

# Pointing Out Inequity



## Curated talking points on tobacco-related health disparities

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A resource from the Tobacco Disparities Framing Project

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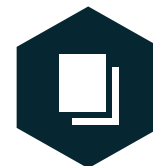


ChangeLab Solutions

Talking About Tobacco-Related Health Disparities  
Pointing Out Inequity

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# Introduction



**Americans know—thanks to the tremendous public education efforts of the tobacco control movement—that commercial tobacco is harmful to one’s health. Most are unaware, however, that the severe and even fatal health problems stemming from tobacco are concentrated among groups who face multiple forms of structural injustices: people of color, people living in rural communities, people with behavioral health conditions, people who are LGBTQ+, young people, and people with lower incomes.**

To advance health equity, we need to talk about these health disparities. However, to build support for big-picture solutions, we need to make the story about much more than uneven rates of tobacco use or disease. We need to consistently explain why tobacco-related inequities exist and persist. And we need to do more than point out the problems—we must also point people toward equity-focused solutions.

This resource is designed to help health equity and tobacco control advocates do just that. It includes talking points—based on reliable, high-quality studies from trustworthy sources—to reference and adapt for education, outreach, and advocacy on tobacco-related health disparities.

Research has shown that pointing people to the cause of a disparity, rather than only inequitable outcomes or effects, is an important framing tactic for building support for health equity efforts.<sup>1</sup> Accordingly, the resource is organized around five causal pathways that connect inequitable practices, policies, and social conditions to health outcomes:

- **The tobacco industry pressures some groups with tailored marketing tactics.**
- **Some Americans are protected from secondhand smoke—others aren’t.**
- **Tobacco companies push flavored products to entice certain social groups.**
- **Some social groups encounter barriers to treatments for nicotine dependence.**
- **Stress increases commercial tobacco use and can make health problems worse.**

FrameWorks recommends that prevention advocates emphasize these five causal pathways in their communications. Together, they build a fuller understanding of the mechanisms that create or widen tobacco-related disparities.

We hope you find this guide helpful as you develop print or online materials, speaker comments, news releases, and other communications or media materials. As you use it, please keep the following points in mind:

1. See especially *Justice in the Air: Framing Tobacco-Related Health Disparities* from the FrameWorks Institute.

- **These talking points are not audience-specific. You're welcome to use them as they are, but consider adjusting the length or style to fit the context.**
- **The language in these talking points has been carefully crafted to highlight the structural, systemic drivers of tobacco-related health disparities. When adapting, please take care to avoid rewording in such a way that leaves room for people to assume that individuals or affected communities are responsible for disparities.**
- **In developing these talking points, we leaned away from traditional tobacco metrics like initiation, cessation, and disease prevalence and leaned toward studies that pointed to social, environmental, and policy conditions. To develop similar talking points with more recent or more specific data, consider collecting or identifying evidence on these topics:**
  - **Retailer density**
  - **Point-of-sale marketing strategies, especially price promotions and product displays**
  - **Flavor advertising, availability, and restrictions**
  - **Products other than cigarettes, especially cigars, cigarillos, chew, and e-cigarettes**
  - **Secondhand smoke protections, especially residential and workplace policies**
  - **Insurance coverage for evidence-based treatments for nicotine dependence**
  - **Disparities in tobacco screening and referral to tobacco-cessation services**
  - **Disparities in risk factors for tobacco initiation, especially experiences of identity-based discrimination, financial strain/economic inequality, and other serious stressors**

## **CAUSAL PATHWAY #1: TARGETED MARKETING**

**The issue: The tobacco industry pressures some groups with tailored marketing tactics.**

A just society ensures that no person—regardless of age, race, ethnicity, income, or place of residence—is exposed again and again to experiences that we know are dangerous. Yet our current policies allow tobacco companies to saturate some communities with tailored ads and discounts, exposing the residents of those communities to more dangerous tobacco products and the health problems that come with them.

**The explanation: How targeted marketing works**

Advertising and marketing play a major role in actively promoting tobacco products—it's the way that tobacco companies get customers for life. Tobacco advertisements can cause young people to develop positive feelings toward tobacco brands.<sup>1</sup> Or, ads can set off cravings among people who are working to end a dependence on nicotine. In fact, exposure to tobacco marketing may be more of an influence on smoking than having family members who smoke.<sup>2</sup>

Since 1998, public health protections have cut Americans' exposure to advertisements for tobacco products like cigarettes, cigars, and chewing tobacco. For example, tobacco



companies cannot advertise cigarettes on billboards or television. Regulations have also stopped some pernicious industry marketing tactics like free cigarette giveaways that once encouraged people to start smoking. We have more to do to ensure that everyone, regardless of who they are or where they live, is protected from the risks that come from exposure to tobacco marketing.

