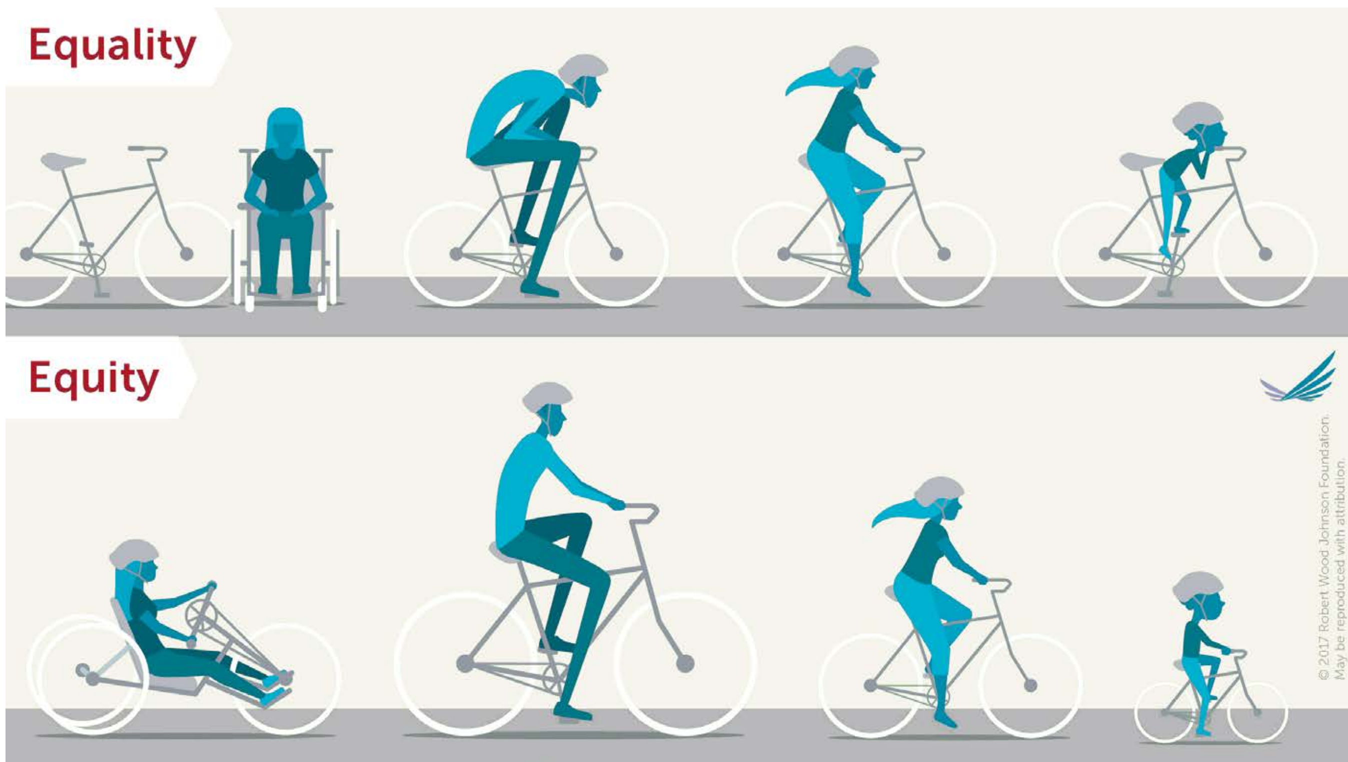
CENTERING EQUITY IN COMMERCIAL TOBACCO POLICY

for New York State

Law and policy are essential tools for improving public health, creating and reinforcing social norms, and addressing health disparities, especially when communities experience disproportionate harms, such as from the use of commercial tobacco.[1]

Laws, in the form of statutes or codes, ordinances, and administrative or agency rules, are powerful because they have the weight of government behind them. Laws can protect us and give us opportunities to lead healthier lives by regulating the use and availability of harmful products like commercial tobacco.

