and defining and promoting a “standard of care” for any smoker, respectively.

- Lack of energy and leadership are seen as barriers to progress on smoking cessation.

Respondents were troubled by the apparent lack of political will for strengthening the above tobacco control policies, and waning awareness of tobacco as a public health threat among the general public. These were considered important barriers to tackling smoking cessation, which has from the start been less politically popular than youth-focused tobacco control. Proposed solutions included strengthening the tobacco control

field's capacity for advocacy, by diversifying its leadership pipeline to include members of highly-affected populations and skilled social activists; and stirring public support for tobacco control policies for cessation through sustained media and education campaigns targeted to the general public.

“Do whatever is necessary to inject new passion, urgency and excitement into tobacco control; ensure that we put new fresh ideas out front and place a new generation of tobacco control advocates on the frontline.”

“The success of excise tax initiatives, policy and environmental changes, clean indoor-air policies, and cessation advice and services are all dependent upon carefully designed efforts to make the public keenly aware of the deleterious impact that tobacco has on themselves, their families, and friends.”

These recommendations reflect a reliance on human resources internal to the field, with advocacy buoyed by diffuse public support. However, in discussing specific priority interventions, respondents clearly reached to identify actors outside the field as potential partners. While those in tobacco control remain critical as advocates, deeper engagement from outside the field is seen as important.

- The tobacco industry is variably seen as a barrier and facilitator for progress.

Opinions were divided on whether the tobacco industry was a barrier or facilitator for progress in smoking cessation. A good deal of respondents fixated on the harmful nature of its primary products, and distrusted its involvement in markets for alternative nicotine delivery systems. Big tobacco was perceived as a barrier to the emergence of products that could be used for genuine harm reduction.

“... By eliminating the ability of shops to mix the e-juice in the store, the only manufacturers of e-juice will be the traditional tobacco companies that could manipulate the product in such a way as to keep people smoking combustible products. So, regulation [of e-cigarettes is needed] — but with reasonable precautions to prohibit a Big Tobacco monopoly.”

Others described the tobacco industry as a potential instrument or partner in phasing out the combustible cigarette, in virtue of the industry's well-funded research enterprise and development of reduced-risk products. It was recommended to open channels of communication, and to enter public negotiations with the industry to offer public health support of their reduced-risk product portfolios in the event that they agree to phase out the manufacturing of combustible cigarettes.

“We need a much more nuanced approach to the tobacco industry and emerging nicotine industry... The whole industry is moving into reduced-risk products, and that means we cannot continue with the comforting illusion of an unambiguously evil enemy.

“I would talk to an oil company about the exit from climate change, so why not talk to companies about the exit from cancer?”

Summary of Findings from Input-Gathering Process	
Finding 1:	Price and tax measures, tobacco product regulation, cessation support measures, smoke free policies, and communication and public awareness are top recommended interventions from WHO FCTC for reducing adult smoking prevalence.
Finding 2:	Development and regulation of reduced-risk products is a top intervention, though not included in the WHO FCTC. The range of recommendations can be characterized as differentially emphasizing the need for additional research, clarification and implementation of regulatory standards, product development and innovation, and careful targeting of the products to adult users of combustible tobacco products.
Finding 3:	Some respondents break with the FCTC in recommending communication and collaboration with the tobacco industry.
Finding 4:	Respondents chiefly recommended tackling smoking cessation by (a) addressing geographic disparities in the implementation of historically-validated tobacco control measures, and (b) integrating reduced-risk products in a comprehensive harm reduction-paradigm that would span regulatory, tax, and education policy. A smaller, but still substantial group emphasized the need to proceed by (c) reshaping tobacco control measures to engage with and prioritize the needs of low SES and special population groups.
Finding 5:	Facilitators and barriers to reducing adult smoking include recent health laws, energy for tobacco control action, and the tobacco industry.

C.3 Implications for Identifying Priority Actions

Our investigation of stakeholders' perspectives focused on the specific interventions recommended, and the strategies, barriers and facilitators that stakeholders see in the effort to accelerate smoking cessation, in order to inform deliberation about a short-list of priorities. It was decided that a proposed strategy should foreground orienting goals and specific related actions, and place in the background supportive measures and considerations common to the priorities defined. Several points of discussion were relevant to the deliberation.

- **Highly recommended interventions are strong candidates for a priorities short-list. Low-recommended interventions that correspond to FCTC categories should not be strongly considered.** The strong support for five interventions recommended in the WHO FCTC validates them as elements of a comprehensive, evidence-based tobacco control framework most relevant to adult smoking cessation in the U.S. Low support for other WHO FCTC interventions plausibly implies that the interventions are not particularly suited to adult smoking cessation (e.g., restricting sales of tobacco products to minors), have been implemented to satisfaction in the U.S. (e.g., packaging and labeling of tobacco products), face obvious and intractable barriers to implementation over the next seven years (comprehensive restriction of tobacco advertising), would not have sufficient impact in the timeframe (provision of support for economically viable alternative activities to tobacco production), or some combination of these factors.
- **The diversity of views around the specific regulatory actions to be taken with regard to reduced-risk products implies that any priority action should be accompanied by public debate, and assessment based on the most recent evidence.** The top recommended intervention not represented in the WHO FCTC, development and regulation of reduced-risk products, was characterized by a wide range of views about the appropriate actions to take in this area in order to support adult cessation. This is to be expected, as reduced-risk products represent a relatively less established area of science and policy than interventions that are listed in the WHO FCTC. The rapid development and research around these products makes the evidence base regarding their risks and benefits beyond the resources of many but the most vigilant specialist to keep pace with. However, definition of priority action in this category must avoid implying a false equivalence between the risks associated with nicotine products and tobacco cigarettes.

- **The intervention involving collaboration and communication with the tobacco industry should be considered, and not be dismissed for the sole reason that it is a minority view.** Another intervention not listed in the WHO FCTC which was infrequently recommended — specifically, communication and collaboration with the tobacco industry — may lack widespread support among respondents in part because it runs counter to the consensus view as represented by article 5.3 in the WHO FCTC. The reasons for this manner of break with a validated tobacco control framework are worth investigating. It was revealed through the analysis that stakeholders who saw the tobacco industry as a facilitator to the 2024 goal perceived an opportunity to tap into a well-funded research enterprise focused on reduced-risk products, or to use public health support for these products as leverage to motivate tobacco companies to phase out combustibles. Views more consistent with the WHO FCTC expressed skepticism that tobacco companies would genuinely pursue reduced-risk products at the expense of combustible cigarettes. This tension should be evaluated in consideration of the role the tobacco industry could play in smoking cessation.
- **Areas of compromise and synergy across strategies for adult cessation should be explored in defining a short-list of priorities.** The emergence of distinct overarching strategies for pursuing the 2024 goal implies that leaders in the tobacco control field approach the problem of adult smoking differently. Stakeholders may differentially support interventions for a short-list of priorities depending on whether they prioritize reducing geographic disparities, integrating a harm-reduction approach into tobacco control, reducing disparities between population groups, or some combination of the above.