### **The facts: How industry marketing tactics drive inequity**

Research shows that some groups and places in the United States are more exposed to tobacco advertisements, branding, coupons, and deceptive sales tactics than others.

#### **Some communities are bombarded with tobacco ads**

- In many places, zoning regulations and other rules about land use limit the number of stores that sell tobacco in some neighborhoods but allow other areas to be saturated with tobacco retailers. In Philadelphia, for example, areas with lower-income residents have 69 percent more tobacco retailers per person.<sup>3</sup>
- When there are many stores that sell tobacco, that area is saturated with tobacco advertising. That's because the vast majority of advertisements for cigarettes, chewing tobacco, or other tobacco products are placed at the store where the products are sold. In 2017, 78 percent of tobacco marketing budgets were spent on in-store or storefront marketing.<sup>4</sup>
- Before states gained the ability to limit tobacco advertising, there were up to 2.6 times as many tobacco advertisements per person in areas with a Black majority compared to white majority areas. More recent research has shown that the proportion of Black residents in a neighborhood was a better predictor of how much tobacco advertising was present in a local store than other factors, such as the size of the store itself.<sup>5</sup>
- A study in San Francisco found that in neighborhoods where people with serious mental health conditions were likely to live, the number of stores that sell tobacco was twice as high as the average neighborhood.<sup>6</sup>

#### **Some social groups are targeted with tailored advertisements**

- Although it has been decades since US tobacco companies were banned from advertising to youth, they are finding creative ways to get around the rules. A 2018 investigation found that tobacco companies are paying young social media influencers to promote cigarettes online to millions of followers—without disclosing that they are engaged in paid advertising. These youth-focused social media campaigns have been viewed at least 8.8 billion times in the United States and 25 billion times globally.<sup>7</sup>
- The tobacco industry tailors marketing to young rural men with advertising for chewing or dipping tobacco featuring imagery of rugged individualism.<sup>8</sup> Ads depicting cowboys, hunters, and race car drivers are carefully placed in the retail areas most likely to reach young rural men.<sup>9</sup>

- Cigarette brand names such as “Rio” and “Dorado” have been heavily advertised and marketed to the US Latinx community, including advertisements in Spanish-language publications.<sup>10</sup> Although Hispanics generally smoke less than other ethnic groups in the United States, lung cancer is the leading cause of cancer death among Hispanic men and the second-leading cause among Hispanic women.<sup>11</sup>

### Discounts and special sales in communities of color keep products cheap and visible

Tobacco companies spend nearly \$8 billion a year to keep their products cheap and visible in communities of color.<sup>12</sup>

- In 2017, the California Department of Public Health found that tobacco companies were aggressively discounting cigarillos (little cigars) in predominantly Hispanic/Latino neighborhoods. These dangerous “starter products” were, on average, 6 percent cheaper in stores that served primarily Hispanic/Latino customers.
- A 2017 study found that stores that sell tobacco in neighborhoods with the highest concentration of Black residents were twice as likely to have a price promotion (sale) than stores in neighborhoods with the lowest concentrations of Black residents.<sup>13</sup>

### Tobacco brands use cultural events to make themselves seem like part of a group’s lifestyle

- The tobacco industry has spent billions to market its products as being part of LGBTQ+ culture. In the early 1990s, tobacco companies were among the first large corporations to advertise in LGBTQ+ publications, offer sponsorship for Pride parades, or give donations to LGBTQ+ organizations.<sup>14</sup>
- Bars and clubs have traditionally been one of the few spaces in which LGBTQ+ people have felt safe to meet and socialize openly, so LGBTQ+ people frequent them more often than other Americans.<sup>15</sup> In cities and states without smoke-free protections for bars, tobacco companies market heavily at nightlife establishments that serve LGBTQ+ patrons, building brand awareness by installing lighted cigarette displays, providing branded ashtrays for tables, and sponsoring nightclub after-parties.
- The Kool brand sponsored jazz festivals for decades to build brand loyalty among Black men, adding spin-offs like the Kool Mixx campaign, which featured hip-hop artists and emcee competitions in the 1990s.
- In 2007, R.J. Reynolds launched “Farm Free Range Music,” a Camel campaign that associated the brand with indie rock bands.<sup>16</sup>

