

Tobacco Taxes

and their impact on populations
of low socioeconomic status



Contributors

Break Free Alliance Coordinating Council

Bruce W. Adkins
West Virginia Bureau for Public Health

Robert H. Anderson
Prevention Research Center, West Virginia University

Rev. Larry J. Arce
Fresno Rescue Mission, Inc.

Joie Brown
Rural Alaska Community Action Program

Jill A. Jarvie
National Coalition for the Homeless

Tiffany J. Netters
Louisiana Tobacco Control Program

Tamatha Thomas-Haase
North American Quitline Consortium

Break Free Alliance Stakeholders/Partners

Marva Brooks
Wisconsin Department of Health & Family Services
Tobacco Prevention and Control Section

Health Education Council Staff

Debra S. Oto-Kent
Executive Director

Janet Porter
Program Director, Break Free Alliance

Lisa Houston
Program Administrator, Break Free Alliance

Kristi Maryman
Program Coordinator, Break Free Alliance

Break Free Alliance is supported by Cooperative Agreement Number 1U58DP001518 from the Centers for Disease Control and Prevention (CDC), Office on Smoking and Health. The contents of this document are solely the responsibility of the authors and do not necessarily represent the official views of CDC.

BREAK FREE ALLIANCE MISSION

Break Free Alliance is a program of the Health Education Council, a nonprofit organization dedicated to promoting healthy communities around the world. The mission of the Alliance is to reduce the burden of tobacco use in low socioeconomic status (SES) populations.

WHO WE REACH

The Alliance focuses on raising awareness about the need for tobacco policy implementation and cessation programming in specific communities with high tobacco use prevalence rates. These communities include but are not limited to, the incarcerated, those who are chemically dependent, individuals experiencing homelessness, 18-24 year olds who are not in college, and others.

WHAT WE DO

Break Free Alliance collaborates with partner organizations who serve low SES populations to implement the following strategies:

- Build partners' institutional capacity in tobacco control
- Assist states, DC, and the US territories with tobacco control education, activities and policy implementation as it relates to reducing tobacco use in low SES communities
- Develop and disseminate recommendations on promising strategies to reduce tobacco use within low SES communities

HOW TO USE THIS DOCUMENT

Break Free Alliance first addressed the tobacco tax issue in 2002 in a newsletter article titled, *Tobacco Taxes and Their Impact on Low SES Populations*. As a follow-up to that article, this document was produced as an informational resource for state/territorial tobacco control programs, social service organizations, community leaders and others working to reduce tobacco use in low socioeconomic status communities.

- Share this document with local coalitions, organizations, advocates, policy makers and others in your state and local communities.
- Download additional copies or contact a Break Free Alliance staff person by visiting: <http://healthedcouncil.org/breakfreealliance/>
- Photocopy and disseminate the one-page summary sheet and include it in press packets, educational material folders, as an agenda supplement, or as a separate educational handout/flyer.

INTRODUCTION AND BACKGROUND

In light of the increase in the federal tobacco excise tax which took effect April 1, 2009, increasing the tax on cigarettes from 39 cents to \$1.01 per pack, this Break Free Alliance brief revisits the issue, summarizes recent data and provides recommendations for advocates for directing funding back into tobacco prevention and cessation programs that serve low socioeconomic status (SES) individuals. Since April 1, 2009, several states have increased their tobacco taxes and others are considering doing so.

For the purposes of this document, Break Free Alliance broadly defines individuals of low SES as adults with 12 years of education or less, and those with low incomes (either at or below the Federal poverty level). Characteristics that may also describe low SES populations include the medically underserved, the unemployed, and the working poor.

