Eliminating Tobacco-Related Disparities through Comprehensive Tobacco Control Policies

Tobacco use is one of the primary causes of cancer-related health disparities - disproportionately impacting people by race, ethnicity, sexual orientation, gender identity, disability status, mental health, income and education levels, and geographic location.[i,ii,iii] Eliminating health disparities depends heavily on eliminating tobacco use.

Overall tobacco use rates have declined in recent years. Yet the tobacco industry's aggressive marketing using advertising, price discounting, and flavors[v,vi] to intentionally target communities of color, limited income communities, veterans, people with disabilities, LGBTQ+ people and youth has caused disproportionate tobacco use among these populations. Tobacco use and exposure to secondhand smoke cause tobacco-related health disparities or worse health outcomes that include various types of cancers, disease, disability, and premature death.[vii] Therefore it is not surprising that tobacco-related cancers disproportionately burden communities of color, limited income communities, and other populations that have been marginalized given these are also the populations with some of the highest tobacco use rates.

What are health disparities?

A health disparity is "a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage. Health disparities negatively affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion."[iv]

The lack of comprehensive tobacco control laws in a locality or state can contribute to disparities in tobacco use. The tobacco industry's constant request for exemptions or requests to delay the implementation of strong tobacco control regulations only benefits Big Tobacco at the expense of public health. Exemptions, such as excluding menthol flavored tobacco products from policy restrictions, are never added to policies for public health reasons and can contribute to worsening health disparities for everyone, but especially communities of color, limited income communities, people with disabilities, LGBTQ+ people and youth. Industry documents have shown how the Big Tobacco has deliberately marketed and manipulated the levels of menthol in their products to increase smoking initiation, decrease successful quitting, and lead to greater addiction among these specific populations.[viii,ix,x]

Comprehensive fact-based tobacco control policies have been proven to reduce tobacco use in all populations, including limited income populations and certain communities of color. Yet not all communities have benefited from tobacco control policies because not all communities are covered by these laws. Without ensuring that the populations that experience the greatest burden of tobacco use and its associated disease and death are also covered by comprehensive tobacco control laws, disparities related to tobacco will persist and potentially widen. In addition to ensuring all communities are covered, policies that specifically address tobacco-related disparities are needed. For instance, there are evidence-based proven cessation resources available, including medications, counseling and quitlines. However, strategies specifically designed to support and provide education to individuals who smoke menthol cigarettes, including people who are Black, LGBTQ+, have limited incomes and youth are still needed.

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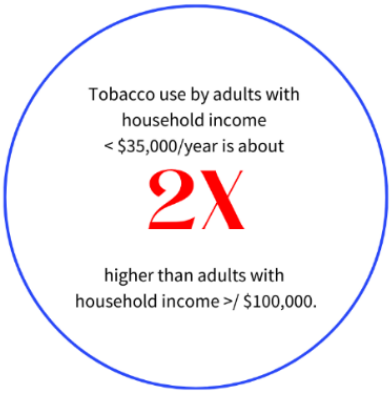
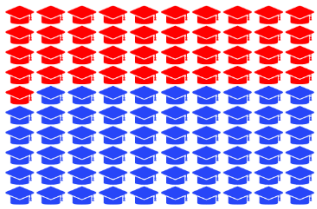
Disproportionate Tobacco Use



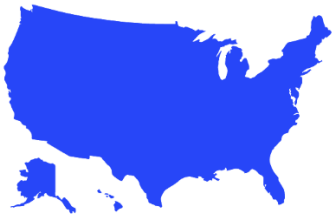
Source: Cornelius ME, Loretan CG, Wang TW, Jamal A, Homa DM. Tobacco Product Use Among Adults — United States, 2020. MMWR Morb Mortal Wkly Rep 2022;71:397–405. DOI: http://dx.doi.org/10.15585/mmwr.mm7111a1.

40.5%



In 2020, 40.5% of adults whose highest level of education was a general educational development certificate (GED) used a tobacco product compared to 11.7% of those with a bachelor's degree.

27.3%



In 2020, the prevalence of any tobacco product use was higher among adults living in rural areas (27.3%) compared to adults living in urban areas (17.7%).

25.4%

In 2020, the prevalence of any tobacco product use was significantly higher among adults with a disability (25.4%) compared to adults without a disability (18.4%).

Source: Cornelius ME, Loretan CG, Wang TW, Jamal A, Homa DM. Tobacco Product Use Among Adults — United States, 2020. MMWR Morb Mortal Wkly Rep 2022;71:397–405. DOI: http://dx.doi.org/10.15585/mmwr.mm7111a1.

NEARLY 1 IN 9

In 2022, nearly one in nine (11.3%) middle and high school students reported current tobacco product use - representing 3.08 million youth - including

- **27.2%** with low academic achievement;
- **18.3%** who reported severe psychological distress;
- **16.6%** who identified as transgender;
- **16.0%** who identified as lesbian, gay, or bisexual;
- **13.5%** of non-Hispanic American Indian or Alaska Native students; and
- **12.5%** with low family affluence.

Source: Park-Lee E, Ren C, Cooper M, Cornelius M, Jamal A, Cullen KA. Tobacco Product Use Among Middle and High School Students — United States, 2022. MMWR Morb Mortal Wkly Rep 2022;71:1429–1435. DOI: http://dx.doi.org/10.15585/mmwr.mm7145a1.

How Do Health Outcomes Compare Across Groups?