### Some solutions: Steps to end marketing practices that drive inequity

Strong tobacco control programs can advance greater fairness. Most Americans can now take for granted that they are protected from heavy or deceptive advertising. Communities that have been left out are organizing and taking steps to expand those protections so that they work just as well for communities of color, LGBTQ+ people, and rural communities. Proven and promising approaches include:

- **LIMIT RETAILER DENSITY.** Local or state policies that restrict the number of tobacco retailers operating in a specific area would greatly reduce the disproportionate health burden of tobacco in urban and low-income communities. Banning the sale of tobacco products within 1,000 feet of any school or playground would dramatically reduce the number of retailers in cities. The effects of a ban would be greatest in urban areas, so they would especially benefit Black communities and lower-income people. In fact, this single change could completely eliminate the current racial disparities in retailer density.<sup>17</sup>
- **EXTEND MARKETING PROHIBITIONS TO EMERGING PRODUCTS.** A 2009 federal law prohibited cigarette and smokeless tobacco companies from sponsoring music, sports, and other cultural events, but newer types of tobacco products, such as e-cigarettes or little cigars, are not covered by these restrictions. Tobacco companies are still promoting cultural events designed to entice certain groups, such as a recent youth-oriented campaign that held pop-up concerts featuring hip-hop stars in convenience stores, promoting a cigar brand instead of a cigarette brand, which would be illegal.<sup>18</sup> Extending the rules for cigarettes and smokeless tobacco to emerging products would limit tobacco companies' ability to market to young people of different racial or ethnic groups through the music or cultural events they attend.
- **DEDICATE FUNDS FROM TOBACCO-RELATED TAXES AND PENALTIES TO ADDRESSING DISPARITIES.** States receive revenue from tobacco taxes and penalties on tobacco companies. But on average, states have budgeted less than 2 percent of this revenue for tobacco prevention and cessation programs. If states spent 13 cents of every dollar of tobacco-related revenue on tobacco control and prevention, they could fully fund all the programs and services that public health experts think are needed to handle tobacco-related health issues.<sup>19</sup>
- **DEDICATE FUNDS FROM TOBACCO-RELATED TAXES AND PENALTIES TO PREVENTING YOUTH TOBACCO USE.** For every dollar that states spend on programs to prevent kids from smoking, tobacco companies spend \$20 to market their deadly products.<sup>20</sup> States receive revenue from tobacco taxes and should devote more of it to keeping harmful tobacco products away from youth.
- **SMART, SENSITIVE CESSATION SERVICES.** When it comes to health issues, one size does not fit all. Different people and different communities have different needs, and they make decisions in different ways. For example, public health advocates may need to provide information in languages other than English. Or health care providers might need to offer treatment for nicotine dependence through a mobile clinic that can visit remote, rural areas. Treatment approaches developed by a particular group to build on their community values and priorities may be more effective than following clinical guidelines not created by or tailored for that group.<sup>21</sup>
- **TAILORED MEDIA CAMPAIGNS THAT FEATURE DIFFERENT TYPES OF PEOPLE AND THEIR EXPERIENCES.** Hard-hitting anti-smoking health marketing strategies and mass media campaigns, such as the Centers for Disease Control and Prevention's [Tips From Former Smokers national tobacco education campaign](#), are effective in reaching many groups. Targeted and tailored messages from diverse people who smoke can help reduce the burden of tobacco-related disease.<sup>22</sup>



## CAUSAL PATHWAY #2: SECONDHAND SMOKE

### The issue: Some Americans are protected from secondhand smoke—others aren't.

A just society ensures that everyone—regardless of age, race, ethnicity, income, occupation, or place of residence—is protected from health risks in their environments.

To do a better job of limiting exposure to harmful tobacco products and their effects, we need to understand how smoke-free air protections and health equity are connected.

### The explanation: Why protection from secondhand smoke matters

There is no safe level of exposure to the smoke produced by burning tobacco, which can cause damage and disease in virtually every organ in the body. Secondhand smoke inhalation can increase lung cancer risk by 20 to 30 percent in people who do not smoke.<sup>23</sup>

Smoke-free environments keep people from being exposed to the toxins, gases, chemicals, and particulate matter that is released by burning tobacco products such as cigarettes, cigars, and e-cigarettes.

