TOBACCO AND SOCIOECONOMIC STATUS

Tobacco is the leading cause of death in the United States, killing more than 400,000 Americans every year.[1] Another 8 million Americans suffer from a smoking-caused disease, disability, and other serious health problems.[2] Thanks to the tobacco industry's targeted marketing efforts, lower-income and less educated populations are particularly burdened by tobacco use – low-income people smoke more, suffer more, spend more, and die more from tobacco use.[3] The tobacco industry has gone to great lengths to target lower income and racial and ethnic groups.[4] Through market research and aggressive promotions, the industry has successfully penetrated these communities and the industry's "investment" in these communities has had a destructive impact.

Tobacco Use Among Lower-Income Populations

Smoking is directly correlated with income level and years of education. Since the release of the first Surgeon General's Report on smoking in 1964, smoking has become ever more concentrated among populations with lower incomes and fewer years of education. Whereas the highest income Americans once smoked at levels even greater than the poorest, they now smoke at barely half the rate of those of lowest income.

- 31.5 percent of adults who are below the poverty level smoke, compared to 19.6 percent of adults who are at or above the poverty level.[5]
- Families with the highest income level experienced a 62 percent reduction in current smoking between 1965 and 1999, while families with the lowest income level only experienced a 9 percent reduction in current smoking rates over the same time period.[6]
- Smoking among Medicaid recipients is much higher than smoking among the overall adult population: 32.6 percent vs. 20.6 percent.[7, 8]
- 27.5 percent of adults who do not graduate from high school smoke compared to just 10.6 percent of those with a college education, and 5.7 percent of those with a graduate degree.[9]
- Smoking among college bound high school seniors is 19.2 percent while smoking among non-college bound seniors is 32.4 percent.[10]
- An analysis of data on ever smokers from the 2003, 2006 and 2007 Tobacco Use Supplement of the Current Population Survey found that individuals in poverty had a median duration of smoking of 40 years while those with a family income three times the poverty threshold had a median duration of 22 years. Similarly, the median duration of smoking among individuals without a high school education was 40 years while it was 18 years among those with at least a bachelors degree.[11]

Health Implications

Because they smoke more, lower-income smokers suffer a disproportionate amount from smoking-caused disease. Smoking is a known cause of cancer of the lung, larynx, oral cavity, and esophagus and is also a contributing cause in the development of cancers of the bladder, pancreas, uterus, cervix, kidney and stomach. [12] Over 125,000 men and women die of smoking caused lung cancer each year.[13] Smoking also causes most cases of chronic obstructive pulmonary disease (COPD) which includes emphysema and chronic bronchitis, and more than 128,000 Americans die from smoking related cardiovascular diseases.[14]

Lower-income people are also more likely to suffer the harmful consequences of exposure to secondhand smoke. People employed in blue-collar and service industry occupations are more likely to be exposed to secondhand smoke on the job than their white-collar counterparts. Only 52.2 percent of blue-collar

workers and 57.5 percent of service industry workers work in an environment with a smoke-free workplace policy, compared to 76.3 percent of white-collar workers.[15] Workers who are exposed to secondhand smoke for hours everyday are at increased risk of lung cancer, heart disease and serious lung ailments.[16]

To make matters worse, lower-income populations have limited access to health care and thus are more likely to be diagnosed later, after their condition has worsened and they are in greater need of care and services.[17] Unfortunately, lower-income populations who have the greatest need for care often go without treatment or receive poor quality care.[18]

Additionally, findings from a recent study indicate that cigarette consumption is associated with increased "food insecurity" – not always being able to put enough food on the table. According to researchers, low-income families who were food insecure were more likely to have a head of household or spouse who smoked cigarettes than low-income families who were food secure (43.6% vs. 31.9%, respectively). On average, low-income families with an adult smoker spent almost $34 per week on cigarettes (assuming an average price of $3.37 per pack).[19] The extent to which cigarettes are substituted for food in low-income families negatively impacts the household's food security.

Helping Lower-Income Smokers Quit

In general, lower-income smokers are not only more likely to start smoking but also less likely to quit than higher-income smokers. For example, the percentage of smokers who have quit is higher for those at or above the poverty level than for those below the poverty line. Similarly, the percentage of smokers who have quit is highest for those with college degrees and lowest among those with less than a high school education.[20]

One of the best ways to prompt lower-income smokers to quit is by raising cigarette prices through cigarette tax increases. Numerous studies have documented the fact that raising the price of cigarettes directly reduces both adult and youth smoking, particularly among low-income smokers.[21] Most notably, smokers with family incomes at or below the national median are four times as likely to quit because cigarette price increases as those with higher incomes.[22] While the big cigarette companies and some other opponents of cigarette tax increases argue that they are unfair to those with lower income, lower-income communities are actually the major beneficiaries because they enjoy the largest declines in smoking and smoking-caused harms and costs.[23] Low income populations can also benefit from the revenue raised by tobacco excise taxes but only if some portion of these revenues are dedicated to programs that deliver services to the underserved.

