

Pointing Out Inequity

Curated talking points on tobacco-related health disparities

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A resource from the Tobacco Disparities Messaging Project

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Introduction

Uneven protections from tobacco are a major driver of disparities in disease and early death, with higher health burdens disproportionately affecting rural communities, low-income communities, communities of color, people who identify as LGBT+, and people with behavioral disorders. It is critical to include health equity and disparities as part of the tobacco control conversation—but it’s also important to frame these issues carefully and with sensitivity. **The following talking points are designed for health equity advocates to reference and adapt for education, outreach, and advocacy around tobacco-related health 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.

- ▶ These talking points are based on reliable, high-quality studies from trustworthy sources.
- ▶ The language in these talking points has been carefully crafted to highlight the structural, systemic drivers of tobacco-related health disparities. When adapting them—as we encourage you to do—please take care not to imply (or leave space for people to assume) that individuals or affected communities are responsible for the disparities they experience.
- ▶ These talking points are arranged around five “disparity drivers”—the processes or mechanisms that create or widen disparities for multiple marginalized social groups—rather than grouping them around the populations that experience 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. When pulling data points for communications, be sure to include some form of the explanation in the language.
- ▶ These talking points align with messaging research that we have conducted with a nationally representative sample of the American public, but they are not audience-specific. Communicators should adjust length, style, or other elements to fit the context. For example, when talking with adult audiences, describing young people as “children,” “kids,” or “adolescents” might help to distinguish the age group under discussion. But when talking with young people directly, those terms might fall flat.
- ▶ The phrase “harmful tobacco products” in these documents refers to commercial products mass-produced by companies, not the sacred and traditional use of tobacco by some Native American communities.

Disparity Driver #1: Pressured 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 harmful. Yet, in communities facing disadvantage, there is a constant flow of advertising, discounts, and displays of commercial tobacco products, channeling more of these dangerous products, and the health problems that come with them, into the very places that have the fewest resources to deal with them. To reduce the intense pressure tobacco companies are putting on these communities, we need to pay attention to how the tobacco industry pushes harmful, deadly products through targeted marketing.

The explanation: How targeted marketing works

Advertising, marketing, and product displays play a major role in actively promoting tobacco products: it's the way that tobacco companies get customers for life. For example, tobacco advertisements can cause young people to develop positive feelings toward tobacco brands.¹ 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 whether an individual starts to smoke than other factors, like coming from a family with smokers in it.²

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 industry marketing tactics—like free cigarette giveaways—that encouraged people to start smoking. However, the industry continues to use a range of marketing strategies to drive sales and encourage potential customers to try their addictive products. We still 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 marketing tactics drive inequity

Research and data show that some groups and places in the US are more intensively exposed to tobacco advertisements, branding, coupons, and deceptive sales tactics than others.

Some communities are bombarded with tobacco ads

- ▶ In many places, zoning regulations or other rules about land use have not been adopted or amended to prevent neighborhoods from being saturated with stores that sell tobacco products. In Philadelphia, for example, low-income areas have 69 percent more tobacco retailers per person than higher-income areas.³
- ▶ When there are many stores in one area 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.⁴
- ▶ 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 to be found in a local store than other factors, like the size of the store itself.⁵
- ▶ Tobacco retailer densities have been found to be twice as high in areas occupied by smokers with a serious mental illness, compared to the general population.⁶

Some social groups are targeted with tailored advertisements

- ▶ Although US tobacco companies are prohibited from advertising to youth, a 2018 investigation found that tobacco companies were paying young social media influencers to promote e-cigarettes 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 US and 25 billion times globally.⁷
- ▶ The tobacco industry tailors marketing to young rural men by advertising chewing or dipping tobacco with imagery of rugged individualism.⁸ Ads depicting cowboys, hunters, and race-car drivers are carefully placed in the retail areas most likely to reach young rural men.⁹

- ▶ 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.¹⁰ Although Hispanics generally smoke less than other ethnic groups in the US, lung cancer is the leading cause of cancer death among Hispanic men and the second leading cause among Hispanic women.¹¹

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

Price promotions are tobacco companies’ top marketing spending category: annually, they devote nearly \$8 billion to discounting.¹² Discounts are a tactic designed to attract lower-income customers, which means they affect marginalized groups more often.

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

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

Tobacco companies have sponsored cultural events to build up people’s associations between tobacco and being part of their social group.

