

# Reversal of Misfortune

## Viewing Tobacco as a Social Justice Issue



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**SINCE THE FIRST SURGEON** General's Report on Smoking was issued in 1964, smoking rates have declined markedly in the United States. The reduction in prevalence suggests healthy progress. But as practitioners track the groups with higher smoking rates, disparities in tobacco use are revealed. In 1964, the cross-section of tobacco users was diverse—broadly distributed by education and socioeconomic status, and in fact the well-off lit up more than those who earned less. In the past 40 years, the smoker's profile has reversed, and now smoking is concentrated in middle- and lower-income populations.

Tobacco remains the leading preventable cause of death in the United States, with an annual death toll of more than 400 000—all, in theory, preventable. The poor, the less educated, and the disenfranchised smoke more than

their better-off counterparts. Consequently, they suffer a disproportionate burden of tobacco-related illness and death. They are also the most exploited victims of predatory marketing practices that capitalize on their lack of education and other vulnerabilities.

When access to certain basic rights, such as good health, education, and fair and equal treatment, has been distributed unevenly or denied to certain groups, the problem becomes an issue of social justice. While social justice is a broad, encompassing construct, it is one that may be used to invoke legal rights in corporate accountability efforts, achieve the equal opportunities that lead to economic justice, or champion health care access.

Tobacco use and its related problems transcend the health arena. Examining how it is bound up in corporate accountability, economic systems, and

public health advocacy contributes to the case for understanding tobacco as a social justice issue. The construct of social justice can help counteract disparities in current tobacco control measures as well. Along the way, public health practitioners may find themselves moving beyond the better health business into the realm of social justice.

### CORPORATE ACCOUNTABILITY

Among the goals of pursuing justice are holding responsible those who have done wrong and, if necessary, forcing them to change their behavior. Tobacco companies have succeeded in addicting those who have the least information about the health risks of smoking, the fewest resources, the fewest social supports, and the least access to cessation services.<sup>1</sup> Internal

Image from the "truth" campaign's 1200 TV ad, run by the American Legacy Foundation.

company documents, made public by suits against tobacco companies, suggest that this was a planned corporate strategy.<sup>2</sup> One such document, entitled “Less Educated . . . Today’s Trend . . . Tomorrow’s Market?,” highlights the importance of young adults with lower education levels to future profits.<sup>3</sup>

In 1998, 46 state attorneys general signed a landmark settlement agreement with the tobacco industry called the Master Settlement Agreement (MSA). The MSA compensated states for costs incurred in providing treatment to those who suffered smoking-related illnesses. It provided funding for potential use in tobacco control to prevent young people from starting to smoke and to help current smokers quit.

Although the MSA prohibited tobacco companies from marketing to youths and ordered an end to paid product placement in films and TV, billboard ads, and sports arena and cartoon advertising to sell cigarettes, marketing expenditures by the tobacco industry have risen from about \$6 billion per year when the MSA was signed in 1998 to \$11.2 billion in 2001,<sup>4</sup> the most recent year for which the Federal Trade Commission has released marketing data. Since the MSA, tobacco companies’ aggressive target marketing has included increased advertising in popular youth magazines and campaigns directed at the Hispanic, Asian, and lesbian, gay, bisexual, and transgender communities, which may not yet be fully aware of tobacco’s serious health risk.

According to a series of case studies of US states, 50% or more of elected state representatives take tobacco industry donations.<sup>5</sup> At the federal level, the 4

largest cigarette manufacturers spent over \$138 000 on lobbying each day that Congress met in 2002.<sup>6</sup> Among federal elected officials, half have accepted tobacco donations,<sup>7</sup> suggesting that decisions on key policy issues may be influenced by industry interests, not the health and welfare of the nation.

Bringing disparities to public attention so they can be addressed is key to promoting social justice. The tobacco industry has pursued efforts to silence effective social marketing campaigns—including those financed by the American Legacy Foundation, an organization that was itself created by the MSA—to educate Americans about the social costs, addictiveness, and health consequences of tobacco. The award-winning “truth” campaign is currently in litigation with Lorillard Tobacco, a company that asserts that the campaign “vilifies” the tobacco industry. The company is seeking the return of all funds provided by the states to the American Legacy Foundation, a public charity. California’s state public education campaign, which is associated with a reduction in heart disease deaths,<sup>8</sup> is similarly under assault by the tobacco industry. RJ Reynolds and Lorillard are suing to silence its life-saving message.

