

# SMOKE FREE LAWS

A Resource Guide Highlighting the  
Health, Economic and Legal Issues of  
Smoke Free Ordinances



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***TABLE OF CONTENTS***

**EXECUTIVE SUMMARY .....3**

**PREVALENCE & PUBLIC OPINION .....4**

**HEALTH CONSEQUENCES .....6**

**ECONOMIC IMPACT .....11**

**HEALTH BENEFITS .....14**

**ECONOMIC BENEFITS.....18**

**LEGAL ISSUES .....23**

**COMMON ARGUMENTS AGAINST AN ORDINANCE .....26**

**RECOMMENDATIONS.....29**

## ***EXECUTIVE SUMMARY***

Inhalation of tobacco smoke during smoking remains the largest single preventable cause of death and disability for the citizens of Kentucky. The health consequences of cigarette smoking and of the use of other tobacco products have been extensively documented and are well known to the public at large.

This resource guide examines the scientific evidence on involuntary smoking (secondhand smoke) as a cause of disease in nonsmokers, the economic impact to communities with smoke free policies in place, the health benefits to these communities and the legality of such laws.

Further, it presents other information that is peripheral to this issue including arguments frequently made in opposition to restrictions on public smoking and documents often referenced by opponents of such laws as “proof” that secondhand smoke is not dangerous.

Nonsmokers’ exposure to secondhand smoke (SHS) is often termed involuntary smoking because the exposure generally occurs as an unavoidable consequence of being in proximity to smokers, particularly in enclosed indoor environments. The terms “passive smoking” and environmental tobacco smoke are also used throughout the scientific literature to describe this exposure.

A complete review of the information in this resource guide leads to four major conclusions:

- 1. Secondhand smoke is a primary cause of disease and death in healthy nonsmokers.**
- 2. Implementation of smoke free policies do not have cumulative negative economic impacts on the hospitality industry or tourism.**
- 3. There are significant health and economic benefits to be realized when a community implements a smoke free policy.**
- 4. The legality of smoke free ordinances has been demonstrated multiple times through our legal system, including in the Kentucky Supreme Court. Governmental bodies not only have the right, but the responsibility to protect public health.**

## ***PREVALENCE & PUBLIC OPINION***

Kentucky is the heart of tobacco country—the second largest tobacco-producing state in the nation and the state with the largest number of tobacco farmers. It is not surprising, therefore, that Kentucky’s adult smoking rate is the worst in the nation at 28.7 percent.<sup>1</sup> Our youth smoking rates are alarmingly high, particularly in middle school where nearly 1 in 7 students smokes (15%) — well above the national average.<sup>2</sup> Also not surprising is the fact that Kentucky’s rates of lung cancer and heart disease are among the highest in the country.

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***“The debate is over – the science is clear.***

***Secondhand smoke is not a mere annoyance but a serious health hazard.”***

– Richard Carmona  
US Surgeon General

As surely as tobacco has been grown in Kentucky for generations, the state’s tobacco culture is changing. Decreasing demands to U.S.-grown tobacco have led to a federal tobacco buyout. More than half of the state’s Master Settlement Agreement funds are going to farmers and their communities to assist in diversification efforts to decrease the state’s dependence on the crop. All the while, states and cities across the Commonwealth and the nation are moving forward with legislation to discourage youth smoking and to protect citizens from the health hazards of secondhand smoke.

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Consideration of smoke free indoor air policies came to the Bluegrass in earnest in 2001 when the Lexington-Fayette Urban County Council began contemplation of an ordinance. That ordinance passed on July 1, 2003 and – after a legal challenge in which the Kentucky Supreme Court upheld the law - went into effect in April 2004. Since that time, many other Kentucky cities – Georgetown, Frankfort, Elizabethtown, Morehead, Ashland – and several counties, Oldham, Letcher, Daviess and Jefferson have also passed ordinances to restrict public smoking. Approximately 30 other communities in the Commonwealth are now currently considering action as well.

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## ***HEALTH CONSEQUENCES***

The scientific evidence on the health risks associated with exposure to secondhand smoke is clear, convincing, and overwhelming. The most recent, and perhaps most compelling evidence for this is found in a 727-page report released in June 2006 by the US Surgeon General “*The health consequences of involuntary exposure to tobacco smoke : a report of the Surgeon General.*” In his presentation of the report Surgeon General Carmona stated unequivocally, “The debate is over. The science is clear. Secondhand smoke is not a mere annoyance but a serious health hazard.”<sup>1</sup> Secondhand smoke is a known cause of heart disease, cancer, chronic respiratory diseases, middle ear diseases, asthma attacks, low birth weights, and sudden infant death syndrome (SIDS). Exposure to secondhand smoke causes the same diseases in nonsmokers as it does in smokers and kills an estimated 53,000 nonsmokers each year in the United States. In addition, secondhand smoke exposure causes over one million illnesses in children.<sup>1,2,3,4,5,6,7,8,9,10,11,12,13,14,15,16,17,18, 19</sup>