Even more lower-income (and other) smokers would quit if they were able to get additional help, such as nicotine replacement therapies, other medications, counseling, and other support. Access to cessation services, however, is still quite limited, especially for lower-income smokers.[24] According to a recent survey by the American Lung Association, only seven states offer comprehensive cessation benefits, including all FDA-approved cessation medications and group and individual counseling, to all Medicaid beneficiaries. Forty-two states provide coverage for at least one FDA-approved medication and twenty-seven states provide some form of cessation counseling.[25] However, every state that provides Medicaid coverage has at least one barrier to accessing coverage such as required co-payments which dissuade Medicaid clients from seeking assistance in helping them to quit smoking. Other barriers to treatment in the Medicaid program include requiring prior authorization for treatment, limiting treatment duration, and limiting the number of times people could access treatment.

Additionally, more than 40 million Americans are without any kind of health insurance; and two-thirds of the uninsured are low-income individuals or low-income families.[26]

Benefits From Reducing Tobacco Use Among Lower-Income Smokers

Reducing tobacco use among any segment of society produces enormous public health and economic benefits by reducing premature death and disability, improving worker productivity, reducing smoking caused costs, and shifting resources currently expended on tobacco use and smoking-caused costs to more productive purposes. Since smoking and other tobacco use is more prevalent among lower-income populations (and there are more lower-income than higher income folks), these benefits can be most

effectively secured by focusing efforts to prevent and reduce tobacco use in lower-income communities. Such efforts will also provide additional, special benefits.

For example, lower-income smokers spend a larger portion of their income on tobacco products and related costs than higher-income smokers, sometimes diverting resources that could be used on necessities such as food, shelter, and health care, or for education and job training. Helping a lower-income pack-a-day smoker to quit would, on average, free up more than $1,300 per year that he or she previously spent on cigarettes for much more productive use – which will produce enormous benefits for lower-income households. Reductions to other smoking-caused costs will add to this benefit, making the lower-income households more secure and self-reliant, and increasing the chances for a much brighter future for lower-income kids.

Reducing tobacco use among lower-income smokers will also directly reduce smoking-caused government expenditures (and related tax burdens). For example, approximately 10 to 20 percent of all state Medicaid program expenditures – totaling more than $30 billion per year – is spent on smoking-related illnesses and diseases among lower-income persons.[27]

Campaign for Tobacco-Free Kids, December 7, 2009 / Meg Riordan

---

[1] U.S. Centers for Disease Control and Prevention, "Annual Smoking-Attributable Mortality, Years of Potential Life Lost, and Productivity Losses – United States, 2000-2004, *Morbidity and Mortality Weekly Report (MMWR)* 57 (45), November 14, 2008 http://www.cdc.gov/mmwr/PDF/wk/mm5745.pdf.

[2] CDC, "Cigarette smoking Attributable Morbidity – United States, 2000" MMWR 52(35): 842-844, September 5, 2003. http://www.cdc.gov/mmwr/PDF/wk/mm5235.pdf.

[3] "CDC, "Cigarette Smoking Among Adults – United States, 2008," *MMWR* Vol. 58 No. 44, November 13, 2009. http://www.cdc.gov/mmwr/PDF/wk/mm5844.pdf

[4] Stoddard, JL, et al., "Target Tobacco Markets: Outdoor Advertising in Los Angeles Minority Neighborhoods," *American Journal of Public Health* 87:1232-3, July 1997.

[5] CDC, "Cigarette Smoking Among Adults – United States, 2008," *MMWR* Vol. 58 No. 44, November 13, 2009.

[6] Current Population Survey, 1999.

[7] National Center for Health Statistics, National Health Interview Survey, 2007 (adults age 18-65, Medicaid population). See also, American Lung Association, *Helping Smokers Quit: State Cessation Coverage 2008*. Overall smoking rate from CDC, "Cigarette smoking Attributable Morbidity – United States, 2000" MMWR 52(35): 842-844, September 5, 2003. http://www.cdc.gov/mmwr/PDF/wk/mm5235.pdf.

