
N O V E M B E R 2 0 0 1

SUBMISSION

TO THE

Health Committee

IN SUPPORT OF THE

Smoke-free Environments
(Enhanced Protection)

Amendment Bill

1999

AND

Supplementary

Order Paper

FROM THE
CANCER SOCIETY
OF NEW ZEALAND

Introduction

This submission is from the Cancer Society of New Zealand, PO Box 12145, 2nd Floor, Molesworth House, 101 Molesworth St, Wellington.

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The Cancer Society would like the opportunity to appear before the Health Committee to speak to this submission. The Society also wishes a hospitality worker with personal experience of the effects of second-hand smoke to appear in support of this submission.

The Cancer Society of New Zealand is a non-profit organisation which aims to minimise the impact of cancer on New Zealanders by:

- funding research into the causes and treatment of cancer
- supporting cancer patients and their families
- promoting education about cancer for health professionals and publicising progress made in research and treatment
- promoting healthy lifestyles to reduce the risk of cancer
- advocating on behalf of cancer patients and their families.

Cancer Society health promotion particularly focuses on areas in which cancer can be prevented, such as tobacco control, skin cancer/melanoma prevention, and nutrition and physical activity.

This submission has been prepared following consultation with a number of health groups. It includes research material sourced from the Ministry of Health.

Summary of submission

The Cancer Society strongly supports the Smoke-free Environments (Enhanced Protection) Amendment Bill (the SFE Bill) and Supplementary Order Paper (SOP). The SFE Bill and SOP seek to extend New Zealanders' protection from second-hand smoke, promote a smokefree lifestyle, reduce the harm to smokers that is caused by their smoking, and reduce young people's access to tobacco products.

Tobacco smoking kills around 5000 New Zealanders every year, either by direct smoking, or by exposure to other people's tobacco smoke.¹ Of these deaths, nearly half are due to cancer.² Tobacco smoking is also causally related to stroke and heart disease and is a major factor in Sudden Infant Death Syndrome (SIDS).

1 Ministry of Health. Tobacco Facts 1999: Wellington 2000.
Woodward A, Laugesen M. Deaths attributable to second-hand cigarette smoke in New Zealand. Report to the Ministry of Health: 2000.

2 Cancer Society of New Zealand. The Big Kill Continues: The human cost of smoking in New Zealand in the 1990s: October 1996.

Smoking by Maori, women and young people is of particular concern. Approximately half of all Maori adults still smoke, while 30 percent of 15 to 24 year olds smoke.³

With the passage of the Smoke-free Environments Act 1990, New Zealand was seen as leading the world in tobacco control. However, we now lag behind many countries in a number of areas – including the lack of legislation requiring smokefree hospitality venues, the easy access that young people have to cigarette vending machines, the availability of confectionery and toy cigarettes, and the blatant display of tobacco products.

Health effects of exposure to second-hand smoke

The Cancer Society is very concerned that some workers continue to be exposed to second-hand smoke. An estimated 388 people die every year because of exposure to second-hand smoke. This figure includes over 240 deaths from heart disease, nearly 90 deaths from stroke, 50 from AIDS, and seven from lung cancer. Around 150 of these deaths are caused by exposure to second-hand smoke in the workplace.⁴ All these deaths are preventable.

The Cancer Society strongly believes that café, bar, restaurant, club and casino workers have the right to work in a safe environment.

HOSPITALITY VENUES SHOULD BE TOTALLY SMOKEFREE

To protect workers' health, the Society believes that hospitality venues should be completely smokefree. Enabling venues to choose to allow smoking in up to half of their public areas has the potential to increase workers' exposure to second-hand smoke and therefore increase their health risk.

Bar and restaurant staff have a higher lifetime risk of heart disease, lung cancer, stroke and respiratory disease, compared to those working in a smokefree environment. A study in 1993 estimated that some bar staff are exposed to six times as much second-hand smoke at work than are other workers.⁵ This study was based on exposures in America and Europe where legislative controls are in many cases not as progressive as New Zealand's 1990 legislation. This means that bar workers' exposure in New Zealand, compared with other workers, is likely to be even more significant.

People working in smoky environments, such as bar or restaurant staff, often have little choice but to stay in that environment hour after hour, day after day. In Sydney in early 2001, Marlene Sharp was awarded over NZ\$500,000 when a jury accepted that her throat cancer was caused by exposure to second-hand smoke over 12 years in the club in which she worked.

CLUBS SHOULD ALSO BE TOTALLY SMOKEFREE

The Society would also like to emphasise that it believes that all clubs should be smokefree. This would serve not only to protect the health of club workers, but would minimise any association between sport and smoking.

3 Ministry of Health, Tobacco Facts 2001: Wellington 2001.

4 Woodward A, Laugesen M. Morbidity attributable to second-hand cigarette smoke in New Zealand. Report to the Ministry of Health: March 2001.

5 Siegel M. Involuntary smoking in the restaurant workplace. *Journal of the American Medical Association*: 1993;270:490–533.

The SOP is confusing and unnecessarily complex with regard to smoking in clubs. Complex legislation is difficult to enforce. This is evidenced by the fact that some clubs to which the public has access (particularly sports clubs) have continued to allow smoking over the past 10 years, when in fact they should have become smokefree with the passage of the 1990 legislation.

The new legislation needs to make it clear that smoking is banned in all clubs, whether chartered, RSA, sports or otherwise.

Smokefree venues benefit in a number of ways

Overseas studies show that, where restaurants and bars have gone smokefree, profits overall have not dropped, and have increased in some cases.⁶ Workers should not have to risk their health just to do their job.

A large number of international studies have shown that restrictions on smoking in workplaces result in decreased smoking by the people working in those places and can encourage quitting.⁷ In addition, smokefree workplaces result in reduced maintenance and cleaning costs for building owners/operators and reduced sick leave and time off work.⁸

The Society urges the Government to introduce totally smokefree bars, restaurants, cafés, casinos and clubs.

Schools should be totally smokefree

The Cancer Society supports the proposal to ban smoking in schools 24 hours a day, seven days a week. However, the Society would like to see the provision for smoking rooms in schools removed, and a provision to ban smoking within five metres of school entrances included. It would also like to see a provision added that bans smoking during school off-site activities. The Society also believes that smoking should be banned in tertiary institutions.

6 Glantz S. Effect of smokefree bar law on bar revenues in California. *Tobacco Control* 2000; 9(1): 111–112.

7 Biener L and Nyman A L. Effect of Workplace Smoking Policies on Smoking Cessation: Results of a Longitudinal Study. *Journal of Environmental Medicine*: 12 Dec 1999;41:1121–7.

