

## Addressing New York City's Smoking Inequities

In the past two decades, fewer adults in New York City (NYC) are smoking cigarettes. Due to community and public health efforts, the prevalence of smoking has been halved, from 22% in 2002<sup>1</sup> to 11% in 2020.<sup>2</sup> However, this progress has not been experienced equally – some New Yorkers continue to smoke at higher rates and receive tobacco treatment at lower rates. These disparities are unjust and should be addressed. Reducing these inequities requires looking beyond individual behaviors or characteristics to the structural factors that create conditions that encourage smoking and make it difficult to stop.

Racism<sup>3</sup> and other forms of injustice based on one's identity (for example, classism, nativism, sexism, and heterosexism) or on mental health status expose

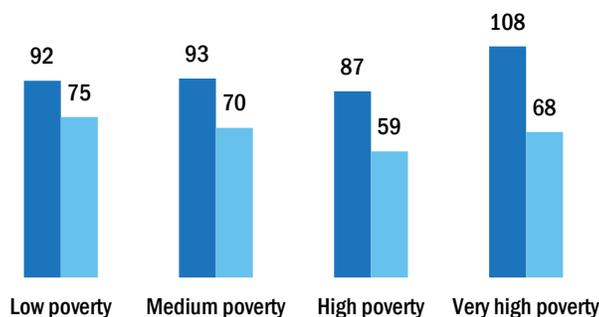
certain communities to more harmful factors that encourage smoking (like industry marketing, retailer access, and stress), as well as fewer protective factors (like treatment support, healthy coping resources, or access to behavioral health care). These exposures contribute to the persistent inequities in cigarette smoking and health outcomes seen today. Importantly, these inequities are compounded for people who live at the intersection of multiple, marginalized identities.

Addressing the root causes of inequities and prioritizing communities experiencing these inequities are vital to prevent the devastating health impacts of smoking, including premature death. This report presents recent data highlighting smoking inequities and offers recommendations to equitably address smoking among communities most affected.

### Environmental and industry factors create inequities in tobacco product exposure

#### Licensing caps in New York City led to decreases in tobacco retailer density between 2018 and 2021

Tobacco licenses per 100,000 population by neighborhood poverty level



Neighborhood poverty (by community district) = percentage of the population living below the Federal Poverty Line (FPL) based on the American Community Survey (2013-2017).

Low poverty= <10% of the population living below the FPL; Medium=10-<20% below FPL; High=20-<30% below FPL; Very high= ≥30% below FPL.

Source: NYC Department of Consumer and Worker Protection 2018 and 2021

- Higher levels of tobacco retailer density and proximity are associated with higher tobacco use.<sup>4</sup> The tobacco industry targets communities with higher poverty through increased marketing and accessibility of products, and often incentivizes retailers to display their products and ads.
- In 2020, among adults who lived in neighborhoods with very high poverty, 14% smoked, compared with 9% of adults who lived in neighborhoods with low poverty.<sup>2</sup>
- Between 2018 and 2021, the number of tobacco retailers decreased by 29% overall. The greatest retailer density decreases were in very high and high poverty neighborhoods (37% and 32% decrease, respectively). This was due to policy changes<sup>5</sup> regulating retailer density in NYC, like neighborhood licensing caps. However, policy changes will take time to affect smoking prevalence.

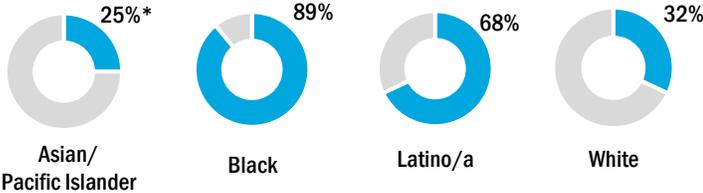
**Data Sources: Community Health Survey (CHS) 2016, 2019-2020, 2020:** CHS is conducted annually by the Health Department with approximately 9,000 -10,000 non-institutionalized adults ages 18 and older. Estimates are age-adjusted to the U.S. 2000 standard population, except where noted. Some analyses use combined year data to increase power for intersectional analysis. The CHS has included adults with landline phones since 2002 and, starting in 2009, has included adults who can be reached by cellphone. For more survey details, visit [nyc.gov/health/survey](https://nyc.gov/health/survey).