Since the 1990s, communities and states have established smoke-free air policies—but because many places aren't covered, secondhand smoke remains one of the leading causes of preventable disease and death in the United States.

### The facts: We're tolerating inequity by allowing uneven protection from secondhand smoke.

Smoke-free air policies are critical public health measures, keeping deadly chemicals out of the air we breathe. Unfortunately, these protections aren't equally available to everyone, leaving some groups exposed to more secondhand smoke than others. This isn't fair, especially since the groups that tend not to be protected also experience other forms of injustice. People of color, members of the LGBTQ+ community, and people who face economic inequality are also more likely to be exposed to secondhand smoke.

- **Four in 10 Americans live in a place that still hasn't fully protected residents from exposure to secondhand smoke.**<sup>24</sup> For example, in many jurisdictions, there are loopholes or exemptions that allow smoking in some types of businesses, placing their employees' health at risk.
- **Income inequality is linked to unequal exposure to secondhand smoke.** Since average housing costs are going up but incomes aren't, fewer Americans are buying homes and more are renting. People who live in apartment complexes that allow smoking are exposed to more secondhand smoke than people who live in a detached home because smoke can travel through vents, doors, and windows. This helps to explain why children of lower-income parents are exposed to more secondhand smoke. Researchers compared different groups of children who live in homes where no one smokes indoors. They found

that kids who live in multiunit housing had 45 percent higher levels of cotinine—a marker of recent nicotine exposure that can be detected with a blood test—than children who lived in single-family homes.<sup>25</sup>

- **Secondhand smoke exposure is a form of racial inequality.**
  - Black people who do not smoke are exposed to more secondhand smoke than white people who do not smoke.<sup>26</sup>
  - Black children are more likely to be exposed to secondhand smoke than any other group, with seven in 10 Black children exposed.<sup>27</sup>
  - Eight of the 10 US states with the highest proportion of Black residents have state laws that prevent local communities from establishing stronger local tobacco control regulations.<sup>28</sup>
- **Progress in smoke-free policies have not reached most Native American communities.** State smoke-free laws do not automatically cover tribal nations or reservations, and many Native jurisdictions do not have the resources to adopt strong smoke-free protections. A study of Northern Plains American Indians who did not smoke found that their levels of cotinine—an indicator of nicotine exposure that can be detected through a blood test—were 28 percent higher than would be expected in general for people who do not smoke.<sup>29</sup>
- **Progress in smoke-free protections has been blocked in many rural states.** Seven of the 10 US states with the highest proportion of rural residents have state laws that prevent local communities from establishing stronger local tobacco control regulations.

### **Some solutions: What we can do to clear the air for everyone**

To eliminate disparities in smokefree protection, important public health measures include:

- **MAKE ALL WORKPLACES SMOKE-FREE—WITH NO EXCEPTIONS.** Many workplaces are now protected, but certain classes of workers are being left behind. Gaps in smoke-free protections that leave out casinos, bars, and other service industry workplaces harm the people most exposed to secondhand smoke and typically most burdened with other health and social inequities.
- **RETURN LOCAL COMMUNITIES' POWER TO CREATE STRONGER SMOKE-FREE AIR POLICIES.**

The tobacco industry has spent billions over the years at all levels of government to block smoke-free protections. One way to do this is using preemption—a tool that prevents local governments from passing laws on a subject because the state or federal government is regulating that subject. When applied to tobacco control, preemption at the state level stifles local policymaking, where innovative solutions to tobacco-related problems have often been created. Authorizing local governments to adopt smoke-free policies would allow more communities to organize for stronger smoke-free air protections. One in five people who aren't protected by a smoke-free policy live in a state that prevents local communities from developing their own smoke-free laws.<sup>30</sup> And because of tobacco industry lobbying, these states also do not have strong smoke-free laws at the state level.



Giving local governments power to adopt stronger smoke-free policies could have an outsized benefit for the groups who are targeted most heavily by tobacco advertisers:

- Eight of the 10 US states with the highest proportion of Black residents have state laws that prevent local communities from establishing stronger local tobacco control regulations.
- Seven of the 10 US states with the highest proportion of rural residents have state laws that prevent local communities from establishing stronger local tobacco control regulations.
- Three of the five US states with the highest proportion of Hispanic residents have state laws that prevent local communities from establishing stronger local tobacco control regulations.
- Six of the 10 US states with the highest proportion of people living in poverty have state laws that prevent local communities from establishing stronger local tobacco control regulations.

