Lerner Center FOR PUBLIC HEALTH PROMOTION
Maxwell | Syracuse University

ISSUE BRIEF #48
March 23, 2021

Battling the Public Health Harms of Tobacco Takes Time, Persistence, and Political Will: Reflecting on the New York State Clean Indoor Air Act of 2003

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This month marks the 18th anniversary of the enactment of the New York State Clean Indoor Air Act[1] (CAA03), one of the state's earliest legislative responses to the negative health impacts of second-hand smoke. This law, which restricts indoor smoking in restaurants, taverns, and workplaces, took more than three legislative sessions and five years to enact.

The history of this policy demonstrates significant roles of official and unofficial actors in the nuts, bolts, and machinery of an iconic public health policy. CAA03, other state-level tobacco control legislation and laws that regulate sales and marketing or impose excise taxes on tobacco products, and the U.S. Surgeon General's 1964 public health warning about the harms of tobacco,[2] are credited with curtailing cardiovascular disease, various cancers, cerebrovascular accident (CVA, or stroke), diabetes, and chronic obstructive pulmonary disease (COPD), including emphysema and chronic bronchitis.[3,4]

Despite state efforts like CAA03, smoking remains the top preventable cause of disease and premature death in the U.S. Almost sixty years after the 1964 Surgeon General's report, it is time for a more serious nationally organized policy response to tobacco and its harms.

KEY TAKEAWAYS

- The U.S. Surgeon General's 1964 Advisory Committee on Smoking and Health Report, warning about the dangerous health effects of tobacco, was a watershed moment in public health history.
- Significant health policy takes time, political will, and multiple players. New York State's Clean Indoor Air Act of 2003 (CAA03) involved the NYS Department of Health, committed and bipartisan state lawmakers, and health professional organizations such as NYSPHA.
- CAA03 set the stage for a steady stream of state smoking legislation over two decades, which are collectively recognized for significant population health benefits.
- Almost sixty years after the 1964 Surgeon General's report, the U.S. needs a nationally organized policy response to address the prevalent but preventable health consequences of tobacco.

The U.S. Falls Short on National Tobacco Policy

In the early 2000s, countries around the globe began adopting national bans that restricted indoor smoking to protect the rights and health of non-smokers and minors. By 2009, all European Union (EU) countries had national tobacco regulations centered on public smoking bans and protections from second-hand smoke.[5,6] Health improvements attributed to smoking laws in the EU include a reduction in acute myocardial infarction (AMI, or heart attack) and improved lung and respiratory health.[6] In 2004, a study reported that New York State experienced a 12% drop in AMI mortality in the year

immediately following the enactment of CAA03.[7]

In contrast, the U.S. remains the world's only high-income country without a national policy designed to unequivocally protect the health of smokers and non-smokers from the harms of tobacco. While U.S. states have developed public health responses to tobacco use, starting with California in 1995, followed by New York eight years later,[8,9] there has been virtually no federally organized response beyond eliminating smoking in federal buildings and on domestic flights. A notable piece of federal legislation was enacted in 2009, during the Obama administration, that placed tobacco industry regulation under the FDA.[10,11] However, this public protection was somewhat tepid. It gave the FDA a reactive oversight capability related to litigation, while leaving the most important tobacco-harm-prevention policy-making decisions to the states.[8,9,10,11]

Given that smoking is the leading cause of preventable death in the U.S. and worldwide, one might wonder why smoking bans have evolved in such a haphazard manner in the U.S. Was it intentional decentralization in an effort to protect states' rights? Or was it the result of national lobbying by the tobacco industry? The available evidence suggests the latter, with the tobacco industry and its lobbyists often embracing the narrative of states' rights to hamstring any national legislation that might reduce tobacco consumption and, therefore, tobacco industry profits.[9,12,13]

Key Players: The Tobacco Industry, the Surgeon General, and Health Advocacy Groups

In his book describing the history of the tobacco industry and the adverse effects of smoking, Robert Proctor[12] characterized cigarettes as "the deadliest artifact in the history of human civilization" and called for a complete ban on their manufacture and sale. His arguments are built on a history of deception and fraud by the tobacco industry over the past century, including:

1. The secret work of tobacco chemists scheming to make tobacco products more addictive.
2. The role of tobacco manufacturers in blocking public information about smoking-related health hazards and creating misinformation about "health benefits."[13]
3. Covert strategies to maximize revenue, profits, and stock values while contributing to the deadliest yet most preventable cause of premature death in the U.S. and the world.[12]

Proctor credited health researchers and public health professionals of the 1950s and early 1960s for the crusade that scientifically linked tobacco smoke to cardiovascular and lung diseases, various cancers, stroke, diabetes, COPD, and premature death.[3,4]

The U.S. Surgeon General's 1964 report caused a momentous shift in attitudes about smoking with its official acknowledgement that smoking is harmful to human health.[2] Prior to this government admission, corporate interests—the tobacco industry and its profits—took precedence and worked directly against public health by promoting tobacco products as safe.[12,13] After 1964, the combination of scientific research, lawsuits, public health campaigns, and information all contributed to gradual changes in public opinion and a mounting trend toward embracing a healthy lifestyle.