Secondhand smoke contains more than 4,000 known chemical compounds<sup>20</sup> and is made up of “sidestream” smoke from the burning tip of the cigarette and “mainstream” smoke from the filter or the mouth end. Tobacco smoke contains thousands of different chemicals that are released into the air as particles and gases. The particulate phase of cigarette smoke includes nicotine, “tar” (itself composed of many chemicals), benzene, and benzo(a)pyrene. The gas phase includes carbon monoxide, ammonia, dimethylnitrosamine, formaldehyde, hydrogen cyanide, and acrolein. Among the chemicals in secondhand smoke are 69 known or probable carcinogens.<sup>20</sup>

In 1986, two landmark reports were published on the association between secondhand smoke exposure and the adverse health effects in nonsmokers: one by the U.S. Surgeon General<sup>21</sup> (which was updated by the 2006 report) and the other by the Expert Committee on Passive Smoking, National Academy of Sciences' National Research Council (NAS/NRC)<sup>22</sup>. Both of these reports concluded that:

- Secondhand smoke can cause lung cancer in healthy adult nonsmokers;
- Children of parents who smoke have more respiratory symptoms and acute lower respiratory tract infections, as well as evidence of reduced lung function, than do children of nonsmoking parents; and
- Separating smokers and nonsmokers within the same air space may reduce, but does not eliminate a nonsmoker's exposure to secondhand smoke.

In 1992, the U.S. Environmental Protection Agency (EPA) confirmed the above findings in its study on the respiratory health effects of secondhand smoke.<sup>12</sup> In addition, the EPA classified secondhand smoke as a Group A carcinogen—a category reserved only for the most dangerous cancer-causing agents in humans. There are currently only seven substances in this category, and all of them *except* secondhand smoke are controlled.

The EPA report, a compilation of 30 epidemiological studies that focused on the health risks of nonsmokers with smoking spouses, concluded that there is a strong association between secondhand smoke exposure and lung cancer. Scientists estimate that secondhand smoke is responsible for approximately 3,000 lung cancer deaths per year among nonsmokers in the

United States. Recent studies and the EPA's report point to a 20 percent increased risk of lung cancer in nonsmokers due to secondhand smoke.

In response to evidence that SHS causes diseases beyond lung cancer and respiratory problems in children, the California Environmental Protection Agency (Cal/EPA) conducted a comprehensive assessment of the range of health effects connected with SHS exposure. In 1999, the National Cancer Institute (NCI) published the Cal/EPA's results as part of its Smoking and Tobacco Control monograph series in *Health Effects of Exposure to Environmental Tobacco Smoke*.<sup>5</sup> The following table outlines the health effects that were found to have a significant association with SHS exposure.

**Table 1: Health Effects Associated With Secondhand Smoke Exposure**

Developmental Effects	Low birth weight or small for gestational age Sudden Infant Death Syndrome (SIDS)
Cognitive Effects	Children exposed to SHS have lower standardized test scores <sup>24</sup>
Respiratory Effects	Acute lower respiratory tract infections in children Asthma induction and exacerbation in children Chronic respiratory symptoms in children Eye and nasal irritation in adults <i>Otitis media</i> (Middle ear infections) in children
Carcinogenic Effects	Lung Cancer Nasal Sinus Cancer
Cardiovascular Effects	Heart disease mortality Acute and chronic coronary heart disease morbidity

According to the International Agency for Research on Cancer (IARC) of the World Health Organization, “involuntary smoking (exposure to secondhand or ‘environmental’ tobacco smoke) is carcinogenic to humans (Group 1).”<sup>3</sup> In addition, the IARC concluded that “involuntary smoking increases the risk of an acute coronary heart disease event by 25-35 percent.”

More than 50 research studies of involuntary smoking and lung cancer risk in never smokers have been published during the last 25 years. According to the IARC report, there is a statistically significant and consistent association between lung cancer and exposure to secondhand smoke among never smokers in the workplace. Never smokers exposed to secondhand smoke in the workplace are 16 to 19 percent more likely to develop lung cancer compared to workers in smoke free workplaces. Servers in the hospitality industry have the greatest risk of developing heart disease and cancer compared to other occupations. Levels of secondhand smoke in restaurants and bars are 1.6 to 6 times higher than in office workplaces.<sup>23,25,26,27,28,29,30</sup>

Among children the risks are even higher, aside from the established health risks and physical development implications, a study of more than 4000 children published in January 2005 by Cincinnati Children’s Hospital found that children exposed to secondhand smoke score significantly lower on cognitive tests than children that were protected from exposure. It is even

more interesting to note that of those children exposed and showing deficiencies, greater than 60% were not exposed at home.<sup>24</sup>

In 2004, it was determined that the risks of SHS exposure are even worse than previously thought prompting for the first time, the Centers for Disease Control and Prevention to issue a warning for people at risk of heart disease to avoid all buildings and gathering places that allow indoor smoking. The CDC disclosed this new advisory in a commentary to a study published in the British Medical Journal, recommending doctors warn people with heart problems that secondhand smoke can significantly increase their risk of a heart attack. The agency said that as little as 30 minutes' exposure can have a serious and even lethal effect.<sup>31</sup>

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## ***ECONOMIC IMPACT***

Any examination of the economic impact on municipalities with smoke free ordinances should include the following questions: “What is the economic impact of a smoke free law on the hospitality industry and tourism? What does secondhand smoke cost the community? and What is the cost of implementing a smoke free ordinance?”