Unlike other consumer products, tobacco is subject to little regulation by the US Food and Drug Administration (FDA). Congressional measures to regulate the manufacture, marketing, and sale of tobacco products are currently being considered, and tobacco giant Philip Morris has voiced support for a type of FDA regulation that would allow marketing of “reduced harm” products. Smokers are given little information about the contents of

their cigarettes, and terms like “light” and “low tar” mislead the public. An Institute of Medicine committee concluded in 2001 that claims for reduced-harm brands can only be made when endpoint (i.e., lower death rate) evidence exists, combined with evidence that smokers do not forgo quitting because of the availability of “reduced harm” products.<sup>9</sup> A National Cancer Institute report issued in 2001 concluded that “light” cigarettes confer no reduced risk and, indeed, lead smokers to switch brands in lieu of quitting.<sup>10</sup>

## ECONOMIC JUSTICE

Defining tobacco as a justice issue can be contentious because many people still believe that tobacco use is solely an individual

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behavior choice and tobacco illness a lifestyle disease. Moreover, the shifting demographics of tobacco use have led many individuals to incorrectly assume that the tobacco epidemic is under control because their own social networks include few smokers. Tobacco marketers’ public relations strategies have long sought, falsely, to frame the issue of tobacco use as one of “freedom of choice” and “smokers’ rights” to downplay the nicotine-dependency argument.

Yet in 2000, Americans living below the poverty line smoked at

## A Call to Action: Summaries of Conversations With American Legacy Foundation Grantees

### African American Youths

Mary Tierney, Howard University, Washington, DC: African American adolescents that we interviewed in DC didn't consider themselves smokers if they only smoked on the weekend, mixed smoking with marijuana or other drug use, or if they rolled their own cigarettes.

**Plan:** We've implemented a curriculum for pediatric residents at Howard University Medical Center with population-based smoking avoidance and cessation techniques and one-on-one training specifically for working with adolescents.

### Asian American/Pacific Islander Youths

Grace Ma, Temple University, Philadelphia, Pa: In Philadelphia, a group of Southeast Asian adolescents born in the US said that their parents' smoking habit, particularly their fathers', influenced them to pick up cigarettes. Smoking is often socially acceptable in their culture—Chinese youths born overseas start before they immigrate with their families to the United States.

**Plan:** Our Center for Asian Health at Temple University developed and implemented the culturally tailored Asian Youth-PASS (preventing Asian youths from smoking and

secondhand smoke) program as well as youth smoking cessation courses. We also field-tested the effectiveness of the programs.

### Gay, Lesbian, Bisexual, and Transgender (LGBT) Youths

Judy Bradford, Fenway Institute, Boston, Mass: Like almost all other smokers, LGBT youths start smoking at or before the teenage years—a time during which they may search for acceptance or struggle with isolation. Some find a link to supportive peers at bars, but role models found there are frequently smokers.

**Plan:** Although HIV/AIDS dominates the public discussion about LGBT health, smoking is an even more serious concern. There is a troubling disconnect between mythology and truth about what causes and supports tobacco use among sexual minority communities, and we hope to narrow this gap by developing and testing new approaches, grounded in real-life knowledge and practice. At Fenway, we're recruiting groups of friends or social networks to join cessation programs—they informally try to quit together, we're trying to formalize it.

rates of about 32% compared with 23% of those at or above the poverty level,<sup>11</sup> and the poor are not only more likely to smoke, they are less likely to quit.<sup>12</sup> A study done by the World Bank concluded that tobacco could be responsible for more than half the difference in adult male mortality between those of highest and lowest socioeconomic status.<sup>13</sup> This statistic does not include women, who have historically smoked at lower rates but are rapidly catching up worldwide owing to target marketing featuring themes of inde-

pendence, weight control, and sophistication. Women-specific brands such as Virginia Slims feature slogans such as "You've come a long way, baby" and "Find your voice."

Education is another key indicator of tobacco dependency. Girls and women who did not graduate from high school are nearly 15 times more likely to smoke during pregnancy than women with 4 years of college education,<sup>14</sup> thus affecting the health of another generation. Thirteen percent of those with an undergraduate college degree

smoke, compared with nearly 38% of Americans who did not complete high school.<sup>15</sup>

Although tobacco use is still portrayed as alluring in movies and in tobacco advertising, real-life tobacco use is more often linked with low material wealth than a glamorous lifestyle. Those in low-wage jobs smoke more: over one third of cooks and truck drivers and more than 40% of construction workers, waiters, and waitresses smoke.<sup>16</sup>

With billions of MSA dollars, the states have a historic opportunity to launch proven programs

## Latinos/Hispanics

Cesar Gaxiola, Maui Economic Opportunity, Maui, Hawaii: The Latino/Hispanic population on Maui has grown enormously in the past 13 years, but they remain a hidden community that doesn't necessarily see tobacco as a health issue. They're preoccupied with other priorities such as paying debts, immigration, and family.