The U.S. Surgeon General's 1964 declaration was a watershed moment in public health history, eventually leading to state smoking bans such as CAA03. In opposition to the tobacco industry and its lobby, professional organizations—including the NYS Public Health Association (NYSPHA), the American Lung Association (ALA), the American Cancer Society (ACS), the American Heart Association (AHA), and the American Medical Association (AMA)—served as interest groups advocating for New York State residents' health. Tobacco control has been a centerpiece of NYSPHA's Policy and Advocacy Committee work for decades. The ALA, ACS, AHA, and AMA have played a crucial role in funding research to create the critical body of knowledge regarding harms caused by smoking and second-hand smoke.

The Smoking Ban's Early Years: NYS Department of Health and Key Businesses

Following the Surgeon General's 1964 proclamation, the New York State Department of Health stepped up efforts to educate residents about tobacco harm and to monitor incidences of smoking and related morbidity and mortality. Tobacco excise taxes and smoking bans followed.

Virtually every state had instituted tobacco excise taxes by the early 1970s. However, it took until the mid-1990s for an organized NYS DOH strategy to emerge regarding public smoking bans. The New York State Tobacco Control Program (NYS TCP) was officially established in 2000, two full years after CAA03 was first introduced in the New York State Legislature. In the early years of the smoking ban bill, restaurants and bars adamantly opposed it, fearing negative economic impacts. However, as time went on, through networking, public hearings, meetings, and various negotiations, opposition faded, and the New York State Restaurant Association (NYSRA) was convinced to throw its support behind the bill. This group's support was considered a significant factor toward passage in the state legislature.[14,15] Various studies have since shown that the economic impact of smoking bans on restaurants and taverns is neutral or positive.[16]

The Seeming Futility of Persistent State Lawmakers

The series of bills that eventually became CAA03 took several years, from introduction in the New York State Legislature (Assembly) to passage and signing into law in March 2003 (see Figure 1). The bills were referred dozens of times to committees for discussion, negotiation, and revision over at least three legislative terms.[17]

CAA03's passage was not easy. In addition to its Democratic Assembly sponsor, the bill had 48 co-sponsors by its final term—a group that crossed party lines, with forty-five Democrats and three Republicans. The Assembly sponsor of CAA03 was Alexander Grannis, an environmentalist and career politician in New York State. In addition to recruiting a large co-sponsorship group in the Assembly, Grannis worked with NYS Senate sponsor (Republican) Charles J. Fuschillo, Jr. and Senate members to convince them of the merits of the bill and to champion the bill through three different committees: Health, Rules, and Codes.

CAA03 passed with 97 yea votes (to 44 nay) in the New York State Assembly on March 26, 2003.[1] This passage was not a landslide, reflecting the fact that public smoking bans were not popular with the public in the early 2000s.

CAA03, while unpopular at first, now has widespread acceptance and was followed by several similar public bans, including restrictions extended to railroad stations and platforms (2011), school and library doorways (2012, 2018), hospitals and residential health facilities (2013), playgrounds (2013), and childcare facilities (2018) as well as provisions for vaping/e-cigarettes (2017, 2019). The steps leading to the enactment of CAA03 exemplifies the virtues of the deliberation process and the rationale for achieving stability when valuable time is taken for discussions, negotiations, compromise, debate, and persuasion.

Despite the persistence of New York and other state lawmakers in addressing tobacco harms, second-hand smoke is still linked to roughly 109 U.S. deaths per day (one-twelfth of the daily total of premature deaths caused by tobacco).[3,4] These preventable deaths and diseases reflect the need for a more robust and coordinated national strategy to reduce tobacco consumption.