- ▶ The tobacco industry has spent billions to market their product as being part of LGBT+ culture. In the early 1990s, tobacco companies were among the first large corporations to advertise in LGBT+ publications, offer sponsorship for Pride parades, or give donations to LGBT+ organizations.¹⁴
- ▶ Bars and clubs have traditionally been one of the few spaces in which LGBT+ people have felt safe to meet and socialize openly, so LGBT+ people frequent them more often than other Americans.¹⁵ In areas without smoke-free protections for bars, tobacco companies market particularly heavily at nightlife establishments that serve LGBT+ 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 that featured hip-hop artists and MC competitions in the 1990s.¹⁶

- ▶ Tobacco companies, especially the US Smokeless Tobacco Company, sponsor rodeos to allow them to reach rural audiences.¹⁷ Rodeo is popular in rural communities, and tobacco companies themselves estimate that 25–30 percent of the audience is made up of children and youth.

Some solutions: What we can do to end marketing practices that drive inequity

Strong tobacco control programs can advance greater fairness while also protecting precious public resources. Some states have seen that for every dollar spent on tobacco control and prevention, they save up to \$55, mostly by avoiding the cost of treating illnesses caused by tobacco products.¹⁸

Most Americans can now take it for granted that they are protected from heavy or deceptive advertising. Communities who have been left out are organizing and taking steps to expand those protections so that they work just as well for communities of color, LGBT+ 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 would especially benefit Black communities and lower-income people. In fact, this single change could completely eliminate the current racial disparities in retailer density.¹⁹
- ▶ **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, like e-cigarettes or little cigars, are not covered by these restrictions. Tobacco companies are still promoting cultural events designed to entice certain groups—like 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.²⁰ 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 allocated *less than two percent* of this revenue for tobacco prevention and cessation programs. If states dedicated 13 cents of every dollar of tobacco revenue to tobacco control and prevention, they could fully fund the programs and services needed to reduce the pressure that tobacco puts on communities facing disadvantage.²¹
- ▶ **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 and to help smokers quit, tobacco companies spend \$20 to market their deadly products.²² States receive revenue from tobacco taxes—and should devote more of it to keeping harmful tobacco products away from youth.
- ▶ **Smart, sensitive anti-tobacco efforts.** When it comes to health issues, one size does not fit all. Different people and different communities have different needs and get information in different ways. For example, public health advocates may need to provide information in English *and* other languages. Or, services that help break nicotine addictions might need to be provided through a mobile clinic that can visit remote, rural areas. To advance better health for communities facing disadvantage, it makes sense to tailor tobacco cessation efforts to communities that might not be reached by general efforts.

Sources: Targeted Marketing

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- ² “Smoking in the movies increases adolescent smoking: A review” in *Pediatrics*, 2005.
- ³ “Place-based inequity in smoking prevalence in the largest cities in the United States” in *JAMA Internal Medicine*, 2019.
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- ⁸ “Cutting Tobacco’s Rural Roots” by the American Lung Association, 2012.
- ⁹ “The role of the media in promoting and reducing tobacco use” in *Tobacco Control Monographs*, 2008.
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- ²² “Broken Promises to Our Children: A State-by-State Look at the 1998 Tobacco Settlement 20 Years Later,” a 2017 report by Truth Initiative and other major tobacco control advocacy organizations.

Disparity Driver #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 20–30 percent in nonsmokers.²³ The aerosol emissions from e-cigarettes haven't been studied as extensively as smoke from cigarettes, but it's clear that these emissions contain substances that are harmful to health.

Smoke-free environments keep people from being exposed to the toxins, gases, chemicals, and particulate matter that is released by burning tobacco products like 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 US.

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 at higher risk of secondhand smoke exposure than others. Inequalities linked to class, race, ethnicity, gender, and sexual orientation are also linked to disparities in secondhand smoke exposure.

- ▶ Four in ten Americans live in a place that still hasn't fully protected residents from exposure to secondhand smoke.²⁴ 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 rent in apartment complexes that allow smoking are exposed to more secondhand smoke than people who live in a detached home because smoke travels through buildings' air ducts. This helps to explain why children whose parents are lower-income are exposed to more secondhand smoke. Researchers compared different groups of children who live in homes where no one smokes indoors. They found that children who live in multi-unit housing had levels of cotinine (a marker of recent nicotine exposure that can be detected with a blood test) that were 45 percent higher than children who lived in single-family homes.²⁵
- ▶ Secondhand smoke exposure is a form of racial inequality that especially affects Black communities. 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.²⁶ This helps to explain why Black nonsmokers are exposed to more secondhand smoke than white nonsmokers.²⁷ Black children are more likely than any other group to be exposed to secondhand smoke, with 7 in 10 Black children exposed.²⁸
- ▶ Progress in smokefree policies has 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 smokefree protections. A study of Northern Plain 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 for nonsmokers in the general population.²⁹
- ▶ Progress in smokefree 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: Actions we can take to end disparities in secondhand smoke exposure

To eliminate disparities in smoke-free 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—that is, the people typically most burdened with other health and social inequities.

