Disparities in Tobacco Use

Overview

Tobacco use and exposure to secondhand smoke is responsible for 480,000 deaths each year in the U.S., including 30 percent of all cancer deaths. Although tobacco-related cancer incidence and mortality have declined in the U.S., we continue to see disparities by socioeconomic status (SES), race/ethnicity, educational level, gender, sexual orientation, and geographic location.

All individuals should have equitable access to quality cancer care and equal opportunity to live a healthy life. Our ability to continue to make progress against cancer relies heavily on eliminating the inequities that exist in cancer prevention and care, including tobacco policies.

Who uses tobacco?

3/10

of American Indian and Alaska Natives (AIANs) use tobacco and have the highest tobacco use prevalence of any racial/ethnic group [1]

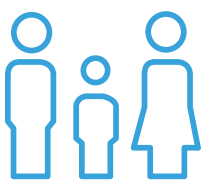
Tobacco use by adults with household income <$35,000/yr is about

2X

higher than adults with household income ≥$100,000[1]

3/10

lesbian, gay, bisexual, and transgender (LGBT) individuals use tobacco products, compared to about 2/10 heterosexual individuals[1]



The prevalence of tobacco use among those with a high school education or less is threefold that of college-educated individuals[2]

Currently more than 31% of high school students and more than 12% of middle school students use tobacco[3]

How do health outcomes compare across groups?

Smoking increases the risk of at least 13 different types of cancer and is responsible for 80% of all lung cancer deaths. Current lung cancer patterns reflect historical smoking prevalence. [2]

- While lung cancer is the leading cause of cancer death in the U.S. in both sexes and across racial/ethnic groups, cancer death rates are higher among males than females and among non-Hispanic Blacks and AIANs compared to other racial/ethnic groups. [2,4]
- Death rates from lung cancer are highest in the South and part of Appalachia for both men and women.[2]
- The 5-year relative survival rate is lower in Blacks than in Whites at all stages for lung and bronchus cancer.[2]
- AIANs have a higher risk of experiencing tobacco-related disease and death due to higher use of tobacco products. [5]

Barriers to Tobacco-Free Living

Tobacco Industry Targeting

Tobacco industry marketing strategies have led to disparities in tobacco use, including higher use of tobacco products in populations of lower SES, Blacks, AIAN, youth, and LGBT individuals.[4,5] The tobacco industry has used menthol for decades to intentionally and aggressively target certain communities for addiction to their addictive and deadly products. As a result, African Americans consistently report the highest prevalence of menthol cigarette use.

Weak or No Tobacco Control Laws

The lack of comprehensive tobacco control laws and funding in a locality or state can contribute to disparities in tobacco use. In fact, about **40%** of the U.S. population are not protected by comprehensive, smoke-free policies. The availability of cheap tobacco products make it easy for people, in particular youth, to start and continue to use tobacco products. The $739.7 million the states have budgeted for tobacco prevention amounts to just **22%** of the $3.3 billion the Centers for Disease Control and Prevention recommends for all states combined.[6]

Lack of Access to Care

- Individuals who rely on Medicaid for their health care have higher tobacco use rates (28%) than those with private insurance (17%).[1] Yet, only **1/3** of people on Medicaid who smoke used cessation medication or counseling, partly due to the gaps in coverage that exist for individuals in the traditional Medicaid program.[6]
- Four out of every nine adult cigarette smokers who saw a health professional during the past year did not receive advice to quit.[7]
- Use of approved cessation aids is particularly low among racial/ethnic minorities and those with low levels of educational attainment.[8]
- LGBT individuals are less likely to have health insurance than heterosexuals,[5] which can negatively affect their access to cessation treatments, including counseling and medication, and therefore their health.

ACS CAN is Taking Action

ACS CAN is pursuing evidence-based policies at the local, state and federal levels that aim to reduce disparities and improve health outcomes for all individuals

Advocating for comprehensive tobacco control laws at the state and federal levels, including:

-Implementing comprehensive smoke-free policies in all workplaces, including restaurants, bars, and gaming facilities

-Increasing the price of tobacco products through regular and significant tobacco tax increases of at least $1 per pack of cigarettes with an equivalent tax on all other tobacco products

-Adequately funding evidence-based tobacco prevention and cessation programs, including the Centers for Disease Control and Prevention's national Tips From Former Smokers campaign and state-based programs

-Advocating for the Food and Drug Administration to use its full authority to regulate tobacco products and prohibit all flavored products, including menthol

-Increasing access to comprehensive cessation coverage in Medicaid and private insurance plans that encompass individual, group, and telephone counseling, including reimbursement through the state quitline and all seven FDA-approved tobacco cessation medications

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