

*Tobacco Control; Health Policy*

# Public and Policy Maker Support for Point-of-Sale Tobacco Policies in New York

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## Abstract

**Purpose.** To compare public and policy maker support for three point-of-sale tobacco policies.

**Design.** Two cross-sectional surveys—one of the public from the New York Adult Tobacco Survey and one of policy makers from the Local Opinion Leader Survey; both collected and analyzed in 2011.

**Setting.** Tobacco control programs focus on educating the public and policy makers about tobacco control policy solutions.

**Subjects.** Six hundred seventy-six county-level legislators in New York's 62 counties and New York City's five boroughs (response rate: 59%); 7439 New York residents aged 18 or older. Landline response rates: 20.2% to 22%. Cell phone response rates: 9.2% to 11.1%.

**Measures.** Gender, age, smoking status, presence of a child aged 18 years or younger in the household, county of residence, and policy maker and public support for three potential policy solutions to point-of-sale tobacco marketing.

**Analysis.** *t*-tests to compare the demographic makeup for the two samples. Adjusted Wald tests to test for differences in policy support between samples.

**Results.** The public was significantly more supportive of point-of-sale policy solutions than were policy makers: cap on retailers (48.0% vs. 19.2%, respectively); ban on sales at pharmacies (49.1% vs. 38.8%); and ban on retailers near schools (53.3% vs. 42.5%).

**Limitations:** cross-sectional data, sociodemographic differences, and variations in item wording.

**Conclusions.** Tobacco control programs need to include information about implementation, enforcement, and potential effects on multiple constituencies (including businesses) in their efforts to educate policy makers about point-of-sale policy solutions. (*Am J Health Promot* 0000; 00[0]:000–000.)

**Key Words:** Public Health, Tobacco Control, Tobacco Policy, Advocacy, Public Opinion, Prevention Research. Manuscript format: research; Research purpose: descriptive; Study design: nonexperimental; Outcome measure: cognitive; Setting: state; Health focus: smoking control; Strategy: policy; Target population age: adults; Target population circumstances: New York public and county-level leaders

## PURPOSE

Policy change is a key element of comprehensive tobacco control programs.<sup>1</sup> Since the late 1980s, states and communities have adopted policies that restrict minors' access to tobacco, increase taxes on tobacco, and ban smoking in indoor and outdoor public places. These policies have created a social and legal climate in which tobacco use has become less desirable and less acceptable, and tobacco products have become less accessible.<sup>2,3</sup> As a result of these policies, tobacco use prevalence rates and exposure to secondhand smoke have decreased markedly.<sup>4,5</sup>

Tobacco control policies have been adopted in response to public education campaigns that created public demand for them.<sup>6,7</sup> However, it is unclear what tobacco control program activities most effectively build public demand and subsequent policy maker support for policy changes.<sup>7,8</sup> Policy makers use public opinion polls to determine whether to support a policy,<sup>9</sup> and they report being greatly influenced by perceived constituent sentiment about tobacco control laws.<sup>10</sup> However, it is difficult to determine whether or how public opinion influences policy maker support for policy change without examining similarities and differences between support for policies among the public and policy makers.

Only two published papers have systematically and directly compared public and policy maker views on tobacco control policies.<sup>11,12</sup> In one study of Ontario, Canada, legislators and the Ontario public, researchers found similarities in perceptions and

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attitudes about tobacco control issues, but only one difference in terms of policy support: the public was more supportive of a policy that would ban retailers from selling tobacco if that retailer had been caught selling to minors.<sup>11</sup> A similar study in Kentucky found that the public was more likely than state legislators to support indoor smoking restrictions in workplaces and restaurants.<sup>12</sup> Although these studies offer important insights into the relationship between public and policy maker sentiment on tobacco control policy solutions, they suffer from limitations such as small response rates, different item wording, or different survey timing between groups, making the validity of the findings uncertain.<sup>11,12</sup> These studies also measure support for policy solutions that are now widely implemented across states, such as cigarette tax increases and clean indoor air laws. Less is known about how current tobacco control model policies are viewed by the public and policy makers.

