TOBACCO-RELATED DISPARITIES IN WASHINGTON STATE

Tobacco is a Health Equity Problem

Tobacco use remains a leading cause of preventable death and disease in Washington State. It is associated with more than half of the top 10 leading causes of death highlighted below, and more than 8,700 people die from tobacco use and/or exposure to secondhand smoke each year. Statewide, nearly 900,000 (about 17%) adults smoke and each year about 5,000 youth start smoking.

The top 10 leading causes of death for Washington State residents, 2013.

1. Cancer
2. Heart disease
3. Alzheimer's disease
4. Chronic lower respiratory disease
5. Unintentional injury
6. Cerebrovascular disease
7. Diabetes
8. Suicide
9. Chronic liver diseases
10. Influenza and Pneumonia

Since the implementation of the Tobacco Prevention and Control (TPC) Program in 1999, Washington State has seen significant declines in tobacco use among the general population and increasing public awareness of the harmful effects of smoking. However, 15 years later smoking is still prevalent and persistent in certain populations. For example, adults with a household income of less than $25,000 report smoking prevalence between 25-30 percent, while adults in households making $75,000 or more report less than 10 percent prevalence of smoking. Lower income households are also more likely to be exposed to secondhand smoke, have less access to resources to help them quit, and may have more tobacco marketing in their neighborhood than higher income households.

These differences are reflected in tobacco-related health disparities, which occur when communities, groups, and individuals have "worse" health outcomes when compared with the rest of the population. Often, disparities occur in groups identified by their race or ethnicity, sex, sexual orientation or identity, age, disability, socioeconomic status, or geographic location.

To eliminate these tobacco-related disparities, we need to ensure that all people benefit from appropriate tobacco-related policies and programs and receive appropriate resources to build and strengthen their communities. Eliminating health disparities benefits everyone. The state currently pays more than $650 million per year in publicly funded smoking-related healthcare costs. State and local efforts to achieve health equity and eliminate tobacco-related disparities will reduce the overall rate of tobacco use in Washington State and subsequently reduce the statewide economic burden.

HEALTH EQUITY exists when all people have the opportunity to attain their full health potential.

HEALTH DISPARITIES develop when economic, social, or environmental conditions prevent a person from meeting their full health potential.

TOBACCO PREVENTION CAN REDUCE CHRONIC DISEASE DISPARITIES

According to the Centers for Disease Control and Prevention's (CDC) Smoking Attributable Mortality, Morbidity, and Economic Costs (SAMMEC) system, cigarette smoking and exposure to tobacco smoke are associated with premature death from the diseases and conditions highlighted in Table 1.

Some of these diseases and conditions identified in Table 1 are more prevalent in certain groups in Washington State, thus increasing the health disparity of tobacco-related harms. For example:

- **Black/African American** adults have a significantly higher rate of diabetes compared with non-Hispanic White adults.
- **American Indian/Alaska Native** adults have significantly higher rates of cancer, heart disease and stroke, diabetes, and asthma compared with non-Hispanic White adults.
- **Asian American** adults have significantly lower prevalence of cancer, heart disease and stroke, diabetes, respiratory disease, and asthma compared with non-Hispanic White adults. National data, however, shows that although Asian Americans are 50 percent less likely to die from heart disease than non-Hispanic white adults, ethnic subgroups show much higher rates of cardiovascular disease-related death.
- **Lesbian, Gay, Bisexual, and Transgender (LGBT)** adults have significantly higher rates of cancer, heart disease and stroke, respiratory disease, and asthma compared with straight men or women.
- **Low Socioeconomic Status** adults have significantly higher rates of heart disease and stroke, diabetes, asthma, and respiratory disease compared with adults who are not experiencing low socioeconomic status.
- **Native Hawaiian and Pacific Islander** adults have a significantly higher rate of diabetes compared with non-Hispanic White adults.