### ***The Impact to the Hospitality Industry and Tourism***

The first smoke free communities emerged well over a decade ago. Since that time, numerous studies assessing the economic impact of smoke free policies in the hospitality industry have been conducted in Alaska, Arizona, Australia, California, Canada, Colorado, Indiana, Massachusetts, New York, North Carolina, Oregon, South Dakota, Texas, Utah, Vermont, and Wisconsin. No properly conducted study using objective measures show a negative economic impact. In fact, some studies show a smoke free policy improves business.<sup>1</sup>

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***“There are a lot of myths about no smoking policies – that your employees will quit, your guests will quit coming, and the place will be empty. We’ve proved every one of those myths wrong.”***

– Mike Scanlon  
CEO and President  
Thomas & King

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It is recognized that a well-designed study should satisfy four basic criteria for methodological quality. These criteria are: 1) collected data should be based on objective measures (taxable sales receipts, employment levels, bankruptcy data, employment insurance claims), 2) review of data for several years before and after policy implementation, 3) utilization of appropriate statistical tests to evaluate significance, controlling for underlying trends and fluctuations in data and 4) controls for changes in the general economic conditions. A minority of studies conducted have concluded a negative economic impact of secondhand smoke ordinances. These studies are predominately funded by the tobacco industry and are based largely on subjective measures (predicted outcomes based on impressions or estimates of changes) rather than on actual, objective, verified, or audited data.<sup>2</sup>

Four monumental studies were released in 2004 from research in communities that had recently passed laws to protect the public from secondhand smoke. All found NO negative economic impact due to the public health measure.

- In March 2004, the New York City departments of Finance, Health and Mental Hygiene, Small Business Services, and the Economic Development Corporation jointly issued a one-year review of the city’s smoke free law. Their conclusion: “One year later, the data are clear. The City’s bar and restaurant industry is thriving and its workers are breathing cleaner, safer air.”<sup>3</sup>
- The city council of El Paso (2000 population 563,662) passed a comprehensive smoke free ordinance on January 2, 2002. The Texas Department of Health and the CDC obtained quarterly sales tax reports and monthly mixed-beverage tax receipts and determined, “no statistically significant changes in restaurant or bar revenue” after the law was passed.<sup>4</sup>

- In Montgomery County (Maryland – Washington D.C. area) restaurant industry tax revenue increased by more than 7% and alcohol sales increased by almost 4.5%.<sup>5</sup>
- Florida voters overwhelmingly approved the Smoke-Free Health constitutional amendment in November 2002. A study conducted by the Bureau of Economic and Business Research at the University of Florida concluded that the smoke free law has had no negative impact on hotel, restaurant or tourism industries.<sup>6</sup>

Logically, this makes sense. If smoke-free policies caused harm to businesses, the number of communities across the country implementing such policies would not be growing. At present, more than 2,000 communities in the United States have enacted policies aimed at reducing exposure to secondhand smoke.

### *Costs to a Community*

Secondhand smoke places significant economic burdens on a community. A 2002 study in Marion County, Indiana (Indianapolis) found that due to the prevalence of secondhand smoke, and the effects that it has on public health, in 2000 Marion County incurred expenses totaling at least \$56 million. More than \$16 million of that was related to the treatment of disease directly attributed to SHS exposure, and an additional \$39 million from premature death from SHS. This study did not begin to assess the health care and loss of life costs incurred by smokers themselves. Nor did it address the hidden costs totaling more than \$260 million incurred by Marion County businesses from employee smoking causing increased insurance premiums, lost productivity, smoking-caused fires in the workplace, absenteeism due to increased illness associated with smoking, and additional housekeeping to maintain establishments (cigarette burns, nicotine stains, dirty ashtrays, increased air filter usage, etc).<sup>7</sup>

### *Costs of Implementation and Enforcement*

In countless examples across the United States, the costs to government to fully implement secondhand smoke ordinances have been minimal and can be offset by any fees levied to violators of the ordinance. Like every other law that is passed by a governmental body, the vast majority of citizens are law-abiding and act in accordance with posted restrictions at establishment entrances. In most cases, as in most KY ordinances, the health department takes on the task of enforcing smoke free ordinances. In addition to routine health department inspections of hospitality industry establishments, targeted inspections are conducted based on reporting of incidents from constituents. Although any code or law enforcement officer may issue citations for violation of the ordinance, no special enforcement “smoke police” are needed. It is the responsibility of management to uphold and enforce laws in the confines of their own establishment and will be held accountable to the penalties written in the code if they refuse. If a customer in an establishment refuses to extinguish their smoking material at the request of management to bring the establishment in compliance with the code, that customer should be treated in much the same way as a belligerent intoxicated individual, someone engaging in any inappropriate behavior or someone using illicit substances. They should be asked to leave the premises by management and if they refuse, then police are called in response to the trespassing violation.