**Tobacco Retailer counts** are from the Legally Operating Businesses dataset maintained by the NYC Department of Consumer Affairs (Consumer and Worker Protection). Available at: [Active Tobacco Retail Dealer Licenses | NYC Open Data \(cityofnewyork.us\)](#)

**New York State Quitline Partner Program:** Demographic information on clients receiving nicotine replacement therapy. [NYS Quitline Partners Site \(nysmokefree.com\)](#)

## Intersecting forms of injustice further inequities in tobacco product exposure and use

Tobacco industry marketing has been shown to target Black and Latino/a communities; in 2020, among New Yorkers who smoke, Black and Latino/a adults were more likely than other adults to smoke menthol cigarettes



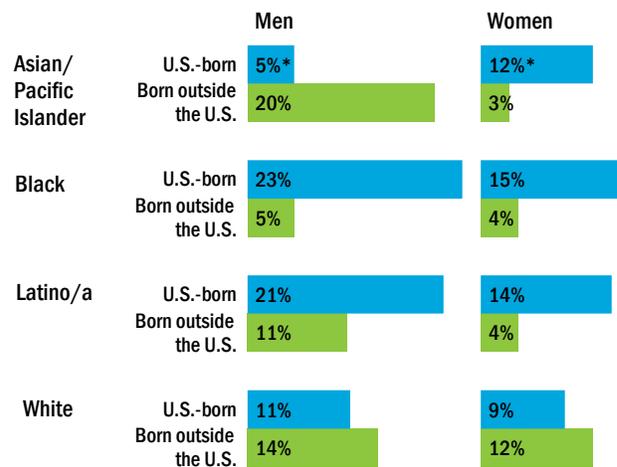
\*Estimate should be interpreted with caution. Estimate's 95% Confidence Interval half-width is greater than 10, making the estimate potentially unreliable. White, Black, Asian/Pacific Islander race categories exclude Latino/a ethnicity. Latino/a includes Hispanic or Latino/a of any race. Source: NYC Community Health Survey 2020; data are age-adjusted.

- The tobacco industry has aggressively promoted menthol cigarettes to communities of color and communities with higher poverty, using tactics like free samples, event sponsorships, targeted marketing, and misleading “medicinal” messaging, contributing to persistent inequities in menthol smoking rates.<sup>6</sup>
- Menthol makes cigarette smoke less harsh and easier for youth to tolerate; it may also make it harder for some people to quit.<sup>7</sup>
- In 2020, 52% of all adults who smoked in NYC usually smoked menthol cigarettes; 89% of Black and 68% of Latino/a adults who smoked used menthol cigarettes, compared with only 32% of White and 25% of Asian/Pacific Islander adults who smoked.

- Overall, smoking prevalence was similar across different race and ethnicity groups in NYC in 2019-2020. However, considering race and ethnicity, gender, and place of birth together reveals inequities and intersecting factors that promote smoking, including policies, product promotion, and product access in NYC and abroad.
- In 2019-2020, Asian/Pacific Islander men (cis- and transgender, here and following) born outside the U.S. smoked at a higher rate than U.S.-born Asian/Pacific Islander men (20% vs. 5%).
- In 2019-2020, U.S.-born Black and Latino men smoked at higher rates (23% and 21%, respectively) than Black and Latino men born outside the U.S (5% and 11%, respectively).
- Smoking rates among Black (15%) and Latina (14%) women born in the U.S. were more than three times higher than among Black (4%) and Latina (4%) women born outside the U.S.

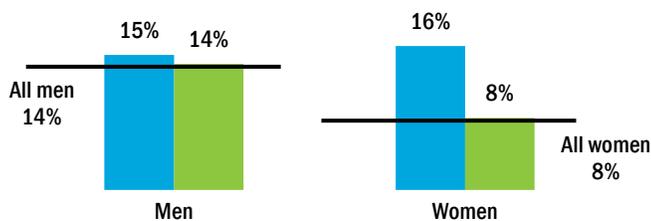
### Smoking prevalence in New York City varies across race and ethnicity, gender, and nativity groups and highlights intersecting forms of injustice

Prevalence of smoking, 2019-2020



\*Estimate should be interpreted with caution. Estimate's Relative Standard Error (a measure of estimate precision) is greater than 30% or the 95% Confidence Interval half-width is greater than 10, making the estimate potentially unreliable. White, Black, Asian/Pacific Islander race categories exclude Latino/a ethnicity. Latino/a includes Hispanic or Latino/a of any race. Source: NYC Community Health Survey 2019-2020; data are age-adjusted.