TABLE 1: Smoking attributable causes of death

Smoking attributable causes of death
Lung cancer
Other cancers including cancers of the lip, pharynx and oral cavity, esophagus, stomach, pancreas, larynx, cervix uteri, kidney and renal pelvis, bladder, liver, colon and rectum, and acute myeloid leukemia
Coronary heart disease
Other heart disease including rheumatic heart disease, pulmonary heart disease, and other forms of heart disease
Cerebrovascular disease
Other vascular diseases including atherosclerosis, aortic aneurysm, and other arterial diseases
Diabetes mellitus
Pneumonia, influenza, and tuberculosis
Chronic obstructive pulmonary disease (COPD)
Prenatal conditions (e.g., acute vascular disorders of intestine, respiratory distress syndrome, and low birth weight)
Sudden infant death syndrome (SIDS)
Residential fires
Lung cancer due to secondhand smoke exposure
Coronary heart disease due to secondhand smoke exposure

WHAT DO TOBACCO-RELATED DISPARITIES LOOK LIKE IN WASHINGTON STATE?

To describe disparities among youth, we present data from the 2012 Washington State Healthy Youth Survey (HYS). For adults, we present data from the 2010-2012 Behavioral Risk Factor Surveillance System (BRFSS).

Youth

Figures 1 and 2 show that racial and ethnic minority youth have a higher prevalence of smoking and a higher prevalence of exposure to secondhand smoke than the state average (indicated by the dotted line). Likewise, a higher prevalence of smoking and exposure to secondhand smoke exists among students with lower grades (C's, D's, and F's), students who come from families with fewer resources, students who have a disability, and students that experienced harassment by other students because of their perceived sexual orientation.

FIGURE 1: Disparities in current cigarette smoking among 10th grade youth in Washington State (2012)

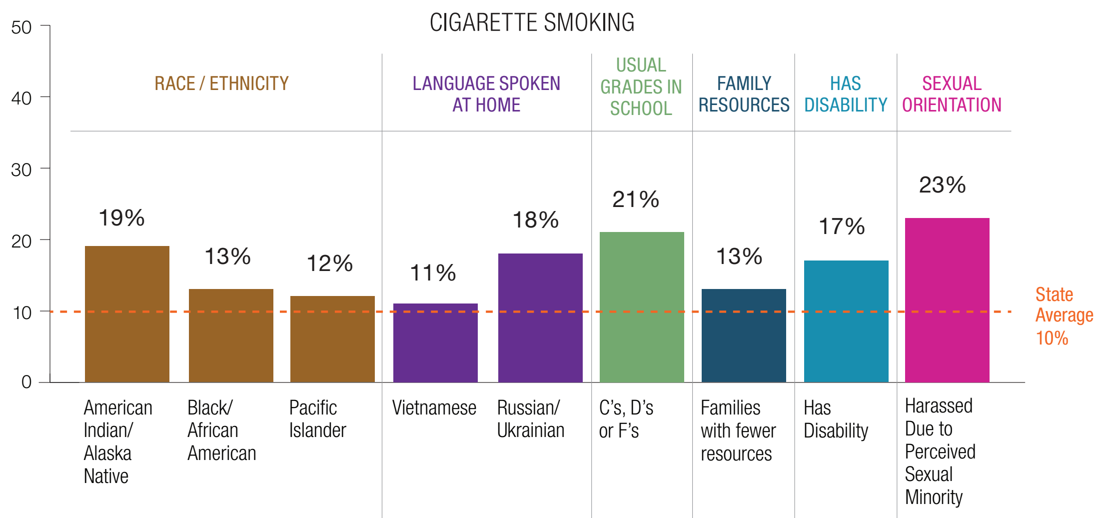
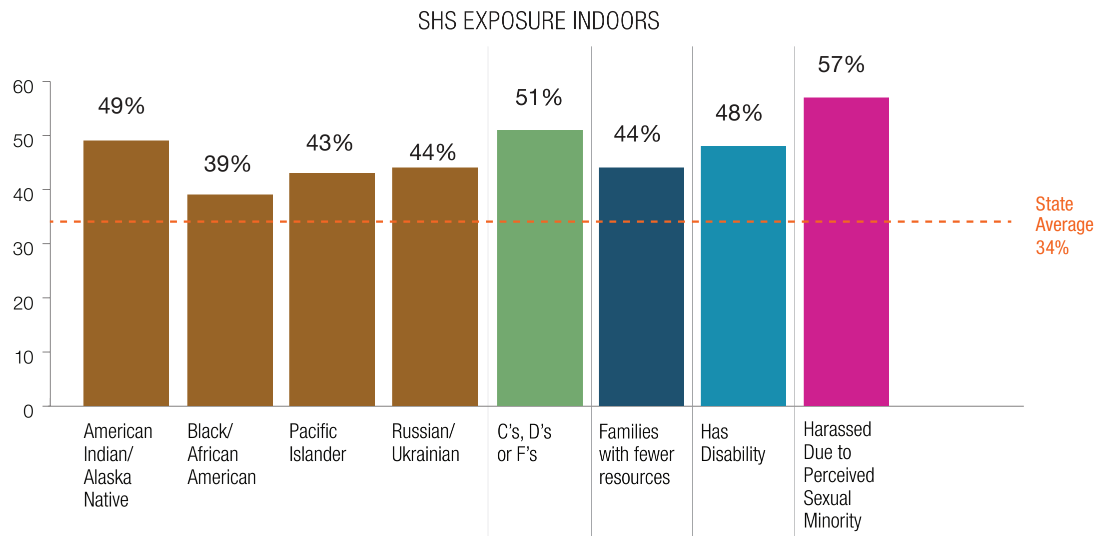