8 The Conference Board of Canada. *Smoking and the Bottom Line: The costs of smoking in the workplace*. Jan 1997 & Alberta Tobacco Control Centre, June 1999 (cited in) *Physicians for a Smoke Free Canada, Second Hand Smoke*, p 17.

PART I

Smokefree Indoor Environments

(Note: As the SOP rewrites the Bill almost completely, the Cancer Society has based its comments on the clauses in the SOP.)

Clause 2

THE DEFINITIONS OF “FULLY VENTED” AND “COMMON AIRSPACE”

(Amendments to section 2 of the principal Act)

The Cancer Society supports the inclusion of these definitions.

The SOP defines “fully vented” as taking air from a workplace directly to a place outside that workplace, thus protecting workers from being exposed to second-hand smoke. “Common air space” is defined as an area that two or more people share.

These definitions mean that people in two different parts of a building are considered to be sharing the same common air space if the ventilation system for both areas is linked. In this situation, smoking will not be allowed. This is a great improvement on the current situation which allows people who are working in physically separate air spaces to still be subjected to the second-hand smoke of others through the air conditioning system.

EXTENDING THE DEFINITION OF “TO SMOKE” TO INCLUDE NON-TOBACCO PRODUCTS AND THEREBY BANNING THE SMOKING OF NON-TOBACCO PRODUCTS IN NO-SMOKING AREAS

(Amendment to section 2 of the principal Act)

The Cancer Society supports the extension of this definition.

Currently, people are able to smoke non-tobacco products such as herbal cigarettes in offices, restaurants etc where they would not be able to smoke tobacco products. When the 1990 Act was passed, non-tobacco smoking products such as herbal cigarettes were not as common as they are now and were not included in the legislation.

Inhaling second-hand smoke from non-tobacco products is potentially as harmful and irritating as inhaling smoke from tobacco cigarettes. Clearly it is nonsense to ban one but not the other. Banning the smoking of non-tobacco products in no-smoking areas would ensure that non-tobacco products are treated in the same manner as tobacco products.

Clauses 3, 4 and 4A

REQUIRING ALL INDOOR WORKPLACES WHERE PEOPLE WORK TOGETHER TO BE SMOKEFREE (RATHER THAN ONLY OFFICE AREAS AS AT PRESENT)

(Replacement clause 4 of the Bill, amendments to section 5 of the principal Act, new sections 5A, 5B and 5c inserted into the principal Act)

The Cancer Society supports this proposal, but believes that the exemption which allows smoking in refreshment rooms and designated smoking rooms should be removed.

The 1990 Act banned smoking primarily in office areas. Workers in other workplaces, such as factories, were not similarly protected from other people's tobacco smoke. The proposal seeks to address this anomaly by requiring all workplaces to be smokefree (with certain limited exemptions), not just office areas. The Cancer Society supports this proposal.

The Society believes, however, that in order to completely protect people's health workplaces should be totally smokefree. The Society would therefore support the removal of clauses 5A, 5B and 5c from the SOP.

Workers who are currently still exposed to smoke in their workplace are more likely to be from lower income groups, and include a disproportionate number of Maori. People from these groups have higher smoking rates, and are therefore at greater risk from smoking-related illnesses, and from illnesses caused by exposure to second-hand smoke. This contributes to the inequality of health status between Maori, Pacific people and people in lower income groups, and people in higher income, non-Maori groups.

The Treaty of Waitangi establishes the relationship between Maori and the Crown and requires both to act reasonably towards each other and with utmost good faith. The third article of the Treaty subscribes to Maori the same rights as non-Maori. However, Maori have poorer health than do non-Maori, and tobacco smoking is a major contributing factor to this inequity. To fulfil its obligations as a Treaty partner the Government needs to take all steps possible to reduce Maori smoking rates, and to reduce the exposure of Maori to second-hand smoke. Requiring all workplaces to be smokefree is a step towards achieving this goal.

Clause 6

BANNING SMOKING IN EDUCATIONAL AND CHILD MINDING ESTABLISHMENTS

(Replacement of clauses 6 & 7 in the Bill, new sections 7A, 7B, 7C of principal Act)

The Cancer Society supports the proposal to ban smoking in schools 24 hours a day, seven days a week. However, the Society would like to see the provision for smoking rooms in schools removed, and a provision to ban smoking within five metres of school entrances included. It would also like to see a provision added that bans smoking during school off-site activities. The Society also believes that smoking should be banned in tertiary institutions.

Studies have shown that children and young people are more likely to smoke if they see people around them smoking (ie: where smoking appears normal⁹). It is therefore vital that schools provide a non-smoking environment to demonstrate a healthy lifestyle. By smoking on school grounds, teachers, other school staff and/or parents are sending a message to children that smoking is an acceptable and normal part of life. Instead, children should be receiving a positive smokefree message.

9 Wakefield M, Chalopuka F et al. Effect of restrictions on smoking at home, at school, and in public places on teenage smoking: cross sectional study. *BMJ* 2000;321:333-7; and Forkas A J, Gilpin E A, White M M, Pierce J P. Association between household and workplace restrictions and adolescent smoking. *JAMA* August 9, 2000. Vol 284 No.6, pp717-722

The proposal to ban smoking in schools will also ensure that workers, children, parents and the public are protected from exposure to second-hand smoke in the school environment.

The Society is concerned, however, at the proposal to allow a smoking room in schools. This completely undermines the considerable resources and effort put into the 'smokefree schools' concept by the Cancer Society and other organisations over the past years. As a result of the work done by these agencies, around 40% of schools are now totally smokefree.¹⁰ The Society would like the provision for a smoking room in schools to be removed from the legislation. The Society supports the addition of a clause that would ban smoking within five metres of school entrances.

Several New Zealand surveys have indicated public support for smoking bans in schools. These include a 1998 Business Research Centre survey that indicated that 71 percent of the parents and guardians of children attending New Zealand schools supported a ban on smoking in schools.¹¹ In addition, a report prepared for the Health Sponsorship Council a year later, found that 88 percent of respondents did not want smoking to occur 'anywhere' in schools.¹²

The Society believes that smoking should also be banned in tertiary institutions. There is some evidence that young people may start to smoke more when they enter tertiary institutions. Smokefree venues would reduce the likelihood of this happening.

Clause 6A

RESTRICTING SMOKING IN LICENSED PREMISES, RESTAURANTS AND CASINOS TO PROVIDE PROTECTION FOR WORKERS AND THE PUBLIC FROM EXPOSURE TO SECOND-HAND SMOKE

(Replacement section 12, 13, 13A, 14 of the principal Act; new sections 12A, 13AA, 13AB, 13C of the principal Act)

The Cancer Society supports this proposal, but believes that it should be extended to require all hospitality venues to be totally smokefree, including all clubs.

