**Policy Statement**

**CLHO Committee:** Health Promotion & Prevention

**Policy Statement:** The Oregon Coalition of Local Health Officials advocates for an effective statewide tobacco retail licensing[[1]](#footnote-1) law that requires retailers to purchase a license in order to sell any tobacco products,[[2]](#footnote-2) including inhalant delivery systems[[3]](#footnote-3).

**Policy Positions:** CLHO supports a strong tobacco retailers licensing law has at a minimum:

1) A requirement that all tobacco retailers obtain a license and renew it annually;

2) An annual licensing fee high enough to fund sufficient enforcement;

3) Meaningful penalties for violators through fines and penalties, including the suspension and revocation of the license;

4) A provision stating that any violation of existing local, state, or federal tobacco laws constitutes a violation of the local law.[[4]](#endnote-1)

5.) Allows (but does not mandate) if the city, county jurisdictional meets the requiremetns above, the jurisdiction could keep the local license. If not thent the stateiwide would go into effect.

In addition, there should be no preemption that restricts local governments from enacting stronger, tailored tobacco point-of-sale policies.

**Public Health Issues that Policy Statement is Addressing:**

* Tobacco use
* Youth initiation of tobacco products, including inhalant delivery systems
* Illegal tobacco product sales to minors

**Justification (data supporting the need to work on this issue):**

Tobacco use is the number one preventable cause of death and disease in Oregon. Annually, tobacco use leads to nearly 8,000 deaths and costs the state $2.5 billion in medical expenses and lost productivity.[[5]](#endnote-2) Approximately 17% of Oregon adults smoke cigarettes; however2smoking rates are higher among African Americans (33%) and American Indians and Alaska Natives (35%) than among whites (21%).2 More than one in three Oregonians who make less than $15,000 per year smoke (39%), compared to one in 10 who make more than $50,000 per year (9%).2 And Oregonians with less than a high school education are nearly four times more likely to smoke, compared to those with a college degree (33% vs. 7%).2

Most addiction to tobacco starts in adolescence; nine out of 10 adults who smoke report initiating before turning 18.[[6]](#endnote-3) Studies show that the younger someone is when they start smoking, the harder it is to quit.[[7]](#endnote-4),[[8]](#endnote-5)

Between 1996 and 2015, smoking among 11th-graders declined by 72% and among 8th-graders by more than 86%. However, the use of other tobacco products (e.g. e-cigarettes) is increasing even while cigarette use by Oregon’s youth is declining. In Oregon, e-cigarette use among 11th-graders increased three-fold from 2013 to 2015 from 5% to 17%. E-cigarettes and other inhalant delivery systems have few restrictions on marketing, flavors and price. The rise in the use of other tobacco products, such as little cigars and hookah, is also a public health concern.2

The tobacco industry spends over $9 billion on advertising and promoting its products each year in the US. In 2015, the industry spent almost $110 million on marketing in Oregon.2,[[9]](#endnote-6) The tobacco industry has redirected more than 90 percent of its resources into the retail environment, typically at the point of sale, since the 1998 Master Settlement Agreement restricted more traditional venues for advertising, such as billboards, TV, radio, and print media.[[10]](#endnote-7) Point of sale refers to any location where tobacco products are purchased, displayed, or advertised, and includes areas inside and outside the retail outlet.

This shift in tobacco industry focus into the retail environment is a public health concern. Youth still have access to the retail environment and are therefore still exposed to tobacco marketing. Evidence shows that the more advertising youth see, the more likely they are to use tobacco.[[11]](#endnote-8) In the retail setting, youth are exposed to advertising, price promotions and discounts, kid-friendly packaging, and flavored tobacco products that increase the appeal of tobacco.[[12]](#endnote-9) Flavored tobacco products in the retail environment are a major concern as they are more popular among youth and young adults compared to older adults, with flavor appearing to be a key component for youth to start using tobacco.[[13]](#endnote-10)