FIGURE 2: Disparities in exposure to secondhand smoke (SHS) among 10th grade youth in Washington State (2012)



The rise of flavored tobacco and alternative tobacco products marketed towards youth contributes to smoking-related disparities. Racial and ethnic minority youth are overwhelmingly more likely to use flavored and alternative tobacco products. Additionally, lower income youth and youth with disabilities are more likely to use these alternative and flavored products. With nearly 9 out of 10 smokers starting before age 18, tobacco policies and programs must adapt to new products introduced to the market and target interventions to prevent youth initiation.

TABLE 2: **Type of tobacco used among 10th graders in Washington State (2012)***

Youth population in Washington State	Flavored Tobacco Use	Menthol Cigarette Smoking	Hookah Use	E-Cigarette Use	Smokeless Tobacco
All Washington State 10th graders	**9%**	**3%**	**9%**	**4%**	**5%**
American Indian/Alaska Native	16%	8%	15%	9%	10%
Black/African American	13%	7%	14%	7%	8%
Pacific Islander	12%	5%	12%	5%	6%
Russian/Ukrainian spoken at home	19%	9%	20%	10%	12%
Vietnamese language spoken at home+	9%	6%	9%	6%	7%
From families with low income	12%	5%	11%	5%	6%
Youth with disabilities	14%	7%	14%	6%	7%

* Percentages shown in shaded cells are significantly higher than relevant comparison groups using formal statistical tests at the $p<.05$ confidence level. Racial or ethnic minorities are compared with non-Hispanic white. Families with low income are compared with families with high income. Youth with disabilities are compared with those without disabilities.

