Understanding SES and the Impact of Tobacco

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Learning Objectives

• Understand the impact of tobacco on SES populations.
• Discuss strategies to address health disparities in this population.
Current Cigarette Smoking Prevalence among Adults 18 and Older*

Race
- AI/AN*: 38.5%
- White*: 23.9%
- African American*: 22.6%
- Hispanic: 15.2%
- Asian*: 8.3%

Education
- Less than high school: 31.5%
- High school graduate: 27.4%
- Some college: 23.4%
- College graduate: 10.4%

Income
- Below poverty level: 32.5%
- At or above poverty level: 20.0%
- Unknown: 7.5%

Geography
- Midwest: 25.1%
- South: 22.9%
- Northeast: 20.6%
- West: 18.7%


*Current cigarette smoking is defined as smoking in the 30 days before the survey and having used 100 cigarettes or more in lifetime.
† American Indian/Alaska Native, non-Hispanic
‡ Non-Hispanic

http://www.cdc.gov/tobacco/disparities/low-ses/index.htm
Low SES

• Adults who have lower levels of educational attainment, who are unemployed, or who live at, near, or below the U.S. federal poverty level are considered to have low socioeconomic status (SES).¹

• According to the U.S. Census Bureau, the poverty rate in 2014 was 14.8%.² In 2014, the number of people aged 18 and older who had completed high school was 29.6%, and the number who had completed some high school but had no diploma was 4.4%.³
Low SES and Tobacco

• In the U.S., people living below the poverty level and people having lower levels of educational attainment have higher rates of cigarette smoking than the general population.4,5 Among people having only a GED certificate, smoking prevalence is more than 40%, the highest of any SES group.5
Partnership for a Tobacco-Free Maine

Socioeconomic Status:
The Single Greatest Predictor of Tobacco

- Social and economic factors influence a broad array of opportunities, exposures, decisions and behaviors that promote or threaten health. Although there are many factors contributing to predicted tobacco use, socioeconomic status is the single greatest predictor.

- Tobacco and poverty create a vicious cycle: low income people smoke more, suffer more, spend more, and die more from tobacco use.

http://www.tobaccofreemaine.org/channels/special_populations/low_income_and_education.php
From Maine:

- **Challenges of Low Socioeconomic Status**
- A study conducted by the National Network of Smoking Prevention and Poverty found that cigarettes served as a tool for those of low socioeconomic status to cope with boredom, relieve stress and as a companion to alcohol and caffeine. **Cigarettes served as a loyal “friend”** – a theme recognizable from cigarette advertising.

[Link to Resources](http://www.tobaccofreemaine.org/channels/special_populations/low_income_and_education.php)
Other results of the studies conducted on this population included:

- **Store promotions** served as major incentives, and there is high brand loyalty among this population.
- Individuals **did not relate smoking to deadly illnesses**, or connect smoking to health risks. Many cited secondhand smoke as more harmful than smoking.
- **Raising cigarette costs do not serve as a deterrent**, instead forcing individuals in this segment to merely “buy down” by buying generic brands or rolling their own cigarettes.
- **Unsuccessful quitting attempts** and relapses are caused by stress, friends and family and environmental cues.
- **Lack of inquiry by providers** and little advice or support by doctors to quit was reported. Some did not admit to smoking for fear of being “scolded.”
- **Lack of self-efficacy** – individuals did not have a belief in their own power to quit.
Homeless Persons

- Homelessness makes people exceedingly susceptible to smoking. Studies suggest that between 70 – 99% of homeless adults smoke.
- Hand-rolled cigarettes without filters, using recycled tobacco from butts, and group smoking can increase the dangers of each cigarette smoked, further endangering the health of this vulnerable population. The hazardous consequences of these behaviors can be seen in the dramatic increase in throat and mouth cancer of homeless people.
Ohio Data

Ohio groups with tobacco-related disparities comprise the majority of the state’s estimated two (2) million adult smokers. Looking at socioeconomic disparities among smokers, tobacco surveillance data shows that:

- 60% of Ohio’s (2) two million smokers (1.2 million people) have only a high school education or less;
- 90% of smokers (1.8 million people) do not have a college or technical school degree.
Ohio Data, cont.

