



Rhode Island Public Health Brief

Funding for Tobacco Programs in RI

Key Takeaways

- Smoking among adult Rhode Islanders costs the state about \$640 million per year.
- In 2020, RI spent only 13.5% of the CDC’s recommendation for tobacco programs.
- Expanding funding for tobacco cessation and prevention would reduce health costs and health disparities.

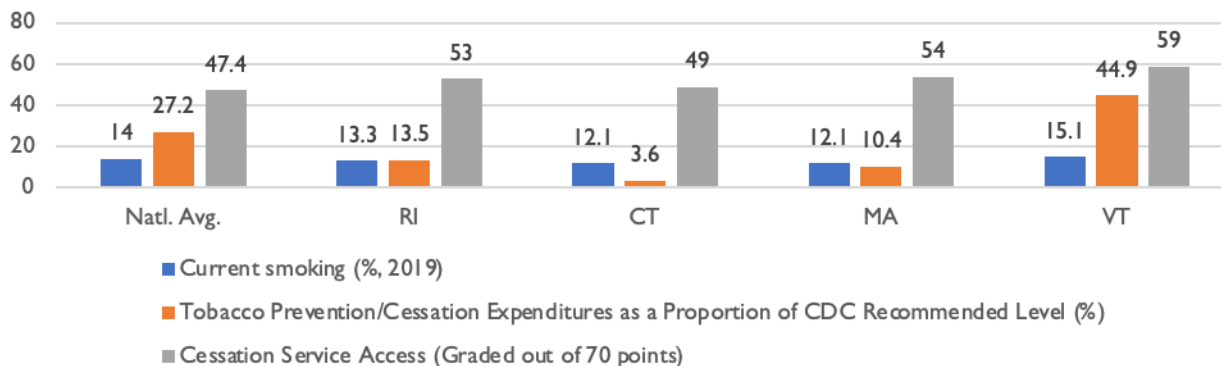
Public health efforts to reduce smoking have made significant progress, yet 13% of adult Rhode Islanders remained cigarette smokers in 2019,¹ and each day 200 RI youth under the age of 18 become daily cigarette smokers.² Smoking causes a range of diseases such as cancer, lung and heart disease, and

diabetes, among others.³ These diseases lead to \$458.9 million in annual costs in RI due to lost productivity and \$640 million per year in health care costs.^{3,4,5}

Quitting smoking can quickly and significantly reduce the health risks associated with smoking. More than half of adult smokers (55%) made an attempt to quit in 2018, however only 10% of those attempting to quit are successful each year.⁶ Cessation support for those attempting to quit can be effective in turning a quit attempt into success, but many states, including Rhode Island, currently provide insufficient funding for cessation services.⁷

The U.S. Centers for Disease Control and Prevention (CDC) provides recommendations to every state for the proportion of total available funding (state and federal sources) to spend on cessation and prevention efforts. Recommendations are based on the state’s average annual smoking- attributable deaths, number of youth projected to die from smoking, and average annual smoking- related medical costs.⁵ Rhode Island spent only 13.5% of the CDC-recommended amount (\$1,732,025 spent, \$12,800,000 recommended), leaving policymakers ample opportunities to make significant investment.

Figure 1. Current Smoking Rates, Spending on Tobacco Prevention and Cessation, and Access to Cessation Services in RI and Neighboring States



Notes: 2019 smoking rates provided by data from the Behavioral Risk Factor Surveillance System.⁸ Expenditures on tobacco prevention activities and cessation services access provided by the American Lung Association, and based on both state and federal sources of funding (state sources are include tobacco tax revenue and MSA funding).⁹

The Master Settlement Agreement (MSA), signed in 1998, was the result of civil litigation filed against cigarette manufacturers in response to the public health burden of smoking. The agreement was signed by the four largest cigarette manufacturers (“the Original Participating Manufacturers”), attorneys general from 46 states, D.C., and 5 U.S. territories, imposing restrictions on marketing, advertising, and promotion, and guaranteeing billions of dollars transferred annually from tobacco manufacturers to U.S. states, in perpetuity.

RI policymakers fund tobacco programs from state tobacco tax revenue, however funding has steadily declined in recent years, despite continued need for resources, significant public health costs associated with smoking, and demonstrated return on investment for funding tobacco cessation support. In 2002 the RI Tobacco Control Program was funded at \$3.2 million; in comparison, the governor's 2022 budget proposed spending just \$397,000.¹⁰

Box 1. Disparities in Access to Cessation Services

- Each year RI spends \$217 million on medical and other costs associated with smoking among Medicaid recipients, and low reimbursement rates for cessation service providers limits meaningful access for these adults.
- Homeless adults smoke at high rates compared to the general population, and do not have sufficient access to cessation services.
- Reaching populations at high risk for smoking-related disease through targeted outreach could significantly reduce disparities in the burden of smoking-related diseases.

The US Department of Health and Human Services (DHHS) and CDC also provide guidelines for evaluating access to cessation treatment. In a national report rating access to services using these guidelines, Rhode Island scored 53 out of 70 possible points, compared to the national average of 47.4 points (Fig 1).⁷ Despite a better than average score across some measures, there are notable gaps in meaningful access to cessation support among some populations of adults (Box 1).

States spending more than 25% of the CDC-recommended level saw significant reductions in per capita cigarette sales. Increasing spending on cessation interventions produced similar reductions.¹¹ For every \$1 spent on cessation interventions across states, the average return on that investment in the form of reduced direct medical costs and losses to productivity is \$1.26.¹² This represents a substantial investment opportunity with proven benefits.

Greater investment also has the potential to improve health equity among vulnerable populations (Box 1). Adults with mental health conditions and substance use disorders, those with lower levels of income and education, sexual and gender minorities, and those experiencing homelessness are more likely to smoke, to smoke more heavily, and therefore suffer health consequences of smoking.³

Conclusions: Rhode Island has an opportunity to substantially reduce the public health burden of smoking by increasing investment in accessible cessation supports and prevention activities. Strategic investment, consistent with national guidelines,⁵ will reduce smoking in RI, improve access to services, and reduce the burden of tobacco-related health disparities among RI's most vulnerable.

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