\+ Significant differences in smoking for boys only

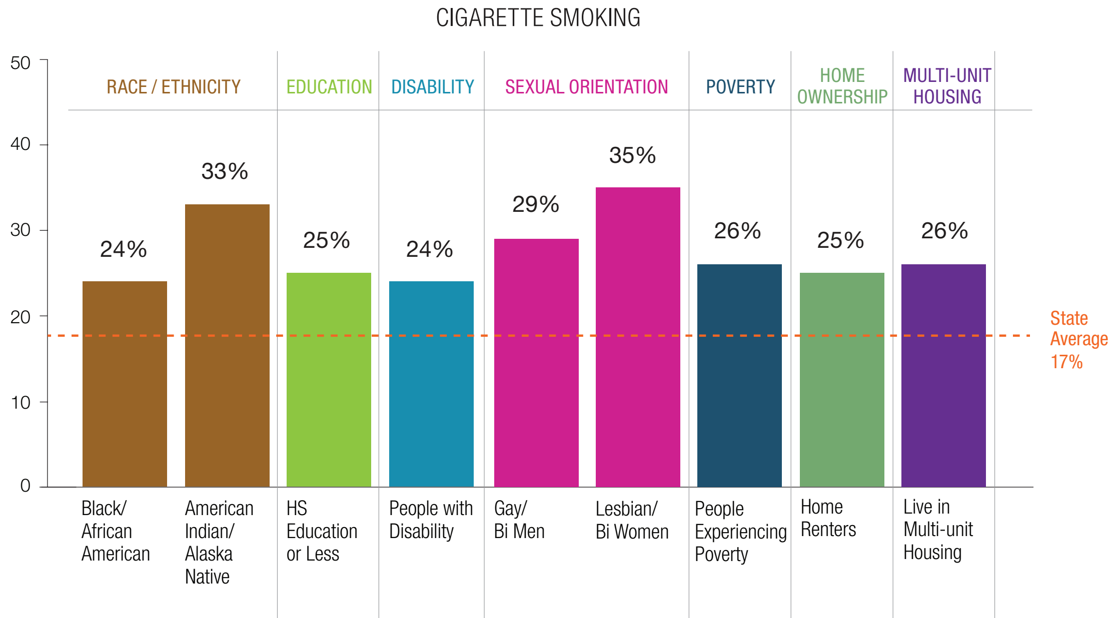
Menthol: According to the U.S. Food and Drug Administration, menthol cigarettes – the only flavored cigarette not banned nationwide – increase smoking initiation among youth, lead to greater addiction, and reduce success in quitting. In Washington State, Black/African American and American Indian/Alaska Native youth who smoke are more likely to use menthol cigarettes than other groups. Among Black/African American youth who smoke, more than half use menthol cigarettes.

In 2010, the Washington State Department of Health collaborated with diverse community organizations to conduct an assessment of neighborhood store environments – the Community Assessment of Neighborhood Stores (CANS). The assessment found no advertising for menthol products in communities with very small percentages of Black/African American youth (less than 5%), but 88 percent of stores in community-identified Black/African American neighborhoods had exterior menthol ads. While the study was based on a somewhat small number of observations and a convenience sample, these findings are consistent with a recent federal report suggesting that menthol advertising is targeted to Black/African American communities.

Adults

Although some groups make up a relatively small proportion of the state population, they account for a disproportionate part of the Washington State's "smoker population." Figure 3 shows that Black/African Americans and American Indian/Alaskan Natives have a higher prevalence of smoking than non-Hispanic Whites, and highlights additional smoking disparities in the state by education, income, sexual orientation, and living arrangements.

FIGURE 3: Disparities in current cigarette smoking among adults in Washington State (2010–2012)



Disparities in smoking mean even small populations have thousands of people at risk as shown in Table 3.

TABLE 3: Cigarette smoking and population size among adults in Washington State (2010–2012)

Adult Population in Washington State	State Total Population (%)	People Who Smoke Cigarettes (%)	Estimated Number of Adults Who Smoke Cigarettes
All Washington State adults	**100**	**17**	**895,000**
Experiencing poverty	26	26	359,000
Hispanic/Latino	9	13	61,000
Lesbian/Gay/Bisexual	3	29% men; 35% women	53,000
Black/African American	3	24	38,000
American Indian/Alaska Native	2	31	35,000
Asian	7	9	35,000
Native Hawaiian/Pacific Islander	0.6	24	8,000

Data Highlight: In Washington State, about 70 percent of Black/African Americans who smoke want to quit and are more likely than non-Hispanic Whites to have made a quit attempt in the previous year. However, Black/African Americans who smoke are less likely to quit successfully. An examination of adult health behavior data shows that Black/African American adults and people experiencing poverty are more likely than other groups to have recently attempted to quit. Between July 2013 and June 2014, the percentage of Black/African American callers to the state's tobacco Quitline (7%) was nearly double the estimated percentage of Black/African Americans who smoke within the total "smoker population."

