Approved: March 21, 2005
Date

MINUTES OF THE HOUSE FEDERAL AND STATE AFFAIRS COMMITTEE

The meeting was called to order by Chairman John Edmonds at 1:30 P.M. on March 9, 2005 in Room 313-S of the Capitol.

All members were present except:	Representative Ray Cox- excused Representative Todd Novascone- excused
Committee staff present:	Athena Andaya, Kansas Legislative Research Department Dennis Hodgins, Kansas Legislative Research Department Mary Torrence, Revisor of Statutes Office Carol Doel, Committee Secretary
Conferees:	Gene Cannata, M.D. Howard Rodenberg, M.D. John Hauxwell, M.D. Elaine Schwartz, KS. Public Health Assn Katherine Bruner, Chairman, Clean Air Lawrence Coalition Shane Reif Terri Roberts, KS State Nurse Association Ron Hein, Kansas Restaurant and Hospitality Chuck Magerl, Free State Brewery - Lawrence, KS. Ron Anderson, Herford House - Lawrence, KS Joni Bocelewatz, Business Owner
Others attending:	See attached list

Chairman Edmonds opened the meeting asking for any bill introductions.

Representative Mary Pilcher-Cook requested a bill that would discover and prosecute perpetrators of sex crimes.

With no objections, the bill was accepted for introduction.

Chairman Edmonds appointed a subcommittee to study **SB 195** and bring back a substitute bill with all the necessary elements of **SB 195, HB 2439, HB 2449, HB 2303,** and **HB 2177** as well as a definition for the concept of the firearm. The committee will be chaired by Representative Siegfreid, with the other members being Representative Burroughs, Representative Ruff, Representative Brunk and Representative Kinzer.

The Chair opened the floor for public hearing on **HB 2495** concerning smoking; enacting the Kansas public smoking ban act; prohibiting certain acts and providing penalties for violation and asked Mary Torrence of the Revisor's Office to brief the committee on the provisions of the bill.

Mary advised that **HB 2495** would enact a Kansas public smoking ban act. It would not take effect until January 1, 2007 and would be effective only in the cities and counties that had not voted to opt out of the provisions of the act. A city or county in an unincorporated area could opt out prior to the taking effect of the ban and then they could opt back in at a later date if they wished. The question would go to the voters either on submission by resolution of the city government body or the county commission or on petition filed by the voters. The bill prohibits smoking in all enclosed places. The bill would also prohibit smoking whether or not the place is enclosed if it is a sports arena, food service establishment, club or drinking establishment or a cereal malt beverage retail business. The bill further would prohibit smoking in enclosed places of employment and enclosed facilities at the state and political subdivisions of the state. There are certain places that the bill makes clear are not subject to the smoking ban and those are private residences unless they are used for travel care, adult day care or as a health care facility. Retail tobacco stores would not be subject to the ban. The bill also makes it clear that any owner/operator or manager or any person that is in control of an establishment can declare the entire establishment to be smoke free. The bill would hold the person who has control of the building or establishment as being responsible for posting signs. The Department of Health and Environment would be responsible for promotion of the act and licensing

authorities for drinking establishments and liquor retailers. There is a prohibition for any person or employee from taking retaliation against any person who tries to enforce the ban. Violation of the act is a misdemeanor subject to a fine not exceeding $100 for the first violation and $200 maximum fine for the second violation and for a third violation it would be a maximum fine of $500. It would also repeal the current criminal statutes that deal with smoking in public places. (No Attachment)

Dr. Gene Cannata was recognized and presented testimony as a proponent on **HB 2495** on behalf of the Kansas Academy of Family Physicians of Wichita, Kansas. Dr. Cannata stated facts regarding the human toll of tobacco use and secondhand smoke as well as the price tag. He further stated that as family physicians in Kansas, they daily see lives that are unalterably affected by the damaging, but preventable, effects of tobacco use and secondhand smoke. (Attachment 1)

Director of Health for the Kansas Department of Health and Environment and Kansas State Health Office, Dr. Howard Rodenberg, came before the committee supporting **HB 2495.** Dr. Rodenberg said the organizations which he represents wholeheartedly support the concept of clean indoor air. He further related that tobacco use is the single most preventable cause of death and disease in Kansas. Dr. Rodenberg also stated that there are several items within the text that will require clarification. These items inadvertently weaken the bill, and impair the collective ability to achieve clean indoor air. (Attachment 2)

Dr. John Hauxwell, Family Practice Physician from Hays, and currently serving as Vice-President of the Tobacco Free Kansas Coalition, testifying in support of **HB 2495** gave their opinion that this bill is the effort to protect all the people of Kansas from tobacco smoke pollution in public places. They urged the committee to acknowledge the importance of the dangers of tobacco smoke pollution by supporting the bill. (Attachment 3)

The Kansas Public Health Association, Inc. was represented by Elaine Schwartz the Executive Director supporting **HB 2495.** The testimony of Mrs. Schwartz was prepared by Dr. Kim Richter a Kansas Public Health Association member relating that this bill will protect the health of Kansans and it will not affect the revenues of restaurants and bars, which are just about the last work sites that permit smoking indoors. (Attachment 4) Included in the testimony were statistics and references regarding smoke-free air. (Attachment 5)

Kathy Bruner, volunteer coordinator for Clean Air Lawrence supports **HB 2495** and has been working over the past two years to establish, and now to maintain a citywide ban on public indoor smoking. It is her organization's stand that we as a state and a society must do everything possible to protect the coming generations from the cycle of nicotine addiction that we can no longer afford both in health care costs and human costs. (Attachment 6)

Shane Reif, an eighteen year old senior at the Hoisington High School in Hoisington, Barton County urged the committee to pass **HB 2495,** and help make the State of Kansas smoke free in all public places and work places. (Attachment 7)

Making a presentation in support of **HB 2495**, was Terri Roberts, J.D., R.N., Executive Director of Kansas State Nurses Association (KSNA). Ms. Roberts spoke of the dangers of secondhand smoke, the economic impact, and changes in employee health. (Attachment 8)

Written testimony in support of **HB 2495** was submitted by Kansas Medical Society (Attachment 9), Kansas Association of Osteopathic Medicine (Attachment 10), American Lung Association (Attachment 11), American Heart Association (Attachment 12)

There were no other proponents wishing to address **HB 2495** and The Chair opened the floor to the opponents recognizing Ron Hein, legislative counsel for the Kansas Restaurant and Hospitality Association (KRHA) who stated that they oppose **HB 2495** as they are a firm believer in the right of a business owner, and a private property owner to determine issues such as the smoking issue. Mr. Hein further stated that this bill is another example of the government protecting people from themselves. (Attachment 13)

Chuck Magerl of the Free State Brewery, Lawrence, Kansas, opposes **HB 2495**. Mr. Magerl is a nonsmoker,

anti-smoking, but certainly not anti-smoker. He further related that the government has no role in accommodating personal preferences at the expense of private businesses, especially when a person has many options to enjoy a smoke free environment if that is important to him. (Attachment 14)

Ron Anderson owns and operates two Hereford House Restaurants in the state of Kansas. Mr. Anderson opposes **HB 2495** because it is his opinion that the drop in business which he has experienced is largely due to the decrease in traffic in their Lawrence location since the total smoking ban was implemented July 1, 2004. He further related that if they do not enforce the smoking clauses they will be obligated to pay a fine as high as $500. He encourages the committee to find an outlet to smoke legally for those who wish to do so. (Attachment 15)

Joni Bocelewatz, KC K drinking establishment owner, spoke against **HB 2495** relating that a smoking ban was going to effect businesses along the state line corridors. She further stated that at a time when we are trying to bring a viable economy to downtown KCK, this would be an economic disaster for the bar owners, in addition to losing valuable Kansas tax dollars to surrounding states. (Attachment 16)

Written testimony in opposition to **HB 2495** was submitted by Ron Hein legislative counsel for the R.J. Reynolds Tobacco Company (Attachment 17), and by Phil Bradley representing the Kansas Licensed Beverage Association (KLBA) (Attachment 18)

With no other persons wishing to address the bill, The Chairman closed the public hearing on **HB 2495**.

There was no other business before the committee and the Chairman adjourned the meeting.

HOUSE FEDERAL & STATE AFFAIRS COMMITTEE GUEST LIST

DATE 3-9-05

NAME	REPRESENTING
Joni Bocelewatz	Bar owner
Jon Hauxwell, MD	TFKC
Mike Reecht	Xcaliber International
Chip Wheelen	Asn of Osteo. Med.
[illegible]	Hein Law Firm
Ward Cook	American Cancer Society
[illegible]	PMCA
Kevin Walker	American Heart Ass'n.
Josh Bender	Rep. Bethell
Terri Roberts	Ks. State Nurses Assn.

Kansas Academy Of Family Physicians

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Aaron Sinclair, Wichita
Student Representative

Carolyn N. Gaughan, CAE
Executive Director

The largest medical specialty group in Kansas.

March 9, 2005

To: House Committee on Federal and State Affairs
From: Gene Cannata, MD
Re: House Bill 2495

Chairman Edmonds and Committee Members:

Thank you for this opportunity to present testimony on House Bill 2495, on behalf of the Kansas Academy of Family Physicians (KAFP). My name is Gene Cannata, MD, and I am a Family Physician in Pratt, Kansas. I am also a member of the Board of Directors of the Kansas Academy of Family Physicians (KAFP). We have over 1,430 members in our organization, including over 825 practicing physicians, 155 resident-physicians, medical students, and retired members.

First, we want to applaud you for addressing the extremely important health issue of tobacco use and secondhand smoke. Other conferees can discuss the political ramifications. I want to talk to you about the health effects.

As a physician, the *very sickest group* of people that we see in our offices, emergency rooms, and hospitals across our state, *are those individuals who have damaged their hearts, lungs, and blood vessels through tobacco use.*

We know that **cigarette smoking is the number one cause of death and disease in the United States.** Sure, everyone knows an Uncle Charlie that smoked til he was 90 or the friend that died of lung cancer even though they never smoked. However, the reality is that nearly half a million people die each year of smoking related causes. <u>More people die of smoking related disease than the combined deaths from alcohol, cocaine, heroin, suicide, homicide, motor vehicle accidents, and AIDs</u>. Tobacco use is responsible for one in five deaths.

Cancer: Tobacco accounts for at least 30% of all cancer deaths and almost 90% of lung cancer deaths. Smokers who die of lung cancer die 20-25 years earlier than those who do not smoke. Lung cancer mortality rates are 22 times higher for male smokers and 12 times higher for female smokers than for those who have never smoked. Smoking also increases the risk for cancers of the mouth, nasal cavities, throat, windpipe, esophagus, stomach, pancreas, liver, cervix, kidney, bladder, and for leukemia. In addition to cancer, smoking is the major cause of **chronic bronchitis** and **emphysema.**

Vascular disease. Smokers also have five times as many **heart attacks** as non-smokers. Tobacco use is responsible for more than 75% of all heart attack deaths in young smokers, under the age of 50. Tobacco use damages blood vessels, causing arteriosclerosis – hardening of the arteries. This dramatically increases the risk of **heart disease** and **stroke**, as well as other problems associated with poor circulation.

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Attachment 1

Other: For **diabetic patients,** smoking *greatly* accelerates the damage to the kidneys, heart and blood vessels. Diabetics who smoke have a greater risk of amputations and an earlier need for kidney dialysis. Smoking causes stomach ulcers and heartburn, and exacerbates asthma, allergies, and eye irritation. It causes chronic coughs, sinus inflammation, and increased tooth and gum disease. The list goes on and on.

Second hand smoke: Secondhand smoke is also a leading cause of preventable death in the United States. Smoke-filled rooms allow people to inhale over 4,000 different pollutants and toxins: 200 of them are poisons; at least 60 are known to cause cancer. Secondhand smoke has been classified by the Environmental Protection Agency as a Group A carcinogen. This group includes only 15 other pollutants, including radon and asbestos. We ban radon. We ban asbestos. Yet we tolerate, and even subsidize, tobacco.

Smoke knows no boundaries. A U.S. Surgeon General report notes nonsmoking sections do not eliminate nonsmokers' exposure to secondhand smoke. And science has yet to find a safe level of exposure to secondhand smoke. Thus, even if you don't smell it, it can still produce its toxic effects on the innocent bystanders, both young and old.

JAMA, the Journal of the American Medical Association states: "Even a half hour of secondhand smoke exposure causes heart damage similar to that of habitual smokers. Nonsmokers' heart arteries show a reduced ability to dilate, diminishing the ability of the heart to get life-giving blood. In addition, the same half hour of secondhand smoke exposure activates blood platelets, which can initiate the process of atherosclerosis (blockage of the heart's arteries) that leads to heart attacks."