- ▶ **Make all health care centers smoke-free—with no exceptions.** Virtually all health care settings are now protected—but behavioral health facilities are often an exception. Mental health or substance abuse treatment centers should be smoke-free, and tobacco cessation services should be part of treatment plans. 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, which are based on studies funded by the tobacco industry.³⁰
- ▶ **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 it has done this is through preemption—a strategy 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 does not allow local communities to develop their own smoke-free laws.³¹ And because of tobacco industry lobbying, there are no strong smoke-free laws at the state level in these places.

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:

- ▶ 8 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.
- ▶ 7 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.
- ▶ 3 of the 5 US states with the highest proportion of Hispanic residents have state laws that prevent local communities from establishing stronger local tobacco control regulations.
- ▶ 6 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.

Sources: Secondhand Smoke

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Disparity Driver #3: Flavored Tobacco Products

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

A just society should ensure that no social group—based on age, race, ethnicity, income, sexual orientation, or place of residence—is singled out and targeted to become consumers of deadly, 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 flavored additives affect nicotine dependence

Flavored additives, like artificial mint, fruit, or candy flavors, mask the harsh and bitter taste of tobacco. This makes it easier to start using tobacco products like cigarettes, cigars, chewing or dipping tobacco, and e-cigarettes.³² Once people start to use any form of tobacco products, it establishes behaviors that can lead to nicotine addiction and long-term use.³³

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—which has a minty flavor that masks the unsavory taste of tobacco and reduces the discomfort of inhaling smoke—is added to about one-third of tobacco products. Menthol makes tobacco products more addictive and makes it more difficult to successfully treat nicotine dependence.³⁴ The FDA flavor rule was also limited to cigarettes—which led tobacco companies to develop and promote other products with candy and fruit flavors, like berry-flavored cigarillos, watermelon chewing tobacco, or candy-corn flavored liquid for e-cigarettes.

The tobacco industry uses flavors to entice new customers to give their products a try, because they know that it is easy to develop a nicotine dependency and hard to break it. Young people are especially susceptible, both to marketing and to nicotine dependency, since their brains are still being built and wired. Flavored products are sold and advertised more often in communities of color and low-income neighborhoods, contributing to health inequities across race, class, sexual orientation, and mental health status. Communities have organized to enact policies that stop tobacco companies from flavoring their deadly products, but there is much more to be done.

The facts: The tobacco industry uses flavors to target youth from diverse backgrounds

- ▶ Flavored tobacco is a “starter product.” Eighty percent of adolescents (aged 12–17) who had ever used a tobacco product reported that the first kind they tried was “flavored.”³⁵

- ▶ A 2016 study of tobacco retailers in California found that 8 out of 10 tobacco retailers near schools sold flavored tobacco products like e-cigarettes or cigarillos, and were especially likely to stock products with sweet-tasting flavors.³⁶
- ▶ Among LGBT+ young people who smoke, 7 in 10 use menthol cigarettes.³⁷
- ▶ Researchers have found that the more Black children who live in a neighborhood, the more likely it is that menthol tobacco products will be advertised near candy displays in stores.³⁸
- ▶ 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 menthol cigarettes through advertising and price cuts. For each 10 percent increase in the proportion of Black students in an area, the odds of there being a Newport advertisement in the store 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 a deliberate “menthol push”—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 4 in 5 Black smokers use menthol cigarettes—as compared to about 1 in 5 white smokers.
- ▶ Researchers found retailers located in neighborhoods with the highest concentrations of Black residents were twice as likely to sell little flavored cigars (cigarillos) than stores in neighborhoods with the lowest concentrations of Black residents.³⁹
- ▶ The tobacco industry has targeted young rural men with advertising for mint-flavored smokeless tobacco with imagery of rugged individualism.⁴⁰ Ads depicting cowboys, hunters, race-car drivers are deliberately placed in the retail areas and media markets most likely to reach young rural men.⁴¹
- ▶ Flavored tobacco products have been marketed to LGBT+ people through ads with phrases like “take pride in your flavor” and images of colored packages arranged in rainbow patterns—red for “robust,” yellow for “mellow,” blue for “frost” and green for “watermelon.”⁴²
- ▶ People who have a serious mental illness are twice as likely as the general population to live in a neighborhood with more tobacco retailers and more advertisements for tobacco products.⁴³ 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.⁴⁴

Some solutions: Actions we can take 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 become cigarette smokers.⁴⁵ But “starter products” are still on the market, because cigarettes can still be flavored with menthol, and other kinds of tobacco products can still have candy or fruit flavors. To protect public health, our public policies should make it harder to start smoking—not easier. We should “expand the ban” to cover more flavors and more types of tobacco products.