PREVALENCE OF TOBACCO USE AND HARM HIDDEN BY LACK OF DATA FOR SOME POPULATIONS

Data alone does not tell the whole story of a community, but a lack of data does not mean that disparities do not exist. Some limitations of general population surveys include:

- **Exclusion of specific groups of people**, including people who do not speak English or Spanish; youth who are not enrolled in public schools; or people who do not feel comfortable taking government-sponsored surveys.
- **Small communities** that do not have enough people included in health surveys to provide reliable results.
- **Grouping of diverse populations** in a way that masks important differences in some groups. (i.e., Asian Americans).

An example of the disparities not captured by general population surveys includes high smoking rates among Asian American communities. Although Washington State data shows that Asian Americans have a lower prevalence of smoking (9%) than non-Hispanic Whites, disaggregated data collected in-language for the National Latino and Asian American Study show that approximately one-in-three (more than 30%) Vietnamese and Korean men in the United States smoke. Further, community-based studies conducted in Asian languages show high smoking prevalence rates among Cambodian, Chinese, Korean, Lao, and Vietnamese men. The Asian and Pacific Islander communities have been strong supporters of appropriate strategies to collect data to accurately represent their communities, including disaggregating data by ethnicity and gender, and using in-language methods.

Data monitoring is also a critical issue for LGBT communities. LGBT communities are sometimes left out of critical surveillance at the national, state, and local levels, and LGBT questions are not routinely included in demographic sections of health monitoring and evaluation surveys. However, there has been some progress in Washington State as the HYS added sexual orientation as a demographic variable in 2014.

SOME COMMUNITIES SUFFER A DISPROPORTIONATE BURDEN OF TOBACCO RETAIL OUTLETS AND ADVERTISING – MAKING IT EASIER TO START AND HARDER TO QUIT

When communities are densely populated with tobacco retailers, increased access to tobacco products and environmental cues may promote smoking. Research shows that young people who are exposed to tobacco advertising or live in areas with high retailer density, or both, are more likely to smoke. Further,

communities that allow the sale of cigarettes and other tobacco products near schools have higher rates of youth tobacco use than communities that have tobacco free zones around schools.

A review of tobacco retailer density in Washington State shows that some minority and low income communities have higher tobacco retailer density and experience disproportionate exposure to point-of-sale advertising and targeted marketing of tobacco products. For example, the density of tobacco retailers in low income census tracts is higher than the state average and the density decreases as the percent of the population living in poverty decreases. A higher density of tobacco-retailers and increased exposure to targeted tobacco advertising makes it harder to successfully quit, even with the availability of cessation resources. (See the infographic on page 8 for a comparison of the density of tobacco retailers within census tracts by sociodemographics.)

COMMUNITIES ADDRESS DISPARITIES

Addressing a pervasive issue like tobacco requires community mobilization, involvement, and support. Among other state-led interventions, the TPC Program funds community and Tribal/Urban Indian organizations that reach populations experiencing tobacco-related disparities. For years, community and Tribal/Urban Indian partners have supported culturally competent prevention and cessation efforts with adults, youth, and families. They have championed community- and Tribally-driven solutions and environmental strategies, and have developed leaders to mobilize and build capacity in their communities. The following are examples of recent efforts:

- **Gay City Health Project** has spent nearly 20 years providing outreach and establishing trust in the LGBT community. They have developed smoke- and tobacco-free policies at PRIDE events. As part of providing trusted, culturally meaningful resources, they create materials to promote tobacco-free communities.

- **Center for Multicultural Health** has mobilized communities to address tobacco-related disparities for more than 10 years. They have supported staff training for student-focused tobacco intervention at selected alternative schools and have assisted local churches and treatment centers in developing tobacco-cessation tools, programs, and resources for the people they support.