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## ***HEALTH BENEFITS***

Smoke free policies have been shown to have a direct and immediate benefit to a community in terms of health. In regards to smoking prevalence and cessation there are three reasons for a city to enact policies against smoking indoors. First, these policies protect the non-smoking public – including our children and the infirm – from the toxins found in secondhand smoke. Second, they encourage smokers to quit or reduce their smoking. Third, by de-normalizing and de-glamorizing tobacco use, these bans assist in preventing youth initiation.

### ***The Protection of Non-Smokers***

The dangers of active smoking are well known among the general public. Therefore it is not surprising that over 70% of the adults in Kentucky choose to not smoke. As highlighted in a previous section of this report, there is also no debate within the medical and scientific communities regarding the negative health effects of secondhand smoke. Unfortunately, the dangers of secondhand smoke are still being learned by the lay population. Moreover, many people have higher levels of exposure to secondhand smoke than they believe, much of it stemming from the workplace. According to a study published in the *Journal of the American Medical Association*, 88% of nonsmokers have significant levels of nicotine residue in their blood.<sup>1</sup>

Smoking causes a great deal of concern in the workplace. 59.2% of nonsmoking employees report suffering discomfort, and even 15% of smoking employees report some degree of discomfort from secondhand smoke.<sup>2</sup> Sadly, although an easily perceived measure of the impact of on employees, it is not merely the annoyance from secondhand smoke exposure that is the primary concern. More important are the unseen health impacts of secondhand smoke exposure and reductions in the productivity of nonsmokers yielding direct, unanticipated costs to the employers. Estimated costs associated with secondhand smoke's effects on nonsmokers reach as high as \$490 per smoker per year.<sup>3</sup>

The International Labor Organization (ILO) reported in 2002 that cancer was the largest killer in the workplace, accounting for approximately 640,000 workplace-related deaths per year globally. ILO stated that secondhand smoke in the workplace is estimated to cause 2.8 percent of all workplace cancer.<sup>4</sup> Specifically, workers exposed to secondhand smoke on the job are 34% more likely to get lung cancer than their counterparts in non-smoking work environments.<sup>5</sup>

Fortunately, in terms of the health of non-smokers, the positive results of a smoke free ordinance can be realized in a short amount of time.

- After the state of California prohibited smoking in bars in January of 1998, researchers at the University of California – San Francisco studied 53 bartenders. The improvement to their health was quick and dramatic – lung function tests showed bartenders had 4% better lung capacity just four weeks after the smoking ban went into effect. Before the law, three-quarters of the bartenders suffered from lung ailments. After the law, symptoms for 60% of the group disappeared completely.<sup>6</sup>

- A study from Helena, Montana – delivered at this 2003 annual meeting of the American College of Cardiology - found that heart attacks in that city fell by more than half in the summer of 2002 after a smoke free ordinance was passed. Although the researchers acknowledged that the small number of heart attacks in Helena (population 26,000) may not indicate large-scale effects of smoking bans, interestingly, the statistics also showed a possible spike back to normal levels after the city stopped enforcing the ban due to a legal challenge in December 2002.<sup>7</sup>

### *Helping Smokers Quit*

It has been well established that the majority of smokers want to quit. When worksites go smoke free it offers smoking employees an increased motivation to kick the habit. This fact has been firmly established not only in the scientific community, but also by the tobacco companies. The link between smoke free policies and cessation is so strong that the tobacco industry considers them one of the biggest challenges to maintaining their profits.<sup>8</sup> As the following quote from an internal memorandum of Philip Morris indicates, comprehensive smoke free ordinances are highly effective at reducing smoking.

*Total prohibition of smoking in the workplace strongly affects industry volume. Smokers facing these restrictions consume 11 –15% less on average and quit at a rate that is 85% higher than average...Milder workplace restrictions, such as smoking only in designated areas have a much less impact on quitting rates and very little effect on consumption.”<sup>9</sup>*

There are hundreds of studies from the academic world of research confirming what the tobacco industry knows very well. This summary offers only a few as examples of the data available.

- Researchers at the University of California – Berkeley and the University of California – San Francisco investigated the effect of local worksite smoking laws in California and their effect on smoking cessation. Their results revealed that smoke free ordinances significantly increased the rate of smoking cessation and did so along a “dose-response” relationship – the stronger the ordinance, the higher the rate of cessation. For example, while there was only a 19.1% cessation rate in areas with no ordinance, there was a 24.6% cessation rate in areas with weak ordinances, and a 36.4% cessation rate in areas with strong ordinances. Overall, the results indicated that smokers who worked in communities with strong ordinances were 38% more likely to quit smoking than smokers in communities with no ordinance.<sup>10</sup>
- In 1993, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) mandated that all hospitals seeking accreditation go smoke free. A study conducted through the University of Missouri-Columbia investigated whether the rate of smoking cessation was higher among hospital employees than among other community employees not subject to a smoke free workplace policy. A total of 1,849 current or former smokers participated in the study over a period of three years. Hospital employees were found to be almost twice as likely as other community employees to quit smoking and tended to take a shorter time to quit.<sup>11</sup>

- Twenty-six studies on workplaces in the United States, Australia, Canada, and Germany were subjected to a process of systematic review and meta-analysis. Entirely smoke free workplaces were associated with a 3.8% reduction in smoking prevalence. Of those employees who continued to smoke, there was an average reduction in consumption of 3.1 fewer cigarettes per day. The combined effects of increased cessation and decreased consumption corresponded to a 29% relative reduction in tobacco use among all employees.<sup>12</sup>

### ***Keeping Youth Smoke Free***

Logically, one could infer from the positive impact smoke free policies have on adults that youth would benefit as well. This conclusion – that smoke free laws reduce smoking uptake and prevalence in youth – is consistent with current research.