With the highest cigarette excise tax in the nation and a comprehensive workplace smoking ban, the New York Tobacco Control Program (NY TCP) has implemented effective traditional tobacco control interventions.<sup>13</sup> NY TCP implements a community intervention that in part educates the community and policy makers on issues of tobacco marketing at the point of sale and possible policy solutions. The point-of-sale initiative leverages the Family Smoking Prevention and Tobacco Control Act, which was adopted after the publication of Institute of Medicine recommendations to decrease the impact of tobacco industry marketing on tobacco use,<sup>14</sup> and allows states and localities to regulate the time, place, and manner in which tobacco products can be sold. Because exposure to tobacco product marketing at the point of sale has been associated with increased youth initiation<sup>15–17</sup> of tobacco use and progression to regular tobacco use,<sup>18</sup> such policies are designed to reduce youth exposure to tobacco product marketing at the point of sale. This study compares public and policy maker support for three point-of-sale model policies.

## METHODS

### Design

Two cross-sectional data sources were used for this study: the New York Adult Tobacco Survey (NY ATS) and the Local Opinion Leader Survey (LOLS). Both surveys were reviewed and approved by Institutional Review Boards at RTI International and the New York State Department of Health.

### Sample

**New York Adult Tobacco Survey.** Data on public support for point-of-sale policies were from the NY ATS, a representative household survey of New York residents aged 18 or older. This survey uses a dual-frame sampling design because the prevalence of cell phone–only households has increased dramatically over time.<sup>19,20</sup> One adult is randomly selected in each household reached. The landline sample includes list-assisted random-digit-dial and directory-listed numbers that cover the entire state of New York. A key feature of the sample is an optimized design for oversampling geographic areas with above average rates of cigarette smoking.

The NY ATS is a computer-assisted telephone interview. In recent years, approximately 1000 NY ATS telephone interviews have been completed each quarter, or about 4000 interviews per year. Data in this analysis are from six waves collected from April 2010 through December 2011 ( $n = 7439$ ). Landline response rates varied by wave, with the lowest rate occurring in the fourth quarter of 2011 (20.2%) and the highest rate in the first quarter of 2011 (22%). Cell phone response rates ranged from 9.2% in the third quarter of 2011 to 11.1% in the third quarter of 2010. Although both the landline and cell phone response rates appear low, both are at the high end of reported response rates for landline and cell telephone surveys.<sup>21</sup>

**Local Opinion Leader Survey.** Data on local policy maker support for point-of-sale policies were from the LOLS, conducted for the New York State Department of Health by RTI International as part of the evaluation of NY TCP. New York municipalities are defined as counties, cities, towns, and

villages. The clustering of cities and towns within counties, in addition to the occasional clustering of villages within towns, would have required a complex sampling plan and a much larger sample size than was feasible. As a result, the authors restricted participants to county-level leaders and made the assumption that county-level opinion leaders could represent leaders of the municipalities within their counties.

The sampling frame consisted of the universe of county-level legislative officials, including executives and council persons, in New York's 62 counties plus all members of the New York City Council. The highest ranking Board of Health staff person in each county plus the New York City Commissioner of Public Health and Mental Hygiene were also included because boards of health have authority to pass relevant policies. The authors identified participants using the 2010 County Directory published annually by the New York State Association of Counties ([www.nysac.org](http://www.nysac.org)). If more complete contact information was needed, analysts reviewed county Web pages and, in some cases, called the county clerk's office. Through this process, 1148 local leaders were identified.

Interviews were conducted between February 2011 and September 2011. One week before the phone interviews, participants received lead letters describing the purpose of the study. All interviews were conducted via telephone and lasted an average of 10 to 12 minutes. Participants who completed the interview selected a local charity to which the authors made a \$25 donation as an incentive. Each participant could also select whether the donation was made in the participant's name or anonymously. A total of 676 policy makers completed the LOLS, for a response rate of 59%.

