TOBACCO AND SOCIOECONOMIC STATUS

Tobacco is the leading cause of death in the United States, killing more than 480,000 Americans every year.[1] Another 16 million Americans suffer from a smoking-caused disease, disability, or other serious health problem.[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. The tobacco industry has gone to great lengths to target lower income and racial and ethnic groups.[3] 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

There are enormous and growing disparities in who smokes and who suffers from tobacco-related disease. Alarmingly, research released by the Brookings Institution in 2016 revealed that the gap in life expectancy between those in the top half of the earnings ladder and those in the bottom half has grown dramatically for both men and women.[4] Research published in the Journal of the American Medical Association (JAMA) in April 2016 found that for men, the richest Americans live nearly 15 years longer than the poorest Americans. For women, the richest Americans live 10 years longer than their poorest counterparts.[5]

Researchers from Duke University and the Centers for Disease Control and Prevention have concluded that differences in smoking rates are a major cause of this gap in life expectancy. Specifically, researchers calculated that the disparity in smoking rates among the rich and poor account for a third of the gap in life expectancy between white men with college degrees and white men with only a high school education. For white women, the disparity in smoking rates accounted for a quarter of the gap in life expectancy.[6]

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. In the past, the highest income Americans smoked at levels even greater than the poorest; now they smoke at less than half the rate of those with the lowest income.

- The smoking rate among adults with the lowest reported income is 19.4%, nearly twice the overall adult smoking rate of 10.8%.[7]

- Among adults 18 and over, 10.3 percent of employed adults smoke versus 11.6 percent of unemployed adults. Overall, 10.4 percent of full-time working adults smoke versus 9.5 percent of part-time working adults.[8]

- Adults who experience job insecurity are more likely to smoke. Among employed adults who are experiencing job insecurity, 13.7 percent smoke, compared to 10.5 percent of those who do not experience job insecurity.[9]

- 18.1 percent of Medicaid and other public insurance enrollees and 16.6 percent of uninsured individuals smoke, compared to 8.6 percent of those with private insurance coverage.[10] Tobacco use among employed adults is significantly higher among those who are not offered workplace health insurance compared to those who are not and among those who are not offered paid sick leave compared to those who are.[11]

- Among adults 25 and older, 20.0 percent who did not graduate from high school smoke and 16.8 percent with a high school diploma or GED smoke, compared to just 4.5 percent of those with a college degree or higher.[12]

From 2002 to 2016, smoking rates declined among all educational levels, but the percentage of smoking decline for those with a college degree or higher was 2.6 times larger than those with a high school diploma and 1.5 times larger than those who had not obtained a high school diploma.[13]

- In 2022, smoking among non-college bound high school seniors is more than twice that of college bound high school seniors (6.9% vs. 2.9%, respectively).[14]

- A study of cigarette smoking prevalence in U.S. counties found that, while the U.S. as a whole has made significant progress in reducing smoking from 1996-2012, rates vary dramatically between counties with different income levels, even within the same state. Counties with higher average incomes experienced more rapid declines than counties with lower average incomes.[15]

A study of smoking prevalence in cities across the U.S. found that smoking prevalence was distributed unevenly both across cities and within cities. Neighborhoods with higher smoking rates were associated with having lower incomes, more likely to be populated by African Americans and Latinos, and increased smoking-related diseases. These neighborhoods also were associated with having a higher exposure to tobacco retailers.[16]

- Compared to white-collar workers, blue-collar workers are more likely to start smoking (and begin smoking at a younger age), more likely to smoke more heavily and less likely to quit. These trends are likely influenced by the lower availability of workplace rules against smoking and workplace smoking cessation programs for blue-collar workers. White-collar workers have greater access to cessation programs and often have workplace rules limiting smoking.[17]

- 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 bachelor's degree.[18]

Health Implications

Because they smoke more, lower-income smokers disproportionately suffer from smoking-caused disease. In addition to causing chronic diseases such as stroke, heart disease and diabetes, smoking is a known cause of cancer of the lung, larynx, oral cavity, liver, colon and rectum, esophagus, bladder, pancreas, cervix, kidney, stomach and blood.[19] Over 130,000 men and women die of smoking caused lung cancer each year.[20] From 2009 to 2013, counties with the lowest educational attainment or highest poverty had the highest tobacco-related cancer incidence and death rates as well as the slowest decline in incidence rates.[21] Smoking causes most cases of chronic obstructive pulmonary disease (COPD), which includes emphysema and chronic bronchitis; and more than 150,000 Americans die from smoking-related cardiovascular diseases each year.[22] Data from 1973-2001 shows that those with less than a high school education had higher lung cancer incidence (twice as high for women and three times as high for men) than those with a college education.[23]