- Workplace smoking restrictions can significantly reduce smoking rates among older teens, according to a study published in the *Journal of the American Medical Association* (JAMA). Researchers used data from the Current Population Surveys from 1992 – 1993 and 1995 – 1996 to question 17,185 adolescents between the ages of 15 and 17. Teens who worked in a smoke free worksite were found to be 32% less likely to smoke than teens in a worksite with no smoking restrictions.<sup>13</sup>
- A cross sectional survey administered in the spring of 1996 to 17,287 high school students aged 14 – 17 agreed claiming that more extensive bans on smoking in public places may reduce teenage smoking. According to this study, having stronger restrictions in place reduced the odds of the transition from early to advanced experimenter smoker by 8% and of making the transition from advanced experimenter to established smoker by 10%.<sup>14</sup>

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## ***ECONOMIC BENEFITS***

### ***Benefits to Businesses***

Prohibiting smoking in the workplace increases profits and productivity while decreasing maintenance costs and business liability.

#### ***Profitability & Lost Productivity***

The U.S. Centers for Disease Control and Prevention (CDC) estimates that businesses spend \$3,391 annually on each employee who smokes: \$1,760 in lost productivity and \$1,623 in excess medical expenditures.<sup>1</sup> In addition, estimated costs associated with secondhand smoke's effects on nonsmokers can add up to \$490 per smoker per year.<sup>2,3</sup>

- Smoke free laws add value to establishments. Restaurants in smoke free cities have a higher market value at resale (an average of 16% higher) than comparable restaurants located in smoke-filled cities.<sup>4</sup>
- Smokers, on average, miss 6.16 days of work per year due to sickness (including smoking related acute and chronic conditions), compared to nonsmokers, who miss 3.86 days of work per year.<sup>5</sup>
- A national study based on American Productivity Audit data of the U.S. workforce found that tobacco use was one of the greatest variables observed when determining worker lost production time (LPT)-greater than alcohol consumption, family emergencies, age, or education. The study reported that LPT increased in relation to the amount smoked; LPT estimates for workers who reported smoking one pack of cigarettes per day or more was 75% higher than that observed for nonsmoking and ex-smoking workers. In addition, employees who smoked had approximately two times more lost production time per week than workers who never smoked, a cost equivalent of roughly \$27 billion annually in productivity losses for employers.<sup>6</sup>
- The U.S. Office of Technology Assessment estimated that in 1990 lost economic productivity from disability and premature mortality caused by smoking was \$47 billion.<sup>7</sup>
- Businesses pay an average of \$2,189 in workers' compensation costs for smokers compared with \$176 for nonsmokers.<sup>8</sup>

#### ***Maintenance & Safety***

- The U.S. Environmental Protection Agency (EPA) estimates that smoke free restaurants can expect to save about \$190 per 1,000 square feet each year in lower cleaning and maintenance costs.<sup>9</sup> The EPA also estimates a savings of \$4 billion to \$8 billion per year in building operations and maintenance costs if comprehensive smoke free indoor air policies were adopted nationwide.<sup>10</sup>

- The Organization for Economic Cooperation and Development estimates that construction and maintenance costs are seven percent higher in buildings that allow smoking than in buildings that are smokefree.<sup>11</sup>
- A 1993 survey of businesses conducted by the Building Owners and Management Association (BOMA) International found that the elimination of smoking from a building reduced cleaning expenses by an average of 10%. Smoking was also cited as the number one cause of fires on a BOMA fire safety survey.<sup>12</sup>
- The National Fire Protection Association found that in the US alone, in the year 2001 smoking materials caused 8,000 fires in non-residential structures resulting 50 deaths, 180 injuries and direct property damage of \$70 million.<sup>13</sup>
- More than 12% of all nightclub and bar fires are caused by smoking. This is more than twice the rate of all other structures.<sup>14</sup>
- Using U.S. Bureau of Economic Analysis data, it was determined that employees who smoke cost Marion County, Indiana, businesses \$260.1 million in increased health insurance premiums, lost productivity, and absenteeism, as well as additional recruitment and training costs resulting from premature retirement and deaths due to smoking.<sup>15</sup>