Children don't escape the effects of secondhand smoke. We know that asthma, lung infections, middle ear infections, and chronic eye irritation occur more frequently in children who live in homes of smokers, even if the smoking occurs outside the home. These health effects directly lead to increased hospitalizations for asthma, pneumonia and bronchitis. And, smoking among expectant mothers is the leading preventable cause of low birth weight and premature infants.

The human toll: As a rural family physician, I see first-hand the direct effects of tobacco usage on our Kansas citizens. I see the infants born 8 weeks early, weighing less than 2 pounds. I see the children suffering through one respiratory illness after another; one infection after another – amplified because a parent chooses to smoke. I am a Hospice Medical Director and provide witness to a large number of patients who, near the end of their life, suffer the anguish of missing out on their grandchildren, and sometimes even children, growing up. These are real people and they desperately need our protection.

When I discuss the harmful effects of tobacco with my patients, I frequently relate that the "lucky" ones get cancer. Despite the tremendous advances in medicine, lung cancer

still carries a dismal prognosis. Just last week, I pronounced dead a 59 year old patient of mine. He'd felt fine until last October when he had shoulder pain and was found to have lung cancer that had spread there. Within 2 months, it was found in his liver and brain. Within 5 months, he had died leaving his wife, children and a business.

But possibly worse than cancer is the chronic disability caused by tobacco-related illnesses, such as:

- The 43 year old mother who has already had 2 heart attacks and still has frequent chest pains. She sent her teenage children to CPR classes so they could help her when the next "big one" comes.

- The 62 year old man who pushes himself to go to work every day with his oxygen bottle in tow. He and his wife were looking forward to retirement and travel. Now, he must exert all his energy just to get through the day.

- The 30 year old man with severe asthma. His medications cost over $300 a month, paid for by our welfare system. If he just quit smoking, he could probably give up half of the medications.

- The 49 year old mother of a 6 year old son. She's been in the hospital twice in the last year for pneumonia, uses oxygen most of the time and can't go to most of her son's school events because she's too short of breath.

Again, the list could go on. The human toll of tobacco use and secondhand smoke is staggering. The price tag is astounding, as well! Nationwide, $89 billion is spent annually on smoking-related health care costs. **That's $89 billion a year—spent on preventable disease.**

HB 2495: As family physicians in Kansas, we see daily lives that are unalterably affected by the damaging, but preventable, effects of tobacco use and secondhand smoke. As an organization, therefore, KAFP is committed to work with policy-makers and other health advocates to ensure cleaner air and better health for all of our citizens.

Again, we want to commend the committee for introducing HB 2495 and we look forward to working with you on its passage.

Gene Cannata, MD
PO Box 308
Pratt, KS 67124

K A N S A S

RODERICK L. BREMBY, SECRETARY

KATHLEEN SEBELIUS, GOVERNOR

DEPARTMENT OF HEALTH AND ENVIRONMENT

Testimony on House Bill 2495
Enacting the Kansas Public Smoking Ban Act

To
House Federal and State Affairs Committee

Presented by
Howard Rodenberg, MD, MPH

Kansas Department of Health and Environment

March 9, 2005

Chairman Edmonds and members of the House Federal and State Affairs Committee, my name is Dr. Howard Rodenberg. I am the Director of Health for the Kansas Department of Health and Environment and Kansas State Health Officer. Thank you for the opportunity to appear before you today regarding House Bill 2495, which proposes to enact a statewide smoking ban.

The Kansas Department of Health and Environment wholeheartedly supports the concept of clean indoor air that is described in HB2495 and sincerely appreciates Representative Edmond's leadership in recognizing the significant toll of tobacco use upon the health of Kansas citizens. Tobacco use is the single most preventable cause of death and disease in Kansas. Cigarette use alone is responsible for killing over 4,000 Kansans annually.

It is a well-known fact that almost all smokers begin smoking before the age of 18. While only 20% of Kansas adults are current smokers, the negative health impact of tobacco use is much more widespread, particularly as it affects the health of children. 63% of Kansas High School students and 48% of Middle school students report being exposed to tobacco smoke on a regular basis. Exposure to second hand smoke early in life not only causes children to suffer

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negative health consequences (asthma, inner ear infections and other respiratory problems), but also exposes children to a model of behavior that many regrettably adopt by the time they enter middle school. In Kansas, more than one in five (21%) high school students report being current smokers.

The health costs of tobacco use are enormous. Cigarette use alone currently costs Kansas $724 million in direct medical costs, plus another $897 million in indirect (lost productivity) costs per year. This includes $153 million in Medicaid program expenditures. These costs will undoubtedly rise year by year if we fail to take action to reduce tobacco use and exposure. The experience of communities who enact smoke free laws indicate without exception that smoking bans have a positive impact on reducing second hand smoke exposure.

While the premise of the bill is beyond question as a means to improve the health of all Kansans, there are several items within the text that will require clarification. These items may inadvertently weaken the bill, and impair our collective ability to achieve clean indoor air as desired by the legislature. We look forward to the consultative process, where all parties interested in this cause can work together to insure that the effect of the bill meets its intent.

Thank you again for the opportunity to speak to you regarding clean indoor air legislation. We are excited about promoting the idea of a smoke-free Kansas in the public mind, and about working with the committee to ensure that intent of the bill matches its effect. As the new Kansas State Health Officer, and someone who lost a grandparent to emphysema caused by smoking, I sincerely appreciate your interest and commitment to this issue. We at the KDHE look forward to our mutual efforts to design and implement evidence-based public health initiatives for all Kansans.

Tobacco Free Kansas Coalition, Inc.

Tobacco Free Kansas Coalition
Testimony in Support of HB 2495
Enacting the Kansas Public Smoking Law Ban

House Federal and State Affairs Committee
Wednesday, March 9, 2005

Mr. Chairman and Members of the Committee. I am Jon Hauxwell, Family Practice physician from Hays, and currently serving as vice president of the Tobacco Free Kansas Coalition. Our group represents more than 100 agencies, professional associations and individuals in Kansas. Thank you for the opportunity to appear before you in support of efforts to protect all the people of Kansas from Tobacco Smoke Pollution in public places.

HB 2495 is first and foremost a public health bill. Some will try to portray Tobacco Smoke Pollution as a matter of rights. It does involve rights, paramount among which is the right of Kansas citizens to conduct business in public without endangering their lives.

But before we accept the transparent efforts of the tobacco industry and its surrogates in the hospitality field to make this about "business rights," we need to specify which of those supposed rights are at issue. We are not legislating the color of the drapes or the soup of the day - we are plugging an egregious public health loophole. We already "impose" upon merchants to remove asbestos, or keep hot food hot and cold food cold, even though it costs them money to do so, in order to protect the public health. We justifiably regulate private enterprise's behaviors when doing so clearly advances the public good.

Let me state this clearly, no beating around the bush - there is no constitutional or moral right to endanger one's employees, or the public, in order to enhance one's profits. And we know now that profits do not suffer from clearing the air. No one is entitled to make a living by injuring others. Some members of the public are aware of smoke's dangers, but despite educational efforts, some are not. Some feel obliged to endure smoke for the sake of available employment, but no one should have to choose between their life and a livelihood.

Tobacco Free Kansas Coalition Officers:

President
Joan H. Smith, MT, MS

Vice-President
Jon Hauxwell, MD

Secretary
Janet Wetta

FEDERAL AND STATE AFFAIRS
Date 3-9-05
Attachment 3

Mary Jayne Hellebust, Executive Director
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Phone 785-272-8396 ★ Fax 785-272-9297 ★ www.tobaccofreekansas.org

Science clearly shows that so-called "accommodation" through separate seating areas, or even robust ventilation, does not prevent toxic exposure to Tobacco Smoke Pollution in enclosed spaces. There is no substitute for smoke-free air; half-way measures just don't work. Even companies that manufacture ventilation systems refuse to make any health claims for their equipment.

Our current community-by-community approach to protecting Kansans has had some notable successes, but the process has been slow, inefficient, and expensive. Most Kansas communities still do not have adequate protection for citizens frequently exposed to Tobacco Smoke Pollution, particularly in workplaces; and the consequent casualty count rises daily. Private funds now spent to combat Tobacco Smoke Pollution at the local level could be spent on programs that help prevent kids from starting tobacco use, or help those addicted to tobacco quit. The economic and human toll that accompanies this currently-necessary diversion of scarce funds is substantial.

A statewide law to protect Kansans against the proven dangers of Tobacco Smoke Pollution is morally right, legally necessary, and fundamentally the right thing to do. I urge you to acknowledge its importance to the lives of your constituents by supporting statewide Clean Indoor Air legislation.

KANSAS PUBLIC HEALTH ASSOCIATION, INC.

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To: The Honorable Representative Edmonds, Date: March 9, 2005
Chair, House Federal and State Affairs Committee
Re: Testimony in support of HB 2495

Thank you, Mr. Chairman, for the opportunity to testify in support of HB 2495. I am Elaine Schwartz, Executive Director of the Kansas Public Health Association. KPHA is the professional home to 500 members committed to and working for a healthier Kansas. We are in support of HB 2495. My testimony has been prepared by Dr. Kim Richter, a KPHA member. Her vitae related to this issue, is attached. This bill will protect the health of Kansans and it will not affect the revenues of restaurants and bars, which are just about the last work sites that permit smoking indoors.

First of all, the members of KPHA are grateful that Representative Edmonds has made such a bold move to reduce Kansans' exposure to second-hand smoke. Recent Surgeon General's Reports have established that environmental tobacco smoke -- which is classified as a "Class A" Carcinogen by the Environmental Protection Agency -- causes heart disease, cancer, asthma, sudden death syndrome, and a variety of other health problems. People who do not choose to smoke should never be exposed to it in public places.

Protecting Kansans from second hand smoke will not harm our small businesses. I have attached peer-reviewed research and reports of the impact of smoke-free ordinances on over 81 communities in 6 states. The sales tax data from these communities consistently demonstrate that ordinances restricting smoking in restaurants have no effect on revenues. The restaurant business is a tough one, and many businesses claim that these ordinances have hurt their sales. These claims are made in virtually every community and state that has adopted smoke-free ordinances. And yet, when objective data become available a year or two later, they turn out to be wrong.

Cigarette smoking and second hand smoke kill over 400,000 Americans a year. A smoking ban for Kansas worksites will save many lives. It is of great public health interest for our children and future generations, to help reinforce healthier lifestyles and choices for longer and stronger lives.

Again, thanks for the opportunity to testify in support of HB2495.

1. Glantz SA. Smoke-free restaurant ordinances do not affect restaurant business. Period. *J Public Health Manag Pract.* Jan 1999;5(1):vi-ix.
2. Hyland A, Cummings KM. Restaurateur reports of the economic impact of the New York City Smoke-Free Air Act. *J Public Health Manag Pract.* Jan 1999;5(1):37-42.
3. NYC Department of Health and Mental Hygeine. The state of smoke-free New York City: One-year review.
4. Richter, K.P. Selected abstracts from peer-reviewed papers.

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Attachment 4

Sr ree restaurant ordinances do not affect restaurant business. Period.
St Glantz
Jou , Public Health Management and Practice; Jan 1999; 5, 1; ProQuest Nursing Journals
pg. VI

Editorial

Smoke-Free Restaurant Ordinances Do Not Affect Restaurant Business. Period.

Stanton A. Glantz, PhD

THE STORY has become tediously familiar: a concerned legislator or group of citizens decides that it is time to pass a local clean indoor air ordinance to protect the public and workers from the toxins in secondhand tobacco smoke.[1-4] After mustering the scientific evidence that secondhand smoke causes heart disease, cancer, sudden infant death, asthma, and a variety of other problems, public health advocates approach the city council or other legislative body to act. Shortly thereafter, a concerned restaurant association sidesteps the issue that secondhand smoke is dangerous and produces a "study" claiming that the result will be economic chaos, with 20–40 percent drops in restaurant business. As time passes, local tobacco control advocates or the media force the restaurant association to admit that it "requested and received some support." Often, it ultimately comes out that the tobacco industry or one of its public relations firms[5] organized the "restaurant association" (Figure 1). After a long debate, the ordinance passes.[6-9]

After Glantz and Smith[10,11] published their study demonstrating that smoke-free restaurant ordinances have no effect on restaurant revenues in the first 15 cities to pass such ordinances, the tobacco industry's claims of economic chaos lost credibility, particularly in California and Colorado, where the cities were located. While this study was also useful to advocates in other states (including those in New York and Massachusetts), the industry started to argue that there was something unique about California or Colorado and, while there might not have been economic chaos there, it would happen elsewhere. The articles in this issue of the *Journal of Public Health Management and Practice* (JPHMP) show that, in contrast to claims by the tobacco industry, smoke-free restaurant ordinances have had no impact on revenues after New York City and several communities in Massachusetts passed such ordinances.