- Who is currently smoking in Ohio?
  - Adult men smoke significantly more than women, at 25.4 percent vs 21.3 percent.¹
  - African Americans smoke significantly more than whites, at 28.9 percent vs 22.4 percent.¹
  - Over 4 in 10 adults living below the poverty level smoke (42.7 percent). Approximately 1 in 10 adults in households who have an income of over $75,000 smoke (10.0 percent).¹
  - College graduates smoke significantly less than those who did not finish high school, 8.2 percent vs 42.5 percent.¹
  - Nearly 1 in 3 young adults aged 25-34 smoke (31.4 percent). Only 1 in 10 residents over 65 are current smokers.¹
  - Appalachian adults smoke more than metropolitan, suburban or rural, non-Appalachian county residents.⁶
  - In the Northeast Central area (Youngstown) and the Southeast area (lower Appalachia), approximately 1 in 3 adult residents smoke, 32.0 percent and 35.2 percent, respectively. These two regions have significantly higher smoking prevalence than all other regions.⁶

¹http://www.odh.ohio.gov/odhprograms/eh/quitnow/Tobacco/Resources/ostats
Disparities

• Tobacco-related health disparities can be demonstrated in terms of various domains of health inequity including:
  • Differences in the patterns, prevention, and treatment of tobacco use;
  • Differences in access to and the use of cessation resources;
  • Differences in risk, incidence, morbidity, mortality and burden of tobacco-related illness;
  • Differences in exposure to secondhand smoke.
So...who should we target?

- Persons of low SES may include:
  - People with limited education
  - People of minority populations (e.g. African-Americans, Latinos, LGBTQ, etc.)
  - People with substance use disorders
  - People with mental health disorders
  - Ohioan’s living in Appalachia
CDC Data

Current Use* of Cigarettes, Cigars, and Smokeless Tobacco Among Adults Living Below Poverty Level Compared with Those Living At Or Above Poverty Level

http://www.cdc.gov/tobacco/disparities/low-ses/index.htm
Current Use* of Cigarettes, Cigars, and Smokeless Tobacco Among Adults with Less Than High School Education Compared With Adults with College Degree†4

http://www.cdc.gov/tobacco/disparities/low-ses/index.htm
Cigarette smoking disproportionately affects the health of people with low SES. Lower income cigarette smokers suffer more from diseases caused by smoking than do smokers with higher incomes.\textsuperscript{6}

- Populations in the most socioeconomically deprived groups have higher lung cancer risk than those in the most affluent groups.\textsuperscript{7}
- People with less than a high school education have higher lung cancer incidence than those with a college education.\textsuperscript{4,8}
- People with family incomes of less than $12,500 have higher lung cancer incidence than those with family incomes of $50,000 or more.\textsuperscript{8}
- People living in rural, deprived areas have 18–20\% higher rates of lung cancer than people living in urban areas.\textsuperscript{7}
- Lower-income populations have less access to health care, making it more likely that they are diagnosed at later stages of diseases and conditions.\textsuperscript{5}
Patterns of Cigarette Smoking

People with low SES tend to smoke cigarettes more heavily.

- People living in poverty smoke cigarettes for a duration of nearly twice as many years as people with a family income of three times the poverty rate.⁹
- People with a high school education smoke cigarettes for a duration of more than twice as many years as people with at least a bachelor's degree.⁹
- Blue-collar workers are more likely to start smoking cigarettes at a younger age and to smoke more heavily than white-collar workers.¹⁰

Secondhand Smoke Exposure

Secondhand smoke exposure is higher among people living below the poverty level and those with less education.¹¹

- Low SES populations are more likely to suffer the harmful health consequences of exposure to secondhand smoke.¹¹
- Blue-collar workers are more likely to be exposed to secondhand smoke at work than white-collar workers.¹⁰
- Service workers, especially bartenders and wait staff, report the lowest rates of workplace smoke-free policies than other occupation categories.¹²
Tobacco Industry Marketing and Targeting

Tobacco companies often target their advertising campaigns toward low-income neighborhoods and communities.\(^4\)

- Researchers have found a higher density of tobacco retailers in low-income neighborhoods.\(^13\)
- Tobacco companies have historically targeted women of low SES through distribution of discount coupons, point-of-sale discounts, direct-mail coupons, and development of brands that appeal to these women.\(^14\)

Culturally appropriate anti-smoking health marketing strategies and mass media campaigns like CDC’s *Tips From Former Smokers* national tobacco education campaign, as well as CDC-recommended tobacco prevention and control programs and policies, can help reduce the burden of disease among people of low SES status.
People of low SES are just as likely to make quit attempts but are less likely to quit smoking cigarettes than those who are not.⁴

- An estimated 66.6% of adult current daily cigarette smokers living below the poverty level attempt to quit smoking cigarettes compared with 69.9% of those living at or above the poverty level.⁴
- An estimated 39.0% of adult current daily cigarette smokers with no high school diploma attempt to quit smoking compared with 44.0% of those with some college education.⁶
- Adults who live below the poverty level have less success in quitting (34.5%) than those who live at or above the poverty level (57.5%).⁴
- Adults with less than a high school education (9–12 years, but no diploma) have less success in quitting (43.5%) than those with a college education or greater (73.9%).⁴
- Blue-collar and service workers are less likely to quit smoking than white-collar workers.¹⁰
Barriers

- So...what do you think the barriers are for those in this population?
How do we create barriers?
Information Transfer Gap

Science communication

scientists

the public
How are we viewed?