### *Insurance Rates*

- Dozens of companies offer discounts on life, disability, and medical insurance for nonsmokers. The total property and contract losses due to fires caused by smoking materials was more than \$10.6 million in 1996. The National Fire Protection Association reports \$391 million in direct property damage for smoking related fires between 1993-1996. Landlords and restaurants with smoke free premises have negotiated lower fire and property insurance premiums.<sup>16</sup> Fire insurance is commonly reduced 25-30% in smoke free businesses.<sup>17</sup>
- The American Cancer Society reports that employees who smoke have an average insured payment for health care of \$1,145, while nonsmoking employees average \$762.<sup>18</sup>

### *Community Development*

Smoke free ordinances directly address a number of valid business concerns while yielding a healthier, more committed workforce. The end results are improved quality of life for all citizens and an improved business environment better positioned to attract new organizations to our community. As more and more of the nation's top rated and most populous cities demonstrate their willingness to make the health interests of their citizens and their workforce a top priority, cities that fail to do so fall farther and farther behind. Smokefree policies have become an important factor in many rankings and evaluations of cities deemed to be best for relocation or to raise a family.

For corroboration of the positive impact a comprehensive smoke free ordinance stands to make on Kentucky's potential for community development, one need look no further than the 2002

study by the Brookings Institution Center on Urban & Metropolitan Policy entitled “Beyond Merger: A Competitive Vision for the Regional City of Louisville.” This report challenges Louisville’s community leaders “to ensure that Louisville’s ascent into the top tier of municipalities leads also to its emergence as one of the most progressive.” It goes on to identify an “agenda of transformation to a changing community” that will help Louisville become a “top-rank ‘competitive city.’” Obviously these recommendations would apply to the entire Greater Louisville community.

Among its recommendations this report encourages Louisville to “build on its assets, strengthen families” and “fix the basics.” It urges community leaders to take a “deliberately broad view of ‘competitiveness’ – one that does not separate strategies to promote economic growth from those that enhance the overall health of the community.”<sup>19</sup>

Numerous economists and CEO’s have said it is not just economic incentives or tax breaks, but rather quality of life issues that draw businesses to a city. This is especially relevant to Louisville, where according to Professor Paul Coomes, health care is the largest, fastest growing and most stable sector of our local economy. In a report he produced for the Greater Louisville Health Enterprises Network, Professor Coomes states that the health care industry accounts for an estimated 1 in 10 jobs in the metropolitan area and an annual payroll of over \$2 billion.<sup>20</sup>

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***“Smoking in public accommodations is inconsistent with local economic development initiatives ...”***

– David A. Jones, Jr.

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Other noted local business leaders echo this conclusion. For example, in an editorial published in the Courier-Journal, David A. Jones, Jr., Chair of the Health Enterprises Network, said:

“Smoking in public accommodations is inconsistent with local economic development initiatives that aim to attract growing industries build around knowledge workers. In fact, smoking in public places increases the cost to recruit and retain these workers. Louisville suffers, and local economic development work is set back, when we can’t recruit or retain talented people. When a potential Bucks-for-Brains scholar, or a health-conscious top physician, or a health-conscious executive or technician we are recruiting arrives at Louisville International Airport, or our largest local hotel, or the lobby of the office tower where I work, or one of the fine restaurants, and gets a nose full of stale smoke, convincing him or her that Louisville is a ‘city on the move’ becomes that much harder.”<sup>21</sup>

The Brookings’ study reiterates this view in saying, “In today’s rapidly changing economy, cities must maintain both a top-notch workforce and a high quality of life.” It should be noted that according to the Brookings’ report, service industry jobs — including hospitality and food service jobs — are Louisville’s second fastest growing job sector. Sadly, not only are most of these new positions low paying, as the report confirms,<sup>19</sup> they are also the jobs in which employees are least likely to be protected by voluntary no-smoking workplace policies. This paints a dismal picture for Louisville’s ability to maintain a healthy, self-sustaining workforce and further underscores the need for an ordinance designed to protect all workers’ health.

As the Brookings report states, “The slow erosion of the region’s livability threatens to undermine a key part of the region’s competitive advantage.”<sup>19</sup> When assessing Louisville’s ability to position itself as a progressive and economically competitive community, it is worth noting that nine of the fifteen cities ranked ahead of Louisville in population have smoke free ordinances currently on the books and that two cities - Indianapolis and Philadelphia – presently have strong smoke free campaigns in progress. Truly progressive cities are moving ahead to protect their citizens from the well-documented adverse health effects of secondhand smoke. Louisville cannot afford to be left behind at this critical time in her development as a prominent US city.