Over the last several decades, commercial tobacco control efforts have succeeded in significantly reducing the number of commercial tobacco users in the United States.[2] Despite these achievements, a comparable decrease in use has not occurred in communities that



have been targeted and disproportionately harmed by the commercial tobacco industry. These communities include African American and Black populations, American Indians and Alaska Natives, Asian Americans, Native Hawaiians and Pacific Islanders, Hispanic and Latino populations, members of the LGBTQIA+ community, people living at or near the poverty level, and individuals with mental health conditions or substance use disorders. Laws and policies that address the health disparities experienced by communities targeted by the tobacco industry can significantly reduce commercial tobacco use in the U.S. This fact sheet provides an overview of how New York State localities can reduce health disparities in their communities by centering health equity at every stage of the policy development process.

Health equity[3] is a state in which everyone has a fair opportunity to reach the highest possible standard of health and where differences in the quality of health for individuals and populations are eliminated.[4] Health equity can be achieved by addressing the social determinants of health, which include the conditions in which people are born, grow, live, learn, work, and age, and the broader set of forces and systems, such as historical, economic, and social injustices and obstacles to healthcare, that shape a person's daily life.[5]

Health equity means paying attention to populations that have been overlooked or marginalized. It is not health equity to simply provide every individual or population with the

same resources; to achieve health equity, resources must be allocated according to need-based principles. Action must be taken to ameliorate past harms, address current inequities, and prevent future inequities.[6]

Promoting Health Equity in the Policy Process

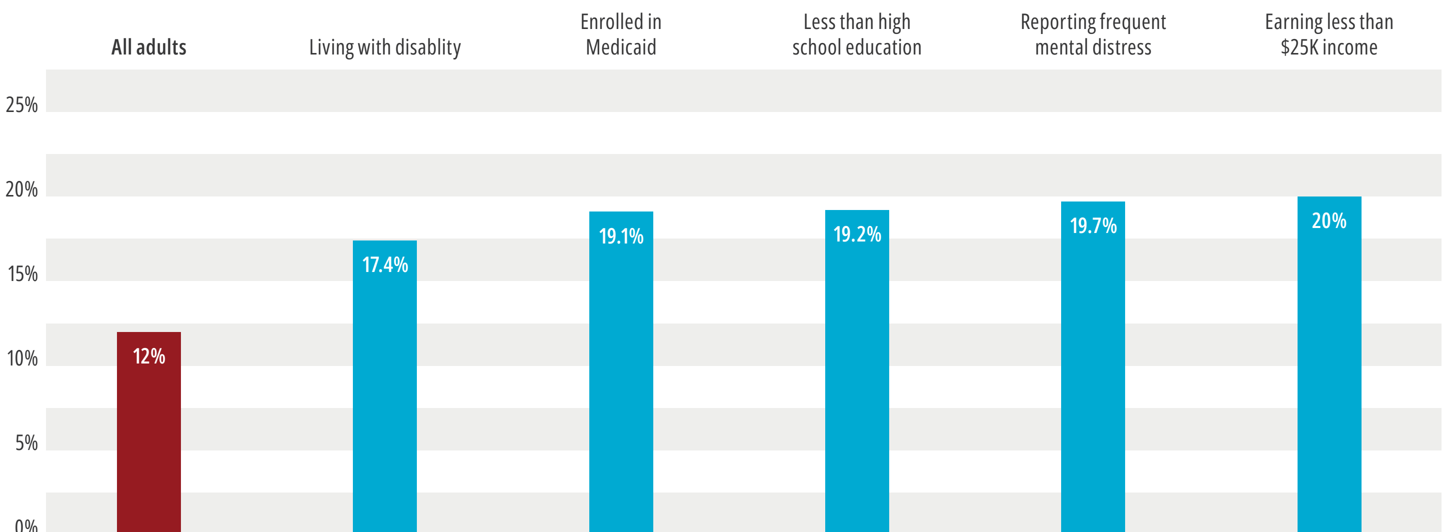
Below are the key phases of public health law and policy development with examples of how to promote health equity at each stage.