With the addition of the articles in this issue of JPHMP, there are now published data[8,10,11,12-18] on the economic impact of smoking restrictions on restaurant sales for 81 localities in six states, 67 of which are 100 percent smoke-free in restaurants (Appendix 1). While there are some differences in the ordinances and the methods used to study them across localities, all have relied on objective sales tax data to assess economic impact. The sales tax data from these 81 localities are consistent in demonstrating that ordinances restricting smoking in restaurants have no effect on revenues.

Studies of economic impact based on sales tax revenues have several advantages. First, and most important, the data are objective. They are collected by tax authorities with no interest in the impact of a clean indoor air ordinance. Second, they are complete; they include all restaurants. Third, they are available over time, so it is possible to adjust for underlying economic trends or seasonal variability. The problem with studies of the impact of clean indoor air ordinances based on sales tax data is that they are not available until well after an ordinance passes. Thus, when confronted with predictions of disaster based on industry-inspired surveys of the city in question, advocates can only point to evidence from other cities.

The appropriate response to such predictions from the tobacco industry and its allies and front groups is to point out that these claims have been made everywhere else and, when the objective data became available a year or two later, they turned out to be wrong.

Faced with the growing evidence that restaurant ordinances do not affect revenues, the tobacco industry has fallen back on a series of secondary claims, that the public will not comply with the ordinance or that it will somehow hurt employment or tourism (even though revenues are not affected). Other articles in this issue of JPHMP also debunk these claims. Indeed, New York City added restaurant jobs faster than the rest of the state after the ordinance went into effect. As already demonstrated in other places,[19-21] the public supports and complies with these ordinances.

These results are not surprising, given growing public awareness of the dangers of secondhand smoke. Indeed, despite a major public relations campaign designed to undermine it, the public sup-

This work was supported in part by National Cancer Institute grant CA-61021 and a gift from Edith and Henry Everett.

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Stanton A. Glantz, PhD, is a Professor of Medicine at the Institute for Health Policy Studies and Department of Medicine, University of California, San Francisco, California.

FEDERAL AND STATE AFFAIRS
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Attachment 5

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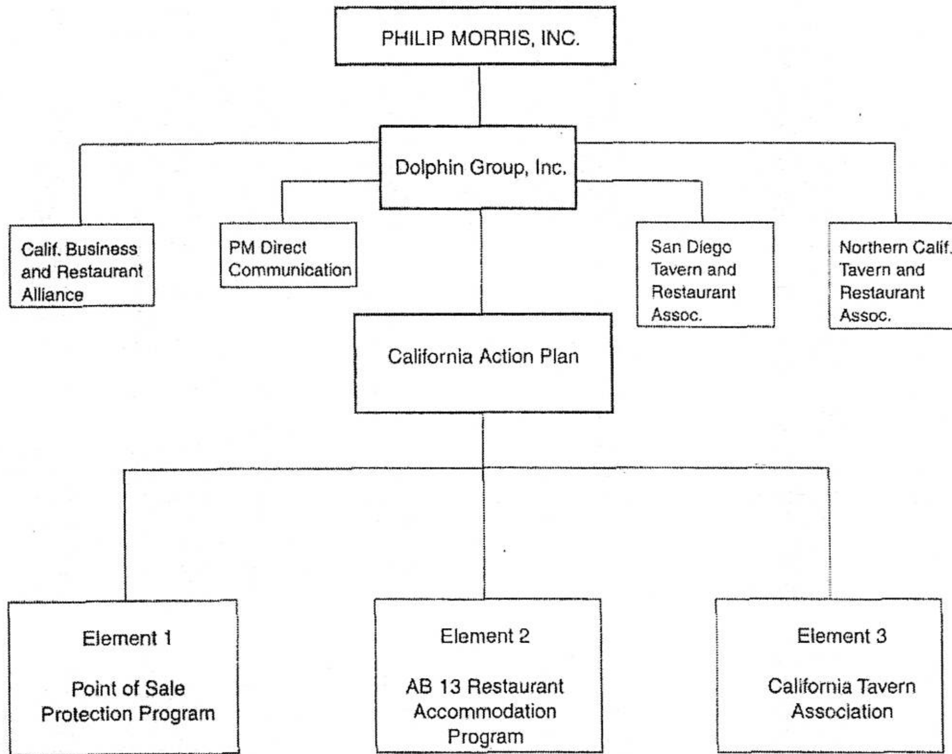

Figure 1. Organization chart prepared by the Dolphin Media Group,[5] a California Public Relations firm, probably for Philip Morris Tobacco, describing planned efforts to fight implementation of California's smoke-free workplace law, AB13, which also includes restaurants and bars. This chart clearly shows that "organizations" such as the California Business and Restaurant Alliance, San Diego Tavern and Restaurant Association, and Northern California Tavern and Restaurant Association are creations of the tobacco industry. Such organizations seek to appear to be legitimate representatives of the business community (as opposed to the tobacco industry) when dealing with the public, the press, and legislators.

ports and complies with California's smoke-free bar law, which went into effect on January 1, 1998. A June 1998 statewide poll conducted by the nonpartisan Field Institute showed that 85 percent of bar patrons go to bars as much or more than they did before the ordinance. At the same time, local health departments reported that compliance is good (90% in restaurant-bar combinations and 70% in stand-alone bars), and is improving over time.[22]

The tobacco industry has created "restaurant associations" since the early 1980s, when it created the Beverly Hills Restaurant Association for purposes of seeking a repeal of Beverly Hills' clean indoor air ordinance.[6] As documented in the history of how the New York ordinance passed, the industry is continuing this strategy. Public health advocates should investigate carefully the bona fides of "restaurant" or "business" groups that suddenly appear willing to spend large amounts of money opposing tobacco control ordinances, with reasonable sounding names like the California Business and Restaurant Alliance or the San Diego Tavern and Restaurant Association (Figure 1).[6,7,9,23,24] In addition, since the industry now knows that public health advocates are looking for this tactic, it may be moving to work through legitimate restaurant organizations, perhaps by funding their efforts or directly or indirectly underwriting their lobbying expenses. Public health advocates should demand that any organization that opposes a local clean indoor air ordinance disclose fully its involvement with the tobacco industry or its public relations apparatus.

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The articles in this issue of JPHMP confirm that continuing local activity to pass clean indoor air ordinances tailored to meet local conditions is the best way to protect nonsmokers from secondhand tobacco smoke.[25] Aware of this fact, it is particularly important that public health advocates defeat efforts by the tobacco industry to enact weak state legislation preempting the ability of local communities to enact tobacco control ordinances.[18,26,27]

The real reason that the tobacco industry opposes these ordinances is that the creation of smoke-free restaurants represents a strong message that smoking around other people is no longer socially acceptable. Creating smoke-free workplaces reduces cigarette consumption.[20,28–31] This changing social environment will help people quit smoking and reduce tobacco industry sales and profits.[20,25] For example, Glasgow et al.[30] estimate that if all workplaces in the United States were smoke-free, an additional 178,000 smokers would stop smoking, and, among those who continued to smoke, they would consume 10 billion fewer cigarettes per year. There is simply no other tobacco control intervention that can contribute this much to public health this quickly—for both nonsmokers and people who would like to quit—as creating smoke-free environments. The battle over clean indoor air in restaurants has become symbolic for the whole battle over clean indoor air.

In any event, there is now evidence from so many cities of varying location, size, and demographics that the question of whether clean indoor air ordinances affect restaurant revenues—adversely or otherwise—should be considered closed. Local officials can now go about their business of protecting the public from the toxins in secondhand smoke without worrying about this phony issue.

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Appendix 1

Cities and Counties with Ordinances Restricting Smoking in Restaurants or Bars that Have Been Studied Based on Sales Tax Data

Amherst, MA[33]
Anderson, CA[12,13]
Andover, MA[33]
Arlington, MA[33]
Aspen, CO[10,11,12,13]
Attleboro, MA[33]
Auburn, CA[10,11,12–14]
Bedford, MA[33]
Bellflower, CA[10,11,12–14]
Belmont, MA[33]
Beverly Hills, CA[10,11,12–14]
Brookline, MA[15,33]
Buncombe County, NC[18] †
Chicopee, MA[33]†
Colfax, CA[14]
Contra Costa County, CA[14]
Craven County, NC[18] *†
Culver City, CA[14] *
Davis, CA[12,13]
East Longmeadow, MA[33]
Easthampton, MA[33]
El Cerrito, CA[10,11,12–14]
Flagstaff, AZ[16]
Foxborough, MA[33]
Framingham, MA[33]
Grass Valley, CA[14]
Greenfield, MA[33]
Halifax County, NC[18] *†
Holden, MA[33]
Holyoke, MA[33]
Indian Wells, CA[14] *
Lanesborough, MA[33]
Lee, MA[33]
Lenox, MA[33]
Lexington, MA[33]
Lodi, CA[10,11,12–14]
Long Beach, CA[14] *
Longmeadow, MA[33]
Los Gatos, CA[14]
Martinez, CA[9,10,12,13,33]
Medfield, MA[33]
Mesa, AZ[8]
Montague, MA[33]
New York, NY[34]
Northampton, MA[33]
Norwell, MA[33]†
Orange County, NC[18] †
Palo Alto, CA[10,11,12–14]
Paradise, CA[10,11,12–14]
Plainville, MA[33]
Plymouth, MA[33]
Rancho Mirage, CA[14] *
Reading, MA[33]
Redding, CA[12,13]
Roseville, CA[10,11,12–14]
Ross, CA[10,11,12,13]
Sacramento, CA[10,11,12,13]
San Luis Obispo, CA[10,11,12–14,32]
San Joaquin County, CA[14] *
San Mateo County, CA[14] *
Santa Clara County, CA[12,13]
Saratoga, CA[14] *
Sharon, MA[33]
Shasta County, CA[12–14]
Snowmass, CO[10,11,12,13]
South Hadley, MA[33]
Southampton, MA[33]
Stockbridge, MA[33]
Stockton, CA[14] *
Sunderland, MA[33]
Sunnyvale, CA[14] *
Telluride, CO[10,11,12,13]
Tewksbury, MA[33]
Tiburon, CA[12,13]
Tracey, CA[14] *
Wake County, NC[18] *†
Wakefield, MA[33]
Walnut Creek, CA[14]
West Springfield, MA[33]
West Lake Hills, TX[17]
Yountville, CA[14] *

*Less than 100% smoke-free restaurants. †Repealed or overturned in court after a period of time in force.

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R[illegible]rateur reports of the economic impact of the New York City Smoke-free A...
A[illegible] Hyland; K Michael Cummings
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pg. 37

Restaurateur Reports of the Economic Impact of the New York City Smoke-Free Air Act

Andrew Hyland and K. Michael Cummings

The objective of this study was to determine the extent to which restaurateurs have reported a change in business since the New York City Smoke-Free Air Act took effect. A population-based cross-sectional telephone survey of 434 owners/ managers of restaurants located in New York City was conducted by an independent survey firm during November and December 1996. There is no evidence to suggest that the smoke-free law has had a detrimental effect on the city's restaurant business.

Key words: *economics, environmental tobacco smoke, policy, smoking*

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ON APRIL 10, 1995, New York City's Smoke-Free Air Act took effect.[1] Details about the provisions of the law are presented earlier in this issue. (See p. 14, "Analysis of Taxable Sales Receipts: Was New York City's Smoke-Free Air Act Bad for Restaurant Business?" by Hyland, Cummings, and Nauenberg this issue.)

Using aggregate taxable sales receipt data for restaurants and consumer surveys, many researchers have concluded that smoke-free restaurant laws do not adversely affect the restaurant business in a given area.[2–9] An alternative methodological approach used to assess the economic impact of smoke-free restaurant laws on restaurant business is to interview restaurant owners/managers directly. One study conducted six months after the New York City smoke-free law took effect by Fabrizio, McLaughlin & Associates found that 70 percent of restaurateurs reported decreased sales since the law was in force; the mean decrease was 16 percent.[10] A similar study conducted by Penn + Schoen Associates, Inc. two months after the law took effect found that 63 percent of New York City restaurant owners claimed the

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new smoking regulations were hurting their business and about half of restaurants in nearby New Jersey counties were experiencing an increase in business during the same time period.[11] Another widely cited but unsubstantiated claim is that smoke-free restaurant legislation causes a 30 percent drop in restaurant business.[12,13]

There are advantages and disadvantages to using surveys of restaurateurs to assess the economic impact of smoke-free restaurant laws. The main advantage is that they allow for the ability to report results for subsets of restaurants rather than for the whole industry as is done when aggregate sales tax receipts are used. Also, taxable sales receipts are subject to misclassification and some feel this approach is inherently flawed.[14] In addition, this is the most direct way to address any issue regarding the effect of smoke-free restaurant laws on restaurants.