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## ***LEGAL ISSUES***

States, municipalities, and other political subdivisions have responded to the health hazards of secondhand smoke by prohibiting smoking in indoor areas. The number of smoke free communities has grown dramatically in recent years. It is not rare to witness a legal challenge against a newly passed smoke free measure. Due to the fact that smoke free laws reduce consumption of cigarettes, it is advantageous to the tobacco companies to forestall implementation of an ordinance as long as they can via the legal system. Even when the industry evidentially loses the case, if they maintained the status quo in a city for 6 months or a year, the stalling tactic was rewarded through continued higher tobacco sales for that period. The vast majority of these challenges fail. When plaintiffs succeed in striking down a smoke free ordinance, the reason is usually a procedural error during the passage of the ordinance. Neither the United States Constitution or state constitutions recognize a constitutional “right to smoke” that would limit the power of federal, state or local authorities to regulate smoking.<sup>1</sup>

As stated above, local laws to protect workers and the public from the hazards of secondhand smoke began to pass nearly two decades ago. It was and continues to be a favorite tactic of the tobacco industry to fight these laws through the court system. Due to the fact that smoke free laws reduce consumption of cigarettes, it is advantageous to the tobacco companies to forestall implementation of an ordinance as long as they can via the legal system. Even when the industry evidentially loses the case, if they can continue the status quo in a city for 6 months or a year, the stalling tactic is rewarded through continued higher tobacco sales. However, the history of these cases has demonstrated that these laws stand on firm legal ground.

The most appropriate example is the suit brought against the Lexington-Fayette Urban County Council after it had passed our state’s first smoke free law. Scheduled to go into effect on September 29, 2003, the legal challenge successfully delayed implementation of the law until late April 2004. The case was eventually decided by the Kentucky Supreme Court.

The Kentucky Supreme Court ruled 6-1 in favor of the city and issued a very strongly worded majority opinion upholding Lexington’s comprehensive ordinance restricting workplace exposure to secondhand smoke. Included in this decision were the following statements by the court.

“This case is not about whether the decision of a local government to enact smoking restrictions is a sound policy matter. Such policy questions are completely within the province of the local legislative body and we do not find it necessary to review that decision in this matter.”

“Protecting the public from exposure to environmental tobacco smoke, sometimes known as second-hand smoke, can be the proper object of the police power of local government. The exercise of police power for the purpose of protecting the public health has been termed ‘the law of overruling necessity.’ *This Court has held on several occasions that the protection of public health is uniformly recognized as a most important municipal function. ‘It is not only a right but a manifest duty of a city.’*”

“*There is perhaps no broader field of police power than that of public health.*”

“It is thus apparent that, insofar as public health is concerned, private property may become of public interest and the constitutional limitations upon the exercise of that power of regulation come down to a question of ‘reasonability’.’ The real issue is whether the public health regulation is reasonable. In this case, we must conclude that it is. Both federal and state courts have determined numerous times that where public interest is involved it is to be preferred over property interests even to the extent of destruction if necessary. In this situation the urban county government considered lengthy public hearings at which evidence of the problems connected with the use of tobacco products and second-hand smoke were extensively discussed by all sides to the controversy. *Evidence was presented that used objective sales data to the effect that ‘no adverse economic effect’ or ‘improved business’ was found. The smoking ordinance is not an improper infringement upon property rights.*”<sup>2</sup>

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## ***COMMON ARGUMENTS AGAINST AN ORDINANCE***

*“The World Health Organization doesn’t even agree that secondhand smoke is harmful!”*

This statement is simply not true. The World Health Organization (WHO), through their cancer research branch, the International Association for Research on Cancer, released a Monograph on Involuntary smoking in 2002 that states conclusively “Involuntary smoking (exposure to secondhand or 'environmental' tobacco smoke) is *carcinogenic to humans (Group 1)*.”<sup>1</sup> Furthermore, in the WHO Framework Convention on Tobacco Control, Article 8 Section 1 it is stated “that scientific evidence has unequivocally established that exposure to [passive] tobacco smoke causes death, disease and disability.”<sup>2</sup> On the WHO website the organization even goes so far as to recommend that governments “Legislate in favour of an individual’s right to a smoke-free environment. Governments can legislate to protect people from involuntary exposure to tobacco smoke by establishing smoke-free public places and workplaces.”<sup>3</sup>

*“The 1993 EPA study cited by pro-ordinance advocates as the seminal document in support of smoke-free laws has been discredited.”*

This statement was, at one time, partially true. In 1993 the EPA released a report “Respiratory Health Effects of Passive Smoking: Lung Cancer and Other Disorders” that found that of the 3,000 lung cancer deaths cause each year by secondhand smoke, approximately 2,200 were from exposure in work or social settings.<sup>4</sup> Aware of the potential ramifications of such a study, the tobacco industry immediately launched a legal and public relations campaign to “discredit the EPA and prevent smoking ban legislation wherever it is proposed” starting with attacks on the report led by an industry front group, The Advancement of Sound Science Coalition.<sup>5</sup> In 1998, North Carolina US District Court Judge William L Osteen, a former tobacco grower lobbyist, ruled that the portion of the EPA study that classifies SHS as a carcinogen be vacated. Upon appeal, in 2002 a three-judge panel of the US 4<sup>th</sup> District Court of Appeals vacated Judge Osteen’s decision vindicating the EPA report and allowing it to remain in good standing. The EPA currently stands by its scientific and well-documented report which was subjected to extensive review by both the public and the EPA’s Scientific Advisory Board. The report and its conclusions have now been endorsed by the US Department of Health and Human Services, the National Cancer Institute, the Surgeon General and many other health organizations.