SMOKING PREVALENCE

During the past 40 years, US smoking prevalence has declined. Among the general population, approximately 20.6% (46 million) of adults were current smokers in 2008 (1). However, large disparities in smoking prevalence continue to exist by race/ethnicity, education, and income levels (2). The continuing higher prevalence among several populations, such as adults with 9-11 years of education (35.7%), adults with GED diplomas (41.3%), and adults reporting family incomes below the federal poverty level (31.5%), emphasizes the need for more effective policy and environmental and individual-level interventions to reach and assist these subpopulations. Failure to do so means that their disproportionately high rates of tobacco-related morbidity and mortality will continue, accompanied by a concomitant health care burden. These high smoking rates contrast sharply with college-educated adults (with college degree, 10.6%; graduate degree, 5.7%). Co-morbidities should also be considered: about 40% of adults with alcohol, other drug disorders, or mental illness are smokers (3).

The immediate and long-term benefits of smoking cessation extend to men and women of all income and education levels but are more pronounced among low SES adults. The risk of lung and other cancers, cardiovascular diseases, chronic lung diseases, and acute heart attack all significantly decrease when individuals quit smoking (4). In order to reduce tobacco use prevalence among individuals of low income and low educational attainment, funding must be directed to programs to prevent youth tobacco initiation and increase cessation rates for current users.

Smoking-related death and disease carry a high cost, not only emotionally for the families coping with such tragedy, but also for the health system and economy at large. Cigarette smoking and exposure to secondhand smoke result in approximately 443,000 premature deaths, 5.1 million years of potential life lost, and \$97 billion in productivity losses in the United States each year (5).

THE ISSUE OF REGRESSIVITY

A regressive tax is one for which the poor pay a higher percentage of their income in taxes than higher income families (6). Certainly this is the case with tobacco taxes. The tobacco industry also takes that position (7). However, their opposition to tax increases has more to do with concerns about decreasing sales, as opposed to concern with the burden higher costs place on low SES consumers.

Public health advocates have generally supported taxes on tobacco products because of the harm that smoking does to both smokers' health and that of others, via secondhand smoke. The Centers for Disease Control and Prevention, Office on Smoking and Health, considers tobacco tax increases an important policy tool that can reduce smoking rates and fund state anti-tobacco programs (8).

We agree with economic analysis finding that cigarette taxes burden poor smokers (9). However, increases in excise taxes can be an *effective policy intervention* for: 1) reducing tobacco initiation; 2) reducing tobacco product consumption; and 3) increasing tobacco cessation attempts (10). This is only the case, however, when a substantial amount of the funds raised by tobacco tax increases are devoted to tobacco prevention and cessation programming.

A REVIEW OF THE LITERATURE

Numerous economic studies in peer-reviewed journals have documented that cigarette price increases can lead to significant reductions in smoking among current smokers and in the number of people who start smoking (11). In addition, young people, pregnant women, and other price sensitive groups, are considered especially sensitive to tobacco price increases (12). Increasing the price of tobacco products results in more cessation attempts and reduces the level of initiation of tobacco use (13). Further, youth are more impacted by price increases because they have less expendable income (14). A 10% increase in the real price of cigarettes is estimated to reduce consumption by nearly 4% in the general population (15). With regard to people with alcohol, other drug, or mental disorders, it is estimated that a 10% price increase would result in an 18.2% decline in smoking (3). The Task Force on Community Preventive Services recommends price increases through excise taxes as an effective policy intervention to prevent smoking initiation by adolescents and young adults, reduce cigarette consumption, and increase the number of smokers who quit (16).

In the wake of significant budget shortfalls, many states have increased cigarette and other tobacco product excise taxes to boost revenues. These increases in price have been studied to examine whether or not increasing the price of tobacco products has an impact on smoking cessation decisions of young adults, thereby influencing public health. The estimates clearly indicate that increasing the price of cigarettes increases the number of young adults who quit smoking. Given the well-documented benefits of smoking cessation, a significant increase in cigarette excise taxes may be one of the most effective means to reduce premature death and disease in the United States (17).

Smokers living in U.S. households at lower than the median income level were about 4 times more responsive to cigarette prices than smokers in households at higher than

the median income level (18). Higher tobacco taxes can lead the young and the poor to quit smoking or not start in the first place. Some studies report that youth and low-income people are much more sensitive to the price of goods. Furthermore, such a price increase, where it leads toward the poor to cease using tobacco, could lead to reallocating their limited funds to food, housing, education and health care (19). Notwithstanding these findings, we note that many smokers (including low SES smokers) will continue to smoke, some will quit, and others will reduce their smoking (9), and the higher cost will be an additional burden to those who do not quit. Some will opt for a lower-cost brand or take other measures (20).