However, there are at least four methodological limitations often found when this approach is used. First, the list of restaurants from which the sample was drawn may not be complete enough to adequately represent the population of restaurants within a given area. Examples of such biased sampling are convenience samples and samples from business or trade association lists. Such samples will not be representative of the population, even if random sampling was performed from the incomplete list. Second, responses are based on non-verifiable, self-reported perceptions of the restaurant owner/manager of how business has done over time. It remains unclear how willingly or accurately this information can be reported by a restaurateur. It is also likely that for at least some restaurateurs, such reports will be affected by the restaurateurs' personal feelings about the law. Due to the vehement opposition the restaurant industry as a whole had against smoke-free restaurant legislation, such biases will tend to exaggerate the negative economic effects of the law. Third, surveys done shortly after a smoke-free law has taken effect are likely to have biased results. Two sources of bias are distorted responses due to the initial outrage over the law and variation in business by seasonal or other transient factors. Fourth, effects isolated to the smoke-free law are impossible to discern because there is no control group.

The goal of this study was to determine if the law is associated with reports of decreased business in the two years since the smoke-free law took effect. To minimize potential biases, this research employed a random sample of restaurants located in New York City nearly two years after the smoke-free law took effect. To compare places that were and were not affected by the law, three separate control groups were used. First, the set of restaurants with 35 or fewer seats served as a control group for the set of restaurants with greater than 35 seats. Second, those restaurants without a bar area acted as a control group for those with a bar area. Finally, among large restaurants without a smoke-free policy before the law, those who continued to allow smoking in some area of the restaurant served as a control group for those places that went entirely smoke-free after the law took effect. The following study question guided the analysis: To what extent do restaurateurs report a change in business since the smoke-free law took effect?

Methods

Data sources

A cross-sectional random sample survey of 126 small (≤ 35 seats) and 308 large (≥ 36 seats) New York City restaurant owners/managers who have been in business at least two years was conducted by an independent survey firm through a five-minute telephone interview during November and December 1996. Telephone numbers were obtained from the Dun & Bradstreet database of the 7,310 restaurants with the Specific Industry Code 58.12 (eating places) that were located in the five-county area that comprises New York City. The interviewer asked each owner or manager about the restaurant's smoking policy and his or her perceptions about how business has performed since the smoke-free law took effect.

Changes in business since the smoke-free law took effect were determined by responses to the question, "Over the past two years, would you say your business has increased, decreased, or stayed the same?" This measure was reduced to a dichotomous variable (decreased versus stayed the same or increased).

A restaurant was defined as being currently 100 percent smoke-free if the respondent reported smoking was not permitted in any of the following areas of the restaurant: indoor or outdoor dining areas, bar or waiting areas, restrooms, kitchen, or the employee break area. Owners/managers of currently smoke-free restaurants who reported their smoking policy

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was implemented more than two years ago were defined as being smoke-free before the law took effect, while smoke-free facilities that enacted their smoking policy more recently were defined as changing to a smoke-free policy after the law took effect.

Independent variables

There were three main predictor variables: (1) size of the restaurant (≤ 35 seats or ≥ 36 seats); (2) presence of a restaurant bar on the premises (yes or no); and (3) presence of a current smoke-free policy among large restaurants that permitted smoking before the law took effect (yes or no).

Other independent factors were: the borough in which the restaurant was located (Manhattan, Bronx, Queens, Staten Island, or Brooklyn); the type of restaurant (takeout/fast food, casual/family dining, or fine dining); length of time in business at the current location (2–5 years, 6–10 years, ≥ 11 years); the restaurant owner's/manager's awareness of the smoke-free ordinance (yes or no); the restaurant owner's/manager's support of the smoke-free ordinance (yes, no, or no opinion); whether any money was spent to implement the law (yes or no); and the job title of the respondent (restaurant owner, restaurant manager, or someone else).

Analysis

The bivariate association between being under jurisdiction of the smoke-free restaurant law and reported business decreases was examined using the Chi-square test. Specifically, reports of lost business in restaurants with 35 or fewer indoor dining seats or a bar area were compared with restaurants with more than 35 seats or without a bar area, respectively. Additionally, among large restaurants that permitted smoking before the law took effect, the percentage of those facilities that continued to permit smoking that reported a decline in business was compared with the percentage of places that are now 100 percent smoke-free that reported a decline. To simultaneously control for independent factors related to the report of lost business, a logistic regression model was constructed. Predictor variables for this model included all independent variables noted previously. Small restaurants and restaurants with existing smoke-free policies were excluded from this analysis.

Results

A total of 434 New York City restaurateurs completed the survey. The response rate was 60 percent. There were 308 (71%) large restaurants and 126 (29%) small restaurants in the sample. Sixty-three (20%) large restaurants had an existing smoke-free policy before the law took effect, and 45 (36%) small restaurants reported the same.

Figure 1 shows how restaurant owners/managers rated their business since the smoke-free legislation was in force by those affected and not affected by the law. Thirty-four percent of smaller restaurants and 36 percent of those with bar areas reported a decrease in business compared with 35 percent of larger restaurants and restaurants without bar areas that reported the same. Thirty-four percent of large restaurants that continued to permit smoking in their facility reported a decrease in business compared with 36 percent of large restaurants that switched to a 100 percent smoke-free policy.

Table 1 shows the results of a multivariate logistic regression analysis modeling of reported lost business by owners/managers of large restaurants (≥ 36 seats) who reported smoking was allowed before the law took effect in April 1995. Casual/family style restaurants and restaurants in Brooklyn were more than three times more likely to report decreased business compared with takeout/fast food places and places in Manhattan, respectively (statistically significant at the $p = 0.05$ level). However, the presence of a smoke-free policy or lack of a bar area was not associated with reports of decreased revenue. Similar conclusions were obtained when all restaurants were included in the model with additional variables for the size of the restaurant and past smoke-free restaurant policy were included as covariates (data not shown).

Thirty-four percent of smaller restaurants and 36 percent of those with bar areas reported a decrease in business compared with 35 percent of larger restaurants and restaurants without bar areas that reported the same.

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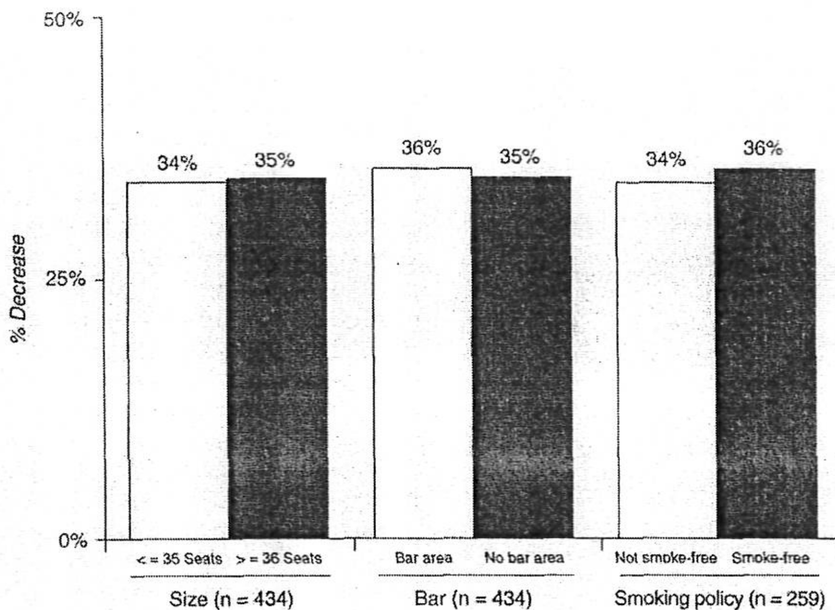

Figure 1. Percent of restaurateurs unaffected and affected by the law that reported business had decreased since the smoke-free law took effect. Unaffected facilities were those with 35 or fewer indoor dining seats, a bar area, and a policy that permitted smoking. Affected restaurants were those places with 36 or more seats, no bar area, and a 100 percent smoke-free policy.

Discussion

The fact that the New York City Smoke-Free Air Act allows some restaurants to permit smoking facilitates the opportunity to set up a control group for those restaurants affected by the law. These results indicate a fair amount of volatility in the restaurant business; 35 percent of restaurateurs reported that their business had decreased in the past two years and 23 percent had fewer employees. Other data from the New York City Department of Health show that 15 percent to 20 percent of restaurants close each year.[15] However, no evidence was found to suggest that the New York City smoke-free restaurant law was a cause of any economic harm in the restaurant industry. Specifically, if smokers were shifting their patronage to places where smoking was allowed, it would be expected that large restaurants, those without bar areas, and restaurants that recently enacted a 100 percent smoke-free policy would be more likely to report business losses. However, these data show that this was not the case. Rather, results from this study confirm the conclusion of no overall economic effect from recent studies of consumers' response to the New York City smoke-free law.[9] (See p. 28, "Consumer Response to the New York City Smoke-Free Air Act," by Hyland and Cummings, this issue) and an analysis of taxable New York City restaurant sales. (See p. 14, "Analysis of Taxable Sales Receipts: Was New York City's Smoke-Free Air Act Bad for Restaurant Business?" by Hyland, Cummings, and Nauenberg, this issue). Furthermore, the findings are consistent with several other research reports examining taxable sales data in other localities throughout the nation.[2–8]

A drawback to the economic analysis presented in this article is that the measure used is crude. Quantitative information on how much business had increased or decreased was not obtained because it is unclear how willingly or accurately the owner can recall this information, let alone the manager or some other employee. Rather, this study treated all responses of decreased business as equals. Therefore, the study does not have the ability to detect an asso-

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Table 1

Logistic regression modeling restaurant managers'/owners' report of decreased business since the smoke-free law took effect (n = 238).*

Characteristic	Odds ratio	95% Confidence interval	
Restaurant bar			
No	1.0	Reference	
Yes	0.8	0.4	1.5
Currently smoke-free			
No	1.0	Reference	
Yes	0.8	0.4	1.6
Borough			
Manhattan	1.0	Reference	
Bronx	0.9	0.2	3.2
Queens	1.7	0.8	3.5
Staten Island	1.8	0.5	6.7
Brooklyn†	3.1	1.4	7.1
Type of restaurant			
Takeout or fast food	1.0	Reference	
Casual†	3.7	1.2	11.7
Fine dining	2.6	0.7	9.3
Aware of law			
No	1.0	Reference	
Yes	0.6	0.2	1.7
Duration at current location			
2–5 years	1.0	Reference	
6–10 years	1.5	0.6	3.6
≥ 11 years	1.2	0.6	2.6
Respondent			
Owner	1.0	Reference	
Manager	0.8	0.5	1.5
Other	0.5	0.1	2.0

*Among large restaurants that permitted smoking when the smoke-free law was passed.

† P-value < 0.05.

ciation if the percentage of decrease was systematically bigger in large restaurants compared with small restaurants. The same holds true for restaurants with and without bar areas and places that are or are not smoke-free. Another potential limitation is that the study does not have data on restaurants that may have gone out of business since the smoke-free law took effect. However, a recent study by the Zagat-Survey Group found that new restaurant openings far outpaced restaurant closings in 1996[16] and data from the New York City Department of Health show that the number of new restaurant permits increased by 20 percent from 1994 to 1995,[15] suggesting that this potential bias is unlikely.

The results examining the effect of smoke-free restaurant laws on restaurant business using the methodology of interviewing restaurateurs differ from previous research.[10,11] These latter two studies were conducted shortly after the law took effect. One theory to explain the discrepancy is that businesses do experience a short-term drop in sales, but as people become accustomed to the law, sales return to their pre-legislation levels. A second possibility is the sampling procedures that were used biased the findings of the two dissenting studies. In these reports, it is unclear whether or not random sampling was conducted and what sampling frame was used; however, the data presented here are from a random sample of all restaurants in New York City. Finally, these reports were commissioned by the National Smokers Alliance, a group with strong ties to the tobacco industry that opposes smoke-free legislation.

Additionally, there is evidence to suggest that restaurateurs' personal attitudes about the smoke-free law are highly correlated with the report of decreased business. In this survey, respondents were also asked if they supported the law and if their opinion had changed since the law went into effect. Among large restaurant owners/managers, 17 percent of those who favored the law reported revenue decreases compared with 52 percent of those who opposed the law (35% overall). Furthermore, 53 percent of those who opposed the law both before and two years after its implementation said their business had declined after the law took effect. This suggests that either restaurants with proprietors who oppose smoke-free legislation are predisposed to revenue losses or that their personal views have influenced their reports of business decreases. Responses of lost business from the set of restaurateurs who reported indifference toward the law both before and after implementation may be a more accurate reading of the overall percent of restaurants that actually lost business. Forty-nine restaurants (17%) were categorized as such and only 20 percent said they had lost business since the smoke-free law took effect; this figure also corresponds more closely to the 15 per-

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cent of consumers in the New York City area that reported dining out less frequently since the law took effect. (See p. 28, "Consumer Response to the New York City Smoke-Free Air Act," by Hyland and Cummings, this issue.) Therefore, self-reported restaurateur reports of lost business elicited from surveys may overestimate the true effect by as much as 75 percent, or perhaps more in studies done shortly after smoke-free restaurant legislation went into effect are when media attention and public displeasure is higher. This finding may explain why such a large percentage of restaurant owners have reported business decreases in the two conflicting studies.[10,11]

In summary, these results indicate that reports of lost business are likely to be overestimated and that the business of restaurants affected by the law performed similarly to the business of restaurants that were not affected by the smoke-free legislation. This evidence, in conjunction with evidence from the literature, suggests that the New York City Smoke-Free Air Act has not had an adverse economic impact on the restaurant industry.