Oregon is one of nine states in the US that does not require retailers to obtain a license to sell tobacco products.[[14]](#endnote-11) Therefore, in Oregon there is no uniform way of knowing who is selling tobacco, what businesses sell tobacco products, or how tobacco is sold. This has resulted in inconsistent compliance with local, state, and federal tobacco-related laws, such as the minimum tobacco sales age. A lack of a complete list of tobacco retailers also poses a challenge to enforcement.[[15]](#endnote-12)

Ensuring tobacco retailers are in compliance with laws that prohibit the sale of tobacco products to underage persons through tobacco retail inspections is crucial to tobacco retail environment policy. However, among known tobacco retailers, statewide Enforcement Inspections in 2017 found that 15% of retailers sold to minors.[[16]](#endnote-13)

Reducing access to tobacco products and limiting tobacco industry presence in the retail environment is a core tobacco control strategy. A comprehensive tobacco retailer licensing law is one of the most effective ways to implement this strategy. Requiring retailers to obtain a license before selling tobacco products would help identify all businesses selling tobacco products in Oregon and provide an effective monitoring and enforcement mechanism to ensure that retailers comply with minimum tobacco sales age laws and other applicable laws.[[17]](#endnote-14) According to the 2017 Oregon Health Authority online panel survey, almost 75% of adults support requiring retailers to have a license to sell tobacco products.[[18]](#endnote-15)

A tobacco licensing law can also be a highly effective vehicle for jurisdictions interested in reducing or restricting the number, location, density, and types of tobacco retail outlets; limiting point-of-sale advertising and product placement; and requiring retailers to comply with other tobacco control measures such as prohibiting flavored tobacco products.[[19]](#endnote-16)

The Center for Tobacco Policy & Organizing classifies a tobacco retailers licensing law as strong if the law has at a minimum: 1) A requirement that all tobacco retailers obtain a license and renew it annually; 2) An annual licensing fee high enough to fund sufficient enforcement; 3) Meaningful penalties for violators through fines and penalties, including the suspension and revocation of the license; and 4) A provision stating that any violation of existing local, state, or federal tobacco laws constitutes a violation of the local law.[[20]](#endnote-17)

In addition, there should be no preemption that restricts local governments from enacting stronger, tailored tobacco point-of-sale policies. One-size-fits all policies can constrain local communities from innovating and passing stronger, more comprehensive ordinances regulating the sale of tobacco products in the retail environment.

Historically, the tobacco industry supports preemptive state laws as a way to reverse existing local tobacco control ordinances and prevent future local ordinances. The tobacco industry's leading legislative strategy against local tobacco control laws has been preemptive state laws.[[21]](#endnote-18) Keeping preemption out of a state tobacco retail license law allows local public health to be responsive to its community, allowing for the strongest point-of-sale policies possible.

**Role of Local Public Health (promising practice/evidenced-based work):**

Local public health departments are charged with protecting the health of Oregonians. Tobacco retail licensing is a proven strategy for reducing illegal sales to minors.[[22]](#endnote-19)

A statewide tobacco retail licensing law without preemption is an opportunity to create a clear framework that allows local communities to build on existing protections. The strongest, most innovative policies to reduce tobacco use historically emerge at the local level before ultimately being adopted at the state or federal level.[[23]](#endnote-20) Increasingly, tobacco retail licensing is being used to promote other innovative policy solutions, including controlling the location and density of tobacco retailers and imposing additional restrictions on the sale and promotion of tobacco products. This includes requiring that tobacco products are sold without flavors or sampling, prohibiting the sale of single cigars, banning the redemption of coupons and multi-pack offers, and restricting the proximity of tobacco retailing near schools.[[24]](#endnote-21)

States and cities that have adopted comprehensive retail restrictions through tobacco licensure have some of the lowest tobacco use rates in the country. For example, New York City has implemented several retail laws such as prohibiting the sale of flavored tobacco products and prohibiting coupon redemption, and has some of the lowest adult smoking rates in the country, at 13.1% in 2017.[[25]](#endnote-22) A parallel approach in Oregon would help local governments to build upon the state’s retail license framework and create responsive regulations that lead to statewide reductions in youth and adult tobacco use.