### **CAUSAL PATHWAY #3: FLAVORED TOBACCO PRODUCTS**

**The issue: Marketers use flavors to entice specific groups to try tobacco products.**

A just society ensures that no social group—based on age, race, ethnicity, income, sexual orientation, or place of residence—is singled out and targeted as customers for harmful, addictive products.

To advance the ideal of justice, we need to pay attention to how the tobacco industry uses flavored additives to entice new users and how this contributes to health disparities.

**The explanation: How flavors affect nicotine dependence**

Flavored additives, such as artificial mint, fruit, or candy flavors, mask the harsh and bitter taste of tobacco. This makes it easier to start using commercial tobacco products, such as cigarettes, cigars, chewing tobacco, and electronic nicotine systems.<sup>31</sup> Once people start to use any form of tobacco products, that establishes habits that can lead to nicotine addiction and long-term use.<sup>32</sup>

In 2008, the FDA banned the sale of cigarettes with sweet-tasting flavors that appeal to children, but the rule did not cover menthol. Menthol—a minty flavor that masks the discomfort of inhaling smoke—is added to about one-third of commercial tobacco products. Menthol makes it easier to inhale tobacco products deeply, which leads to a bigger dose of nicotine and a stronger addiction.<sup>33</sup> This is why menthol tobacco products are easier to start and harder to quit. The FDA flavor rule was also limited to cigarettes, which led tobacco companies to develop and promote other products with candy and fruit flavors, such as berry-flavored cigarillos, watermelon tobacco chew, or candy corn-flavored liquid for e-cigs.

The tobacco industry uses flavors to entice new customers to give their products try—especially young people, whose brains are still developing and whose habits are being wired in. Flavored products are sold and advertised more often in communities of color and low-income neighborhoods, contributing to health inequities by race, class, sexual orientation, and mental health status. Communities have organized to pass policies that stop tobacco companies from flavoring their harmful products, but there is much more to be done.

## **The facts: Flavors are one way that the tobacco industry targets youth from diverse backgrounds.**

- Flavored tobacco is a “starter product.” About 80 percent of adolescents (aged 12–17) who had ever used a tobacco product reported that the first kind they tried was flavored.<sup>34</sup>
- A 2016 study of tobacco retailers in California found that eight in 10 tobacco retailers near schools sold flavored tobacco products like e-cigs or cigarillos, and they were especially likely to stock products with sweet-tasting flavors.<sup>35</sup>
- Among LGBTQ+ adults who smoke, four in 10 use menthol cigarettes—and it is likely that the rate is higher for LGBTQ+ youth.<sup>36</sup>
- Researchers have found that the more Black children who live in a neighborhood, the more likely it is that menthol tobacco products are advertised near candy displays.<sup>37</sup>
- A study of tobacco advertising and promotions near California high schools found that near schools with higher proportions of Black students, stores were more likely to promote cigarettes with menthol through advertising and price cuts. For each 10 percent increase in Black students in an area, the odds of a Newport ad were 50 percent higher.

## **Tobacco marketers promote flavored products more heavily in communities where people have the least access to proven treatments for nicotine dependency.**

- The mentholated brands Newport and Kool have been purposefully marketed to Black consumers through decades of ad campaigns with culturally tailored images and messages, such as ads featuring Black models or hip-hop music and imagery. Today, more than four in five Black people who smoke use menthol cigarettes, compared to one in five white people who smoke.
- Researchers found retailers located in neighborhoods with the highest concentration of Black residents were twice as likely to sell little flavored cigars than stores in neighborhoods with the lowest concentrations of Black residents.<sup>38</sup>
- The tobacco industry has targeted young rural men with advertising for mint-flavored smokeless tobacco featuring imagery of rugged individualism.<sup>39</sup> Ads depicting cowboys, hunters, and race car drivers are carefully placed in the retail areas and media markets most likely to reach young rural men.<sup>40</sup>
- Flavored tobacco products have been marketed to LGBTQ+ people through ads with phrases like “take pride in your flavor” and images of colored packages arranged in a rainbow pattern—red for “robust,” yellow for “mellow,” blue for “frost,” and green for “watermelon.”<sup>41</sup>
- People who have a serious mental illness are twice as likely to live in a neighborhood with more tobacco retailers and more advertisements for tobacco products.<sup>42</sup> People who use menthol-flavored tobacco are more likely to report anxiety and depression than non-menthol tobacco users and people who do not use tobacco.<sup>43</sup>