*“A 2003 study in the British Medical Journal proves that secondhand smoke is harmless!”*

In May of 2003, an article was published in the BMJ stating that the authors found no apparent causal relationship between exposure to secondhand smoke and death from such exposure, however they did not rule out a possible small effect.<sup>6</sup> The study was based on a previous data set collected by the American Cancer Society in a 40 year longitudinal cohort that was not designed to assess the impact of secondhand smoke exposure. This alone created multiple confounding issues and the study was quickly denounced by ACS upon release. It was revealed that the authors of the paper had not fully disclosed their relationships with the tobacco industry, which via direct payments and “independent” front groups had completely funded the project.<sup>7</sup> The firestorm in the scientific community ultimately resulted in the editor of the BMJ USA printing a column in the July 2003 issue highlighting the fact that the authors were paid by the tobacco industry and that “the study had an obvious design flaw. The control group meant to

represent unexposed persons consisted of spouses of nonsmokers, who in that era encountered cigarette smoke almost everywhere they went.”<sup>8</sup> Numerous other recently released studies, including one in the June 2004 BMJ have reiterated the fact that secondhand smoke is indeed a significant health risk whose effects might have even been underestimated in previous investigations.<sup>9</sup> Of course the recent report from the Surgeon General should also finally dispel any notion that secondhand smoke is anything but a serious health threat to our population.<sup>10</sup>

*“If SHS is truly a workplace safety issue then why doesn’t OSHA regulate it?”*

When OSHA was considering creating a rule to regulate secondhand smoke in the workplace in late 1994 and early 1995, there were reams of studies giving evidence that SHS was indeed a human carcinogen and likely contributed to heart disease. The vast majority of these studies were conducted in spouses of smokers, not in workplace exposures. After several months of review, and massive lobbying by tobacco companies, the proposed rule was never implemented. There is clear direction, however from The National Institute for Occupational Safety and Health (NIOSH), another Federal agency that is concerned with ETS exposure in the workplace. NIOSH conducts ETS-related research, evaluates work sites for possible health hazards, and makes safety recommendations including on to severely restrict or eliminate SHS from the workplace. In their Current Intelligence Bulletin 54, NIOSH offers the following conclusions and recommendations, “NIOSH considers the OSHA classification system (Identification, Classification, and Regulation of Potential Occupational Carcinogens also known as the OSHA carcinogen policy) the most appropriate for use in identifying occupational carcinogens... a large body of evidence indicates that exposure to ETS has produced lung cancer in nonsmokers. NIOSH therefore considers ETS to be a potential occupational carcinogen in conformance with the OSHA carcinogen policy.” They continue stating “If elimination [of hazardous substances, i.e. SHS] is not possible, emissions should be removed from the pathway between the source and the worker. Therefore, the best method for controlling worker exposure to ETS is to eliminate tobacco use from the workplace and to implement a smoking cessation program.” NIOSH reiterates then need for employee protections stating “Worker exposure to ETS is most efficiently and completely controlled by simply eliminating tobacco use from the workplace.”<sup>11</sup>

*Can’t modern ventilation methods take care of the health threat of secondhand smoke?*

Unfortunately, no. There is no known product on the market today at any level that is capable of removing the toxins and carcinogens from SHS. While the “smell” can be effectively dealt with, the toxins themselves are not removed and continue to linger and be recirculated throughout the establishment. The American Society for Heating, Refrigerating and Air-conditioning Engineers (ASHRAE), the expert body determining the standards and ventilation requirements for healthy indoor environments clearly states in their position document on Environmental Tobacco Smoke that “At present, the only means of effectively eliminating health risk associated with indoor exposure is to ban smoking activity.” As to the effects of ventilation on secondhand smoke, “No other engineering approaches, including current and advanced dilution ventilation or air cleaning technologies, have been demonstrated or should be relied upon to control health risks from ETS exposure in spaces where smoking occurs.” They conclude their position with “Because of ASHRAE’s mission to act for the benefit of the public, it encourages elimination of smoking in the indoor environment as the optimal way to control ETS exposure.”<sup>12</sup>

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## ***RECOMMENDATIONS***

On the basis of the evidence presented in this Resource Guide, it is clear that actions to protect nonsmokers from secondhand smoke exposure not only are warranted but essential to protect health. The Centers for Disease Control and Prevention's Healthy People 2010 objectives in the tobacco priority area (27-13) state the need to: "Establish laws on smoke free indoor air that prohibit smoking or limit it to separately ventilated areas in public places and worksites."

Therefore, the recommendations are as follows:

- Cities and Counties across Kentucky should adopt a comprehensive smoke free ordinance for the protection of the nonsmoking majority of citizens and the protection of all workers.
- Health Departments and local community public health coalitions should plan and implement a public education campaign to ensure public understanding of the health benefits and compliance with the ordinance, as well as provide cessation opportunities for smokers wishing to quit.
- Employers must ensure that nonsmokers are not exposed to tobacco smoke in the workplace and that compliance with the ordinance is 100%.
- For smokers, it is their responsibility to assure that their behavior does not jeopardize the health of others.
- For nonsmokers, it is their responsibility to provide a supportive environment for smokers who are attempting to stop.