- Lung cancer incidence in the general population has been declining since the early 1990s among men and the mid-2000s among women.[xi] In contrast, rates in American Indian and Alaskan Natives (AIAN) since the late 1990s remained generally stable in women and only began to decline recently in men (by 5.4% per year during 2014 through 2018).[xii]
- While lung cancer is the leading cause of cancer death in the U.S. in both sexes and across racial and ethnic groups, cancer death rates are higher among males than females and among non-Hispanic Black individuals compared to other racial and ethnic groups.[xiii] Death rates from lung cancer are highest in the South and part of Appalachia for both men and women. [xiv]
- The 5-year relative survival rate for lung cancer is significantly lower in Black individuals than in white individuals overall, 20% versus 22%, with the largest difference for localized-stage disease (55% versus 60%). Localized-stage lung cancer is only diagnosed in 21% of Black people and 25% of White people because symptoms generally do not appear until the disease is advanced.[xv]

Contributing Factors Influencing Tobacco-Related Disparities

Tobacco-related health disparities are largely driven by social factors like structural racism and discrimination against historically marginalized groups, but also the direct actions of the tobacco industry in designing products and targeting its marketing to specific communities. For instance, the tobacco industry aggressively markets menthol tobacco products in African American neighborhoods, magazines popular with African Americans, and events that are aimed for African Americans.[xvi] The industry has also provided more shelf space for menthol products located in the community's neighborhood stores.[xvii] Reducing deaths from cancer not only requires ensuring that everyone has the opportunity to benefit from advances in cancer prevention and treatment, but it also requires putting an end to the tobacco industry's predatory marketing practices that are contributing to health disparities.

Tobacco Industry Targeting

- The tobacco industry directly uses culturally specific names, symbols, and icons in the marketing of commercial tobacco products to target the American Indian and Alaskan Native communities.[xviii,xix]
- Tobacco retailers are disproportionately located in communities with limited incomes where tobacco retailers are more likely to be near schools compared to other neighborhoods.[xx] One study of 30 U.S. cities found that there are nearly five times more tobacco retailers per square mile in the neighborhoods with the lowest income compared to the neighborhoods with the highest income.[xxi]
- The tobacco industry has used menthol for decades to target their addictive and deadly products intentionally and aggressively to Black communities and LGBTQ+ people through advertising, price promotions, retail, and point-of-sale advertising.[xxii,xxiii]
- As a result of aggressive tobacco industry marketing, menthol cigarettes are also popular among other non-white racial and ethnic populations. In 2019-2020, between **33%-57%** of Hispanic, Native Hawaiian or Pacific Islander, and American Indian or Alaska Native people who smoke used menthol cigarettes.[xiv]
- Tobacco industry marketing strategies have led to disparities in tobacco use, including higher use of tobacco products in limited income communities and among people of color & LGBTQ+ people.[vii, xxiv]

Weak or Lack of 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 **38%** of the U.S. population is not protected by comprehensive smoke-free policies.[xxv]
- The availability of cheap tobacco products due to low tobacco excise taxes makes it easy for people, in particular youth, to start and continue to use tobacco products.
- In fiscal year 2023, despite states receiving nearly $27 billion from the tobacco settlement and tobacco taxes, only 2.7% of it – $733.1 million – will be spent on tobacco prevention and cessation programs. This is only **22.2%** of the total funding levels recommended by the Centers for Disease Control and Prevention (CDC), with state spending varied widely.[xxvi]

Lack of Access to Care

- Individuals who receive health insurance through Medicaid have higher rates of tobacco use (**22.7%**) compared to those with private insurance (9.2%).[xxvii]
- In 2020, the percentage of successful quit attempts was less than **40%** for individuals insured by Medicaid,[xxviii] whereas it was 65% overall.[xxix] Medicaid enrollees are more likely to need cessation support given their economic status and higher likelihood of tobacco use, yet not all Medicaid plans provide a comprehensive tobacco cessation benefit.
- **Four out of every nine adults** who smoke cigarettes who visit a healthcare professional do not receive advice to quit.[xxx]
- LGBTQ+ individuals are less likely to have health insurance compared to heterosexual individuals, which can hinder their access to cessation treatments, including counseling and medication.[xxxi]
- Limited access to health care professionals, hospital services, and specialty care is an even greater challenge for rural residents.

Secondhand Smoke Exposure

- Tobacco smoke contains over 7,000 substances, more than 69 of which are known or suspected to cause cancer.[xxxii] Approximately **42%** of Black nonsmoking people ages ≥20 years were exposed to secondhand smoke compared to 22.7% of nonsmoking Asian people and just 18% of White people during 2017-2018.[xxxiii]
- Since smoke travels between units in the same building, individuals who live in apartments or condos that are multi-unit buildings without smokefree policies can be exposed to secondhand smoke.[xxxiv,xxxv,xxxvi]
- The prevalence of secondhand smoke exposure has been found to be higher among individuals who do not smoke and live below the poverty level (**47.9%**), rent (**38.6%**) or have lower educational attainment (**30.7%**) compared to individuals who do not smoke and are living at or above the poverty level (21.2%), own a home (19.2%), or obtained a bachelor's degree or higher (10.8%).[xxxvii]

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 by:

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 that work to identify and eliminate tobacco-related disparities, 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 (FDA) 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 and all seven FDA-approved tobacco cessation medications.

Advocating that state and local government pass comprehensive policies to end the sale of flavored tobacco products that include all tobacco products, all flavors, and all tobacco retailers.

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