Women who identified as gay, lesbian, or bisexual were more likely to smoke than straight women in New York City, 2019-2020



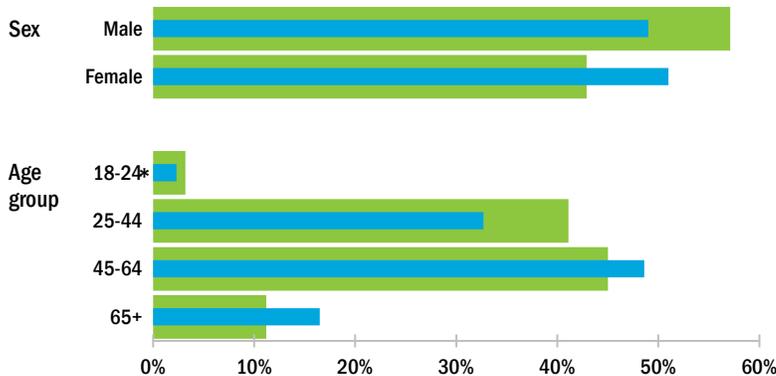
Source: NYC Community Health Survey 2019-2020; data are age-adjusted.

- Industry targeted marketing efforts and systemic injustice, which can lead to social exclusion and stress, may influence smoking prevalence among gay, lesbian, or bisexual (GLB) New Yorkers.
- Although women have lower smoking rates overall, women who identify as GLB were almost twice as likely to smoke as straight women in 2019-2020 (16% vs. 8%).

## Communities need tailored outreach and treatment support

### The New York State Smokers' Quitline is underutilized by male and younger adults in New York City

Proportion of adults who smoke daily and Quitline clients by sex and age group, 2020



\*Estimate should be interpreted with caution. Estimate's Relative Standard Error (a measure of estimate precision) is greater than 30%, making the estimate potentially unreliable.

Source: New York State Smokers' Quitline 2020; NYC Community Health Survey 2020; data are not adjusted for age

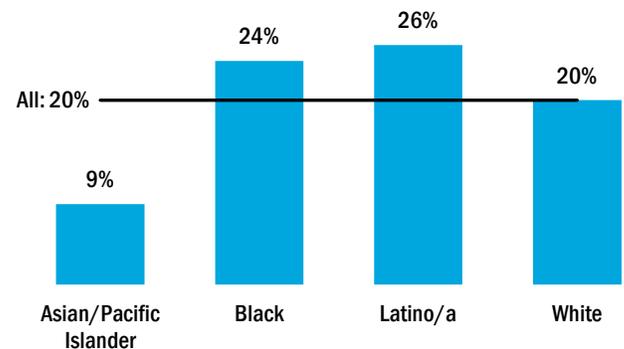
- Tobacco treatment is most effective when medications and counseling are combined. New Yorkers can access treatment services through their healthcare providers, local programs, and quitlines. The New York State Smokers' Quitline (NYSSQL) is a free and confidential program that provides evidence-based services (counseling, medication, and skill-building) to people who want to stop smoking. The NYSSQL is underutilized by some groups, indicating a need for more strategic promotion and outreach.
- In 2020, although 57% of adults who smoked daily were male, males only comprised 49% of NYSSQL users in NYC. Similarly, while 41% of adults who smoked daily were ages 25 to 44, they only comprised 33% of NYSSQL users in NYC.

- There are seven tobacco treatment medications including two non-nicotine pills and five types of nicotine replacement therapy.<sup>^</sup> Tobacco treatment utilization varies by community due to unequal access to health care and/or treatment options and other environmental influences (cigarette marketing, promotion, and accessibility), both in the U.S. and abroad.
- In 2016, Asian/Pacific Islander New Yorkers who smoke were less likely to use nicotine replacement therapy than those identifying with any other race or ethnicity group.
- In 2016, White (20%), Black (24%), and Latino/a (26%) adults were two to three times more likely than Asian/Pacific Islander (9%) adults to use nicotine replacement therapy for help quitting.