1. Research, Evidence, and Expertise

Public health and commercial tobacco control policies traditionally rely on quantitative data compiled in a controlled research setting. These studies often exclude diverse perspectives. Qualitative data drawn from communities can be key to drafting an equitable law or policy.[7] This data can be compiled in several ways:

- Gaining input from community members through focus groups or key informant interviews. This includes actively seeking feedback from marginalized or historically excluded groups.
- Gathering knowledge from Indigenous elders.
- Partnering with community leaders to ensure the understanding and use of culturally appropriate language to foster inclusivity.

Table 1: Smoking Among All Adults vs. Adults in Demographic Groups With High Smoking Rates in NYS



Source: Advancing Tobacco-Free Communities, *The Human Cost of Tobacco in New York State*, (Feb. 2024), based on data from NYS BRFSS (2021)

Table 2: Menthol Tobacco Retail Environment in Three Buffalo Districts: Fillmore, Lovejoy, and Ellicott (excerpt from Cicatelli Associates, Inc. findings)

What is the issue?

Tobacco companies aggressively market menthol products using elements of Black culture, putting more products on shelves In Black communities and making them cheaper.

What did we do?

To better understand the menthol tobacco retail environment here in Buffalo, CAI trained a group of community members, our Tobacco Action Group, to observe a random sample of 88 small tobacco retallers, mostly convenience stores, in three Buffalo Common Council Districts. This is what they observed.

Menthol Advertising

Nearly **2 in 5 stores** had exterior ads for menthol cigarettes.

About **1 in 5 stores** had exterior menthol cigarettes ads within 1,500 feet of a school.

60% of Black youth prefer Newport Menthol cigarettes compared to 22% of white youth, nationwide.

Menthol Sales

$11.21
The minimum price a pack of cigarettes should be sold to consumers in NYS.

$10–$15
Price range for a pack of Newport Menthol cigarettes.

$4–$8
Price range for a pack of Seneca Menthol cigarettes.

1 in 10
Stores sell Newport Menthols below the NYS minimum floor price.

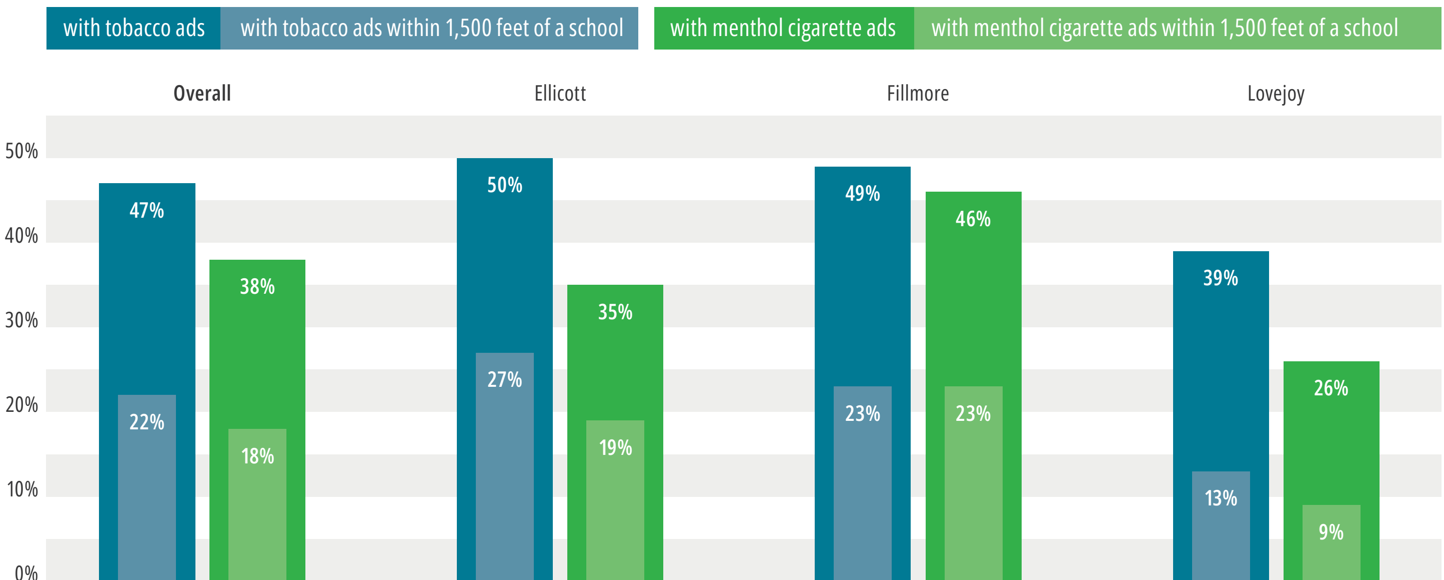
Source: *Findings from Tobacco Retail Environment Observations in Buffalo, NY*