THE OPPORTUNITY FOR STATES

For the low-income populations we serve, this creates a dilemma: Does the benefit to those that respond to price increases outweigh the cost to those that continue to smoke? Yes. However, Break Free Alliance recommends that a substantial portion of revenue from the tax be allocated for prevention and cessation programs in low SES communities. Increases in state and federal cigarette excise taxes per pack since 1995 have provided an important contribution to preventing tobacco use and promoting cessation. The Institute of Medicine (IOM) concluded that because excise taxes place a disproportionate burden on lower-income smokers, revenue from excise tax increases should be coupled with existing governmental financing to support cessation programs and services, especially for lower-income smokers. Telephone-based, tobacco-use quitlines are an example of existing cessation services that might be expanded using excise tax revenue (21).

CONCLUSION

Tobacco tax increases are an important policy tool that can reduce smoking rates and fund state anti-tobacco programs (21). However, because tobacco tax increases place a disproportionate burden on low SES individuals, we believe tobacco tax revenues should be used to prevent initiation in low SES communities and help low SES smokers quit. Unfortunately, few states are investing tax revenues in programs to combat tobacco use specifically among low SES populations, while some are making dramatic cuts in spending on existing tobacco programs. The current trend could impact low SES populations and their ability to obtain the resources they need to quit. Given high smoking rates of low SES smokers, states should make the greatest possible efforts to motivate and assist smokers to quit. The decision to divert tobacco tax revenues into non-tobacco related programs may lead to ending the downward trend of smoking rates, if not reversing them. Were that to happen it would mean future increases in tobacco-related health care costs.

RECOMMENDATIONS

- Advocates Should Support Tobacco Tax Increases: Break Free Alliance supports tobacco tax increases. Any tobacco tax increase should have a portion of the increased revenues allocated to tobacco and other chronic disease programs targeted to the low SES population. Examples of tailored interventions include but are not limited to:
 1. Collaborating with social service organizations (such as Community Action Programs) that serve the poor to assist with outreach and promotion of state quitline services and policy adoption to promote social norm change.
 2. Partnering with not-for-profit organizations, such as faith-based agencies, homeless service providers and substance abuse treatment facilities to integrate brief cessation counseling and client support.
 3. Collaborating with state correctional systems and their prisons to assist them with adopting policies prohibiting tobacco use and integrating cessation support for inmates and staff and as a component of discharge planning.
- Advocates Should Continue to Work on Strategies that Change the Social Norm: Smoking is still normative behavior in poor communities. Therefore, even though tobacco may become more expensive to purchase, the social norm in poor communities keeps tobacco products “affordable”. Individuals will continue to borrow from other users, may buy single cigarettes (although single sales are now illegal), and support each other in their addiction. Some promising practices to address social norm change in low SES communities include:
 1. Assisting agencies that provide services in low SES communities to adopt strong policies prohibiting tobacco use among clients/consumers on the grounds of the facility and to integrate cessation programming into their continuum of care.
 2. Continuing to work on the passage of local ordinances prohibiting tobacco use in worksites, bars, parks, day care centers, public housing, personal automobiles, etc.
 3. Making sure social service providers and business owners are in compliance with statewide clean indoor air laws. Many shelters, bars (especially in rural areas), and social service providers may ignore laws and continue to allow smoking to appease their clientele and employees.
- Advocate for the Passage of Minimum Pricing Laws that Prohibit Trade Discounts: The tobacco industry continues to target the poor with tobacco advertising and employ tactics that offset tobacco tax increases in poor neighborhoods. Minimum pricing laws require that a minimum percentage markup be added to the wholesale and/or retail price of tobacco products. These laws can also prohibit trade discounts, coupons and other promotions and can offset the discounting tactics of the tobacco companies. Additionally, by monitoring tobacco advertising in low SES neighborhoods in one’s community,

this affords opportunities to educate community leaders and policy makers about the importance of addressing the issue.