## **Some solutions: What we can do to reduce the availability of flavored tobacco products**

When the FDA banned the sale of cigarettes with sweet-tasting flavors, young people became 17 percent less likely to start smoking cigarettes.<sup>44</sup> But “starter products” are still on the market because companies can still add menthol to cigarettes, and are still allowed to add candy or fruit flavors to other types of tobacco products. To protect public health, our policies should make it harder to start smoking, not easier. We should “expand the ban” to cover more flavors and more types of commercial tobacco products. We can:

- **Restrict menthol. Hundreds of cities have taken most flavored tobacco products off the shelves, but few have restricted menthol, the flavor that causes the most harm in Black communities. This isn’t fair or just. A study that modeled what would happen if the United States stopped tobacco companies from adding menthol to their products found that the policy would save more than 600,000 lives, including nearly a quarter million Black lives.**<sup>45</sup>
- **“Expand the Ban” on flavors to all types of tobacco, not just cigarettes. It works. Restricting the sale of flavored tobacco products reduces the number of new users, especially young people. We’ve taken most flavored cigarettes off the shelves, but because we still allow companies to add flavors to other products, sales of flavored cigars have increased by nearly 50 percent and, in 2015, made up more than half of all cigar sales.**<sup>46</sup>
- **Dedicate funds from tobacco-related taxes and penalties to addressing disparities.** States receive revenue from tobacco taxes and penalties on tobacco companies for the health care costs caused by their products. But states have budgeted less than 2 percent of this revenue for tobacco prevention and cessation programs. If states spent 13 cents of every dollar of tobacco revenue on tobacco control and prevention, they could fully fund all the programs and services that public health experts think are needed to handle the problem.<sup>47</sup>

## **CAUSAL PATHWAY #4: ACCESS TO HEALTH CARE**

**The Issue: Some social groups encounter barriers to treatment for tobacco dependence and related health issues.**

When it comes to health care, people have varying needs, and different situations call for different responses. A commitment to fairness involves making sure that everyone has access to key health care services and that the care meets their particular needs. This includes making sure that everyone—regardless of their background or where they live—can get appropriate, proven treatment that can break a dependence on harmful, addictive tobacco products. It also includes making sure that race, ethnicity, sexual orientation, place of residence, or health status doesn’t lock people out of health services that detect tobacco-related illnesses early and provide the latest, most effective treatments.

## **The explanation: Most people who smoke want to quit but encounter barriers along the way.**

The majority of people who smoke want to quit, and more than half of them try each year.

Reversing tobacco dependence is difficult but possible. Studies have shown what works to end people's dependency on harmful commercial tobacco products, such as cigarettes, cigars, or chewing tobacco. These effective approaches are called evidence-based cessation services. They include things such as counseling and nicotine replacement therapy ("patches").

Right now, not enough people know about evidence-based cessation approaches, and not everyone has access to care that meets their needs. When it comes to getting professional treatment for nicotine dependence, people may need the ability to get care at a location that is easy to get to by public transportation, or can accommodate their work schedule, or takes their insurance, or has staff who are fluent in their language.

## **The facts: Most people who smoke want to quit, but only some have access to help.**

Research shows that when doctors start a conversation with patients about tobacco use, this brief interaction, called clinical screening, can make a difference—often because it allows people to learn more about the approaches to quitting that work best. But some social groups are more likely to be asked about tobacco use than others.

- Studies comparing the experiences of white and Black patients have shown that Black patients are less likely to be asked about tobacco use by health care providers and less likely to get advice about how to quit.<sup>48</sup>
- Research comparing the experiences of white and Hispanic patients has shown that Hispanic patients are less likely to be asked about tobacco use by their health care providers, and they are less likely to get advice about how to quit.<sup>49</sup>
- The experience of discrimination can make people reluctant to get medical care. One in three Black adults say they have personally experienced racial discrimination when going to the doctor—and many report avoiding seeking medical care as a result.<sup>50</sup> This helps explain why African Americans who smoke are more likely than whites to call a tobacco quit line yet less likely to enroll in a program or quit smoking as a result.<sup>51</sup>
- Nationally, 42 percent of LGBTQ+ adults who smoke and had seen a health care professional in the past year did not report receiving advice to quit from a health care provider.<sup>52</sup> This is much lower than the average rates of cessation advice,<sup>53</sup> which helps explain why LGBTQ+ adults are significantly less likely to report use of effective cessation approaches like medications or counseling.
- Eight in 10 adolescents who smoke report that they are thinking about quitting, and 77 percent have made a quit attempt in the past year. If their doctor starts a conversation with them about tobacco, they are more likely to be successful at heading off a lifelong addiction. But fewer than half of adolescents who visited a physician within the past year reported being asked about tobacco use.<sup>54</sup>