The Cancer Society believes that it is vital for the health of workers that they be protected from second-hand smoke. Around 150 workers die in New Zealand each year because of exposure to second-hand smoke.¹³ These deaths are completely preventable.

The provision of vented smoking rooms for smokers will not reduce levels of second-hand smoke to a safe level for workers in these rooms. Hospitality workers are exposed to significantly higher levels of second-hand smoke than other workers in New Zealand – and hence have an increased risk of cancer, stroke and heart disease. Hospitality workers deserve a similar level of protection from exposure to second-hand smoke as other workers.

10 Personal communication from Trish Fraser of Acton on Smoking and Health.

11 Business Research Centre. Parents' views on health-related issues impacting on children. Smoke-free environments. Wellington Business Research Centre; 1998.

12 CM Research Limited. Auahi Kore/Smokefree Research Report, prepared for: Health Sponsorship Council, CM Research (New Zealand) Limited, 29/3/99.

13 Woodward A, Laugesen M. Deaths attributable to second-hand cigarette smoke in New Zealand. Report to the Ministry of Health: 2000.

There are no compliance costs for venues to become smokefree, and significant potential savings in terms of less maintenance/cleaning costs, less staff sickness, and decreased potential for litigation from employees and the public.

The Society recognises that a transition period is needed before venues become smokefree, but believes that, for the health of workers, this period should be no more than six months.

Clubs should be smokefree too

By not including all clubs in the ban on smoking in hospitality venues, the Government is continuing to allow a number of workers to be subjected to second-hand smoke. As the SOP is currently drafted, clubs with two or more employees must be smokefree (other than in permitted smoking areas and certain refreshment areas). In addition, the requirement of the present legislation continues; ie, that clubs with employees and to which the public has access must be smokefree. However, clubs with volunteers or that have only one employee and to which the public (arguably) does not have access are not required to have a smokefree work environment.

Sports clubs, in particular, are likely to have volunteer workers rather than paid employees. Continuing to allow smoking in these clubs has the potential to resurrect links between smoking and sport and leisure activities. This would be extremely unfortunate given that the banning of tobacco company sponsorship in the 1990s went some way towards debunking the myth that smoking and sport go together.

Chartered clubs with only one employee may also be able to successfully argue that the public does not have access and that therefore they do not need to be smokefree. Allowing smoking in any club puts people's health at risk.

The SOP is confusing and unnecessarily complex with regard to smoking in clubs. Complex legislation is difficult to enforce. This is evidenced by the fact that some clubs to which the public has access (particularly sports clubs) have continued to allow smoking over the past 10 years, when in fact they should have become smokefree with the passage of the 1990 legislation.

The new legislation needs to make it clear that smoking is banned in all clubs, whether chartered, RSA, sports or otherwise.

The Society would like to see:

- a new clause in the SOP which makes it clear that all clubs, whether sporting, chartered, RSA or other, must be smokefree, and
- an amendment to the definition of employee to include volunteer workers and an amendment to the definition of 'common air space' so that it reads "... an entire workplace shared by 1 or more people ..." (rather than "2 or more people ..." as at present).

Health effects of exposure to second-hand smoke

A number of studies, both in New Zealand and overseas, have shown the effects of working in a second-hand smoke filled environment. These include a New Zealand Ministry of Health-

sponsored study of salivary cotinine levels of bar workers versus other workers¹⁴ and a Wellington School of Medicine study of nicotine in the hair of hospitality workers.¹⁵

Numerous overseas studies have shown that hospitality industry workers suffer disproportionately from tobacco-related causes of death (for example, cancers of the mouth, oesophagus, larynx and lung). Overall, it has been suggested that a 50 percent increase in lung cancer risk exists among food service workers.¹⁶

A 2001 study of morbidity attributable to second-hand smoke¹⁷ found that exposure to second-hand smoke increases the risk of many diseases, and that many New Zealanders are still exposed to second-hand smoke despite the progress that has been made in the last ten years in reducing tobacco use.

Findings of the study included that each year in New Zealand second-hand smoke causes:

- more than 500 hospital admissions of children under two years who are suffering from chest infections
- almost 15,000 episodes of childhood asthma
- approximately 50 cases of meningococcal disease
- approximately 1200 admissions to hospitals for ischaemic heart disease
- almost 50 admissions for persons suffering from strokes.

It is estimated that admissions to hospital following heart attacks include about 190 events that would not have occurred if all workplaces had been totally smokefree. The study also found that Maori are, as a population group, more severely affected than non-Maori since they are more commonly exposed to second-hand smoke.

Reasons for having smokefree hospitality venues

The public wants smokefree areas

Studies have shown that the public and workers want smokefree areas. For example, a 1999 survey of 2,600 New Zealanders found that 79 percent of people overall (including 62 percent of smokers and 85 percent of non-smokers) wanted some form of protection against smoking in bars and 74 percent of people overall (including 56 percent of smokers and 79 percent of non-smokers) wanted stronger controls in restaurants than currently apply.¹⁸

A 2001 survey of 500 people found that 70 percent of respondents felt that people should not be allowed to smoke at all in bars and pubs, or should only be allowed to smoke in set areas. For restaurants, 97 percent of people felt that way.¹⁹

14 Institute of Environmental Science and Research Limited. Assessment of Exposures of New Zealand Hospitality Workers to Environmental Tobacco Smoke: March 2001. Wellington: ESR.

15 Al-Delaimy W, Fraser T, Woodward A. Nicotine in hair of bar and restaurant workers. NZ Med J 2001; 114:80-3.

16 Siegel, M, Involuntary smoking in the restaurant workplace, Journal of the American Medical Association, 1993;270:490-33.

17 Woodward A., Laugesen M. Morbidity attributable to second-hand cigarette smoke in New Zealand. A report to the New Zealand Ministry of Health, March 2001.

18 National Research Bureau of New Zealand. Attitudes Towards Environmental Tobacco Smoke: 1999. Wellington: NRB.

19 CM Research. Auahi Kore/Smokefree Research Report prepared for: Health Sponsorship Council. March 2001. (unpublished).

The same survey suggested that if restaurants were totally smokefree, 47 percent of people would be *more likely* to go to restaurants (eight percent of respondents would be less likely to attend, and it would make no difference to 44 percent of respondents). For bars, 35 percent would be more likely to attend and it would make no difference to 46 percent of people. Only 15 percent would be less likely to attend.²⁰

Smoking bans denormalise smoking

Limiting smoking in workplaces and public places make smoking seem “less normal” and discourages the uptake of smoking by young people.