- States Should Take Advantage of Medicaid Match: Because of the State's high federal match for Medicaid, the impact of the tobacco tax could be tripled by investing some of these revenues in Medicaid tobacco prevention efforts, such as funding tobacco quitlines or providing nicotine replacement therapy (NRT) specifically for this population. States could elect to use a portion of tax revenues to fund programs such as state earned income tax credit or child care assistance to help low SES residents.
- State Quitline Services Must Be Promoted to Low SES Populations: Work with state quitlines to develop tailored outreach campaigns to low SES populations. Social service providers, community clinics and others can promote the quitline to their consumers.
- Provide Grassroots Organizations with Support to Mobilize Local Advocates: Encourage community mobilization efforts to send a message to policy and decision makers that their constituents support funding for tobacco prevention and cessation programs, especially those that target low SES consumers. Let policy makers know that by providing programs for low SES communities, their state will see their health care costs gradually decline as prevention and cessation programs reduce tobacco use.

The Break Free Alliance is a valuable resource for those seeking information or in need of consultation on tobacco use and low SES populations. The goal of the Alliance is to engage key organizations serving low SES populations in tobacco control efforts and to assist them with resource development and assessments, technical assistance, capacity building, and evaluation to prevent and reduce tobacco use among their constituents. Additional information and specific contact information can be found at: <http://healthdcouncil.org/breakfreealliance/index.html>

References

1. Centers for Disease Control and Prevention. Cigarette smoking among adults--- United States, 2008. *MMWR*2009;58(44):1227-32.
2. Heaton C, Nelson K. Reversal of misfortune: viewing tobacco as a social justice issue. *Am J Public Health*2004 Feb;94(2):186-91.
3. Ong MK, Zhou Q, Sung HY. Sensitivity to cigarette prices among individuals with alcohol, drug, or mental disorders. *Am J Public Health*2010 Jul;100(7):1243-5.
4. U.S. Department of Health and Human Services. The Health Consequences of Smoking: A Report of the Surgeon General. Atlanta, GA: 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; 2004.
5. Centers for Disease Control and Prevention. Smoking-Attributable Mortality, Years of Potential Life Lost, and Productivity Losses --- United States, 2000--2004. *MMWR*2008;57(45):1226-8.
6. Stiglitz J. *Economics of the Public Sector*, 3rd edition. New York, NY: WW Norton & Company; 2000.
7. Philip Morris USA. Cigarette Excise Taxes - A National View. 2010 [July 7, 2010]; Available from: http://www.philipmorrisusa.com/en/cms/Responsibility/Government_Affairs/Legislative_Issues/Excise_Taxes.aspx.
8. Centers for Disease Control and Prevention. Best Practices for Comprehensive Tobacco Control Programs—2007. Atlanta, GA: US 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; 2007.
9. Remler DK. Poor smokers, poor quitters, and cigarette tax regressivity. *Am J Public Health*2004 Feb;94(2):225-9.
10. Decicca P, Kenkel D, Mathios A, Shin YJ, Lim JY. Youth smoking, cigarette prices, and anti-smoking sentiment. *Health Econ*2008 Jun;17(6):733-49.
11. U.S. Department of Health and Human Services. The Health Benefits of Smoking Cessation: A Report of the Surgeon General. In: Department of Health and Human Services CfDCaP, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, editor. Atlanta, GA1990.
12. U.S. Department of Health and Human Services. Reducing Tobacco Use: A Report of the Surgeon General. Atlanta, GA: 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; 2000.
13. National Cancer Policy Board Institute of Medicine and National Research Council. Taking action to reduce tobacco use. Washington, DC: National Academies Press; 1998.
14. Grossman M, Chaloupka FJ. Cigarette taxes. The straw to break the camel's back. *Public Health Rep*1997 Jul-Aug;112(4):290-7.
15. Jha P, Chaloupka F. *Curbing the Epidemic: Governments and the Economics of Tobacco Control*. Washington, DC: The World Bank; 1999.
16. Task Force on Community Preventive Services. Guide to community preventive services: tobacco use prevention and control. *American Journal of Preventive Medicine*2001;20(2 Suppl 1):1-87.
17. Tauras JA, O'Malley PM, Johnston LD. Effects of Price and Access Laws on Teenage Smoking Initiation: A National Longitudinal Analysis. 2001; NBER Working

Paper No. W8331]. Available from:

http://papers.ssrn.com/sol3/papers.cfm?abstract_id=273699.