**Connection to Modernization Manual Foundaional Programs/Capabilities:**

Foundational Programs:

Health Promotion & Prevention

Foundational Capabilities:

Policy & Planning

Health Equity

1. An effective retail licensing system includes:

   1. A requirement that all tobacco retailers obtain a license and renew it annually;
   2. An annual licensing fee high enough to fund sufficient enforcement, surveillance and other tobacco retail program costs;
   3. Meaningful penalties for violators through fines and penalties, including the suspension and revocation of the license;
   4. A provision stating that any violation of existing local, state, or federal tobacco laws constitutes a violation of the local law; and

   No preemption that restricts local governments from enacting stronger, tailored point of sale polices. [↑](#footnote-ref-1)
2. Per ORS 431A.175,

   “Tobacco products” means:

         (A) Bidis, cigars, cheroots, stogies, periques, granulated, plug cut, crimp cut, ready rubbed and other smoking tobacco, snuff, snuff flour, cavendish, plug and twist tobacco, fine-cut and other chewing tobaccos, shorts, refuse scraps, clippings, cuttings and sweepings of tobacco and other forms of tobacco, prepared in a manner that makes the tobacco suitable for chewing or smoking in a pipe or otherwise, or for both chewing and smoking;

         (B) Cigarettes as defined in ORS 323.010 (1); or

         (C) A device that:

         (i) Can be used to deliver tobacco products to a person using the device; and

         (ii) Has not been approved by the United States Food and Drug Administration for sale as a tobacco cessation product or for any other therapeutic purpose, if the product is marketed and sold solely for the approved purpose. [↑](#footnote-ref-2)
3. “Inhalant delivery system” means:

         (A) A device that can be used to deliver nicotine or cannabinoids in the form of a vapor or aerosol to a person inhaling from the device; or

         (B) A component of a device described in this subparagraph or a substance in any form sold for the purpose of being vaporized or aerosolized by a device described in this subparagraph, whether the component or substance is sold separately or is not sold separately.

   “Inhalant delivery system” does not include:

         (A) Any product that has been approved by the United States Food and Drug Administration for sale as a tobacco cessation product or for any other therapeutic purpose, if the product is marketed and sold solely for the approved purpose; and