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THE STATE OF SMOKE-FREE NEW YORK CITY: A ONE-YEAR REVIEW

New York City Department of Finance
New York City Department of Health & Mental Hygiene
New York City Department of Small Business Services
New York City Economic Development Corporation

MARCH 2004

5-11

EXECUTIVE SUMMARY

When the Smoke-Free Air Act went into effect on March 30, 2003, questions were raised about how the law would affect the City's restaurants and bars. Would the law hurt business? Would some establishments have to lay off workers or close?

One year later, the data are clear. The City's bar and restaurant industry is thriving and its workers are breathing cleaner, safer air.

Since the law went into effect, business receipts for restaurants and bars have increased, employment has risen, virtually all establishments are complying with the law, and the number of new liquor licenses issued has increased—all signs that New York City bars and restaurants are prospering. The vast majority of New Yorkers support the law and say they are more likely to patronize bars and restaurants now that they are smoke-free. And, most importantly, the health of all New Yorkers, customers and workers alike, is now protected from the harmful health effects of second-hand smoke.

The data show that:

- **Business tax receipts in restaurants and bars are up 8.7%;**
- **Employment in restaurants and bars has increased by 10,600 jobs (about 2,800 seasonally adjusted jobs) since the law's enactment;**
- **97% of restaurants and bars are smoke-free;**
- **New Yorkers overwhelmingly support the law;**
- **Air quality in bars and restaurants has improved dramatically;**
- **Levels of cotinine, a by-product of tobacco, decreased by 85% in nonsmoking workers in bars and restaurants; and**
- **150,000 fewer New Yorkers are exposed to second-hand smoke on the job.**

While this report focuses largely on the economic impact, if any, that the Smoke-Free Air Act has had on the food and beverage industry, it is important to keep in mind the primary intent of the law: to protect workers from exposure to second-hand smoke. Just 30 minutes of exposure to second-hand smoke produces some of the same physical reactions that occur due to long-term smoking, and can increase the risk of heart attacks in non-smokers. Now, because of the passage of the Smoke-Free Air Act, workers and patrons of the City's bars and restaurants are breathing cleaner, safer air every day.

The report is divided into 8 sections:

1. Bar and restaurant tax receipts
2. Bar and restaurant employment
3. Bar and restaurant openings and closings
4. Compliance with the Smoke-Free Air Act
5. Public opinion
6. Workplace air quality
7. Worker protection
8. The State of a Smoke-Free City

I. Bar and Restaurant Tax Receipts in a Smoke-free City

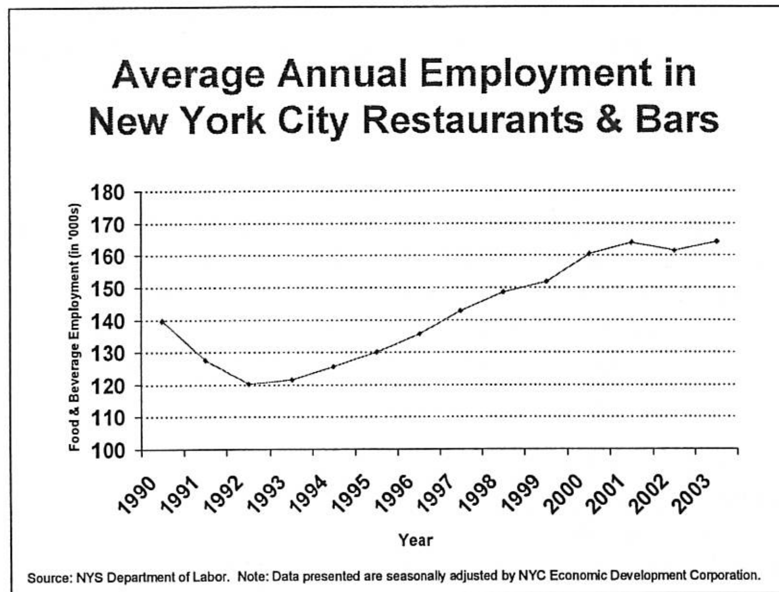
Data from the New York City Department of Finance show that the amount of money spent in New York City's bars and restaurants has increased over the past year.

From April 1, 2003, through January 31, 2004—the most recent data available—bar and restaurant business tax receipts were up 8.7% from the same period in 2002-2003. From April 2003 through January 2004, the City collected $17,375,688 in tax receipts from bars and restaurants; in the same period one year previously, the City collected $15,984,811.

II. Bar and Restaurant Employment in a Smoke-free City

New York City's improved financial climate has translated into employment gains for the bar and restaurant industry. Now, as a result of the Smoke-Free Air Act, these workers can also enjoy a safer, smoke-free workplace.

Employment data from the New York State Department of Labor, and seasonally adjusted by the New York City Economic Development Corporation, show that the City's restaurant and bar industry is expanding once again after a downturn at the end of 2001 and throughout 2002 (prior to the implementation of the Smoke-Free Air Act). More people are employed in the City's bars and restaurants with an average number of workers employed in the industry during 2003 of 164,000, the highest number recorded in at least a decade.



Source: NYS Department of Labor. Note: Data presented are seasonally adjusted by NYC Economic Development Corporation.

In the months following the law's enactment from March 2003 to December 2003, employment in New York City's restaurants and bars increased by about 2,800 seasonally adjusted jobs, amounting to an absolute gain of about 10,600 jobs.

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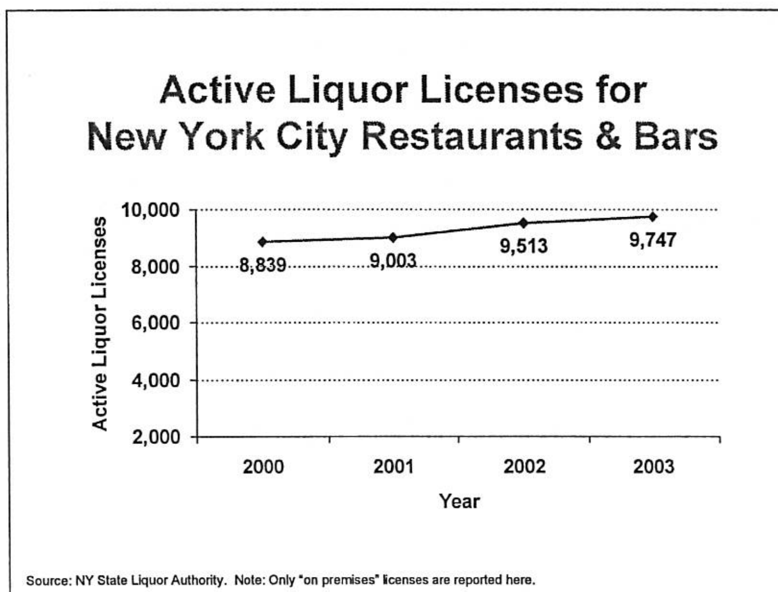
III. Bar and Restaurant Openings and Closings in a Smoke-free City

According to the New York State Department of Labor, the number of New York City bars and restaurants remained essentially unchanged between the third quarter of 2002 and the third quarter of 2003. This is an improvement compared with the same period in 2002, during which 280 more bars and restaurants closed than opened.

Furthermore, the New York State Liquor Authority issued 1,416 new liquor licenses to New York City bars and restaurants in 2003, compared with 1,361 issued in 2002, prior to the passage of the Smoke-Free Air Act. Citywide, at the end of 2003, there were 9,747 active liquor licenses—a net gain of 234 from 2002. Bar and restaurant owners as well as investors remain confident in the strength of the industry and of their ability to flourish in this vibrant and varied sector of the City's economy.



IV. Compliance with the Smoke-Free Air Act

The overwhelming majority of City bars and restaurants are now smoke-free. The New York City Health Department inspected more than 22,000 establishments from April 2003 to February 2004. Of those inspected, 97% were smoke-free—no patrons or workers were observed smoking, no ashtrays were present, and "No Smoking" signs were properly posted.

Compliance with the Smoke-Free Air Act, April 2003 – February 2004

	All Food Service Establishments
Establishments inspected	22,003
Establishments cited for violation 15L only	2,219
Establishments cited for SFAA violations other than 15L	670
% smoke-free establishments	**97%**

Note: Violation 15L—failure to adequately post a smoke-free workplace policy—is considered a minor violation.

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V. Public Opinion and Bar & Restaurant Attendance in a Smoke-free City

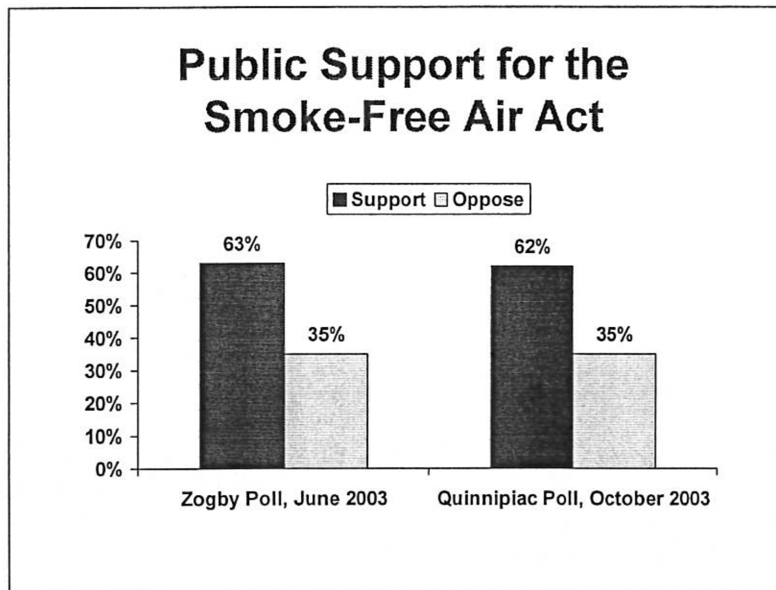
New liquor licenses, employment growth, and increased tax receipts in the bar and restaurant sector all point to one conclusion: after a difficult 2001 and 2002, more people are spending more money in New York's bars and restaurants, and the City's protection of workers has not stopped this progress.

The overwhelming support of New Yorkers for the Smoke-Free Air Act suggests that the law did not hurt, and might even have helped, the bar and restaurant industry. In public surveys, New Yorkers consistently voice approval for smoke-free establishments.

Approval of the Law

- A poll conducted by Zogby International in June 2003 of voters throughout New York State showed that 63% of New Yorkers approved of the state Clean Indoor Air Act (CIAA), compared with 35% who opposed it. The poll showed even more support for the smoke-free law among New York City voters, with 69% supporting the law.

- A poll conducted by Quinnipiac University in October 2003 of New York City voters found that New Yorkers overwhelmingly supported the Smoke-Free Air Act by a margin of nearly 2 to 1 (62% supported vs. 35% opposed).



Going to Smoke-Free Bars and Restaurants

- 16% of respondents to the Zogby poll said they would patronize smoke-free restaurants on a *more* regular basis after passage of the law, and 73% said they would go out to eat just as often as before. Only 11% said they would go to restaurants less as a result of the law.

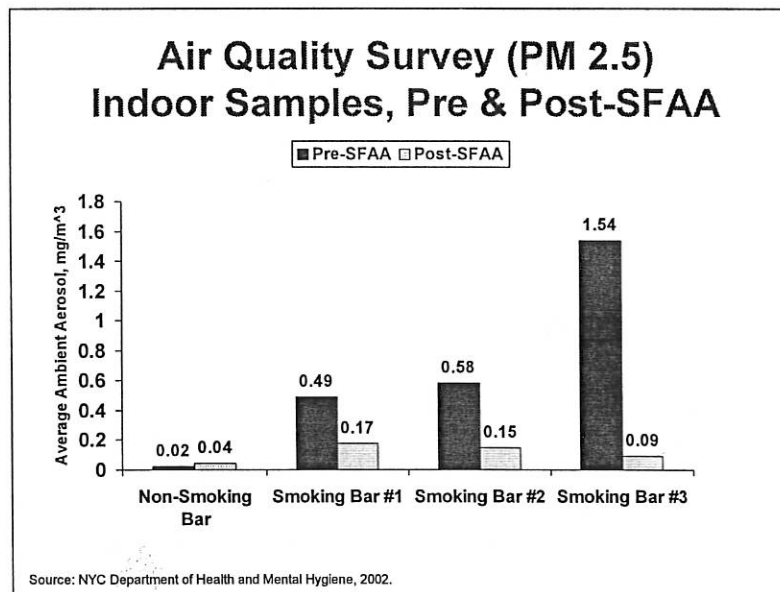
- 19% of respondents to the Zogby poll said they would patronize bars and nightclubs *more* often after passage of the law, and 65% said they would go out just as often as before. Only 14% said they would go to bars and nightclubs less.