### Measures

Measures from the NY ATS and LOLS relevant to this analysis included gender, age, smoking status, presence of a child aged 18 years or younger in the household, and county of residence. Smoking status was defined by responses to three questions: participants were asked whether they had ever smoked a cigarette, whether they

**Table 1**  
**NY ATS and LOLS: Question Items and Responses Compared\***

NY ATS	LOLS	Response Comparison
What is your opinion about a policy that would limit the number of stores that could sell tobacco in your community?	What is your opinion about a policy that would put a cap (or a maximum) on the number of retailers who could sell tobacco products in a community?	Strongly in favor, somewhat in favor, neither in favor nor against, somewhat against, strongly against, don't know
What is your opinion about a policy that would ban the sale of tobacco products in stores that are located near schools?	What is your opinion about a policy that would prohibit the sale of tobacco products in stores near schools?	Strongly in favor, somewhat in favor, neither in favor nor against, somewhat against, strongly against, don't know
What is your opinion about a policy that would ban the sale of all tobacco products in pharmacies?	What is your opinion about a policy that would prohibit the sale of tobacco products in pharmacies?	Strongly in favor, somewhat in favor, neither in favor nor against, somewhat against, strongly against, don't know

\* NY ATS indicates New York Adult Tobacco Survey; LOLS, Local Opinion Leader Survey.

had smoked at least 100 cigarettes, and whether they currently smoked cigarettes. Never smokers were defined as those who indicated they had never smoked even a puff and/or had not smoked at least 100 cigarettes in their lifetime. Former smokers were defined as those who indicated they had smoked at least one puff, at least 100 cigarettes in their entire life, but who did not currently smoke. Current smokers were defined as those who had smoked at least one puff, at least 100 cigarettes in their entire life, and currently smoked either every day or some days.

Participants in both surveys were asked to rate their support for three potential policy solutions relevant to the point-of-sale initiative—(1) capping the number of tobacco retailers in a community, (2) prohibiting the sale of tobacco products in pharmacies, and (3) prohibiting the sale of tobacco products near schools. Ratings were measured on a scale from 1 (*strongly against*) to 5 (*strongly in favor*). Item wording and response options varied slightly between surveys. See Table 1 for a comparison of wording for the relevant items. Respondents who indicated being either “strongly in favor” or “somewhat in favor” of a policy were considered to support that policy. Respondents to the LOLS who indicated they were strongly or somewhat against a policy were asked to describe why they did not support that policy. These qualitative data were analyzed and used to help interpret differences

in support between the LOLS and the NY ATS.

#### Analysis

During a significant portion of the data collection period, New York City council members were engaged in challenging city budget negotiations. As a result, the response rate for policy makers in New York City was lower than in the rest of the state. To better account for this, data from the LOLS were weighted. Weights were created based on the census of all county-level officials in New York at the time of the survey. Each observation was weighted based on county and position. NY ATS data were also weighted to adjust for demographics based on 2010 census data. All data were analyzed using Stata v12.<sup>22</sup>

The authors used *t*-tests to compare the gender, age, and smoking status of NY ATS and LOLS participants; *t*-tests were also used to compare the geographic region that participants lived in or represented, and whether a child younger than age 18 lived in the participant’s home.

Average support for each tobacco control policy was calculated among the New York State adult population and New York local leaders. Analyses also tested for differences between policy support by population (adult population versus local opinion leaders) with adjusted Wald tests, which account for the complex survey designs of the NY ATS and LOLS. Logistic regression analyses were also conducted to determine whether differences

between public and policy maker support for the point-of-sale policies could be attributed to sociodemographic differences.