Studies in the British Medical Journal and the Journal of the American Medical Association published in 2000 have suggested that restrictions on smoking in public places and workplaces may reduce teenage smoking levels.²¹

Bans can save employers money

Premises that continue to allow smoking face significant ongoing costs including:

- maintenance/cleaning and refurbishment of surfaces and furnishings as a result of tobacco smoke damage
- staff sickness and absenteeism
- increased potential for litigation by employees and the public for lack of protection from SHS.

Premises could avoid these costs by becoming smokefree.

Ventilation is not the answer

The hospitality and tobacco industries maintain that ventilation will resolve the second-hand smoke issue. This is not the case. For ventilation systems to deal effectively with second-hand smoke they would have to be the strength of a tornado. In 1998 the United States Occupational Safety and Health Administration (OSHA) brought together a panel of 14 ventilation experts to consider whether ventilation technology existed to control second-hand smoke in hospitality venues. The panel concluded that second-hand smoke could not be controlled by ventilation.

Ventilation systems filter out only a part of the contaminants found in SHS and recirculate still contaminated air back into the workplace. In addition, workers continue to be exposed to SHS before the ventilation removes it.

Air filtration systems likewise are not effective as it takes time to circulate the smoky air through filters (and tobacco smoke continues to be added to the room) and they are not able to remove all gaseous and hazardous components from the air.

20 CM Research. Auahi Kore/Smokefree Research Report prepared for: Health Sponsorship Council. March 2001. (unpublished).

21 Wakefield M, Chalopuka F et al. Effect of restrictions on smoking at home, at school, and in public places on teenage smoking: cross sectional study. *BMJ* 2000;321:333-7; and Forkas AJ, Gilpin EA, White MM, Pierce JP. Association between household and workplace restrictions and adolescent smoking. *JAMA* August 9, 2000. Vol 284 No.6, pp717-22.

Bans on smoking do not harm hospitality venues

Overseas studies show that, where restaurants and bars have gone smokefree, profits overall have not dropped, and have increased in some cases. This makes sense when you consider that 75 percent of the population don't smoke. Having smokefree venues will result in restaurants and bars beginning to attract back non-smokers.

Clause 6B

CLARIFYING THE REFERRAL TIMEFRAME FOR WORKPLACE SMOKING COMPLAINTS

(Amendment to section 15(6) of the principal Act)

The Cancer Society supports this proposal

This clause gives a timeframe of 40 days for employers to refer unresolved complaints to the Director-General of Health. Currently, there is no timeframe given for such complaints to be referred to the Director-General.

Clause 7

MAKING IT AN OFFENCE NOT TO COMPLY WITH SECTION 15(6) OF THE ACT

(Amendment to section 17 of the principal Act)

The Cancer Society supports this proposal.

Currently it is almost impossible for a complaint about smoking in a workplace to be dealt with via court action. In instances where an employer refuses to comply with the Act, the wording of section 15 of the Act makes it very difficult for the Ministry of Health to take further action as there is no obligation for the employer to refer the complaint in writing to the Director-General of Health. The proposal to make it an offence not to comply with section 15(6) will ensure that, if necessary, action can be taken against non-complying employers in the future.

Clause 7A

CLARIFYING THAT COMPLIANCE WITH THE MINIMUM REQUIREMENTS OF THE SFE ACT DOES NOT EXCUSE EMPLOYERS FROM THE REQUIREMENTS OF THE HSE ACT.

(New section 20A of the principal Act)

The Cancer Society supports this proposal.

It needs to be made clear that compliance with the minimum requirements in the SFE Act does not exempt employers from the responsibility to provide a safe and hazard-free premises, as required under the Health and Safety in Employment Act 1992 (HSE Act).

The HSE Act states that every employer must identify and assess hazards to employees and take all practicable steps to eliminate or isolate significant hazards. Where elimination and

isolation is not practicable, employers must take steps to minimise the hazard. In addition, section 16 of the HSE Act states that a person who controls a place of work must take all practicable steps to ensure that people in the vicinity of a place of work, people who are working in the place for the person who controls the place, and people with consent to be in the place and who have paid to be there or who are customers, are not harmed by hazards in the place of work.

The Cancer Society understands that the Ministry of Health and the Occupational Safety and Health Service have agreed that these obligations would apply to the hazard of tobacco smoke in the workplace.

PART II

Tobacco Products Control

Clauses 8 and 8A

PROPOSAL: RESTRICTING THE DISPLAY OF TOBACCO PRODUCTS IN RETAIL OUTLETS.

(Replacement clause 8 of the Bill, new section 23A of the principal Act)

The Cancer Society supports this proposal, but believes it should go further.

The Society recommends that instead of allowing displays of tobacco in shops, that tobacco products be placed under the counter, with only a black and white product list of limited size displayed to show what is available.

The display of tobacco products for sale is virtually the only form of tobacco product advertising allowed in New Zealand. The tobacco industry has capitalised on this, and has engineered the display of large banks of tobacco products.

As well as being an ‘in-your-face’ way of promoting tobacco products, the widespread display of tobacco products at check-outs etc makes purchasing tobacco seem like a normal part of everyday life. At the counter you can purchase a newspaper, a packet of chewing gum ... and a packet of cigarettes. However, smoking is not a normal way of life – 75 percent of people don’t smoke. Therefore, tobacco products have no place at check-out counters.

The positioning of tobacco products by lollies, and other items that appeal to children, is particularly reprehensible. Placing tobacco products under the counter would remove, once and for all, this point-of-sale association between children’s products and cigarettes.

If the Committee agrees with this proposal, it will be important to carefully prescribe in the Act what may and may not be listed on the product information board, and in what manner. Otherwise the tobacco industry will take advantage of the signage to promote their products, as they have with other avenues for price advertising in the past.



A large bank of Benson & Hedges cigarettes is “displayed for sale”

Clause 8B

PROPOSAL: TO BAN SELF-SERVICE VENDING MACHINES.

(New section 29A)

The Cancer Society supports the proposal to ban self-service vending machines but believes that the location of these machines should continue to be limited to restricted or supervised areas.

Self-service vending machines are currently an easy source of cigarettes for young people. A 1999 survey of fourth formers' access to tobacco products suggested that 8.5 percent of fourth form daily-smokers had obtained tobacco products from a vending machine. In addition, a recent survey by Hutt Valley Health found that a minor could obtain cigarettes from a vending machine in 18 out of 20 attempts. The two non-sales were due only to the minor not having the correct change.²²

At present, self-service vending machines are required to be located in restricted or supervised areas (as defined by the Sale of Liquor Act 1982). However, young people are still able to be in some areas if accompanied by a parent or guardian and therefore have access to these self-service machines. In addition, many restricted or supervised areas are easily accessed by young people, regardless of whether or not they are with a parent or guardian.