- People with mental illnesses are among the heaviest users of commercial tobacco in the United States, but tobacco cessation treatment is rarely part of mental health treatment plans. Only one in four mental health treatment facilities offer tobacco cessation services.<sup>55</sup> (Research shows that when people quit smoking, their mood, anxiety, and other symptoms of mental illness often improve—contrary to myths about the mental health benefits of smoking based on studies funded by the tobacco industry.<sup>56</sup>)

### **Some solutions: Steps we can take to increase access to necessary health services**

If we connected everyone who wants to quit to an effective program that made sure they can quit, we would improve health across America and go a long way toward creating greater health equity. Here are sensible public health steps we can take:

- **RESTORE FUNDING FOR SERVICES THAT TREAT NICOTINE DEPENDENCY.** Many state legislatures have redirected the funds from tobacco taxes from their intended purpose—addressing tobacco-related problems—to other priorities. Three states (Connecticut, New Jersey, and Tennessee) have no dedicated state funding whatsoever for tobacco prevention, although each brings in hundreds of millions in revenue from tobacco taxes and penalties.
- In 2019, the state of Tennessee zeroed out its entire tobacco prevention budget even though it brought in approximately \$422 million in tobacco revenue that year. Experts estimate that Tennessee needs to devote 17 cents of each tobacco revenue dollar to prevention to fully fund the kinds of tobacco prevention programs that work.<sup>57</sup>
- **REQUIRE THAT ALL TYPES OF HEALTH INSURANCE COVER TOBACCO CESSATION SERVICES.** Tobacco dependence is a threat to public health, and public insurance should cover treatment for it. Most people who smoke and who rely on Medicaid programs for health insurance want to quit smoking, and the majority have attempted to quit in the past year. Yet only 10 state Medicaid programs in the nation fully cover tobacco cessation services.<sup>58</sup> When Massachusetts widely publicized that the state Medicaid program had started to cover treatment for nicotine dependency, 37 percent of Medicaid recipients who smoked used the benefit. The overall smoking rate fell from 38 percent to 28 percent.<sup>59</sup>
- **ENSURE THAT PUBLICLY FUNDED HEALTH CARE CENTERS HAVE CONVERSATIONS WITH ALL TYPES OF PATIENTS ABOUT TOBACCO.** Community health centers, rural health clinics, and low-cost health clinics serve the patients who are least likely to be offered professional support in quitting tobacco. Integrating tobacco screening as a regular part of visits to publicly funded health care settings will go a long way toward ensuring that no groups are excluded from the latest, most effective treatments for ending nicotine dependency.
- **RESEARCH AND REFINE CESSATION SERVICES SO THEY WORK BETTER FOR DIFFERENT CULTURAL GROUPS.** What works for some people may not work for others. For example, a major way that states connect people to cessation services is through tobacco quit lines, a phone number that people can call to be referred to professional assistance. But we know that some cultural groups tend to avoid seeking advice from strangers, and people who speak a language other than English may be reluctant to call.



Some communities have experimented with ways to build awareness and encourage treatment in culturally appropriate ways. For instance, in St. Louis, the health department partnered with a Chinese community center to conduct traditional Chinese puppet shows to encourage smoking cessation for Asian American restaurant employees with high rates of smoking.

- **CHANGE AMERICA'S HEALTH ENVIRONMENTS.** Nearly a fifth of all Americans live in unhealthy neighborhoods that are marked by limited job opportunities, low-quality housing, pollution, limited access to healthy food, and few opportunities for physical activity.<sup>60</sup> Policies and programs that promote equitable, inclusive neighborhood revitalization would go a long way toward preventing chronic health problems of all kinds, including tobacco-related diseases.

## **CAUSAL PATHWAY #5: PRESSURE OF INEQUALITY**

### **The issue: Inequality and injustice affect health.**

A just society ensures that no person—regardless of age, race, ethnicity, income, health status, or sexual orientation—is exposed again and again to things we know are harmful. To work toward justice, we need to address the role that racism, homophobia, economic inequality, and other forms of inequity play in health. These factors can push people toward using commercial tobacco to cope with stress – and can also compound the health problems caused by tobacco use.

