


Maximizing the Impact of Tobacco 21 Laws Across the United States

 See also Macinko et al., p. 669.

Tobacco 21, the prohibition of retailers from selling cigarettes, cigars, chewing tobacco, powdered tobacco, electronic cigarettes, and other tobacco products to customers younger than 21 years, has become an increasingly popular tobacco-control strategy.¹ As of early 2018, Tobacco 21 laws exist in almost 300 separate locations across 19 different states and cover more than 25% of the US population. In this issue of *AJPH*, Macinko et al. (p. 669) found that adolescent tobacco use declined slightly in New York City after the city raised the minimum legal sales age to 21 years. Although New York City already had relatively low rates of tobacco use for adolescents, rates continued to decline during the 18 months after implementation of the new law. Macinko et al. also found that across New York State and in four comparator cities in Florida, rates of adolescent tobacco use fell at a steeper rate than that seen in New York City. Put another way, those comparator locations tended to catch up to New York City in terms of adolescent tobacco use during the short study period.

Denormalization of tobacco use in society, higher taxes on tobacco products, smoke-free laws, local point-of-sale restrictions, tobacco-control campaigns, and tobacco-cessation programs with coverage for tobacco-dependence treatment medications all play a part in the continued downward trend of adolescent and adult tobacco use in the United States.²

MODELS AND REAL-WORLD TIMING

According to the National Academies of Science, Tobacco 21 laws can be a significant contributor to an effective tobacco-control landscape, with an estimated 25% reduction in tobacco use by those aged 15 to 17 years and a 12% reduction in population tobacco use over time.³

Although those estimates were determined by mathematical models, more recent data from Needham, Massachusetts demonstrated a 47% reduction in high school smoking five years after implementation of the Tobacco 21 law.⁴ From the mathematical models and from the real-world data, time remains the first necessary component for realizing the full benefits of Tobacco 21 laws. Social norms and culture change in high schools may take time because of the behavioral-modeling tendency of 9th and 10th graders to imitate what they see in their 11th and 12th grade schoolmates.

ADEQUATE ENFORCEMENT

Adequate enforcement is a critical component of Tobacco 21 laws.³ Unfortunately, in New York City, as Macinko et al. showed, adolescent purchasers reported no increase in ID checks after the Tobacco 21 law came into effect. Previous research

looking at enforcement of the minimum sales age of 18 years may be relevant for Tobacco 21.

Best practices for enforcement include having an articulated plan for enforcement, giving enforcement responsibility to a single agency, conducting ongoing compliance check inspections, allocating funding for enforcement inspections, prosecuting violators, setting high penalties for violations, and practicing effective merchant education.⁵ Success in Needham was achieved through a combination of these best practices for enforcement. Most notable among them was a compliance check inspection program with steep penalties and a six-month suspension of the tobacco license for a subsequent violation. The news of a license suspension in Needham spread immediately to all retailers in town, and subsequent infractions dropped to near zero. Because tobacco sales to those younger than 21 years comprise only about 2% of total retail tobacco sales, merchants will not want to risk losing all tobacco sales for a few illegal transactions.⁶ Enforcing Tobacco 21 should be easier than enforcing Tobacco 18 for a few key reasons. First, in New York and many other states, the orientation of the driver's license changes when the bearer turns 21, making an underage purchaser easier to identify. Second, compliance check

personnel who are aged 18 to 20 years are easier to recruit than those aged 17 years, who require parental consent. Third, when the minimum legal age of sale for tobacco and alcohol are the same, the commercial and societal norms of that single age become mutually reinforcing.

CAP AND WINNOW

However, New York City and other densely populated cities face the particular challenge of too many tobacco retailers within easy access of high school students. Finding a noncompliant retailer in the neighborhood is much easier when there are 10 retailers on the way home from school. The imperative of adequate enforcement increases as retail density increases because potential access to tobacco products is greater in these locations. The penalty in New York City for first-offense tobacco sales to those younger than 21 years is \$1000; it is \$2000 with potential revocation of tobacco license for a second offense occurring within three years.

It is unclear in how many neighborhoods and in what percentage of retail establishments those New York City fines have been levied. For multiple repeat offenses, the only acceptable remedy is revocation of the tobacco license. Supporting this hard-line approach is the fact that a single convenience store could supply an entire high school with tobacco by selling the product to those aged 18 and 19 years

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who then resell it in school. Tobacco-control programs should retire those revoked licenses so they cannot be resued. This strategy, known as “cap and winnow” could eventually lead to lower youth access for tobacco products even in high-density tobacco retail neighborhoods.

SEVEN RECOMMENDATIONS

On the basis of the study of Macinko et al. and the existing Tobacco 21 literature, I offer seven recommendations to help maximize Tobacco 21 as an effective tobacco-control strategy:

1. Increase random compliance check inspections by having those aged 18 to 20 years attempt to buy tobacco products multiple times per year at each location where tobacco is sold.
2. Use epidemiological mapping to track where illegal sales are occurring and where fines are being imposed to identify high-priority locations to crack down on youth access to tobacco, especially in areas where tobacco retail density is high.
3. Levy maximum penalties for each infraction to help deter illegal sales and to defray the cost of enforcement activities.
4. Publicize fines and license suspensions so that all tobacco retailers understand the severe consequences of noncompliance with Tobacco 21 laws.
5. Revoke and then retire the license to sell tobacco when multiple infractions occur within a defined period.
6. Pursue maximum criminal penalties for illicit tobacco suppliers and for selling illegal loose single tobacco products.
7. Continue studying Tobacco 21 laws in real-world settings to optimize effectiveness for different geographic and regulatory contexts.

ACROSS THE NATION

The Macinko et al. study has important implications for New York City’s tobacco-control efforts and for improving the effectiveness of the wave of Tobacco 21 legislation that is making its way through towns, cities, counties, and states across the nation. **AJPH**

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Local Health Departments’ Role in Nonprofit Hospitals’ Community Health Needs Assessment

 See also Carlton and Singh, p. 676.

Health care and public health industries have historically operated in siloes, with distinct and often contradictory approaches to health. Public health has traditionally focused on ensuring healthy outcomes and their equitable distribution in population subgroups through essential public health services consistent with public health agency mandates and community priorities.¹ By contrast, health care providers have arguably operated as part of an industrial medical complex focused primarily on treatment

and cure rather than prevention. Several recent developments have converged to encourage health care and public health to focus on population health, leading to cooperation between strange bedfellows toward this common goal.¹

HISTORICAL INTEGRATION

A growing consensus that business as usual is unacceptable has arisen in both the public

health and the health care sectors. Nonprofit hospitals are expected to provide community benefits to maintain their tax-exempt status. Certain provisions of the Patient Protection and Affordable Care Act require these hospitals to complete a community health needs assessment (CHNA) incorporating input from a broad

range of community stakeholders, including local health departments (LHDs).

Public health accreditation board accreditation standards require that LHDs complete a community health assessment in collaboration with community partners, for which the CHNA can be an important source of data. Public health accreditation board accreditation and other national initiatives, such as Public Health 3.0, are increasingly challenging public health agencies to be collaborative and accountable in their practice and services. These

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