If vending machines were placed behind counters and bars in restricted or supervised areas, the staff at that venue would have to get the cigarettes for the young person, and would therefore be able to go through the steps of accessing the age of the person, and checking their identification. Clearly this is far more satisfactory than the system that exists at the moment whereby, in many venues, under-18s can simply wander up to a vending machine and purchase cigarettes.

However the Society believes that vending machines should continue to be able to be located only in restricted or supervised areas as defined by the Sale of Liquor Act 1982. Wider placement of vending machines, even when they are not self-service, risks making it easier for young people to access cigarettes.

Self-service tobacco vending machines are already banned in a number of overseas jurisdictions and it is time New Zealand offered similar protection to its young people.



Vending machine located in the entrance way of a bar in Wellington. The green door opens onto the street. The vending machine is separated from the bar by a closed door.

22 Hutt Valley Health, personal communication: July 2001.

Clause 9

PROPOSAL: TO BAN THE SALE OF HERBAL SMOKING PRODUCTS TO PEOPLE UNDER THE AGE OF 18 YEARS.

(Replacement section 30 of principal Act)

The Cancer Society supports this proposal.

Currently a bizarre situation exists whereby it is illegal to sell tobacco products to those under 18 years of age, but legal to sell them herbal smoking products. Herbal smoking products, like any combustible product, can damage people's health. Studies indicate that smoking herbal cigarettes leads to at least similar degrees of exposure to carbon monoxide (CO) and tar as does smoking tobacco cigarettes. CO is strongly linked to the development of coronary heart disease and may contribute to cancers and other diseases of the respiratory tract.

Banning the sale of herbal cigarettes to people under 18 years of age would further protect them from the harmful effects of smoking.

PROPOSAL: BANNING THE SUPPLY OF TOBACCO PRODUCTS AND HERBAL SMOKING PRODUCTS TO PEOPLE UNDER 18 YEARS OF AGE.

(New section 30AA of principal Act)

The Cancer Society supports this proposal.

Banning the supply of tobacco products to those under 18 sends a message that it is not acceptable to help young people become addicted to tobacco by furnishing them with cigarettes. Surveys of fourth form students have found that the number of young people being supplied with cigarettes by friends or family rose dramatically in the 1990s. For example, in 1998, 40.7 percent of fourth formers surveyed sourced their cigarettes from someone else who bought them, compared to 14.5 percent in 1992.²³

The proposed amendment will make it more difficult for young people to access tobacco products, thereby helping to reduce the number of young people who begin to smoke regularly. The earlier people start to smoke, the more likely they are to remain smokers for the rest of their lives, smoke heavily, and die from smoking.²⁴

For reasons of consistency and similarity of risk it is important that the restrictions that are applied to tobacco products also apply to herbal smoking products.

23 Laugesen M, Scragg R. Trends in cigarette smoking and purchasing by fourth-form students in New Zealand, 1992, 1997 and 1998. Report for the Ministry of Health.

24 National Institute on Drug Abuse. Drug Use, Drinking and Smoking: National Survey Results from High School, College and Young Adult Populations. Washington, D.C.: USDHHS, 1993

Clause 9A

PROPOSAL: TO GIVE JUDGES, WHEN CONVICTING A PERSON FOR A REPEAT OFFENCE OF SELLING TOBACCO TO MINORS, THE ABILITY TO PROHIBIT RETAILERS FROM SELLING TOBACCO OR HERBAL PRODUCTS FOR A PERIOD OF UP TO THREE MONTHS.

(Replacement clause 9 of Bill, new section 30AB of principal Act)

The Cancer Society supports this proposal, but believes these retailers should be banned from selling tobacco for a minimum of six months.

Reducing young people's access to tobacco products is an important part of an overall strategy to reduce the uptake of smoking. Currently, retailers who are convicted of selling tobacco products will usually receive fines of between \$0 and \$500, despite a maximum fine of \$2000 being available. The Cancer Society understands that the average fine is around \$200. Furthermore, a retailer in Auckland was recently convicted of selling tobacco to a minor for a third time, and only received a fine of \$600. Such low fines provide little incentive for retailers to obey the law, particularly given the large amount of profit retailers make from the sale of tobacco.

Giving judges the ability to ban retailers from selling tobacco and herbal products for a specified period, or placing restrictions on the sale of tobacco and herbal products, will result in more retailers obeying the law and not selling tobacco products to young people.

The Cancer Society believes, however, that banning retailers from selling tobacco for a period of between four weeks and three months is an insufficient penalty for such a repeat offence. There is no excuse for retailers to sell tobacco to minors – and particularly not to Ministry of Health volunteers who usually look no older than their actual age, and often look younger. Retailers in doubt of a young person's age only need to ask to see identification. If a retailer has failed to take these easy steps twice (or more) they should receive a significant penalty. The Cancer Society believes that a minimum of six months is necessary as a deterrent.

PROPOSAL: REQUIREMENT FOR PHOTO IDENTIFICATIONS

(Replacement section 30 of the principal Act)

The Cancer Society supports this proposal, but believes that it should go further and make it a requirement to sight an evidence of age document.

Currently, there is a defence available to retailers charged with selling tobacco to minors, if they can prove that they took reasonable precautions and exercised due diligence to prevent the commission of the offence. Unlike sales of liquor to young people, there is not a requirement that a photo identification be sighted. Adding a defence that a person who is charged with selling or supplying tobacco products or herbal smoking products to a person under 18 years proves that the contravention occurred without his or her knowledge if they can prove that they sighted an evidence-of-age document, will enable retailers to take clearly defined steps before selling tobacco to young people. The end result will be that young people will have reduced access to tobacco products.

However, the Cancer Society would support a change in emphasis so that instead of it being a defence to prosecution if the retailer sights a proof of age document, that it be make a requirement of sale that such a document is sighted. In certain jurisdictions in the United States, for example, it is a requirement that retailers ask to see evidence of age from people aged up to 27 years. This is to ensure that it is made that much more difficult for the age of minors to be mistaken by retailers.

Clause 9c

REGULATION-MAKING POWERS FOR PICTORIAL HEALTH WARNINGS

(Replacement section 32 of the principal Act)

The Cancer Society supports this proposal.

Pictorial health warnings have recently been introduced in Canada. These warnings feature graphic illustrations of the harm that can be caused by smoking-related diseases (for example pictures of cancer of the mouth, brain and lungs, or gangrenous body parts) or smoking-related situations (such as the health effects of second-hand smoke associated with a picture of a child/baby, or graphs showing the deaths each year from tobacco smoking in comparison with other illnesses, homicides and car accidents).