### **The explanation: Stress increases commercial tobacco use, and can make related health problems worse**

When people experience severe or long-lasting forms of stress, their bodies respond by elevating stress hormones and keeping them high. When stress systems are activated like this for a long time, health problems like high blood pressure and a faster heart rate can develop.<sup>61,62</sup> The use of commercial tobacco products can make these health problems worse.

When people are under multiple forms of pressure – like financial problems, discrimination, or systemic racism – they become much more likely to smoke.<sup>63</sup>

### **Chronic financial pressures help explain tobacco-related health disparities**

Chronic financial problems are a major source of stress. The pressures of poverty help explain why the health problems caused by commercial tobacco tend to be worse for people with lower incomes.

- Native Americans have the highest poverty rate of all racial/ethnic groups in the US.<sup>64</sup>
- People with mental illnesses are more likely than the general population to have stressful living conditions, and to have a low yearly household income.<sup>65,66</sup>
  - In rural areas, unemployment rates are generally high, and rural residents are more likely than urban residents to have incomes below the poverty level.<sup>67</sup>

## **Discrimination is widespread - and pushes people toward using tobacco**

The majority of Americans report having experienced some form of discrimination, but it is a more common and more severe problem for people of color, LGBTQ+ people, and people with mental illness.<sup>68</sup> The pressure of discrimination makes it more likely that a person will begin to use commercial tobacco to cope with stress, or to mask the symptoms of health problems caused by stress.<sup>69,70</sup> It also makes it harder to quit.<sup>71</sup> The US social groups that smoke at the higher rates – American Indians/Alaska Natives, people with behavioral health conditions, and people who are LGBT+ - are also groups that experience higher levels of discrimination and bias.

- American Indian/Alaska Native youth (aged 11-15) are more likely to report that they have experienced discrimination due to their ethnicity than whites.<sup>72</sup>
- Negative attitudes toward people with mental illness are common, and everyone knows it: Most Americans agree that others are not caring or sympathetic to people with mental health issues.<sup>73</sup> The stress of discrimination and stigma helps to explain why 40 percent of cigarettes smoked by adults in the United States are consumed by people with a diagnosed mental disorder.
- The majority of LGBT+ Americans say they have experienced some form of harassment or discrimination due to their sexual orientation or gender identity. More than half have experienced slurs, and 57 percent report that they or a close friend have been physically threatened.<sup>74</sup> The stress of discrimination helps explain why LGBT+ people are twice as likely to smoke than straight people.
- Trans people who have been discriminated against in ways that prevent them from succeeding or moving forward—such as being turned down for a job or for housing—have 65% higher odds of currently smoking.<sup>(4)</sup>
- LGBT+ youth who attend schools with LGBT-friendly policies and student groups are less likely than other LGBT+ youth to begin smoking.<sup>75</sup>

## **Experiences with racism in systems pushes people toward using tobacco**

Because racism has shaped the design of our society's institutions and systems—including housing loans, banking policies, and law enforcement strategies—people of color encounter prejudice and discrimination in many forms. African Americans, for example, report extensive experiences of discrimination across a range of situations. Half or more of African Americans say they have personally been discriminated against because they are Black when interacting with police (50 percent), applying for jobs (56 percent), and when it comes to being paid equally or considered for promotion (57 percent). These experiences of systemic racism add up to a major source of environmental pressure that can cause and compound health problems, including tobacco dependence.



## The experience of discrimination can make people reluctant to get medical care

Facing discrimination can also make people reluctant to get medical care. Fewer interactions with health care providers means fewer opportunities for tobacco-related health problems to be detected and treated early, when taking action is most effective.

- **One in three Black adults say they have personally experienced racial discrimination when going to the doctor—and many report avoiding seeking medical care as a result.**<sup>76</sup>
- One in four Latinx patients in California reported experiences of discrimination in the health care setting compared to one in nine whites.<sup>77</sup> Nearly one in five Latinos have avoided medical care due to concerns of being discriminated against or treated poorly.<sup>78</sup>
- The 2015 U.S. Transgender Survey found that nearly 1 in 4 trans people (23 percent) reported avoiding looking for health care they needed in the past year, because they were afraid of discrimination or mistreatment on the basis of gender identity.

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For more information about framing tobacco as a health equity issue, visit <https://www.changelabsolutions.org/product/framing-tobacco-disparities>



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