#### RESULTS

Table 2 summarizes the demographic characteristics of both samples. The New York public and policy maker samples differed in regard to gender, age, smoking status, region, and parental status ( $p < .00$ ). The sample of New York adults was split almost evenly by gender, covered a broad age range, and had a much higher smoking rate than local policy makers. Smoking prevalence among this sample (16.3%) is comparable to the 2010 national rate (19.3%),<sup>23</sup> but higher than other state estimates.<sup>24</sup> New York policy makers were predominantly male, aged 50 or older, nonsmokers without a child at home. Local policy makers were much more likely to come from the capital and central regions, with the New York City region underrepresented in the LOLS sample.

The Figure shows the proportion of New York adults and local policy makers who were somewhat or strongly in favor of the three point-of-sale policies. More New York adults than local policy makers supported the point-of-sale tobacco control policies. Specifically, more New York adults than local policy makers supported policies that would cap the number of tobacco retailers in a community (48.0% vs. 19.2%), prohibit the sale of tobacco

**Table 2**  
**Sociodemographic and Smoking Characteristics of NY ATS (n = 7439) and LOLS (n = 676) Samples\***

Characteristic	NY ATS % (95% CI)	Policy Makers % (95% CI)	Adjusted Wald Test p Value
Gender			
Female	47.8 (45.8 to 49.8)	25.7 (22.1 to 29.3)	0.000
Age, y			
25 or under	15.4 (13.8 to 17.0)	0.3 (-0.1 to 0.7)	0.000
26 to 35	15.8 (14.0 to 17.7)	2.9 (1.6 to 4.2)	0.000
36 to 49	25.8 (24.2 to 27.5)	14.7 (11.9 to 17.6)	0.000
50 to 65	27.3 (25.7 to 28.9)	54.9 (50.9 to 58.9)	0.000
65 or older	15.6 (14.4 to 16.7)	27.1 (23.7 to 30.6)	0.000
Smoking status			
Current smoker	16.3 (15.0 to 17.7)	3.8 (2.3 to 5.2)	0.000
Former smoker	24.9 (23.4 to 26.5)	39.8 (35.8 to 43.8)	0.000
Never smoker	58.7 (56.9 to 60.6)	56.4 (52.3 to 60.4)	0.301
Region			
MARO	69.3 (67.8 to 70.9)	17.6 (14.3 to 20.8)	0.000
Central	8.8 (8.0 to 9.6)	24.5 (21.2 to 27.7)	0.000
Western	14.2 (13.1 to 15.3)	28.3 (24.8 to 31.9)	0.000
Capital	7.7 (6.9 to 8.4)	29.6 (25.9 to 33.4)	0.000
Parental status			
Child under 18	39.7 (37.7 to 41.6)	22.3 (18.9 to 25.8)	0.000

\* Reported are weighted means of county means for NY ATS and unweighted means of county means for local leaders, except for the region variables, which are the direct unweighted means of both samples. NY ATS indicates New York Adult Tobacco Survey; LOLS, Local Opinion Leader Survey; CI, confidence interval; and MARO, Metropolitan Area Regional Office (New York City and surrounding counties).

products in pharmacies (49.1% vs. 38.8%), and prohibit the sale of tobacco products in stores near schools (53.3% vs. 42.5%) ( $p = .000$ ). Analyses accounting for the sociodemographic and smoking status differences between the two populations did not change these findings.

## DISCUSSION

This study found that more New York adults than local policy makers supported three of NY TCP's proposed point-of-sale policy solutions.