Pictorial health warnings have an advantage over written health warnings in that they are able to better inform smokers about the damage smoking can do to their health. These warnings also cross the language barrier and can convey a graphic message to those who may not have a good understanding of English.

REGULATION-MAKING POWERS FOR INSERTS IN TOBACCO PACKETS TO CONTAIN INFORMATION ON THE CONTENTS OF TOBACCO

(Replacement section 32 of the principal Act)

The Cancer Society supports this proposal and urges the Government to require full product information on the contents of tobacco and the compounds in tobacco smoke to be available with tobacco packets.

Smokers have the right to know what they are smoking, and therefore to be able to make an informed choice about whether or not to continue smoking. While warnings on cigarette packets enable brief targeted information to be provided to every smoker, there is not enough room on the pack for detailed consumer information to be provided. This regulation-making power provides a future opportunity to provide smokers with a full range of consumer information (subject to better content disclosure obligations being imposed on tobacco companies – see regulation-making power below). This is only fair given that food and other products must provide such information. Given that tobacco products are the only consumer product that, when used as directed, kill half their consumers, it would seem logical that the state require tobacco manufactures to provide that information to smokers.

REGULATION-MAKING POWERS FOR DISCLOSURE OF THE CONTENTS OF TOBACCO

(Replacement section 35 of the principal Act)

The Cancer Society supports this proposal and urges Government to require full disclosure of the contents of tobacco products and the compounds in tobacco smoke.

The limited information currently supplied to the Ministry of Health by tobacco companies makes it impossible to know which additives are in a particular tobacco product and in what amount. Which chemicals are in tobacco smoke is also unknown. Public health policy makers and advocates need that information to better target health messages for smokers – and potential smokers.

This information should then be passed on to smokers by way of inserts in tobacco packets (see above). Such information could also provide the basis of media campaigns and education programmes in schools discouraging smoking.

REGULATION-MAKING POWERS FOR LABELING AND HEALTH WARNINGS ON HERBAL SMOKING PRODUCTS

(New section 32AA of the principal Act)

The Cancer Society supports this proposal and urges Government to make regulations which require health warnings on herbal smoking products, and which also require a list of the harmful constituents in those products and in the smoke of those products.

As detailed above, herbal cigarettes, like any combustible product, can damage people's health. It is important that herbal products carry health warnings and constituent information that convey similar messages to those required on tobacco products.

REGULATION MAKING POWERS THAT REQUIRE THE TESTING OF HERBAL PRODUCTS AND THE SUPPLYING OF ANNUAL REPORTS ON THE CONTENTS OF HERBAL PRODUCTS TO THE DIRECTOR-GENERAL OF HEALTH.

(Replacement sections 33 to 35 of the principal Act)

The Cancer Society supports this proposal and urges the Government to require annual reports on the contents of herbal products.

PART IIA

Powers of Enforcement Officers

PROPOSAL: TO GIVE SOME BASIC POWERS TO ENFORCEMENT OFFICERS.

(Replacement section clause 5 of the Bill, new Part 2A in the principal Act)

The Cancer Society supports this proposal.

Ministry of Health enforcement officers currently have no powers under the Act. Enforcement officers need powers that enable them to effectively administer and monitor compliance with the legislation, such as powers of entry and inspection and the power to require a person to give identifying information. The lack of these powers risks situations where the law is broken, but action cannot be taken.

The Cancer Society also understands that the proposal to make it an offence to purchase cigarettes for supply to a minor will be unenforceable without the power to seek information relating to the name of the person alleged to have carried out the supply.

Suggested Additions to the Legislation

PROPOSAL: TO BAN THE SALE OF TOBACCO PRODUCT LOOK-ALIKES IN THE FORM OF CONFECTIONERY AND JOKE/TOY CIGARETTES.

The Cancer Society believes the Act should be amended to ban the sale of confectionery and joke or toy cigarettes.

Confectionery and joke cigarettes are counter to one of the major purposes of the Act, which is to reduce the social approval of tobacco use, particularly among young people.

Confectionery cigarettes are available from some dairies and supermarkets. For example, Hitschler brand chewing gum cigarettes consist of sticks of chewing gum with a tobacco paper-coloured wrapper complete with 'filter' tip, and come in mock cigarette packets which have a flip-top in the same way as real cigarette packets. They are labelled "Chewing gum cigarettes" and are clearly targeted at children and promote mimicry of smoking. Other brands that are available internationally mimic actual cigarette brand labels.

The Cancer Society is also concerned about the availability of imitation or joke cigarettes. These items are clearly designed for young people to mimic smoking. One product, for example, is a cardboard roll with a white substance that can be blown out of its top to mimic smoking. They can be purchased at \$2 Shops and joke shops.



Joke cigarettes



"Chewing gum" cigarettes

A number of Australian jurisdictions (Australian Capital Territory, Queensland, and Tasmania) prohibit the sale of cigarette confectionery and toys. Western Australia is considering such controls. In Finland, all tobacco imitations that do not contain tobacco, but are produced for consumption, have been banned since 1977.

PROPOSAL: TO RESTRICT SMOKING IN ALL PUBLIC PLACES

The Cancer Society believes that all public places should be smokefree, not just workplaces.

The Cancer Society urges the Government to include all indoor public places in this legislation, including houses, shopping malls, indoor sports arenas etc. At present, smoking is allowed in a number of venues to which the public has access because they are not workplaces. These venues include houses, shopping malls and some indoor sports arenas. A ban on smoking in all indoor public places would require these venues to be smokefree.

PROPOSAL: TO BAN MISLEADING TERMS DESCRIBING TOBACCO, SUCH AS 'LOW TAR' AND 'MILD' CIGARETTES.

Recent research in the United States shows that many smokers believe that 'low tar', 'light' and 'mild' cigarettes are safer. In fact, these cigarettes cause at least as much harm to health as do regular cigarettes.²⁵ Therefore, the Cancer Society seeks to ban the use of these misleading terms in relation to cigarettes.