**Plan:** We're adapting and implementing a curriculum called *Promotores/Promotoras* that trains Hispanic community leaders as tobacco educators; they'll present tobacco information to residents in the neighborhoods they represent. This way, the tobacco issue can be raised on the Hispanic social agenda through direct participation of the Hispanic community.

## Low Socioeconomic Status Adults

Stephen Rose, University of New England, Portland, Me: Our population is made up of people with mental illness diagnoses, very low income, and marginal connection to medical care providers. Most smoke heavily and have been doing so for more than 15 years, despite their average ages of 37 (men) and 32 (women).

**Plan:** A group of smokers from York County, Me, was hired to design an intervention for themselves that would con-

tribute to their smoking reduction or cessation. Their response was a co-led support group that was also a source of mutual aid in dealing with obtaining medical care, financial problems, and other issues central to their lives.

## American Indian and Alaska Native Youths

Kimberly Horn, West Virginia University, Morgantown, WVa: American Indian youths have among the highest smoking rates of any US racial/ethnic group. In spite of residing in the heart of tobacco country and, in many cases, having been sustained by the economy of tobacco farming for centuries, concerned American Indians from several tribes in North Carolina emphasized the need to stop tobacco addiction.

**Plan:** Tribal leaders, the North Carolina Commission of Indian Affairs, 2 universities, parents, teachers, and clergy are adapting the successful adult Not On Tobacco (N-O-T) program for American Indian youths to ensure that it is effective, accessible, and flexible enough to meet the needs of youths across race, ethnicity, class, and gender lines. A pilot study of the adapted N-O-T program for American Indian youths is under way.

to prevent and reduce smoking. Although states have developed successful public service campaigns, many are using their MSA money to address budget crises, thus letting this crucial opportunity slip away. Over the past 5 years, states have received \$39.4 billion in tobacco settlement revenue but have devoted only 5% of it to tobacco use prevention<sup>17</sup> such as educational, treatment, or enforcement efforts.

State tax increases on tobacco products are increasingly popular and are proven to drive down consumption.<sup>18,19</sup> Even though

cost may be an incentive to quit, tobacco addiction can be stronger than a rational financial decision. In order to prevent higher taxes on cigarettes from taking a bigger bite out of poor smokers' wallets, states that raise taxes have a moral obligation to expand cessation programs and help their citizens pay for cessation products and services.

Economic justice can rarely be achieved without corporate accountability through appropriate regulation. The Federal Trade Commission reports that since the MSA's ban on billboard advertis-

ing, tobacco companies have increasingly paid retailers to display posters and such items as promotional racks and clocks with their brand names. They have also invested in value-added deals such as "Buy one get one free" or "Buy three, get a free T-shirt." Such strategies may provide a disproportionate incentive for retail shops in disenfranchised communities to post tobacco advertising, and two-for-one deals take advantage of the price sensitivity of the poor, making cigarettes easier to buy and habits cheaper to maintain.



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Passing clean-air laws to create tobacco-free workspaces and public places helps denormalize smoking and remove smoking cues. Such measures lower population-based smoking rates both by reducing social acceptability and by increasing quit attempts.<sup>20</sup>

While over half of all white-collar workers are covered by smoke-free policies in their workplaces, only about one third of service workers and little more than a quarter of blue-collar workers have any regulations on the use of tobacco in their work environment.<sup>21</sup> Smoke-free workplaces are good for workers’ health and do not reduce restaurant revenues.<sup>22</sup> Here, too, the tobacco industry has sought to frame smoking in the workplace as a workers’ rights issue.

## PUBLIC HEALTH ADVOCACY

Public health advocacy perhaps fits into the social justice construct on the most obvious level—promoting health and well-being.

Public and private health care systems can play a larger role in assisting smokers’ quit attempts. There are evidence-based treatments that can dramatically increase the likelihood of long-term cessation,<sup>23</sup> and they include the intensive treatments that low-income smokers often require. At present, the US health care system is not equipped to deliver these interventions consistently and efficiently. However, the US Interagency Committee on Smoking and Health’s Subcommittee on Cessation made recommendations to the surgeon general and the secretary of the US Department of Health and Human Services on how best to promote tobacco use cessation.<sup>24</sup>

Providers must be trained to deliver prevention and cessation interventions as a fundamental part of their medical practice. Only 21% of physicians surveyed felt they received adequate training to help their patients stop smoking.<sup>25</sup> Perhaps more importantly, few receive culturally appropriate prevention training,<sup>26</sup> a clear problem given the ethnic

makeup of the poor in the United States.