[8] CDC, "Cigarette Smoking Among Adults – United States, 2008," *MMWR* Vol. 58 No. 44, November 13, 2009.

[9] CDC, "Cigarette Smoking Among Adults – United States, 2008," *MMWR* Vol. 58 No. 44, November 13, 2009.

[10] University of Michigan, Monitoring the Future Study, 2008, www.monitoringthefuture.org

[11] M. Siahpush, et al., "Racial/ethnic and socioeconomic variations in duration of smoking: results from 2003, 2006 and 2007 Tobacco Use Supplement of the Current Population Survey," *Journal of Public Health*, Published online November 5, 2009.

[12] National Institutes of Health, "Cancer Rates and Risks", 1996. HHS, *The Health Consequences of Smoking. A Report of the Surgeon General*, 2004. http://www.surgeongeneral.gov/library/smokingconsequences/; See also, HHS, *Reducing the Health Consequences of Smoking: 25 Years of Progress. A Report of the Surgeon General*, 1989, www.cdc.gov/tobacco/sgrpage.htm.

[13] CDC, "Annual Smoking-Attributable Mortality, Years of Potential Life Lost, and Productivity Losses —United States 2000-2004," *MMWR* 57(45):1225-1228, November 14, 2008 http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5745a3.htm.

[14] CDC, "Annual Smoking-Attributable Mortality, Years of Potential Life Lost, and Productivity Losses —United States 2000-2004," *MMWR* 57(45):1225-1228, November 14, 2008.

[15] Current Population Survey, 1999.

[16] Health Effects of Exposure to Environmental Tobacco Smoke, The Report of the California Environmental Protection Agency, National Institutes of Health, 1999.

[17] Adler, NE, et al., "Socioeconomic inequalities in health: No easy solution," *JAMA* 269:3140-5, 1993.

[18] Fiscella, K, et al., "Inequality in quality: Addressing socio-economic, racial, and ethnic disparities in health care. *JAMA* 283(19):2579-2584, May 17, 2000.

[19] Armour, Brian S., et al. Cigarette Smoking and Food Insecurity among Low-Income Families in the United States, 2001. *American Journal of Health Promotion*, Volume 22, Issue 6:386.

[20] CDC, "Cigarette Smoking Among Adults – United States, 2002," *MMWR* 53(20):427-431, May 28, 2004, http://www.cdc.gov/mmwr/PDF/wk/mm5320.pdf.

[21] See, e.g., CDC, "Responses to Cigarette Prices By Race/Ethnicity, Income, and Age Groups—United States, 1976-1993," *MMWR* 47(29):605-609, July 31, 1998, http://www.cdc.gov/mmwr/preview/mmwrhtml/00054047.htm. Chaloupka, FJ & Pacula, P, *An Examination of Gender and Race Differences in Youth Smoking Responsiveness to Price and Tobacco Control Policies*, National Bureau of Economic Research, Working Paper 6541, April 1998.

[22] CDC, "Responses to Cigarette Prices By Race/Ethnicity, Income, and Age Groups—United States, 1976-1993," *MMWR* 47(29):605-609, July 31, 1998, http://www.cdc.gov/mmwr/preview/mmwrhtml/00054047.htm. Farrelly, M., et al., "Responses to Cigarette Prices by Socioeconomic Characteristics," *Southern Economic Journal*, 68(1):156-65, 2001.

[23] See, e.g., Campaign for Tobacco-Free Kids factsheet, *State Cigarette Tax Increases Benefit Lower-Income Smokers and Families*, http://tobaccofreekids.org/research/factsheets/pdf/0147.pdf, and *Responses to Misleading and Inaccurate Cigarette Company Arguments Against State Tobacco Tax Increases*, http://www.tobaccofreekids.org/research/factsheets/pdf/0227.pdf.

[24] Halpin, HA, et al., "Update: State Report: Medicaid Coverage for Tobacco-Dependence," *Health Affairs,* March/April 2006.
[25] American Lung Association, *Helping Smokers Quit, State Cessation Coverage*, 2008,
[26] Urban Institute and Kaiser Commission on Medicaid and the Uninsured, analysis of March 2002 Current population Survey, 2002 http://www.kff.org/uninsured/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=14185.
[27] CDC, *State Data Highlights, 2006.* http://www.cdc.gov/tobacco/datahighlights/index.htm. See also, Miller, L, et al., "State Estimates of Total Medical Expenditures Attributable to Smoking, 1993," *Public Health Reports*, September/October 1998.