         (B) Tobacco products. [↑](#footnote-ref-3)
4. The Center for Tobacco Policy & Organizing, American Lung Association, Matrix of Strong Local Tobacco Retailer Licensing Ordinances (2009). [↑](#endnote-ref-1)
5. Oregon Health Authority Public Health Division, Health Promotion and Chronic Disease Prevention Section. 2018. Oregon tobacco facts. Available at https://public.health.oregon.gov/PreventionWellness/TobaccoPrevention/Pages/pubs.aspx. [↑](#endnote-ref-2)
6. U.S. Department of Health and Human Services. Preventing tobacco use among youth and young adults: A report of the Surgeon General, U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2012. [↑](#endnote-ref-3)
7. See also, Health and Human Services (HHS). Preventing tobacco use among youth and young adults: A report of the surgeon general, 2012. Available at http://www.surgeongeneral.gov/library/reports/preventing-youth-tobacco-use/full-report.pdf. See also, Hegmann KT, et al. The effect of age at smoking initiation on lung cancer risk. Epidemiology 4(5):444-48, September 1993; Lando HA, et al. Age of initiation, smoking patterns, and risk in a population of working adults. Preventive Medicine 29(6 Pt 1):590–98, December 1999. [↑](#endnote-ref-4)
8. U.S. Department of Health and Human Services, Preventing tobacco use among young people: A report of the surgeon general, 1994. [↑](#endnote-ref-5)
9. Campaign for Tobacco-Free Kids. 2015 March 30. FTC Reports Tobacco Marketing Increased to $9.6 Billion in 2012 – Efforts to Fight Tobacco Use Must Also Intensity. Available at http://www.tobaccofreekids.org/press\_releases/post/2015\_03\_30\_ftc. [↑](#endnote-ref-6)
10. Wakefield M, et al. Tobacco Industry Marketing at Point of Purchase After the 1998 MSA Billboard Advertising Ban. Am J Public Health 2002;92(6):937-40. [↑](#endnote-ref-7)
11. U.S. Department of Health & Human Services. Prevention Tobacco Use Among Youth and Young Adults: A Report of the Surgeon General, 2012. Available at: http://www.cdc.gov/tobacco/data\_statistics/sgr/2012/index.htm. [↑](#endnote-ref-8)
12. U.S. Department of Health and Human Services. E-Cigarette Use Among Youth and Young Adults. A Report of the Surgeon General. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2016. [↑](#endnote-ref-9)
13. Myers ML. New study finds over 40 percent of youth smokers use flavored little cigars or cigarettes, shows need for FDA to regulate all tobacco products. Campaign for Tobacco-Free Kids. Oct. 22, 2013 [↑](#endnote-ref-10)
14. State Tobacco Activities Tracking and Evaluation (STATE) System. Available at <https://www.cdc.gov/statesystem/index.html>. June 13, 2018. (North Carolina, South Dakota and Wyoming were included as having tobacco retail licensure after review of state websites.) [↑](#endnote-ref-11)
15. Oregon Annual SYNAR Report. 42 U.S.C. 300x-26. OMB No. 0930-0222. (FFY 2016) [↑](#endnote-ref-12)
16. Oregon Tobacco Retail Enforcement Inspection, 2016-2017, unpublished data. [↑](#endnote-ref-13)
17. McLaughlin, I. Tobacco Control Legal Consortium, License to Kill?: Tobacco Retailer Licensing as an Effective Enforcement Tool (2010). [↑](#endnote-ref-14)
18. Online Panel Survey, 2017, Health Promotion and Chronic Disease Prevention section, Oregon Health Authority, Unpublished data [↑](#endnote-ref-15)
19. Center for Public Health Systems Science. Point-of-Sale Strategies: A Tobacco Control Guide. St. Louis: Center for Public Health Systems Science, George Warren Brown School of Social Work at Washington University in St. Louis and the Tobacco Control Legal Consortium; 2014. [↑](#endnote-ref-16)
20. The Center for Tobacco Policy & Organizing, American Lung Association, Matrix of Strong Local Tobacco Retailer Licensing Ordinances (2009). [↑](#endnote-ref-17)
21. National Association of County & City Health Officials. Statement of Policy. Local Tobacco and Vaping Control Regulations. (Updated Nov. 2016). [↑](#endnote-ref-18)
22. The Center for Tobacco Policy and Organizing, The American Lung Association. Tobacco Retailer Licensing is Effective. August 2012 [↑](#endnote-ref-19)
23. Tobacco Control Legal Consortium. Fact Sheet. Why Preemption is Bad for Tobacco Control. (Updated Oct. 2014). Available at http://www.publichealthlawcenter.org/sites/default/files/resources/tclc-fs-why-preemption-bad-tobacco-control-2014.pdf [↑](#endnote-ref-20)
24. McLaughlin, I. Tobacco Control Legal Consortium, License to Kill?: Tobacco Retailer Licensing as an Effective Enforcement Tool (2010). [↑](#endnote-ref-21)
25. City of New York – Preliminary Mayor’s Management Report, 2018. Available at http://www1.nyc.gov/assets/operations/downloads/pdf/pmmr2018/2018\_pmmr.pdf [↑](#endnote-ref-22)