For example, residents of the New York City neighborhood of Harlem have strikingly high smoking rates (48% among men, 41% among women), and their mortality rates are among the highest in the United States.<sup>27</sup> The multiple stressors and risk factors that make vulnerable populations more likely to smoke require community-based efforts. Campaigns targeted at such groups can be successful—and in some instances are more cost-effective than general antismoking campaigns.<sup>28</sup>

Grassroots public health efforts often take advantage of creative strategies to expose the truth about tobacco’s harmful effects, such as countermarketing campaigns to educate the populations that the industry targets. Similar innovative programs will help groups at higher risk—youths, minorities, and the disenfranchised—with tailored, community-based programs to give them a fighting chance to reject tobacco.

States pay more than 17% of smoking-related health expenses through Medicaid programs. Investing in prevention, therefore, can result in long-term savings to states.<sup>29</sup> Medicaid coverage to

make smoking cessation affordable and accessible for the poor is crucial. Currently, 14 states offer no coverage at all.<sup>30</sup> Comprehensive prevention and treatment plans will also save providers money in the long run. A study of health maintenance organization (HMO) expenses found former smokers’ health care costs higher in their first year of quitting, but they are equivalent to those of continuing smokers in the second year, after which costs continue to drop.<sup>31</sup>

Health advocates and political leaders in some international communities have framed tobacco as a social justice issue, a perspective that is crucial as developing countries implement legislation to counter the tobacco industry’s growing global influence. Supported by a diverse coalition of public health, environmental, and human rights groups, the World Health Organization’s Framework Convention on Tobacco Control was adopted in May 2003. It is a worldwide success for tobacco control advocates.

**Image from the “truth” campaign’s 1200 TV ad, run by the American Legacy Foundation.**



However, most tobacco control news is sobering. The World Health Organization has suggested that tobacco-related morbidity will be the leading cause of preventable death for adults worldwide by 2030. Over 10 million US residents have died of tobacco-related illness since the 1964 Surgeon General's Report.

Achieving social justice in the arena of tobacco control will be a mammoth task. Today, 2000 young people in the United States will be offered their initial cigarette. A teenager in Beijing, a shift worker in Poland, or an elementary school student in Finland will light up for the first time. The concerted efforts of community activists and health care providers are capable of improving on prevention and cessation programs to reach these individuals. If tobacco industry advertising and marketing are met by providers, insurers, policymakers, litigators, and the complex web of actors responsible for educating and caring for the public on a mass scale, these players will be able to implement programs and policies already known to be effective. ■

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This article was accepted October, 27 2003.

#### Acknowledgments

Brion J. Fox, SM, JD, Michael Pertschuk, and Paul Smolarcik, provided important recommendations and Ella Watson-Stryker provided research assistance; however, errors of commission or omission belong solely to the authors.

K. Nelson and C. Heaton based this article on Heaton's keynote speech given

at the National Conference on Tobacco or Health, New Orleans, La, November 27, 2001. The ideas expressed in that speech were solely those of C. Heaton. This article is substantially updated and differs from the speech as delivered.