Forgive me if I get a little tired of the do-gooder, preachy, hypocritical, self-righteous, self-involved, never had to make a really tough choice in their lives crowd...

someecards user card
How Can Tobacco Control Programs Support Health Equity?

A comprehensive tobacco control program requires coordinated efforts by state and community partners to provide education and support for policies that work to reduce and eliminate disparities. Although work toward achieving health equity may look different in each tobacco control program, staff and partners should use the following best practices as a guide:
Commitment to Cultural Competence

➢ Offer culturally competent technical assistance and training to grantees and partners.

➢ Develop health communication materials in multiple languages and with culturally relevant themes.

➢ Make sure that quitline services are culturally sensitive and have adequate reach to meet the needs of specific populations.
Coordination & Collaboration

- Include diverse leaders from specific population groups, tribes, and community-based organizations in all phases of policy planning, implementation, and evaluation. Their experiences will help naturally tailor efforts to priority populations.

- Distribute resources to organizations that can effectively reach and mobilize specific populations.

- Work with representatives from community organizations to make sure that health equity issues are included in tobacco control strategic plans.
Administrative & Evaluation Support

➤ Conduct surveillance and evaluation activities to help understand the burden of tobacco-related disparities and guide policy development and implementation.

➤ Share and disseminate data on targeted marketing and other industry practices with communities that experience tobacco-related disparities.

➤ Develop accountability measures and take steps to make sure tobacco control policies are fully and consistently enforced.
What Works: Addressing the Issue

MYTH: Low income patients are too stressed with daily living to make changes for long-term health

Many healthcare providers believe that the stressors of housing instability, food insecurity, raising children, and unsafe neighborhoods are overwhelming. In addition, they view people with low-incomes as living in “chaos” or continual “crisis.” As a result, providers shy away from discussing chronic disease, believing their patients have “enough” to manage and can’t tackle yet another problem.

FACT: Low-income patients die as a result of unaddressed chronic disease

Although providers are trying to be empathetic with patients, this is a dangerous decision for patients and furthers health disparities for this population. It is vital that healthcare providers balance patient “crisis” with long-term health.
Practice Strategies for Low-Income Patients

- Use simple language and visual tobacco cessation aids for low-literacy patients.
- Demonstrate empathy for the patient’s experience.
- Request help from other providers, social caregivers, and specialists who can support patients with other stressors (child care, housing, food acquisition, etc.).
- Provide free medication samples or tobacco cessation medication enrollment programs offered by pharmaceutical companies.
- See the Pfizer Varenicline Program [https://www.chantix.com/index.aspx](https://www.chantix.com/index.aspx)
- Adjust the patient’s medication plan to match their resources. For example, not all patients are able to use combination therapies due to cost.
**Screening Isn’t Enough**

According to self-reports, many primary care providers who work with low-income populations ask about tobacco use and advise individuals to quit. However, few providers assist in creating a plan for quitting or arrange for follow-up.\(^6^0\)

- While providers asked about tobacco use 92% of the time and advised low-income individuals to quit 82% of the time;
- Providers only assisted in creating a plan 32% of the time and arranged follow-up 21% of the time.\(^6^1\)

However, research examining physician adherence to recommended screening protocols differs from these self-reports. The National Ambulatory Medical Care Survey found\(^6^2\):

- Only 62.7% of office visits included tobacco screening;
- Tobacco screening occurred more often for patients with private insurance (64.8%) than those with Medicaid/SCHIP (63.4%) or patients who self-pay (63.7%).
- Among patients who were identified as current tobacco users, only 7.6% received a prescription or an order for a medication associated with tobacco cessation.

Both of these studies point to the critical need for providers to screen for tobacco and to follow up with assessment, planning, and assistance.
Example of What’s Working

• A Portal for Cessation and Protection: Legacy's Head Start Initiative

• https://www.youtube.com/watch?v=hmFmfCwE-5c&list=UULTcqjxNhju_E9eq_uO_wrg
Summary

• We can tailor our work to meet the needs of this target population by looking for meaningful and relevant ways to share information and provide services.

• Collaboration with members of the community is key to our success.

• Connection to other services and resources that may help alleviate other barriers may also help the target population address their tobacco use.
Questions/Comments

COMMENT
WAIT
ADD MORE
QUESTION
References

From the CDC:


References, continued

• From ODH slide:
• Centers for Disease Control and Prevention, Behavior Risk Factor Surveillance System, Year 2012.
• Ohio Medicaid Assessment Survey, 2012.
CDC Data References

References


Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2014 [accessed 2016 Mar 29].