- 23% of those who participated in the Zagat 2004 New York City survey said they would patronize smoke-free restaurants on a *more* regular basis after passage of the law, and 73% said they would go out to eat just as often as before. Only 4% said they would go to restaurants less as a result of the law.

VI. WORKPLACE AIR QUALITY IN A SMOKE-FREE CITY

The high rate of compliance to the Smoke-Free Air Act translates into better air quality in workplaces. The Health Department conducted an air quality survey of various indoor and outdoor locations throughout the City in August 2002, prior to the implementation of the Smoke-Free Air Act. The Department found that the average air pollution levels in bars that permitted smoking were as much as 50 times higher than at the entrance to the Holland Tunnel at rush hour.

The Department returned to the same locations in May 2003, after the Smoke-Free Air Act went into effect, and documented substantial improvements in air quality. The follow-up samples showed, on average, a six-fold reduction in air pollution levels in establishments that previously allowed smoking.

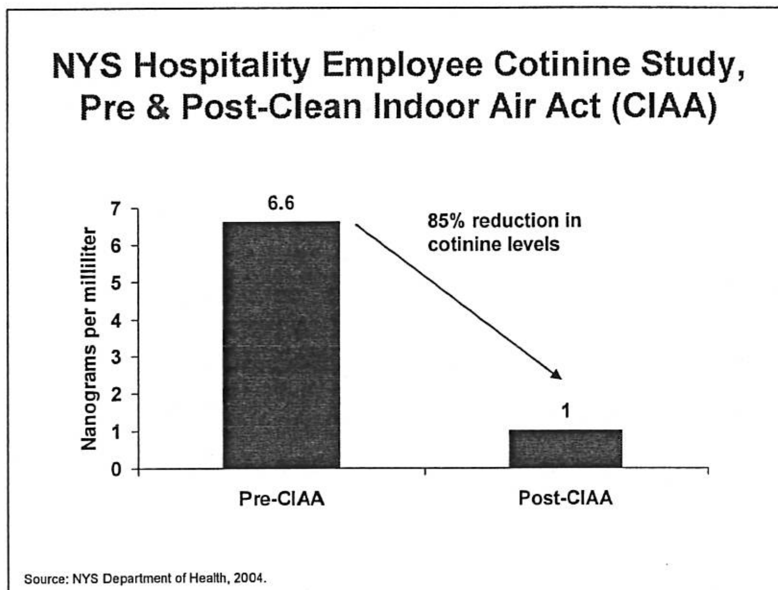


5-16

VII. Worker Protection in a Smoke-free City

Within a short period after the implementation of the Smoke-Free Air Act, 150,000 fewer adult New Yorkers reported being exposed to second-hand smoke at work.

A New York State Department of Health study confirms the reduction in second-hand smoke exposure at work by documenting a marked decrease in cotinine in New York bar and restaurant workers. Cotinine, a nicotine by-product, is found in people who have inhaled tobacco smoke, and is used to determine nonsmokers' exposure to second-hand smoke. Researchers collected biological samples from nonsmoking bar and restaurant employees during the month before the New York State Clean Indoor Air Act (CIAA) went into effect in July 2003, and again three months later. They found that cotinine levels declined by 85% after the state law went into effect.



VIII. The State of a Smoke-free City

As New York City, home of the world's finest restaurants and most celebrated nightlife, emerges from the difficult economic times of 2001 and 2002, so has its bar and restaurant industry. Economic data confirm that New Yorkers love their bars and restaurants, and so do the millions of tourists that come here every year to enjoy all that the City has to offer. Thanks to the Smoke-Free Air Act, the City's bar and restaurant experience is a safer and healthier one for everyone.

FINANCIAL IMPACT RESTAURANT/BAR BANS

MMWR Morb Mortal Wkly Rep. 2004 Feb 27;53(7):150-2.
Impact of a smoking ban on restaurant and bar revenues--El Paso, Texas, 2002.
Centers for Disease Control and Prevention (CDC).

No statistically significant changes in restaurant and bar revenues occurred after the smoking ban took effect

Smoke-free indoor air ordinances protect employees and customers from secondhand smoke exposure, which is associated with increased risks for heart disease and lung cancer in adults and respiratory disease in children. As of January 2004, five states (California, Connecticut, Delaware, Maine, and New York) and 72 municipalities in the United States had passed laws that prohibit smoking in almost all workplaces, restaurants, and bars. On January 2, 2002, El Paso, Texas (2000 population: 563,662), implemented an ordinance banning smoking in all public places and workplaces, including restaurants and bars. The El Paso smoking ban is the strongest smoke-free indoor air ordinance in Texas and includes stipulations for enforcement of the ban by firefighting and law enforcement agencies, with fines of up to $500 for ordinance violations. To assess whether the El Paso smoking ban affected restaurant and bar revenues, the Texas Department of Health (TDH) and CDC analyzed sales tax and mixed-beverage tax data during the 12 years preceding and 1 year after the smoking ban was implemented. This report summarizes the results of that analysis, which determined that no statistically significant changes in restaurant and bar revenues occurred after the smoking ban took effect. These findings are consistent with those from studies of smoking bans in other U.S. cities. Local public health officials can use these data to support implementation of smokefree environments as recommended by the Task Force on Community Preventive Services.

SMOKING BANS AND EXPOSURE TO ETS

Tob Control. 2002 Jun;11(2):125-9. Exposure of hospitality workers to environmental tobacco smoke.
Bates MN, Fawcett J, Dickson S, Berezowski R, Garrett N.

Nonsmoking bar and restaurant workers in premises permitting customer smoking had higher tobacco smoke exposure and respiratory and irritation symptoms than workers in a) smokefree bars and restaurants, and b) other smokefree workplaces

OBJECTIVE: To determine quantitatively the extent of exposure of hospitality workers to environmental tobacco smoke (ETS) exposure during the course of a work shift, and to relate these results to the customer smoking policy of the workplace. SUBJECTS: Three categories of non-smoking workers were recruited: (1) staff from hospitality premises (bars and restaurants) that permitted smoking by customers; (2) staff from smokefree hospitality premises; and (3) government employees in smokefree workplaces. All participants met with a member of the study team before they began work, and again at the end of their shift or work day. At each meeting, participants answered questions from a standardised questionnaire and supplied a saliva sample. MAIN OUTCOME MEASURES: Saliva

samples were analysed for cotinine. The difference between the first and second saliva sample cotinine concentrations indicated the degree of exposure to ETS over the course of the work shift. RESULTS: Hospitality workers in premises allowing smoking by customers had significantly greater increases in cotinine than workers in smokefree premises. Workers in hospitality premises with no restrictions on customer smoking were more highly exposed to ETS than workers in premises permitting smoking only in designated areas. CONCLUSIONS: Overall, there was a clear association between within-shift cotinine concentration change and smoking policy. Workers in premises permitting customer smoking reported a higher prevalence of respiratory and irritation symptoms than workers in smokefree workplaces. Concentrations of salivary cotinine found in exposed workers in this study have been associated with substantial involuntary risks for cancer and heart disease.

2: Addiction. 2003 Aug;98(8):1111-7.
Four-year follow-up of smoke exposure, attitudes and smoking behaviour following enactment of Finland's national smoke-free work-place law. Heloma A, Jaakkola MS.

Smoke-free work place laws reduce environmental tobacco smoke exposure at work.

AIMS: This study evaluated the possible impact of national smoke-free work-place legislation on employee exposure to environmental tobacco smoke (ETS), employee smoking habits and attitudes on work-place smoking regulations. DESIGN: Repeated cross-sectional questionnaire surveys and indoor air nicotine measurements were carried out before, and 1 and 3 years after the law had come into effect. SETTING: Industrial, service sector and office work-places from the Helsinki metropolitan area, Finland. PARTICIPANTS: A total of 880, 940 and 659 employees (response rates 70%, 75% and 75%) in eight work-places selected from a register kept by the Uusimaa Regional Institute of Occupational Health to represent various sectors of public and private work-places. MEASUREMENTS: Reported exposure to ETS, smoking habits, attitudes on smoking at work and measurements of indoor air nicotine concentration. FINDINGS: Employee exposure to ETS for at least 1 hour daily decreased steadily during the 4-year follow-up, from 51% in 1994 to 17% in 1995 and 12% in 1998. Respondents' daily smoking prevalence and tobacco consumption diminished 1 year after the enforcement of legislation from 30% to 25%, and remained at 25% in the last survey 3 years later. Long-term reduction in smoking was confined to men. Both smokers' and non-smokers' attitudes shifted gradually towards favouring a total ban on smoking at work. Median indoor airborne nicotine concentrations decreased from 0.9 micro g/m3 in 1994-95 to 0.1 micro g/m3 in 1995-96 and 1998. CONCLUSIONS: This is the first follow-up study on a nationally implemented smoke-free work-place law. We found that such legislation is associated with steadily reducing ETS exposure at work, particularly at work-places, where the voluntary smoking regulations have failed to reduce exposure. The implementation of the law also seemed to encourage smokers to accept a non-smoking work-place as the norm.

PMID: 12873245 [PubMed - indexed for MEDLINE]

WORKPLACE SMOKING BANS AND HEALTH OUTCOMES

4: Eur Respir J. 2003 Apr;21(4):672-6. Passive smoking and respiratory symptoms in the FinEsS Study. Larsson ML, Loit HM, Meren M, Polluste J, Magnusson A, Larsson K, Lundback B.

Whether or not someone smokes in your home, if you are exposed to environmental tobacco smoke outside of the home you're more likely to have respiratory symptoms, the more exposure, the more likely you are to have symptoms. If you daily spend 5 or more hours outside of the home exposed to ETS you're more likely to be diagnosed with asthma (i.e., bartenders and servers fall into this category).

The aim of the present study was to examine the relationship between reported environmental tobacco smoke (ETS) exposure and respiratory symptoms. In 1996, a postal questionnaire was randomly distributed in three areas of Estonia to a population-based sample, of which 4,995 females and 1,822 males had never smoked. The main outcome measures were current respiratory symptoms and the amount of reported ETS exposure outside the home. ETS exposure at home was more common in females (31% versus 19%), while exposure outside of the home was more common in males (53% versus 7%). Females reported more symptoms from tobacco smoke than males (37.7% versus 21.6%). If ETS exposure outside of the home exceeded 5 h daily, the risk for wheeze (odds ratio (OR) 2.67, 95% confidence interval (CI) 1.98-3.61) and physician-diagnosed asthma (OR 1.79, 1.02-3.16) were increased. ETS exposure outside of the home was shown to be strongly related to almost all respiratory symptoms in a dose/response manner. ETS exposure at home did not show significantly elevated ORs for any respiratory symptoms. This study shows that females seem to be more troubled by environmental smoke exposure than males and provides further evidence of the serious health hazards associated with environmental smoke exposure. Indeed, the findings of this study support a ban on smoking in the workplace and public areas.

PMID: 12762355 [PubMed - indexed for MEDLINE]

1: JAMA. 1998 Dec 9;280(22):1909-14. Bartenders' respiratory health after establishment of smoke-free bars and taverns. Eisner MD, Smith AK, Blanc PD.

Establishing smoke-free bars and taverns in California was associated with a rapid improvement of respiratory health among bartenders, regardless of whether they were smokers.

CONTEXT: The association between environmental tobacco smoke (ETS) exposure and respiratory symptoms has not been well established in adults. OBJECTIVE: To study the respiratory health of bartenders before and after legislative prohibition of smoking in all bars and taverns by the state of California. DESIGN: Cohort of bartenders interviewed before and after smoking prohibition. SETTING AND PARTICIPANTS: Bartenders at a random sample of bars and taverns in San Francisco. MAIN OUTCOME MEASURES: Interviews assessed respiratory symptoms, sensory irritation symptoms, ETS exposure, personal smoking, and recent upper respiratory tract infections. Spirometric assessment included forced expiratory volume in 1 second (FEV1) and forced vital capacity (FVC) measurements. RESULTS: Fifty-three of 67 eligible bartenders were interviewed. At baseline, all 53

bartenders reported workplace ETS exposure. After the smoking ban, self-reported ETS exposure at work declined from a median of 28 to 2 hours per week (P<.001). Thirty-nine bartenders (74%) initially reported respiratory symptoms. Of those symptomatic at baseline, 23 (59%) no longer had symptoms at follow-up (P<.001). Forty-one bartenders (77%) initially reported sensory irritation symptoms. At follow-up, 32 (78%) of these subjects had resolution of symptoms (P<.001). After prohibition of workplace smoking, we observed improvement in mean FVC (0.189 L; 95% confidence interval [CI], 0.082-0.296 L; 4.2% change) and, to a lesser extent, mean FEV1 (0.039 L; 95% CI, -0.030 to 0.107 L; 1.2% change). Complete cessation of workplace ETS exposure (compared with continued exposure) was associated with improved mean FVC (0.287 L; 95% CI, 0.088-0.486; 6.8% change) and mean FEV1 (0.142 L; 95% CI, 0.020-0.264 L; 4.5% change), after controlling for personal smoking and recent upper respiratory tract infections. CONCLUSION: Establishment of smoke-free bars and taverns was associated with a rapid improvement of respiratory health.