When collecting qualitative data from individuals, it is important to identify barriers that community members may face and consider compensating them for their participation. For example, it might be possible to provide help with transportation fares or childcare services.

The New York State Tobacco Control Program webpage features several reports, including short one to two page StatShots, BRFSS Briefs, annual independent evaluation reports, and various topical reports that contain useful tobacco-related quantitative data. For instance, this overview of the *Human Cost of Tobacco Use in New York* contains a variety of compelling data points on demographic groups with high smoking rates in New York (see **Table 1**).[8] Reports such as the State Health Department's one-page StatShot, *Prevalence of Menthol Cigarette Use among Adults by Race/Ethnicity*, also provide helpful data, such as the finding that 86 percent of Black smokers use menthol cigarettes compared with 36 percent of White smokers in New York State.[9]

Using data not just from New York State but from specific communities is the most effective way to ensure a policy is tailored to local needs. For example, a New York State Department of Health-funded Advancing Tobacco-free Communities grantee in the Western Region successfully highlighted compelling local data gathered through an assessment of tobacco retailer density and tobacco product availability and pricing in Buffalo, New York (see **Table 2** and **Table 3**).[10]

Table 3: Stores with Tobacco Ads vs. Menthol Tobacco Ads Near Schools in Buffalo, NY



Source: *Findings from Tobacco Retail Environment Observations in Buffalo, NY*

Response data can be sorted, compiled, and analyzed in a way that advances equity, but the reverse can also be true. Be mindful of who is funding the research or promoting the information and be on the lookout for disingenuous messaging and opposition-sponsored data. The tobacco industry is notorious for co-opting and exploiting culture and shaping information to fit its narratives, casting doubt on potential options or solutions.

2. Identify Policy Solutions

Policy solutions should directly reflect the needs of the community based on the information and insights compiled in Phase 1. Tailored policy measures, founded on strong and equitable solutions, are more likely to be supported by the community. Some commercial tobacco policy solutions with an equity-focused impact include:

- Prohibiting the sale of all flavored tobacco products, especially menthol cigarettes
- Removing provisions that criminalize users and consumers (note: New York State does not have laws prohibiting the possession, use, and purchase of tobacco products by minors (i.e., PUP laws))
- Providing funding for culturally competent cessation and prevention services
- Removing barriers to accessing services and educating on cessation

A Closer Look: Retailer Density Policy Provisions

Commercial tobacco retailers are more concentrated in neighborhoods that have a higher percentage of low-income residents, as well as in majority African American and Hispanic neighborhoods, especially in urban communities.[11] Studies show that in communities with a higher density of commercial tobacco retailers, life expectancy is shorter than in other communities.[12] Rural communities also suffer from health inequities.[13] In general, commercial tobacco use is more common in rural than urban communities and tobacco-related health harms are compounded by lower incomes, lower levels of education, and less access to health care.[14]

The following policy solutions could equitably address these issues:

Licensing: Requiring commercial tobacco retailers to be licensed can be an effective way for communities to regulate sales practices. For example, with the establishment of a tobacco retail licensing system, communities can limit the sale of flavored products and restrict the location, density, number, and type of tobacco retailers. This *Comprehensive Tobacco Retailer Licensing Model Ordinance* developed for New York communities provides examples of these types of provisions.