Restrict menthol.

- ▶ A study that modeled what would happen if the US adopted a nationwide ban on menthol found that the policy would save more than 600,000 lives, including nearly a quarter million Black lives.⁴⁶
- ▶ More local communities can take action. According to the American Nonsmokers’ Rights Foundation, as of spring 2019, 18 cities and counties had enacted laws prohibiting the sale of tobacco products with any added flavors, including menthol.⁴⁷

“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.

- ▶ In 2008, the FDA banned the sale of cigarettes with sweet-tasting flavors that appeal to children. After the flavor ban, the likelihood of a young person becoming a cigarette smoker fell by a remarkable 17 percent.⁴⁸ But in the years that followed, sales of flavored cigars increased by nearly 50 percent and, in 2015, made up more than half of all cigar sales.⁴⁹
- ▶ Some cities have responded by establishing local protections—and have seen positive results. Young people in New York City are 28 percent less likely to try *any* type of tobacco as a result of the city’s ban on sweet-flavored tobacco products.⁵⁰
- ▶ After Chicago restricted the sale of flavored tobacco products, and regulated e-cigarettes, smoking of cigarettes and e-cigarettes among 18–20-year-olds dropped by 36 percent almost immediately.

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 two percent* of this revenue for tobacco prevention and cessation programs. If states dedicated 13 cents of every dollar of tobacco revenue to tobacco control and prevention, they could fully fund all the programs and services that public health experts think are needed to handle the problem.⁵¹

Sources: Flavored Tobacco

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Disparity Driver #4: Access to Health Care

The issue: Access to treatment for tobacco-related health issues varies widely

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 deadly, 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: Proven treatments can reverse tobacco dependence – but access is limited

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

Reversing tobacco dependence is difficult, but possible. Studies have shown what works to end people's dependency on harmful tobacco products like cigarettes, cigars, or chewing tobacco. These effective approaches are called *evidence-based cessation services*. They include things like counseling and nicotine replacement therapy (like "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, individual needs can vary enormously: people may need to access care that's easy to get to by public transportation, or that can accommodate their work schedule, or takes their insurance, or has staff who are fluent in their language.

The facts: Most smokers 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, in part because health care providers sometimes mistakenly assume that some patients couldn't, wouldn't, or shouldn't quit. The effect of *implicit bias* helps to explain why. People absorb associations and stereotypes about social groups from culture and media, and can hold negative assumptions about groups without being explicitly aware of the assumptions. These associations can drive automatic 'snap judgments' –

sometimes leading people to act in discriminatory ways though they do not hold conscious feelings of antipathy toward the group.

- ▶ 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.⁵²
- ▶ 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.⁵³
- ▶ 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.⁵⁴ This helps to explain why African American smokers are more likely than white smokers to call a tobacco quitline, yet less likely to enroll in a program or quit smoking as a result.⁵⁵
- ▶ Nationally, 42 percent of LGBT+ adults who smoke and had seen a healthcare professional in the past year did not report receiving advice to quit from a health care provider.⁵⁶ This is much lower than the average rate of cessation advice,⁵⁷ which helps to explain why LGBT+ adults are significantly less likely to report use of effective cessation approaches like medications or counseling.
- ▶ Eight out of 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 quitting, and 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.⁵⁸
- ▶ People with mental illnesses are among the heaviest users of tobacco in the US, but tobacco cessation treatment is rarely part of mental health treatment plans. Only 1 in 4 mental health treatment facilities offer tobacco cessation services.⁵⁹ 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, which are based on studies funded by the tobacco industry.⁶⁰

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 receives hundreds of millions in revenue from tobacco taxes and penalties.
- ▶ In 2019, the state of Tennessee cancelled 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 in order to fully fund the kinds of tobacco prevention programs that work.⁶¹
- ▶ **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 smokers 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 ten state Medicaid programs in the nation fully cover tobacco cessation services.⁶² When Massachusetts widely publicized that the state Medicaid program had started to cover treatment for nicotine dependency, 37 percent of smokers in the program used the benefit. The overall smoking rate fell from 38 percent to 28 percent.⁶³
- ▶ **Ensure that 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 that 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 quitlines, a phone number that people can call to be referred for 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 successfully 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.⁶⁴ 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.