<sup>^</sup>Non-nicotine pills include bupropion SR (Zyban® or Wellbutrin®) and varenicline (Chantix®). Nicotine replacement therapy includes patch, gum, lozenge, inhaler, and nasal spray.

### Asian/Pacific Islander adults who smoke were less likely than other groups to use nicotine replacement therapy

Prevalence of use by race/ethnicity, New York City, 2016



White, Black, Asian/Pacific Islander race categories exclude Latino/a ethnicity. Latino/a includes Hispanic or Latino/a of any race.

Source: NYC Community Health Survey 2016; data are age-adjusted.

**Definitions: Race/ethnicity:** For the purpose of this publication, Latino/a includes people of Hispanic or Latino/a origin, as identified by the survey question "Are you Hispanic or Latino/a?" and regardless of reported race. Black, White, and Asian/Pacific Islander race categories exclude those who identified as Latino/a.

**Neighborhood poverty** (by community district) is defined as the percentage of the population living below the Federal Poverty Line (FPL) based on the American Community Survey (2018, 2021). Neighborhoods are categorized into four groups as follows: "Low poverty" neighborhoods are those with <10% of the population living below the FPL; "Medium poverty" neighborhoods have 10-20% of the population below FPL; "High Poverty" neighborhoods have 20-30% of the population living below the FPL; "Very high poverty" neighborhoods have ≥30% of the population living below the FPL.

**Gender** categories include men who identify as cisgender or transgender and women who identify as cisgender or transgender. Those with other gender identities (non-binary, or a gender not among the survey options) were excluded from the analyses due to small numbers. Gender is used for CHS analyses, except where CHS data are compared with Quitline data, where sex assigned at birth is used to compare with Quitline data which are classified by male/female sex.

**Health equity** is attainment of the highest level of health and well-being for all people. Not all New Yorkers have the same opportunities to live a healthy life. Achieving health equity requires focused and ongoing societal efforts to address historical and contemporary injustices such as discrimination based on race/ethnicity and other identities. For more information, visit the Centers for Disease Control and Prevention's [Health Equity](#) page.

## Recommendations



### Community-based organizations, public health practitioners, and social service providers:

- Refer to the [Race to Justice Action Kit](#) (visit [nyc.gov/health](http://nyc.gov/health) and search “Race to Justice”) for tips to communicate effectively and respectfully about health inequities and implement meaningful community engagement projects.
- Acknowledge that racism and other forms of injustice contribute to tobacco-related health inequities.
- Use person-first language (“person who smokes” not “smoker”).
- Use language that highlights getting treatment, not only quitting. Treatment can help everyone who smokes.



### Health care providers:

- Adopt clinical best practices to address health inequities. Refer to the NYS Department of Health’s [Health Care Organization Considerations In Support of Equity](#)<sup>8</sup> for tips.
- Ask all patients about their smoking history and offer [tobacco treatment](#)<sup>9</sup> to *all who smoke*. Refer to the [Health Department’s clinician page](#) (Visit [nyc.gov/health](http://nyc.gov/health) and search “Tobacco Clinicians”) for tools and resources.
- For patients who are not ready to quit, nicotine replacement therapy can still help them reach personal goals and increase future interest in quitting. (Visit [nyc.gov/health](http://nyc.gov/health) and search “Nicotine Withdrawal”)
- Follow-up regularly with all patients who smoke<sup>10</sup>, including providing ongoing counseling and medication support, and referring to relevant resources ([New York State Smokers’ Quitline](#), [Asian Smokers Quitline](#), [local programs](#)).



### Public health researchers, funders, and policymakers:

- Apply anti-racism approaches to tobacco research and surveillance. Recognize that race is a social construct and is distinct from ethnicity, genetic ancestry, or biology. Collect and report disaggregated data when possible.
- Prior to presenting data on cigarette smoking and related health outcomes, explain why smoking inequities exist and persist by including context on the structural, systemic drivers of tobacco-related health inequities.
- Involve communities most impacted by smoking inequities in planning and communication of findings.
- Advocate for tailored solutions and policies grounded in equity that challenge tobacco industry influences, change unjust community conditions, and break down barriers to health-seeking behaviors.

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