- **Foundation for Healthy Generations (formerly Comprehensive Health Education Foundation)** has been advancing health policy, environmental, and systems changes since 2009. The Foundation and its partners work with public housing authorities to adopt no-smoking policies. Currently, 32 of the 38 Public Housing Authorities in the state have at least one property covered by a no-smoking policy (compared with only four in 2009).

- **American Indian Health Commission for Washington State** has been working to improve health outcomes for American Indians and Alaska Natives for more than two decades. They developed the *Pulling Together for Wellness* framework, a culturally-grounded approach that blends public health practice with Native epistemology (Native beliefs and “ways of knowing”). This holistic framework builds capacity to improve the health of Native Americans and Alaska Natives through sustainable policy and environmental change.

- **Asian Pacific Islander Coalition Advocating Together for Healthy Communities** has been successfully engaging Asian American and Pacific Islander communities to address tobacco policy issues for 15 years. They developed a community based approach to adopt “no smoking in the home” policies for affordable housing complexes. They support a culturally and linguistically appropriate cessation model and have effectively promoted the National Asian Language Quitline.

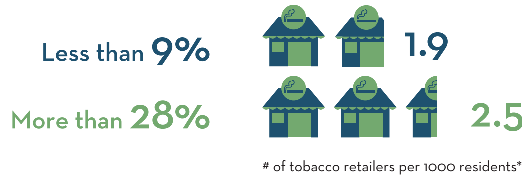
COMMUNITY CHARACTERISTICS AND PRESENCE OF TOBACCO RETAILERS[1]

STATE AVERAGE NUMBER OF TOBACCO RETAILERS PER 1,000 PEOPLE IS 2.0

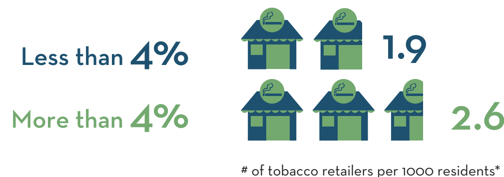
POPULATION LIVING IN POVERTY

POPULATION LACKING A HIGH SCHOOL DIPLOMA

POPULATION THAT IDENTIFIES AS NON-WHITE



POPULATION THAT IDENTIFIES AS BLACK/AFRICAN AMERICAN



POPULATION THAT IDENTIFIES AS AMERICAN INDIAN/ALASKAN NATIVE

POPULATION THAT IDENTIFIES AS HISPANIC/LATINO

1 Based on number of tobacco retailers by census tract per 1000 residents
* Results are significantly different between census tracts for each sociodemographic category.

DESPITE PROGRESS – WE NEED TO DO MORE

Good work is in progress, but despite efforts, tobacco-related disparities persist. We know what works to prevent and eliminate tobacco-related disease and disparities.

- Implement and sustain a **comprehensive program**. This costs money and requires political will and commitment. Research shows that the more money states invest in comprehensive programs, the greater the reductions in smoking. The longer states invest, the greater the impact.
- Provide greater attention to populations carrying a disproportionate burden related to tobacco use by creating and sustaining **funded community partnerships**.
- Advance **public policies** to reduce exposure to targeted tobacco industry advertising, promotion, and sponsorship; restrict youth access; and create and expand smoke-free places.
- Implement strategic, culturally appropriate, targeted and mass **media campaigns**.
- Provide adequate and appropriate **cessation resources**.
- Enhance **data and evaluation** systems to ensure the disaggregation of subpopulation data and the evaluation of culturally appropriate interventions.

Everyone – whether policymakers, community leaders, or public health professionals – has a role to play in eliminating tobacco-related disease, disability, and death.

> The mission is to achieve a tobacco-free, healthy, and fit society to be able to flourish in the 21st century…Enough is enough.
>
> *—Remarks from Acting Surgeon General RADM Boris Lushniak, January 17, 2014*

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