Lower-income people are also more likely to suffer the harmful consequences of exposure to secondhand smoke. In 2017-2018, 44.6 percent of people living below the poverty level were exposed to secondhand smoke, compared to 21.3 percent of people living at or above the poverty level.[24] People employed in blue-collar occupations also are more likely to be exposed to secondhand smoke on the job than their white-collar counterparts. Only 83.2 percent of blue-collar workers (and just 67.8 percent of construction workers) work in an environment with a smoke-free workplace policy, compared to 90.7 percent of white-collar workers.[25] Workers who are exposed to secondhand smoke for hours every day are at increased risk of lung cancer, heart disease and serious lung ailments.[26] The prevalence of secondhand smoke exposure in the home is also highest among lower-income adults and children. Almost 50% of low-income children live with a smoker.[27]

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.[28] Unfortunately, lower-income populations who have the greatest need for care often go without treatment or receive poor quality care.[29]

Additionally, data suggest 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).[30] On average, low-income families with a pack-a-day adult smoker spent more than $51 per week on cigarettes (assuming an average price of $7.39 per pack).[31] The extent to which cigarettes are substituted for food in low-income families negatively impacts the household's food security.

Targeting Lower-Income Smokers

As smoking rates have declined in higher income populations, the tobacco industry increasingly relies on low-income populations for its consumer base, targeting this price-sensitive population through price discounting and promotions, undermining policy efforts to reduce the price of tobacco. In 2022, price discounts for cigarettes (e.g., off-invoice discounts, buy downs and voluntary price reductions to reduce the price of cigarettes to consumers) totaled over $6.8 billion, accounting for nearly 86 percent of total cigarette company marketing expenditures and making it by far the largest marketing expense category. Cigarette companies spent an additional $89.5 million on coupons in 2022.[32] These price discounts are often specifically targeted towards low-income communities. For example, a 2011 study found that cigarettes sold in low-income and minority communities in Boston had a lower mean advertised price.[33]

Researchers have also found a higher density of tobacco retailers in lower-income neighborhoods. [34] The neighborhoods of residents in the lowest income quintile are closer to tobacco retailers (an average of 10 retailers within 0.88 miles) than neighborhoods of residents in the highest income quintile (one retailer within 1.25 miles).[35] This is concerning giving the substantial amount of evidence indicating that tobacco retailer density is associated with greater exposure to tobacco product marketing [36] and more access and availability to tobacco products, which can curb quit attempts, prompt impulse purchases, and cue cravings to smoke.[37]

Helping Lower-Income Smokers Quit

In general, lower-SES smokers are not only more likely to start smoking but also less likely to quit than higher-SES smokers. For example, the percentage of smokers who have quit is highest for those with college degrees and lowest among those with a GED or less than a high school education. In 2015, 50.4 percent of adult smokers with less than a high school degree had made a quit attempt, compared to 57.6 percent of those with a college degree.[38]

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.[39] An examination of population-level tobacco control interventions found that raising tobacco product prices has the strongest evidence of effectiveness on reducing smoking among lower-income populations.[40] While 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.[41]

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. More smokers would quit if they had additional help from cessation resources, such as nicotine replacement therapies, other medications and counseling. Research shows that comprehensive tobacco cessation coverage, which includes pharmacotherapy and counseling, is associated with a greater likelihood of Medicaid recipients quitting smoking than with pharmacotherapy coverage alone or no coverage at all.[42]

Access to cessation services, however, is still quite limited, especially for lower-income smokers.[43] As of December 31, 2018, all 50 states and the District of Columbia covered some cessation treatments for all traditional Medicaid enrollees, but only 15 states* offer all seven FDA-approved cessation medications and individual and group counseling to all traditional Medicaid enrollees.† Regardless of the extent of

* The fifteen states are California, Colorado, Connecticut, Indiana, Kansas, Kentucky, Massachusetts, Maine, Minnesota, Missouri, Ohio, Oregon, Rhode Island, South Carolina, and Wisconsin.

† Telephone counseling is available free to callers to state quitlines (including Medicaid enrollees) in all 50 states and the District of Columbia through the national quitline portal 1-800-QUIT-NOW and, therefore, was not included in the 2018 report.

Medicaid coverage, all states but two – Kentucky and Missouri – still had at least one barrier to accessing coverage, such as prior authorization requirements and required co-payments, which could dissuade enrollees from seeking assistance to quit smoking.[44] Further, research indicates that many smokers with Medicaid coverage do not receive help in quitting even though cessation benefits are covered. It has been estimated that only 1 in 10 current smokers on Medicaid received cessation medications in 2013.[45]

In addition, 28.5 million Americans are without health insurance.[46] Individuals below poverty are more likely to be uninsured; eight out of ten uninsured individuals are low- or moderate-income (below 400% of poverty).[47] This barrier is compounded by research showing that those without insurance and with lower education and income are less likely to report receiving cessation assistance from a healthcare provider.[48]

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 individuals), 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 $3,150‡ per year that he or she previously spent on cigarettes. This would produce enormous benefits for lower-income households. Reductions to other smoking-caused costs would 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, 30.1 percent ($72.7 billion) of Medicaid expenditures are attributed to smoking.[49]

Campaign for Tobacco-Free Kids, August 29, 2024 / Hope Neuling

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‡ Based on average savings across all states. Actual amount would vary based on state of residence. See https://www.tobaccofreekids.org/research/factsheets/pdf/0337.pdf for more information.

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