BMJ. 2004 Apr 5 Reduced incidence of admissions for myocardial infarction associated with public smoking ban: before and after study. Sargent RP, Shepard RM, Glantz SA.

During the six months a ban on workplace and public smoking was in effect, hospital admissions was significantly less than before the law or after the law was repealed.

OBJECTIVE: To determine whether there was a change in hospital admissions for acute myocardial infarction while a local law banning smoking in public and in workplaces was in effect. DESIGN: Analysis of admissions from December 1997 through November 2003 using Poisson analysis. SETTING: Helena, Montana, a geographically isolated community with one hospital serving a population of 68,140. PARTICIPANTS: All patients admitted for acute myocardial infarction. MAIN OUTCOME MEASURES: Number of monthly admissions for acute myocardial infarction for people living in and outside Helena. RESULTS: During the six months the law was enforced the number of admissions fell significantly (-16 admissions, 95% confidence interval -31.7 to -0.3), from an average of 40 admissions during the same months in the years before and after the law to a total of 24 admissions during the six months the law was in effect. There was a non-significant increase of 5.6 (-5.2 to 16.4) in the number of admissions from outside Helena during the same period, from 12.4 in the years before and after the law to 18.0 while the law was in effect. CONCLUSIONS: Laws to enforce smoke-free workplaces and public places may be associated with an effect on morbidity from heart disease.

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KPHA member, Kimber P. Richter, Ph.D., M.P.H., M.A., Assistant Professor of Preventive Medicine and Public Health at the University of Kansas Medical Center, has an extensive background in public health and tobacco/smoking research.

Dr. Richter's Honors and Awards related to her research on smoking and tobacco use include: the 2002 New Investigator Award, Society for Research on Nicotine/Tobacco

Dr. Richter's Peer-reviewed publications that relate to tobacco and smoking include:

1. Lewis, R.K., Paine-Andrews, A., Fawcett, S.B., Francisco, V.T., **Richter, K.P.**, Copple, B., Copple, J.E. (1996). Evaluating the effects of a community coalition's efforts to reduce illegal sales of alcohol and tobacco products to minors. Journal of Community Health, 21, 429-36.
2. Paine-Andrews, A., Fawcett, S.B., **Richter, K.P.**, Berkely, J.Y., Williams, E.L., & Lopez, C.M. (1996). Community coalitions to prevent adolescent substance abuse: The case of the "Project Freedom" replication initiative. Journal of Prevention and Intervention in the Community, 14, 81-99.
3. Fawcett, S.B., Lewis, R.K., Paine-Andrews, A., Francisco, V.T., **Richter, K.P.**, Williams, E., & Copple, B. (1997). Evaluating community coalitions for prevention of substance abuse: The case of Project Freedom. Health Education and Behavior, 24, 812-828.
4. Paine-Andrews, A., Harris, K.J., Fawcett, S.B., **Richter, K.P.**, Lewis, R.K., Francisco, V.T., Johnston, J. & Coen, S. (1997). Evaluating a statewide partnership for reducing risks for chronic diseases. Journal of Community Health, 22(5), 343-59.
5. Harris, K. J., **Richter, K. P.**, Schultz, J., & Johnston, J. A. (1998). Formative, process, and intermediate outcome evaluation of a pilot school-based A Day for Better Health project. American Journal of Health Promotion, 12, 378-381.
6. **Richter, K.P.**, Ahluwalia, J.S. (2000). A case for addressing cigarette use in methadone maintenance treatment. Journal of Addictive Diseases, 19(4), 35-52.
7. Jolicoeur, D.J., Ahluwalia, J.S., **Richter, K.P.**, Mosier, M., Harris, K.J., Gibson, C., Moranetz, C. (2000). Free Nicotine Patches: Are They Effective? Preventive Medicine, 30, 504-512.
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12. **Richter, K.P.**, Ahluwalia, H.K., Mosier, M.C. Nazir, N., Ahluwalia, J.S. (2002). A population-based study of cigarette smoking among illicit drug users in the United States. Addiction, 97 (7), 861-870.
13. **Richter, K.P.,** McCool, R.M., Okuyemi, K., Mayo, M.S., Ahluwalia, J.S. (2002). Patients' views on smoking cessation and tobacco harm reduction during drug treatment. Nicotine & Tobacco Research, S139-S136.
14. Okuyemi, **K., Richter**, K.P., Mosier, M.C., Nazir, N. (2002). Smoking reduction practices among African American smokers. Nicotine & Tobacco Research, S147-S153.
15. Jolicoeur, D.J., **Richter, K.P**., Ahluwalia, J.S., Mosier, M.C., Resnicow, K. (2003). Smoking cessation, smoking reduction, and delayed quitting among smokers given nicotine patches and a self-help pamphlet. Substance Abuse, 24(2), 101-106.

16. McCool, R.M., **Richter, K.P.** (2003). Why do so many drug users smoke? Journal of Substance Abuse Treatment, 25(1), 43-49.
17. **Richter, K.P.**, Choi, W.S., McCool, R.M., Harris, K.J., Ahluwalia, J.S. (2004). Smoking cessation services in U. S. methadone maintenance facilities. Psychiatric Services, 55, 1258-1264.
18. **Richter, K.P.**, Ahluwalia, H.K., Resnicow, K., Nazir, N., Mosier, M.C., Ahluwalia, J.S. (2004). Cigarette smoking among cannabis users in the United States. Substance Abuse, 25(2) 55-62.
19. McCool, R.M., **Richter, K.P.**, Choi, W.S. (in press). Benefits of and barriers to providing smoking treatment in methadone facilities: Findings from a national study. American Journal on Addictions.
20. **Richter, K.P.**, McCool, R.M., Catley, D., Hall, M., Ahluwalia, J.S. (in press). Dual pharmacotherapy and motivational interviewing for tobacco dependence among drug treatment patients. Journal of Addictive Diseases.
21. **Richter, K.P.**, Choi, W.S., Alford, D. (in press). Smoking policies in U.S. methadone maintenance facilities. Nicotine and Tobacco Research.
22. Caldwell AR, Okuyemi K, Thomas JL, Born, W., **Richter, K.P.**, et al.. (in press) Homelessness and smoking cessation: Insights from focus groups. Nicotine and Tobacco Research.
23. **Richter, K.P.** (in press). Good and bad times for treating cigarette smoking in drug treatment. Journal of Psychoactive

Dr. Richter's Research Support related to Smoking and Tobacco Use includes:

ONGOING

(Richter, P.I.) 02/05/00 - 01/31/05
National Institutes of Health KO1 DA00450
Addressing Nicotine Addiction Among Drug Abuse Patients
A five year development award to pursue research in the field of substance abuse treatment. The project consists of a career development and research plan designed to enable Dr Richter to become a fully independent researcher. The research plan includes three studies to assess a) drug treatment patients' views on smoking cessation, b) interactions between cigarette smoking and methadone dose and timing, and c) the effects of combined behavioral- and pharmaco-therapy on smoking cessation among drug treatment patients.

COMPLETED

(Richter, P.I.) 04/01/01 - 03/30/02
Robert Wood Johnson Foundation
A National Survey of Smoking Cessation Services in Methadone and Other Opioid Treatment
A one year award from the RWJ Substance Abuse Policy Research Program to conduct a national survey of methadone and opioid providers to ascertain the current level of smoking cessation services they offer.

(Richter, Fellow) 11/01/98 – 10/30/01
Center for Substance Abuse Prevention
Faculty Development Project. A 3-year award to KUMC School of Nursing to develop substance abuse research and teaching in the KUMC Masters of Public Health Program. Conducted faculty evaluations, curriculum development to strengthen MPH program substance abuse curriculum.

PENDING

(Okuyemi, K., P.I., Richter, Co-Investigator) 07/01/05 - 06/30/09
National Institutes of Health (Submitted Oct, 2004)
Improving NRT adherence and outcomes in homeless smokers. A four-year R01 award to conduct a two-arm randomized controlled trial assessing the effects of adherence-focused motivational interviewing (MI) for smoking cessation in homeless smokers. Both groups will receive 21 mg nicotine patches for eight weeks. The project will be conducted in collaboration with Kansas City homeless shelters and service facilities.

Testimony on March 9, 2005
House Federal and State Affairs Committee
In support of HB 2495

Good afternoon. My name is Kathy Bruner. I am the volunteer coordinator for Clean Air Lawrence, a community grass roots organization which has been working over the past two years to establish, and now to maintain our citywide ban on public indoor smoking.

A 5th generation Kansan. I have lived in Lawrence the past 28 years, and raised two daughters with my husband of 35 years. He is a Family Practice physician. I worked in his office for 20 years, then was licensed to sell health insurance while my kids were in college. That was a sobering experience. I fought for lower premiums for folks I knew in Lawrence who had serious medical problems and expenses. It was a losing battle.

I have been involved with many community organizations in Lawrence including Hospice as my neighbors and elderly relatives faced end of life issues. But caring for younger folks who died prematurely do to preventable smoking related illness was sobering and unexpected.

A little over two years ago a young woman who worked in a smoky Lawrence bar came home after her shift with an asthma attack. Her roommates called for an ambulance and she was intubated so she could breathe. Unfortunately she became combative and pulled out her airway, the paramedics could not get her airway restored and she died before they could get her to the hospital. Young people should not have to risk their lives in workplaces with secondhand smoke to get a college education. These and other experiences led me to get involved with Clean Air Lawrence

There is NO QUESTION that cigarette smoke, either directly or indirectly consumed, is harmful. Every governmental agency that has looked at the problem of smoking and second hand smoke has arrived at the same conclusion. Over 50,000 innocent non-smokers a year die from the effects of second hand smoke, which has been declared carcinogenic by the EPA. In addition to causing cancer, second hand smoke exposure has been shown to be a major cause of heart disease and heart attacks.

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The CDC recently took the drastic action of recommending that all individuals at risk for a heart attack, which includes most of us in this room, avoid smoky environments which have been shown to produce changes in the coronary arteries in less than ½ hour.

As baby boomers we have begun experiencing the harms described in the Surgeon Generals report that was generated 40 years ago. We are beginning to pay attention as we watch our parents, who were given free cigarettes during World War II, die gasping for breath. We have seen friends in the prime of life die from lung cancer. They have died from years of exposure, either directly or indirectly, to the 4,000 chemicals and 60 carcinogenic agents that make up tobacco products. These and many other experiences have steeled our resolve to help protect our society and our children from the scourge of smoking and the involuntary risks assumed from exposure to second hand smoke.

Social smoking is also a danger due to eventual nicotine addiction. Very few begin smoking after age 25, but kids don't know what to do with their hands to look cool, and can't afford that many beers, so they light up. Many KU students have told me the only time they smoked was when they went out with friends to the bars. Young people used to come to Lawrence to get an education but some left with an addiction which would eventually take their lives. We believe Lawrence's indoor smoking ban will help prevent this cycle of social smoking and addiction.

The US Surgeon General has stated that, in addition to cigarette taxes, restrictions on public smoking are the most effective way to reduce overall smoking while also protecting employees and the general public from the danger of second hand smoke. Indeed a recent survey from Ireland, the first country to ban indoor smoking, has shown an 11% decrease in the number of individuals who describe themselves as regular smokers in a little over a year since the enactment of their ban.

We, in Lawrence, are not alone. There is a world wide cultural shift against smoking and especially against indoor smoking. There are now 7 states that have gone smoke free. They are New York, California, Rhode Island, Massachusetts, Connecticut, Maine, Delaware, with Idaho, Utah, Florida and Vermont whose restaurants are all smoke free. 1811 other municipalities are smoke free.

There is every reason for Kansas to join in this world wide cultural change and endorse a comprehensive state wide indoor smoking ban. All levels of government worldwide have decided that is the only way to protect their citizens. Mechanical systems to attempt to clean the air are very expensive and don't work. Common courtesy between individuals should govern but doesn't. Patchwork restrictions produce an uneven competitive playing field between businesses and communities. The Lawrence task force studied and debated the smoking ordinance for a year before our city commissioners voted on the ban in late April last year, and it was enacted July 1. The task force was made up of bar owners, health professionals, architects & concerned citizens. Nothing takes place in Lawrence without a lot of discussion and public comment. We have done the gnashing of teeth for the state already, let's move on. We would suggest that what we have learned is the fewer the exemptions, the easier the enforcement. We have had remarkable compliance in a community with 27,000 college age students.