18. Farrelly MC, Bray JW, Pechacek T, Woollery T. Response by Adults to Increases in Cigarette Prices by Sociodemographic Characteristics. *Southern Economic Journal*2001;68(1).

19. World Health Organization. WHO Report on the Global Tobacco Epidemic. 2008 [January 11, 2010]; Available from:

<http://apps.who.int/bookorders/anglais/detart1.jsp?sesslan=1&codlan=6&codcol=93&codcch=220>.

20. Anderson RH, Oto-Kent D, Porter J, Brown K, Quirk L, Johnson SB. Smoking Habits and Prevention Strategies in Low Socio-economic Status Populations. Sacramento, CA: Health Education Council. 2004.

21. Centers for Disease Control and Prevention. Federal and State Cigarette Excise Taxes --- United States, 1995—2009. *MMWR*2009;58(19):524-7.



SUMMARY SHEET

Tobacco Taxes and Their Impact on Populations of Low Socioeconomic Status

RECOMMENDATIONS:

- **Tobacco tax increases should be supported, as these tax increases deter youth from starting and encourage some adults to quit.** However, because an increase in the tobacco tax falls disproportionately on low-income individuals, some tax revenues should be used primarily to benefit them. Any tobacco tax should have a portion of the new revenues generated be applied to tobacco and other chronic disease prevention programs targeted to the low SES population.
- **Advocates Should Continue to Work on Strategies that Change the Social Norm and Acceptance of Tobacco Use.** Assist agencies that provide services in low SES communities with adopting strong policies prohibiting tobacco use among clients/consumers and on the grounds of the facility. Continue to work on local ordinances prohibiting tobacco use in worksites, bars, parks, day care centers, public housing, etc. Lastly, make sure social service providers are in compliance with state and local clean indoor air laws.
- **Advocate for the Passage of Minimum Pricing Laws.** The tobacco industry continues to target the poor with tobacco advertising and employ tactics that offset tobacco tax increases in poor neighborhoods. Minimum pricing laws require that a minimum percentage markup be added to the wholesale and/or retail price of tobacco products. These laws can also prohibit trade discounts, coupons and other promotions and can offset the discounting tactics of the tobacco companies.
- **States Should Take Advantage of Medicaid Match:** Because of a State's high federal match for Medicaid, the impact of the tobacco tax could be tripled by investing it in Medicaid tobacco cessation and prevention efforts, such as funding tobacco quitlines or providing nicotine replacement therapy (NRT) specifically for this population.
- **State Quitline Services Must Be Promoted to Low SES Populations:** State quitline services need be tailored with outreach campaigns to low SES populations. Social service providers, community clinics and others can promote the quitline to their consumers.
- **Provide Grassroots Organizations with Support to Mobilize Local Advocates:** Let policy makers know that by providing cessation programming for low SES communities, their state will see health care costs gradually decline as prevention and cessation programs reduce tobacco use.

Break Free Alliance should be considered as a foremost resource for those seeking information or in need of consultation on tobacco use and low SES populations. The goal of the Alliance is to engage key organizations serving low SES populations in tobacco control efforts and to assist them with resource development and assessments, technical assistance, capacity building, and evaluation to prevent and reduce tobacco use among their constituents. Additional information and specific contact information can be found at:

<http://healthedcouncil.org/breakfreealliance/index.html>



Health Education Council
3950 Industrial Boulevard, Suite 600
West Sacramento, California 95691
Phone (916) 556-3344
Fax (916) 446-0427

healthedcouncil.org



HEALTH
EDUCATION
COUNCIL