#### References

- Kiefe CI, Williams OD, Greenlund KJ, et al. Health care access and seven-year change in cigarette smoking: The CARDIA Study. *Am J Prev Med*. 1998;15:146–154.
- 1998–1992 five year plan: business planning & analysis. Philip Morris Tobacco Company. March 1988. Bates No. 2043774321. Available at: <http://legacy.library.ucsf.edu/tid/cgc12a00>. Accessed October 6, 2003.
- Less educated . . . today's trend . . . tomorrow's market? RJ Reynolds Tobacco Company. 1985. Bates No. 505394539. Available at: <http://legacy.library.ucsf.edu/tid/tmc25d00>. Accessed October 6, 2003.
- Federal Trade Commission cigarette report for 2001. June 2003. Available at: [www.ftc.gov/os/2003/06/2001cigreport.pdf](http://www.ftc.gov/os/2003/06/2001cigreport.pdf). Accessed September 19, 2003.
- Reports on tobacco industry activity. Center for Tobacco Control Research and Education. Tobacco Control Policy Making: United States. Available at: <http://www.library.ucsf.edu/tobacco/state.html>. Accessed September 26, 2003.
- Tobacco industry spent more than \$20 million to lobby Congress in 2002 [press release]. Washington, DC: Campaign for Tobacco Free Kids Action Fund and Common Cause; August 13, 2003. Available at: <http://www.tobaccofreekids.org/Script/DisplayPressRelease.php3?Display=682>. Accessed October 6, 2003.
- Campaign for Tobacco-Free Kids. Buying influence, selling death: campaign contributions by tobacco interests. January 2002. Available at: <http://tobaccofreekids.org/reports/contributions/>. Accessed October 6, 2003.
- Fichtenberg CM, Glantz SA. Association of the California Tobacco Control Program with declines in cigarette consumption and mortality from heart disease. *N Engl J Med*. 2000;343:1772–1777.
- Stratton K, Shetty P, Wallace R, et al., eds. *Clearing the Smoke: Assessing the Science Base for Tobacco Harm Reduction*. Washington, DC: National Academies Press, Institute of Medicine; 2001.
- Shopland DR, ed. Smoking and tobacco control monograph 13: risks associated with smoking cigarettes with low machine-measured yields of tar and nicotine. National Cancer Institute. 2001. Available at: <http://cancercontrol.cancer.gov/tcrb/monographs/13/index.html>. Accessed October 6, 2003.
- Centers for Disease Control and Prevention. Cigarette smoking among adults—United States, 2000. *MMWR Morb Mortal Wkly Rep*. 2002;51:642–645.
- Flint AJ, Novotny ET. Poverty status and cigarette smoking prevalence and cessation in the United States, 1983–1993: the independent risk of being poor. *Tob Control*. 1997;6:14–18.
- Curbing the Epidemic: Governments and the Economics of Tobacco Control*. Herndon, Va: World Bank; June 1999. Available at: <http://www1.worldbank.org/tobacco/reports.htm>. Accessed on October 6, 2003.
- Matthews TJ. Smoking during pregnancy in the 1990s. *Natl Vital Stat Rep*. 2001;49(7).
- Centers for Disease Control and Prevention. Cigarette smoking among adults—United States, 1999. *MMWR Morb Mortal Wkly Rep*. 2001;50:869–873.
- Pederson L. Prevalence of selected cigarette smoking behaviors by occupation in the United States. Paper presented at: Organized Labor, Public Health, and Tobacco Control Policy Conference; September 24–25, 2000; Boston, Mass.
- McKinley A, Dixon L, Devore E. *State Management and Allocation of Tobacco Settlement Revenue—FY 2000 Through FY 2004*. Denver, Colo: National Conference of State Legislatures; September 2003.
- Meier KJ, Licari MJ. The effect of cigarette taxes on cigarette consumption, 1955 through 1994. *Am J Public Health*. 1997;87:1126–1130.
- Farrelly MC, Bray JW. Response to increases in cigarette prices by race/ethnicity, income, and age groups—United States, 1976–1993. *MMWR Morb Mortal Wkly Rep*. 1998;47:605–609.
- Bitton A, Fichtenberg C, Glantz S. Reducing smoking prevalence to 10% in five years. *JAMA*. 2001;286:2733–2734.
- Gerlackh KK, Shopland DR, Hartman AM, et al. Workplace smoking policies in the United States: results of a national survey of more than 100,000 workers. *Tob Control*. 1997;6:199–206.
- Glantz SA, Smith LR. The effect of ordinances requiring smoke-free restaurants and bars on revenues: a follow-up. *Am J Public Health*. 1997;87:1687–1693.
- Fiore MC, Bailey WC, Cohen SJ, et al. *Treating Tobacco Use and Dependence: Quick Reference Guide for Clinicians*. Rockville, Md: US Dept of Health and Human Services, Public Health Service; 2000.
- Fiore MC, et al. Preventing 3 million premature deaths and helping 5 million smokers quit: a national action plan for tobacco cessation. *Am J Public Health*. 2004;94:205–210.
- Ferry LH, Grissino LM, Runfola PS. Tobacco dependence curricula in US undergraduate medical education. *JAMA*. 1999;282:825–829.
- Spangler JG, George G, Foley KL, et al. Tobacco intervention training: current efforts and gaps in US medical schools. *JAMA*. 2002;288:1102–1109.
- Northridge ME, Morabia A, Ganz ML, et al. Contribution of smoking to excess mortality in Harlem. *Am J Epidemiol*. 1998;147:250–258.
- Stevens W, Thorogood M, Kayikci S. Cost-effectiveness of a community anti-smoking campaign targeted at a high risk group in London. *Health Promot Int*. 2002;17:43–50.
- Miller LS, Zhang X, Novotny T, et al. State estimates of Medicaid expenditures attribute to cigarette smoking, fiscal year 1993. *Public Health Rep*. 1998;113:140–151.
- Schauffler HH, Barker DC, Orleans CT. Medicaid coverage for tobacco-dependence treatments. *Health Aff*. 2001;20:298–303.