Capping the number of retailers: Communities can decrease the availability of commercial tobacco by limiting the total number of tobacco and vapor product retailers within a geographic area. There are several ways to do this, including setting a cap on the number of

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A Closer Look: Retailer Density Policy Provisions *(continued)*

existing retailers, limiting the number based on population density, or gradually decreasing the number based on the non-renewal of licenses (reduction through attrition).[15]

Restricting the location of retailers: Local governments can prohibit tobacco retailers from operating near certain locations through licensing and land-use regulations, such as zoning. Communities can prohibit tobacco and vapor product retailers from locating near areas frequented by youth, such as schools or parks, thereby reducing youth access and exposure to tobacco product advertisements.

Sample language could read: "No license will be granted to any person for a retail establishment location that is within [1,000] feet of a youth-oriented facility, as measured by the shortest line from the property line of the space to be occupied by the proposed licensee to the nearest property line of a youth-oriented facility."

A recent study evaluated the impact of New York City's policy of capping the number of tobacco retail licenses in neighborhoods (also known as "community districts"). After reviewing retail licensing data from 2010 to 2022, researchers found that the City's policy substantially reduced tobacco retailer density and appeared to close longstanding patterns of inequity in tobacco access. The study heralded New York City's approach as a rare example of a way communities across the U.S. can effectively address tobacco-related racial disparities.[16]

3. Policy Drafting and Scope

When a law or policy is drafted, the intention of the identified solution should be clearly stated. Policies are effective when they advance equity and do no further harm to marginalized communities. Words matter; consider how language used in commercial tobacco policies, particularly around penalties, can impact communities, and how eviction language in the enforcement of a smoke-free policy can contribute to housing insecurity, especially in multi-unit housing settings.

- This *Smoke- and Vape-free Multiunit Housing Ordinance for New York State* includes equitable considerations in this area.
- This recent resource, *Smoke-free Multiunit Housing in New York State*, provides examples of equitable enforcement strategies.

- These webinars provide information on ways to integrate equity in smoke-free housing policies:
    - Smoke-free Multi-Unit Housing in New York: Lessons from California
    - Equity in Smoke-Free Housing: How a Social Justice Approach Shaped a Model Smoke Free Housing Ordinance
    - Exploring Key Elements of an Equity-Focused Smoke-free Multiunit Housing Model Ordinance

A Closer Look: Words Matter

Policy language should be clear, easy-to-understand, and culturally respectful. For example, the use of seemingly benign phrases such as "tobacco-free" or "tobacco is harmful" has the potential to diminish Indigenous communities who use tobacco traditionally for ceremony or prayer.[17] Adding the word "commercial" before tobacco-free, i.e., "commercial tobacco-free," distinguishes between the harmful product developed by the tobacco industry and the traditional tobacco used by many Indigenous people. For more information about traditional tobacco, visit the Keep It Sacred website.

4. Education and Advocacy

Public health professionals and community members have the power to educate and, depending on their role, influence decision-makers. It is important to draw on the expertise of those committed to equitable law and policy, including stakeholders and representatives from priority populations. Working with individuals from communities who will most benefit from prospective policies can help identify potential dealbreakers and how to resolve them. Rushed law and policy can lead to exemptions and penalties at the expense of priority populations and underserved communities. New York State's "It's Not Just" campaign is a good example of a media campaign that educates about menthol's disproportionate impact on communities targeted by the tobacco industry.

A Closer Look: Menthol

For a local community seeking to prohibit all flavored commercial tobacco products, a potential dealbreaker is how to address menthol-flavored products. Menthol products were

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A Closer Look: Menthol *(continued)*

left out of the 2009 Family Smoking Prevention and Tobacco Control Act, and the tobacco industry tries to replicate this exemption at the state and local level to continue profiting from the sale of these products. Since the 1950s, the tobacco industry has targeted Black Americans with menthol cigarette product advertising. As a result, almost 9 out of 10 African Americans who smoke use menthol cigarettes.[18] Menthol cigarette use is also higher among youth and the LGBTQIA+ community as a result of tobacco companies' targeted marketing and advertising.[19] When a policy is in this stage, it may be tempting to let it pass through to the governing body; however, this is the most important stage to remain steadfast and true to the main objective of passing the policy. In this instance, removing menthol from a flavor prohibition policy would not benefit the community equitably because those who are most harmed by menthol cigarettes would be left out.