25 Paper presented by Saul Shiffman to First National Tobacco Control Conference, Adelaide June 2001.

Additional References

Second-hand smoke is a killer

International (authoritative reports on the health risks of exposure to SHS)

- Boffetta P. et al. Multicenter case-control study of exposure to environment tobacco smoke and lung cancer in Europe. *Journal of the National Cancer Institute*. 1998;90:1440–1450
- Bonita, R et al, Passive smoking as well as active smoking increases the risk of acute stroke, *Tobacco Control*, 1999; 8:156–160
- Californian Environmental Protection Agency. Health effects of exposure to environmental tobacco smoke, Office of Environmental Health Hazard Assessment, 1997
- Hackshaw AK, Law MR, Wald NJ, The accumulated evidence on lung cancer and environmental tobacco smoke, *BMJ*. 1997;315:980–988
- He J et al. Passive smoking and the risk of coronary heart disease – a Meta-Analysis of Epidemiologic Studies, *The New England Journal of Medicine*, 25 March 1999, 340:12:920–926
- International Agency for Research on Cancer, Tobacco Smoking, IARC Monographs on the Evaluation of the Carcinogenic Risk of Chemicals to Humans Vol.38 1986
- Law, MR et al, Environmental tobacco smoke exposure and ischaemic heart disease: an evaluation of the evidence, *British Medical Journal*, 1997;315:973–980
- National Health and Medical Research Council. Effects of Passive Smoking on Health: Report of the NHMRC Working Party on the Effects of Passive Smoking on Health, 1987 NHMRC, Canberra Australia
- UK Independent Scientific Committee on Smoking and Health. Fourth Report of the Independent Scientific Committee on Smoking and Health, 1988
- US Dept of Health and Human Services, The Health Consequences of Involuntary Smoking: A Report of the Surgeon General. Office on Smoking and Health, Center for Health Promotion and Education, Centers for Disease Control, Public Health Service, US Dept of Health and Human Services. 1986
- US Environmental Protection Agency. Respiratory Health Effects of Passive Smoking: Lung Cancer and Other Disorders. USEPA, Office of Research and Development, 1992
- US National Research Council, Environmental Tobacco Smoke – Measuring Exposures and Assessing the Health Effects. Committee on Passive Smoking, Board on Environmental Studies and Toxicology, National Research Council, 1986
- You RX et al, Ischemic stroke risk and passive exposure to spouses' cigarette smoking. Melbourne Stroke Risk Factor Study Group, *American Journal of Public Health*, 1999; 89: 572–575

Hospitality workers have a higher exposure to second-hand smoke, and hence increased health risk

New Zealand-specific

- Al-Delaimy W, Fraser T, Woodward A. Nicotine in hair of bar and restaurant workers. *NZ Med J* 2001;114:80–3
- Institute of Environmental Science and Research Limited. Assessment of Exposures of New Zealand Hospitality Workers to Environmental Tobacco Smoke. Wellington: ESR (not yet published)
- Jones S, Love C, Thomson G, Green R, Howden-Chapman P. Second-hand smoke at work: The exposure, perceptions and attitudes of bar and restaurant workers to environmental tobacco smoke. *Aust NZ J Public Health* 2001; 25:90–3
- Woodward, A and Laugesen M. *Deaths in New Zealand attributable to second hand cigarette smoke*. 2000. Wellington: Ministry of Health. Available at <http://www.ndp.govt.nz>
- Woodward, A and Laugesen M. Morbidity attributable to second hand cigarette smoke in New Zealand. 2001 (in preparation). Unpublished (expected to be released April–May 2001)
- Woodward, A and Fraser T, Passive Smoking in New Zealand: health risks and control measures, *The New Zealand Public Health Report*, May 1997;4(5):35–36

International (references relating to hospitality workers in particular)

- Andersen, AA et al, Cancer in Waiters, *British Journal of Cancer*, 60 (1989) 112–5 Bergman, TA et al, Occupational exposure of nonsmoking nightclub musicians to environment tobacco smoke, *Journal of the American Industrial Hygiene Association*, 1996;57:46–52
- Brauer, M and 't Mannetje A, Restaurant Smoking Restrictions and Environmental Tobacco Smoke Exposure, *American Journal of Public Health*, 1998;89(1):1834–1836
- Brown, KG, Lung Cancer and Environmental Tobacco Smoke: Occupational Risk to Nonsmokers, *Environmental Health Perspectives*, 1999;107(Supp.6):885–890
- Cuddeback, JE et al, Occupational aspects of passive smoking, *Journal of the American Industrial Hygiene Association*, 1976;37:263–267
- Davis, RM, Exposure to Environmental Tobacco Smoke: Identifying and Protecting Those at Risk, *Journal of the American Medical Association*, 9 Dec 1998;280:1947–1949
- Dimich-Ward, H et al, Occupational Mortality among Bartenders and Waiters, *Canadian Journal of Public Health*, 1988;79:194–7

- Dimich-Ward, H et al, Analysis of Nicotine and Cotinine in the Hair of Hospitality Workers Exposed to Environmental Tobacco Smoke, *Journal of Environmental Medicine*, Oct 1997;39(10):946–948
- Eisner, E et al, Bartenders' Respiratory Health After Establishment of Smoke-Free Bars and Taverns, *Journal of the American Medical Association*, 1998;280(22):1909–1914
- Jarvis, MJ et al, Exposure to passive smoking among bar staff, *British Journal of Addiction*, 1992;87:111–3
- Maskarinec, MP et al, Determination of exposure to environmental tobacco smoke in restaurant and tavern workers in one US city, *Journal of Exposure Analysis and Environmental Epidemiology*, 2000;10(1):36–49
- Repace, J and Lowrey AH, A Quantitative Estimate of Nonsmokers' Lung Cancer Risk From Passive Smoking, *Environmental International*, 1985;11:3–22.
- Reynolds P, Epidemiologic Evidence for Workplace ETS As a Risk Factor for Lung Cancer among Nonsmokers: Specific Risk Estimates, *Environmental Health Perspectives*, Dec 1999;107(Supp.6):865–872
- Schoenberg, JB et al, Occupation and Lung Cancer risk among New Jersey white males. *Journal of the National Cancer Institute*, 1987;79:13–21
- Siegel, M, Involuntary smoking in the restaurant workplace, *Journal of the American Medical Association*, 1993;270:490–3
- Sterling, TD and Weinkam JJ, Smoking characteristics by type of employment, *Journal of Occupational Medicine*, 1976;18:743–754
- Zahm, S.H. et al, Study of Lung Cancer Histologic Types, Occupation and Smoking in Missouri, *American Journal of Industrial Medicine*, 1989;15:565–578.
- Goldstein, AO and Sobel RA, Environmental Tobacco Smoke Regulations Have Not Hurt Restaurant Sales in North Carolina, *North Carolina Medical Journal*, Sept/Oct 1998;59(5):284–288.
- Huang, P et al, Assessment of the impact of a 100 percent smoke-free ordinance on restaurant sales – West Lake Hills, Texas, 1992–1994. *Journal of the American Medical Association*, 1995;274:205 & 208
- Hyland, A and Cummings M, Consumer Response to the New York City Smoke-Free Air Act, *Journal of Public Health Management Practice*, 1999;5(1):28–36.
- Hyland, A et al, Analysis of Taxable Sales Receipts: Was New York City's Smokefree Air Act Bad for Restaurant Business? *Journal of Public Health Management Practice*, 1999;5(1):14–21.
- Hyland, A and Cummings KM, Restaurateur reports of the economic impact of the New York City Smoke-Free Air Act, *Journal of Public Health Management Practice*, 1999;5(1):37–42
- Hyland, A and Cummings KM, Restaurant employment before and after the New York City Smoke-Free Air Act, *Journal of Public Health Management Practice*, 1999;5(1):22–27
- Sciacca, JP, A Mandatory Smoking Ban in Restaurants: Concerns Versus Experiences, *Journal of Community Health*, April 1996; 21(2):133–150.
- Sciacca, J. and Ratliff M, Prohibiting smoking in restaurants: effects on restaurant sales, *American Journal of Health Promotion*, 1998;12(3):176–84.
- Semmonds, A et al, Smoking in hotels: prevalence and opinions about restrictions, *Australian Journal of Public Health*, 1995;19(1):98–100