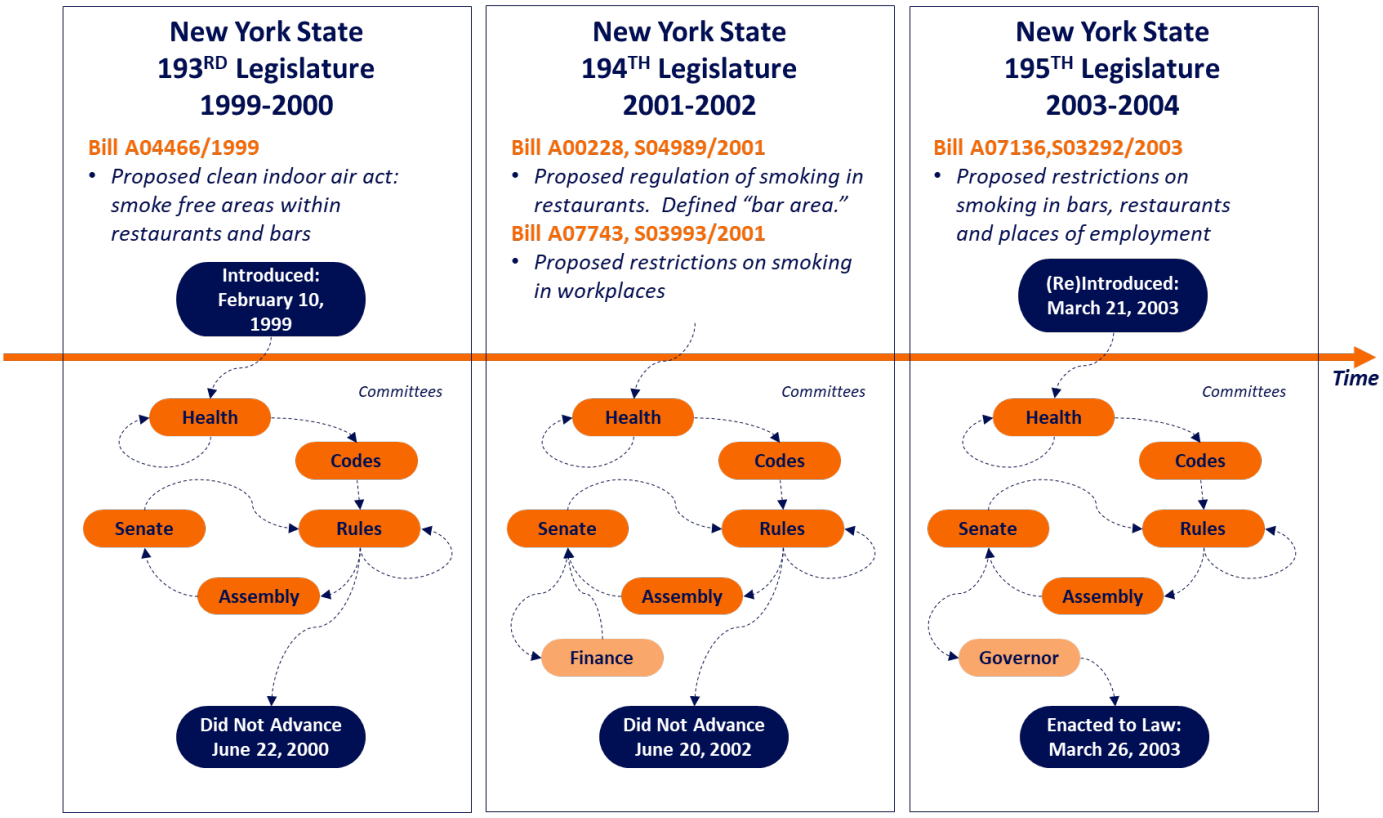

Figure 1: A Detailed Timeline of the New York State Legislative Process Leading to Enacting the New York State Clean Indoor Air Act of 2003.
Source: Figure created by the author using information obtained from https://nyassembly.gov.

Lessons from the New York State Clean Indoor Air Act of 2003

The Clean Indoor Air Act of 2003 epitomizes the intertwining of policy and politics, public health and economics, true grit and strategy, and the common good versus corporate and individual business interests. It demonstrates how parties with seemingly polarized positions can reach an important agreement for the good of public health despite years of public misinformation—in this case, from the tobacco industry and business owners worried about the loss of smoking patrons in restaurants and taverns.

The U.S. Surgeon General, the NYS DOH, and key state legislators (particularly sponsors Assemblyman Grannis and Senator Fuschillo, Jr.) played crucial official roles with impacts not to be seen for decades. Health advocacy groups, such as NYSPHA, ALU, ACS, and AHA, helped to ensure an active research community. In unofficial roles, the professional trade organization NYSRA was necessary for CAA03's passage— passage that likely would not have happened without the advocacy of health interest groups.

In summary, CAA03 set the stage for a steady stream of smoking-related bills over the next seventeen years, which are collectively recognized for saving and improving the quality of many lives.[18] Behind these health improvements were many key players, spanning several decades, whose collective contributions have impacted and continue to shape public health at the state levels. It is time now for more serious consideration, and for finding the political will, to address the persistent public health problem of tobacco at the U.S. national level.

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Acknowledgments

The author thanks Amy J. Kellogg (Harter Secrest & Emery LLPPG in Albany, New York), Dr. Lutchmie Narine (Syracuse University/Falk College Department of Public Health), and Dr. Saba Siddiki (Syracuse University/Maxwell School Department of Public Administration and International Affairs) for topic setup; Dr. Shannon Monnat (Lerner Center Director), Marita Begley and Nicole Replogle for helpful feedback and edits on previous drafts, and the Lerner Center staff for publication and dissemination efforts.

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