These findings provide a baseline against which to measure future changes in support for these policies and to examine whether public opinion precedes local leader opinion. They also suggest that local policy makers have a different perspective and set of criteria when considering policies for their communities. Unlike the general public, they must consider whether a proposed policy would negatively affect any of their constituencies. The three point-of-sale policies

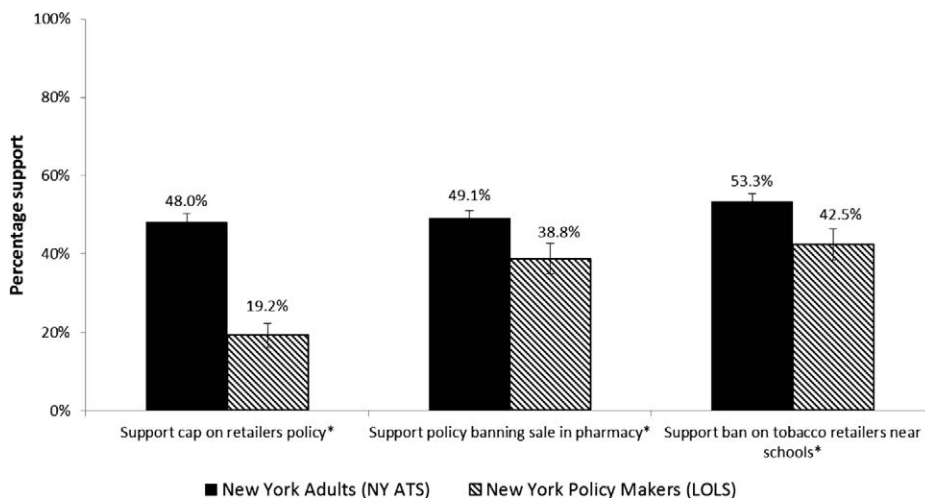
were less preferred by local policy makers and all have the potential to negatively affect individual businesses. A ban on tobacco sales in pharmacies could negatively affect the income of a community's local pharmacies. Cigarettes and other tobacco products account for more than one-third of in-store sales in convenience stores,<sup>25</sup> and a policy that threatens their ability to sell tobacco products also threatens the viability of their business. Even if such a policy included a grandfather clause to exempt current businesses from a proposed restriction, any future restrictions applied to that business based on location is a threat to the value of that business should the owner decide to sell it.

Local policy makers may also see challenges to implementing and enforcing policies that the general public may not. When asked why they would not support a policy, policy makers thought it would be difficult to fairly implement a retailer cap or ban on tobacco sales near schools. They also expressed concerns about perceived favoritism and the potential for cor-

ruption, as some retailers would eventually be excluded from selling tobacco.

This study is the first in almost a decade to compare public and policy maker support for tobacco control policies. Although the specific policies examined in past studies differed from those in this study, there is a unifying theme for all of these findings: unlike the general public, legislators have a unique perspective that requires them to weigh the needs of multiple constituencies as they prioritize the policies they will support and promote. These constituencies may have competing priorities. Hahn and Rayens<sup>12</sup> concluded that the public was "ahead" of legislators on tobacco control policy issues, but an alternative explanation is that Kentucky legislators were concerned that smoke-free restaurant and bar legislation would have negative economic effects on their business constituents, a counterargument frequently raised by the tobacco industry.<sup>26</sup> Although tobacco control programs can cite a strong body of evidence to allay these economic

**Figure**  
**Percentage Support for POS Policies Among New York Adults and Local Policy Makers, NY ATS (n = 7439) and LOLS (n = 676)**



“Support” was operationalized as respondent indicating he or she was “strongly in favor” or “somewhat in favor” of the policy. POS indicates point-of-sale; NY ATS, New York Adult Tobacco Survey; and LOLS, Local Opinion Leader Survey.

\* Statistically significant difference between New York adults and New York policy makers ( $p = 0.000$ ).

counterarguments,<sup>27,28</sup> the first of these studies was only published in 1994.<sup>29</sup> Until recently, tobacco control advocates did not have this evidence available and were unable to present strong arguments to prevent legislators from prioritizing business economic concerns at the expense of the public’s health. Likewise, although Canadian legislators and the public held similar attitudes about the public health impact of tobacco use, legislators were significantly less likely to support a policy that had the potential to threaten the income of retailers.<sup>11</sup> These interpretations are consistent not only with our findings but with recent assessments of resistance to smoke-free policies in Nevada, where legislators raised concerns about economic impacts to small gaming businesses.<sup>30</sup> In total, our data and these studies suggest that the evidence needed to educate the public may be different from the evidence needed to educate policy makers effectively. Tobacco control programs not only need to be aware of potential counterarguments and competing constituencies, they

also need to consider differences in how the public and policy makers weigh the information about a policy and to whom they may be accountable.