The public supports smokefree areas

New Zealand specific

- CM Research. Auahi Kore/Smokefree Research Report prepared for: Health Sponsorship Council. March 2001. (unpublished)
- Forsythe Research. TVC/Me Mutu Campaign Monitoring Baseline Report. Prepared for the Quit Group. March 2001 (draft, unpublished report)
- National Research Bureau of New Zealand. *Attitudes Towards Environmental Tobacco Smoke*. 1999. Wellington: NRB.
- Jones S, Love C, Thomson G, Green R, Howden-Chapman P. Second-hand smoke at work: The exposure, perceptions and attitudes of bar and restaurant workers to environmental tobacco smoke. *Aust NZ J Public Health* 2001; 25:90–3

International:

- Biener, L and Fitzgerald G, Smoky Bars and Restaurants: Who Avoids Them and Why?, *Journal of Public Health Management Practice*. 1999;5(1):74–8
- Biener, L & Siegel S, Behavior Intentions of the Public after Bans on Smoking in Restaurants and Bars, *American Journal of Public Health*, Dec 1997;87(12):2042–2044

Smokefree venues are profitable

- Bartosch, WJ and Pope GC, The Economic Effect of Smoke-Free Restaurant Policies on Restaurant Business in Massachusetts. *Journal of Public Health Management Practice*, 1999; 5(1):53–62.
- Corsun, DL et al, Should NYC's Restaurateurs Lighten Up? *Cornell Hotel and Restaurant Administration Quarterly*, April 1996;25–33
- Cremieux, P and Ouellette P. Actual and perceived impacts of tobacco regulation on restaurants and firms. *Tobacco Control* 2000; 10:33–37.
- Glantz, SA and Charlesworth A, Tourism and hotel revenues before and after passage of smoke-free restaurant ordinances, *Journal of the American Medical Association*, 1999;281:1911–1918
- Glantz, S and Smith L, The Effect of Ordinances Requiring Smoke Free Restaurants on Restaurant Sales, *American Journal of Public Health*, 1994;84(7):1081–5
- Glantz, S and Smith L. The Effect of Ordinances Requiring Smoke-Free Restaurants and Bars on Revenues: A Follow-up, *American Journal of Public Health*, 1997;87(10):1687–1693.

- Brooks D and Mucci L. Support for Smoke-Free Restaurants Among Massachusetts Adults, 1992–1999. *American Journal of Public Health*, February 2001, Vol 91, No.2.
- Schofield, MJ and Edwards K, Community attitudes to bans on smoking in licensed premises, *Australian Journal of Public Health*, 1995;19(4):399–402
- Trotter L, Survey of Melbourne Restaurant Patrons on Smokefree Dining 1997, Centre for Behavioural Research in Cancer, May 1997

Smoking bans encourage smokers to quit or cut down

- Biener, L and Nyman, AL, Effect of Workplace Smoking Policies on Smoking Cessation: Results of a Longitudinal Study, *Journal of Environmental Medicine*, 12 Dec 1999;41:1121–1127
- Borland, R et al, Effects of Workplace Smoking Bans on Cigarette Consumption, *Australian Journal of Public Health*, February 1990;180(2):178–180
- Borland, R et al, Changes in smoking behaviour after a total workplace smoking ban, *Australian Journal of Public Health*, 1991;15(2):130–134
- Chapman, S et al, The Impact of Smoke-Free Workplaces on Declining Cigarette Consumption in Australia and the United States, *American Journal of Public Health*, July 1999;89(7):1018–1023
- Evans, WN et al, Do Workplace Smoking Bans Reduce Smoking? *American Economic Review*, Summer 1999;89:728–747
- Glasgow, RE et al, Relationship of worksite smoking policy to changes in employee tobacco use: findings from COMMIT, *Tobacco Control*, 1997;6 (Supp 2): S44–48
- Moskowitz, JM et al, The Impact of Workplace Smoking Ordinances in California on Smoking Cessation, *American Journal of Public Health*, May 2000;90(5):757–761

- Olive, K and Ballard JA, Changes in Employee Smoking Behaviour After Implementation of Restrictive Smoking Policies, *Southern Medical Journal*, 1996;89:699–706

- Stave, GM and Jackson GW, Effect of a Total Work-site Smoking Ban on Employee Smoking and Attitudes, *Journal of Occupational Medicine*, August 1991; 33(8):884–890

- Wakefield, MA et al. Workplace Smoking restrictions, Occupational Status, and Reduced Cigarette Consumption, *JOM*, July 1992;34(7):693–697

Ventilation does not protect against exposure to second-hand smoke

- Australian Council on Smoking and Health, Is Ventilation the Answer to Passive Smoking, c.1998.
- Johansson, J et al, Long Term Test of the Effect of Room Air Cleaners on Tobacco Smoke, *Proceedings of Indoor Air '93*;6:387–392
- Repace, J and Lowrey AH, c.1982. Tobacco Smoke, Ventilation and Indoor Air Quality, HO-82-6 No.2.
- Repace, J et al, Fact Sheet on Secondhand Smoke, 23–7 Feb 1999, 2nd European Conference on Tobacco or Health.
- Repace, J and Lowrey AH, Indoor Air Pollution, Tobacco Smoke, and Public Health. *Science*, 2 May 1980;208:464–472.
- Repace, J and Lowrey AH, An Enforceable Indoor Air Quality Standard for Environmental Tobacco Smoke in the Workplace, *Risk Analysis*, 1993;13(4):463–475.
- Sterling, TD et al, Indoor Byproduct Levels of Tobacco Smoke: A Critical Review of the Literature, *Journal of the Air Pollution Control Association*, Mar 1982;32(3):250–259