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Disparity Driver #5: Discrimination

The issue: Discrimination has a negative impact on health

A just society ensures that no person—regardless of age, race, ethnicity, income, health status, or sexual orientation—is exposed to prejudice or discrimination based on their identity.

To advance the ideal of justice, we need to pay attention to how racism, homophobia, and other forms of discrimination contribute to tobacco-related health disparities.

The explanation: Discrimination increases stress, and tobacco-related harms, for some groups

When people experience severe or long-lasting forms of stress, their bodies respond by elevating stress hormones and keeping them elevated. When stress systems are on permanent high alert, health problems like high blood pressure, elevated heart rate, and anxiety develop.

The experience and fear of prejudice and discrimination is a chronic source of stress for people who are part of marginalized social groups. The constant pressure of stress can lead people to start using tobacco as a way to relieve the stress, or to mask or manage symptoms of other health issues caused by stress. And, under the pressure of stress, it is harder for people to quit using tobacco.

The facts: Discrimination is widespread, and is linked to tobacco use and related health harms

The experience of discrimination elevates the body's stress response, which can increase susceptibility to tobacco dependence. 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, people who identify as LGBT+, and people with mental illnesses.

- 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.⁶⁵ The stress of discrimination can lead people to start using tobacco and makes it harder to quit. This helps to explain why 40 percent of cigarettes smoked by adults in the US 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.⁶⁶ The stress of discrimination can lead people to start using tobacco and

makes it harder to quit. This helps to explain why people who identify as LGBT+ are twice as likely to smoke than people who identify as straight.

- 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 or a health clinic, and 22 percent have avoided seeking medical care out of fear of racial discrimination.⁶⁷ 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 four Latinx patients in California reported experiences of discrimination in the healthcare setting compared to 1 in 9 whites.⁶⁸ Nearly 1 in 5 Latinx people have avoided medical care due to concern of being discriminated against or treated poorly.⁶⁹
- Because racism has shaped the design of our society's institutions and systems—like housing loans, banking policies, and law enforcement—people of color encounter prejudice and discrimination in many forms. African Americans 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), when applying to jobs (56 percent), and when it comes to being paid equally or considered for promotion (57 percent). These experiences of discrimination add up to a major source of environmental pressure that can cause and compound health problems, including tobacco dependence.

Some solutions: Steps we can take to alleviate the pressure on groups facing discrimination

It's within our power to create a more equitable, inclusive, and welcoming society—but all of our systems and institutions must accept the responsibility for change. Here are just a few directions that the tobacco control and prevention sector can pursue on the path toward equity.

- ▶ **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 allocated *less than two percent* of this revenue for tobacco prevention and cessation programs. If states dedicated 13 cents of every dollar of tobacco revenue to tobacco control and prevention, they could fully fund the programs and services needed to reduce the pressure that tobacco puts on communities facing disadvantage.⁷⁰

- ▶ **Ensure that health care centers have conversations about tobacco with all types of patients.** 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, in part because health care providers sometimes mistakenly assume that certain types of patients couldn't, wouldn't, or shouldn't quit. Standardizing the routines in health care visits would help community health centers, rural health clinics, and low-cost health clinics serve the patients that are most likely to experience the pressure of discrimination, but who are the least likely to be offered professional support in quitting tobacco. Integrating tobacco screening as a regular, routine part of visits in all 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.
- ▶ **Smart, sensitive anti-tobacco efforts.** When it comes to health issues, one size does not fit all. Different people and different communities have different needs and get information in different ways. For example, public health advocates may need to provide information in English *and* other languages. Or, counseling for nicotine addictions might be more effective if the health professional shares the cultural or social background of the patients. To advance better health for communities facing disadvantage, it makes sense to tailor tobacco cessation efforts to communities that might not be reached by general efforts. This requires efforts to attract, recruit, prepare, and retain professionals from diverse cultural, social, and linguistic backgrounds.
- ▶ **Work with partners to 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.⁷¹ Policies and programs that promote equitable, inclusive neighborhood revitalization would go a long way toward alleviating the pressure of stress—and the chronic health problems it causes—in communities facing disadvantage.

Sources: Discrimination

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About this guide

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