For more information about regulating flavored commercial tobacco products, see *New York State and Flavored Tobacco Products*, which describes tobacco companies' efforts to evade policies that target flavored tobacco products and ways that local communities can enact evidence-based, equitable local laws, ordinances, and resolutions to protect their communities and promote public health.

5. Implementation and Education

Culturally and linguistically appropriate materials are important when educating a community about a new law or policy. Tailoring and delivering messages, advertisements, and signage to specific populations help reinforce community buy-in and understanding of a new social norm. Community champions and youth leaders, such as members of New York State's Reality Check youth action group, can educate about new commercial tobacco measures and share information in peer groups. During this stage, it is crucial to plan how to link community members to appropriate cessation services. Often local cities or municipalities have limited resources. For suggestions on how Juul settlement funds and other funds can be allocated strategically to address the youth vaping epidemic, read this Public Health Law Center blog post.

6. Enforcement and Evaluation

Enforcement strategies should reflect community values and not further oppression of structurally disenfranchised populations. Community partners from earlier development stages can help guide the development of enforcement strategies and the evaluation of a policy's

effectiveness. Equitable enforcement may vary, depending on the policy. For example, some enforcement measures may include:

- Graduated enforcement focused on providing education and resources rather than civil or criminal penalties.
- Alternatives to suspension for students who violate school tobacco policies. An example of possible policy language is available in *Student Commercial Tobacco Use in Schools: Alternative Measures*.

Conclusion

Law and policy have historically been used to perpetuate inequality, including health inequities. To counter this, health equity should be centered in the policy development process of commercial tobacco control measures. Addressing inequities at each stage of policy development will help prevent further harm to communities most impacted by commercial tobacco and close gaps in community health disparities.

Contact us for assistance! If you're working on New York State commercial tobacco control issues and need assistance, contact the Public Health Law Center at (651) 290-7506 or phlc.nys@mitchellhamline.edu.

This fact sheet was prepared by the Public Health Law Center, a nonprofit organization that provides information and legal technical assistance on issues related to public health, and was made possible through a contract with the New York State Department of Health. The Center does not provide legal representation or advice. The information in this document should not be considered legal advice.

Endnotes

1 The Public Health Law Center recognizes that traditional and commercial tobacco are different in the ways they are planted, grown, harvested, and used. Traditional tobacco is and has been used in sacred ways by Indigenous communities and tribes for centuries. Comparatively, commercial tobacco is manufactured with chemical additives for recreational use and profit, resulting in disease and death. For more information, visit http://www.keepitsacred.itcmi.org. When the word "tobacco" is used throughout this document, a commercial context is implied and intended.

2 U.S. Dep't Health & Hum. Servs., The Health Consequences of Smoking: 50 Years Of Progress, A Report of The Surgeon General (2014), https://www.ncbi.nlm.nih.gov/books/NBK179276/pdf/Bookshelf_NBK179276.pdf.

3 Paula Braveman, *What Are Health Disparities and Health Equity? We Need to Be Clear*, 129 Pub. Health Reps. 5, 6 (2014), https://journals.sagepub.com/doi/epdf/10.1177/00333549141291S203.

4 *See* CTRS. FOR DISEASE CONTROL AND PREVENTION, *What is Health Equity?*, https://www.cdc.gov/nchhstp/healthequity/index.html.

5 *See* CTRS. FOR DISEASE CONTROL AND PREVENTION, *Social Determinants of Health at CDC*, https://www.cdc.gov/about/sdoh/index.html.

