Unintended Consequences of Tobacco Policies
Implications for Public Health Practice

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Tobacco use is the leading cause of preventable death in the U.S., killing over 440,000 people each year.[1,2] In 1964, when the Surgeon General's Report Smoking and Health[3] was released, smoking was fairly common across the economic spectrum; in fact, the 1965 National Health Interview Survey (NHIS) showed that smoking rates were higher among individuals who had attended some college than among those who did not graduate from high school. In 2007, the same study showed that smoking had become concentrated among those with the least education, and the least income.[4]

Higher smoking rates among the disadvantaged are exacerbated in several ways: Smokers with lower SES quit smoking at a much lower rate than those with higher incomes, are less likely to have continuous health insurance coverage, and are less likely to seek care because of financial concerns.[5–7] Further, tobacco industry documents reveal industry marketing efforts designed to influence those who have the least information about the health risks of smoking, the fewest resources, and greatest barriers to cessation services.[8] As a result of these influences, disadvantaged individuals suffer disproportionately from the burden of tobacco-related illness and death.[9,10] These disparities have transformed today's contemporary tobacco epidemic into an issue of social justice.

The socioeconomic gradient of smoking is made more complex by the intersection of gender. Although women have historically smoked at lower rates than men, the gender difference in tobacco use is declining.[11] Changes in women's role in society, increased labor-force participation, and the tobacco industry's targeted marketing efforts toward women have all contributed to smoking prevalence among women.[11,12] During the past year, RJ Reynolds introduced a new brand of cigarette named "Camel No. 9" to be evocative of the famous perfume and packaged in pink, and Philip Morris developed Virginia Slims Purse Packs, which include slender cigarettes packaged in a lipstick-like box for a women's purse—both designed to appeal to young female smokers.

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Tobacco-control policies have made a significant contribution toward reducing tobacco use in the U.S. and worldwide.[1,13] These interventions, such as clean indoor air laws and excise taxes, have been found to both prevent initiation and prompt cessation. However, tobacco-control researchers and practitioners need to be ever vigilant in exploring how these population-based interventions may differentially impact low SES communities. Since the implementation of policies occurs in changing contexts, the supports, incentives, and constraints to implementation are ever evolving.[14] As such, this evolutionary process requires a reflective and continuous approach to evaluating policy effects across a wide spectrum of settings.

The papers in this supplement to the *American Journal of Preventive Medicine*[15–23] focus on the unintended consequences of tobacco policies on low SES women and girls, and provide evidence of the differential effects of policy implementation within a variety of social contexts. In the study by Greaves and Hemsing,[15] smoke-free ordinances are associated with an increase in smoking in the homes. For low-income women, whose male counterparts smoke at higher rates than the general population, this increases the likelihood for exposure to secondhand smoke. The authors also find that smoke-free policies are not as effectively implemented in workplaces traditionally dominated by women, such as work done in private homes and bars.

These findings highlight the need for public health practitioners to further adapt the content and delivery of tobacco-control prevention and cessation programs to respond to different policy environments. A first step for practitioners is to acknowledge that some tobacco-control strategies may require additional support and/or further modification to increase their efficacy. While there is evidence that some smokers may be more likely to quit in certain policy contexts, a better understanding is needed of the complexities that surround them. In the study by Burgess and colleagues,[16] lower smoking rates were found in states with higher levels of negative attitudes toward smokers, even after controlling for the effects of state-level tobacco-control initiatives; however, there was less of a reduction in smoking prevalence among socially disadvantaged women. Findings indicate that barriers to utilization of smoking-cessation services, their reduced capacity to maintain a smoke-free home, and fewer options for

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coping strategies to replace smoking play a role in reducing the impact of policy interventions.

Some recommendations for practitioners include:

- Help ensure that secondhand smoke-related messages target *parents*, not solely mothers, and are delivered in culturally appropriate ways.
- When reaching out to women with children, focus smoking-cessation messages on the individual woman's health, as well as the health of her children and families.
- Help build acceptance and trust within the patient–provider relationship to reduce the effects of stigma on women and mothers who smoke.
- Underscore the need for smoke-free policy initiatives to be coupled with increased access to smoking-cessation programs.
- Help develop strategies for women who work in bars and restaurants where smoking is still allowed and/or where smoke-free laws are not enforced.

Achieving social justice in the tobacco arena is a mammoth undertaking, but with the concerted efforts of our collective leadership—including policymakers, tobacco-control practitioners, researchers, healthcare providers, advocates, and the public at large—it can and must be done. We must ensure that policies to combat this epidemic are effectively implemented to reduce tobacco use, particularly for those who most need our help.

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