The main limitation of this study is the cross-sectional nature of our data. The authors will be able to address this limitation in the future because the NY ATS is administered quarterly, and the LOLS will be readministered in 2013. Analyzing the next wave of data from this initiative will allow us to assess change over time and better examine the temporal relationships between public and policy maker support for tobacco control policies.

Another limitation may that the two samples differed by sociodemographic factors and smoking status. For example, there were significantly fewer smokers in the local leader sample than in the New York adult sample, and some studies have found that smokers are less likely to support tobacco control policies than nonsmokers.<sup>12</sup> However, we conducted logistic regression analyses accounting for these factors and the differences in support for policy remained. As a result, we

## SO WHAT? Implications for Health Promotion Practitioners and Researchers

### What is already known on this topic?

Little is known about the level of support for the next generation of policy initiatives in tobacco control, such as restrictions on advertising and displays at the point of sale. The Family Smoking Prevention and Tobacco Control Act (FSPTCA) of 2009 presents an opportunity for states and localities to change the regulatory landscape of tobacco marketing.

### What does this article add?

As communities across the country leverage the FSPTCA, New York’s experience in strengthening traditional tobacco control measures and educating the public and local leaders on newer policies to decrease the impact of tobacco industry marketing can be informative. We compared public and policy maker opinion about tobacco control policies among New York residents and county level leaders. This was the first study in over a decade to do such an analysis. Our results and our interpretation of the few articles on the subject suggest that local policy makers see challenges to implementing and enforcing policies that the general public may not, suggesting that the evidence needed to educate policy makers may be different from that needed to educate the public. Finally, this study gives us a baseline to measure support for tobacco control policy among the public and policy makers alike over time, as we plan to repeat the surveys that gave us these data in 2013.

### What are the implications for health promotion practice or research?

Our findings suggest that the public and policy makers bring different perspectives to assessing the potential value of a policy in their communities. The traditional focus on monitoring public support for tobacco control policies may not identify the policies that local leaders are more likely to support, even if public opinion is used to bolster the argument in support of a policy. Rather, the perspective of local policy makers needs to be considered as tobacco control programs continue to make progress toward the traditional and more aggressive policies recommended by the Institute of Medicine and made possible by the Family Smoking Prevention and Tobacco Control Act.

concluded that the different characteristics of the two populations did not account for the findings.

The low response rate for the NY ATS may also be considered a limitation. However, these rates are consistent with other random-digit-dialed telephone surveys using both landlines and mobile phones.<sup>21</sup> Research examining how low response rates affect data quality have consistently concluded that current low response rates are not a serious threat to the quality of the survey estimates.<sup>31</sup> Although the low response rate needs to be acknowledged as a limitation, it is unlikely to have had a significant negative impact on the quality of the NY ATS data.

Finally, the wording of the NY ATS question on retailer limits differed from a similar item in the LOLS. The question was framed in a more personal way for the public (“What is your opinion about a policy that would limit the number of stores that could sell tobacco in your community?”) whereas policy makers are not asked about “limiting” the number of stores, but rather whether they would “put a cap or a maximum” on the number of stores in “a” community, as opposed to responding specifically about their own community. However, short answer responses collected in the LOLS suggest that the lower support shown by local policy makers over the public for this policy reflects a true difference in support and a concern about the business impact, implementation, and enforcement of point-of-sale policies. The question has been worded both ways in the 2012 NY ATS so that the effect of wording on question responses can be assessed.

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