6 *See, e.g.*, Alison B. Breland et al., *Centering Racial Justice for Black/African American and Indigenous American People in Commercial Tobacco Product Regulation*, 165 PREVENTIVE MED. 107117 (2022), https://www.sciencedirect.com/science/article/pii/S0091743522001669?via%3Dihub.

7 *See, e.g.*, Center for Health Care Strategies, *A Community-Centered Approach to Data Sharing and Policy Change: Lessons for Advancing Health Equity* (2022), https://www.chcs.org/resource/a-community-centered-approach-to-data-sharing-and-policy-change-lessons-for-advancing-health-equity; Tiffany Ford & Annilies Goger, *The Value of Qualitative Data for Advancing Equity in Policy, Brookings* (2021), https://www.brookings.edu/articles/value-of-qualitative-data-for-advancing-equity-in-policy.

8 Advancing Tobacco-Free Communities, *The Human Cost of Tobacco in New York State* (2024), https://tobaccofreenys.org/wp-content/uploads/2024/01/TOB-20199_Human-Cost-One-Pager_Digital.pdf.

9 N.Y. STATE DEP'T OF HEALTH, Prevalence of Menthol Cigarette Use Among Adults Smokers by Race/Ethnicity (2021), https://health.ny.gov/prevention/tobacco_control/reports/statshots/volume14/n1_menthol_cigarette_use.pdf.

10 *See* Cicatelli Ass. Inc., *Findings from Tobacco Retail Environment Observations in Buffalo, NY* (2024), https://caiglobal.org/projects/tobacco-free-coalition-of-erie-and-niagara-counties (e.g., districts where more than half of the population identify as White contain 12 percent of Buffalo's tobacco retailers, while districts where more than half of the population identify as Black contain 34 percent of tobacco retailers. This number increases from 34 percent to 44 percent of tobacco retailers when additional people of color are included).

11 Joseph G. L. Lee et al., *Inequalities in Tobacco Outlet Density by Race, Ethnicity and Socioeconomic Status*, 71 J. EPID. AND COMMUNITY HEALTH 487-92 (2017), https://pubmed.ncbi.nlm.nih.gov/28249990/#:~:text=In%20unadjusted%20models%2C%20tobacco%20outlet,the%20proportion%20of%20Hispanic%20residents.

12 Panagis Galiatsatos et al., *Neighbourhood Characteristics and Health Outcomes: Evaluating the Association Between Socioeconomic Status, Tobacco Store Density and Health Outcomes in Baltimore City*, 27 TOBACCO CONTROL e19-e24 (2018), https://pubmed.ncbi.nlm.nih.gov/29170167/#:~:text=Results%3A%20Compared%20with%20higher%2Dincome,P%3C0.001)%2C%20even%20when.

13 *See* Public Health Law Center, *Limiting Tobacco Sales in Rural New York Communities* (2023), https://www.publichealthlawcenter.org/sites/default/files/resources/Rural-Tobacco-Sales-NYS.pdf.

14 *Id.*

15 *Id.*

16 Daniel P. Giovenco et al., *Impact and Equity of New York City's Tobacco Retail Reduction Initiative*, 66 AM. J. PREVENTIVE MED. 235-42 (2024) https://www.sciencedirect.com/science/article/pii/S0749379723004063?ref=pdf_download&fr=RR-2&rr=855e935f583267db.

17 KEEP IT SACRED, NATIONAL NATIVE NETWORK, *Traditional Tobacco* https://keepitsacred.itcmi.org/tobacco-and-tradition/traditional-tobacco-use.

18 *See, e.g.*, Public Health Law Center, *Commercial Tobacco Control: Menthol and Other Flavored Products*, https://www.publichealthlawcenter.org/topics/commercial-tobacco-control/menthol-and-other-flavored-products#:~:text=Menthol%20and%20other%20flavors%20have,who%20smoke%20choose%20menthol%20cigarettes.

19 Amanda Fallin et al., *Menthol Cigarette Smoking Among Lesbian, Gay, Bisexual, and Transgender Adults*, 48 AM. J. PREVENTIVE MED. 93-7 (2015), https://pubmed.ncbi.nlm.nih.gov/25245795.