The bar and restaurant owners in Lawrence are our friends and neighbors. We want them to be successful. We were so proud that Free State Brewery was mentioned recently in the National Geographic Traveler magazine and other venues were in a recent New York Times article. This is a place to be treasured. Indeed the first place we take visitors is to Massachusetts Street. Our daughters who live in Boulder and LA love coming home to show off their hometown, but even more so now, that it is smoke free as their cities have been for sometime.

The lines to be served at the Free State Brewery are longer than ever. The popular traveling poker game that visits Johnny's was packed when we were over there recently. One downtown restaurant said that his beer distributor told him he was down on sales, when he was actually up 12%. The great musicians who come from both coasts are thrilled with the clean air they breathe now in our popular music venues. I had one man tell me that his wife (and the neighbors) were much happier now that he was not stripping off his smoke filled clothes on the deck when he got in at night from watching basketball games and having a burger at Henry T's. The college girls love having their hair not smell of smoke. We went out to the Jazz Haus for the first time in 10 years for New Years and there was a great eclectic crowd from all over the state. The change is great !

While some individual bars may feel they are down, we know that Hooters is coming

to Lawrence this spring a year after the ban has been enacted. Two other chains opened just before the smoking ban "The Longhorn" and "On the Boarder" they are always busy. Obviously they are not concerned, but that does slice the pie a bit thinner for the existing venues. We love the locally owned bars and restaurants in Lawrence and want them to remain, and a level playing field makes that possible.

The best and only effective remedy to protect the health of Kansans, is a consistent governmental ban on indoor smoking in public places and that is what we would ask this committee to advance.

We know that 450,000 Americans die every year from complications attributable to smoking. The smoking related health care costs in the US are now over 75 Billion Dollars a year, or $1,000 a year for every family of four, and rising rapidly. This represents the largest preventable expenditure in a health care economy that threatens to bankrupt our country. Much of this cost is born by government.

No state can afford these smoking related health care costs, especially one like Kansas, that has trouble just funding its schools. Now it has been shown that screening for lung cancer by CT scan will find cancers in an earlier, potentially more curable state. It is just a matter of time before private and governmental insurers will be expected to provide this expensive technology on a yearly basis to all smokers. We can't afford to deal with the costs of this addiction any longer, we have got to find a way to prevent it.

In summary the health risks of the exposure of innocent employees and consumers to life threatening second hand smoke in Kansas work places is no longer acceptable. Furthermore, **we as a state and a society must do everything possible to protect the coming generations from the cycle of nicotine addiction that we can no longer afford both in health care costs and human costs.** We hope this committee will have the courage to move forward to protect the citizens of this state, their children and themselves. As my husband the physician has said," YOU can save more lives with this one vote than he will in his entire career."

Legislative Testimony on March 9, 2005

To the House Federal and State Affairs Committee

On HB 2495 enacting a Kansas public smoking law

Chairman Edmonds and members of the House Federal and State Affairs Committee. My name is Shane Reif. I am 18 years old and a senior at Hoisington High School in Hoisington located in Barton County. Thank you for the opportunity to come before you today to let you know how I feel about House Bill 2495 and the state of Kansas going smoke free in all public places and work places.

- **Kansas' youth's views on this bill**

- **Ways smoke free policies can help youth**

- **How secondhand smoke in public affects teens**

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Exposure to passive smoke associated with increased heart disease risk. Harvard School of Public Health, News Release, April 15, 1997.

FEDERAL AND STATE AFFAIRS
Date 3-9-05
Attachment 7

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H.B. 2495—Eliminate Smoking in Public Places
March 9, 2005

Chairman Edmonds and members of the House Federal and State Affairs Committee,
my name is Terri Roberts, R.N., and I am here representing the KANSAS STATE NURSES ASSOCIATION (KSNA). KSNA is the professional organization for Registered Nurses, representing the more than 27,000 RN's licensed in the state of Kansas.

We are very pleased that this committee is having a hearing on House Bill 2495. H.B. 2495 raises a significant public policy debate about one aspect of prevention in the leading cause of preventable death, tobacco usage. Secondhand smoke, as you heard from other conferees, poses an unnecessary health risk forced upon those non-smokers who are in public places where smoking is unrestricted. Statewide smoking prohibitions have been implemented in six states, and the Delaware statutes passed in 2003 is the strongest and most sought after by tobacco control advocates throughout the country (attached). KSNA supports H.B. 2495 in concept, and is committed to working on changes needed to make it enforceable.

This public policy debate is about eliminating an unnecessary health risk and protecting those who don't smoke from secondhand smoke. I'm going to share with you some highlights from the California Case Study that are designed to refute arguments opponents will offer, with evidence based data.

Attached to my testimony is the Chronological Description of the Preparation and Implementation Activities following the first, a1994 statute passed in California. The first law did not include bars and or gaming clubs, these were not added to law until four years latter, 1998. There were also substantial challenges to the state law, referendum votes and other court challenges are referenced in the list with an annotated outcome description.

First, the Health Data
The Dangers of Secondhand Smoke
During the early to mid 1990s, Californians increasingly recognized secondhand smoke as a serious threat to their health, on the job, in public places and at home. Secondhand smoke exposure was scientifically linked to lung cancer, nasal sinus cancer, chronic coronary heart disease, heart attack, exacerbation of asthma in children and Sudden Infant Death Syndrome (SIDS).2 In fact, secondhand smoke was identified as America's third leading cause of preventable death.3 While exposure to secondhand smoke was a critical health hazard for all indoor employees, studies showed that food service workers, especially bar and restaurant employees, were in particular danger.

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Bar employees working an 8-hour shift involuntarily inhaled amounts of smoke that were the approximate equivalent of smoking 16 cigarettes, nearly a pack. This made secondhand smoke a significant occupational health hazard for food-service workers.1

California waitresses died from higher rates of lung cancer and heart disease than any other female occupational group and were found to have four times the expected lung cancer mortality rate and 2.5 times the expected heart disease mortality rate of any female occupation group.1

Bartenders were discovered to have rates of lung cancer higher than firefighters, miners, duct workers and dry cleaners.4

The Economic Impact is misrepresented and scare tactics are used about economic loses (jobs, revenue, etc.)

The California Department of Health Services tracked Economic indicators throughout the implementation of both aspects of their laws implementation.

Statewide Patron and Market Data: Tracking studies in 1997 and 1998 indicated that the majority of California bar patrons were non-smokers who preferred smoke-free environments. Findings included:

Although patronage patterns were unrelated to smoking status, 78% of frequent bar users and 82% of frequent restaurant users were nonsmokers. 17

Nearly 9 in 10 (87%) of adult bar patrons said that a ban on smoking in bars would Increase or have no affect on their overall patronage of bars. 11

As sales tax data accumulated from 1998 forward, following the implementation of the ban in bars and gaming clubs, economic fears proved groundless. Support from business owners increased as sales tax figures for each succeeding quarter emerged from the California State Board of Equalization, showing no negative statewide economic impact from the law. The California Smoke-free Workplace Act went into effect in bars in January, 1998. Nearly 89% of all California bars were attached to restaurants at that time.

Annual Taxable Sales figures from the California Board of Equalization (BOE) for such establishments selling beer and wine and for those selling all types of liquor increased every single quarter of 1998, 1999 and into 2000. 16

Revenue data from the BOE, the only state agency that collected sales data directly from business owners also showed that:

For establishments selling beer and wine, annual sales in 1997 were $7.16 billion dollars; annual sales in the same category for 1998 increased to $7.6 billion and in 1999 they rose to $8.27 billion.

For establishments selling all types of alcohol, 1997sales were $8.64 billion dollars; 1998 sales increased to $9.08 billion and 1999 annual sales increased to $9.82 billion.

An additional $879,816,000 in sales were made in California's beer, wine and liquor serving establishments during 1998 as compared to 1997—after the California Smoke-free Workplace Act became effective for bars.

The rate of grow thin beer, wine and liquor serving establishments outpaced all retail outlet taxable sales in 1998 compared to 1997 by 7.7%. In fact, in 2000, California's bars and restaurants had over 108,000 more employees than in 1995, bringing the total workforce to nearly 926,000 people for the hospitality sector.

In summary, the BOE reported increased sales tax revenues for California's smoke-free liquor licensees every quarter from January 1998 through the year 2000. Sales tax figures indicated that Taxable Annual Sales for bars and restaurants serving just beer and wine and for those serving all types of alcohol increased in 1998 over 1997 figures by more than 5%. Their sales increased again in 1999 over 1998 by more than 8% and the increases continued in 2000.

Tourism in California

Reports from the California Department of Tourism showed that smoke-free work-place laws did not have an adverse affect on visitor activity or spending, contrary to tobacco industry claims that tourists would resent California's smoke-free policies. While the California Smoke-free Workplace Act was not directly responsible for an increase in tourism to the state, the fact remained that the tourist industry flourished since the statewide ban went into effect.

Demonstrated Improvement in Employee Health

Reaction to the law from bar and restaurant employees was understandably favorable. Elated servers, bartenders, casino dealers, musicians and other hospitality industry employees declared they would never go back to smoke-filled work environments. Their high regard for the law was well founded. A 1998 University of California, San Francisco, study revealed that 59% of bartenders surveyed who had symptoms of respiratory ailments and impaired lung capacity before the law went into effect for bars showed a significant decrease in symptoms and measurably improved lung capacity just one month after the law took effect. 1

Conclusion

Research on public opinion and statewide compliance rates clearly demonstrated that support for the California Smoke-free Workplace Act and levels of compliance with the law grew from quarter to quarter between 1998 and 2001. Polls showed more than 72% of bar patrons and over 80% of the general public approved of smoke-free workplaces, including bars. In California, smoke-free environments became the accepted norm, at work, in public places, and at home

Additionally, smoke-free workplace legislation withstood repeated attacks by the tobacco industry and its front groups between 1994 and 2000. Voters delivered a clear rejection of tobacco industry propaganda when Proposition 188, attempting to overturn Labor Code 6404.5 was voted down in 1994. The tobacco industry made no progress in their lobbying efforts to halt smoke-free bars. **Subsequent attempts to limit or overturn the state's smoke-free bar law have failed. Why? Because cancer rates went down, revenues went up and public acceptance of smoke-free bars became a "social norm".**

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**Statement of the Kansas Medical Society
on HB 2495; Concerning the Kansas Public Smoking Ban Act
House Federal and State Affairs Committee
March 9, 2005**

The Kansas Medical Society supports the enactment of HB 2495, which outlaws smoking in enclosed public places after January 1, 2007. We support this legislation because it will have positive, demonstrable effects on the health of all Kansans.

Secondhand smoke, also known as environmental tobacco smoke (ETS), is a mixture of the smoke given off by the burning end of tobacco products and the smoke exhaled by smokers. It is a known carcinogen, and authoritative studies over the past two decades have conclusively linked ETS to adverse health outcomes, including death. ETS-related health conditions affect the entire population, including our most vulnerable citizens - children and the elderly. Because their lungs are not fully developed, young children are particularly susceptible to secondhand smoke. Exposure to ETS is associated with an increased risk for sudden infant death syndrome (SIDS), asthma, bronchitis, and pneumonia in young children. Nonsmoking adults are at a significantly greater risk for lung cancer and cardiovascular disease, also brought on and exacerbated by ETS.

People are exposed to secondhand smoke in the home, workplace, and in public establishments such as restaurants, bars, and other places of business. This legislation makes a strong, and long overdue, statement of public policy that the state of Kansas is taking steps to reduce the levels of second hand smoke in enclosed public places, and thereby diminish the exposure of nonsmoking Kansans to ETS. It will make our workplaces, restaurants and other public establishments safer and healthier. This is a positive action the legislature can take to dramatically improve the health of Kansans, and it requires virtually no tax dollars to implement. We strongly urge you to report this legislation favorably for passage.

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Statement To
House Federal and State Affairs Committee
In Support of House Bill 2495
By Charles L. Wheelen
March 9, 2005

The Kansas Association of Osteopathic Medicine supports the provisions of HB2495 because this bill would accomplish one of the important goals of the American Osteopathic Association's official policy position on smoking and tobacco products. Disease prevention is one of the fundamental principles of osteopathic medical practice, and for that reason, we believe the Kansa Legislature should adopt a statewide public policy that protects our citizens from the ill effects of secondary tobacco smoke.

Thank you for considering our position on this issue. The official position of the American Osteopathic Association is the following:

SMOKING - TOBACCO PRODUCTS

WHEREAS, cigarette smoking has been identified as a chief preventable cause of death in our society; and WHEREAS, smoking is a major cause of cancer, heart and lung disease; and WHEREAS, cigarettes and other forms of tobacco are addicting; and WHEREAS, the pharmacologic and behavioral processes that determine tobacco addiction are similar to those which determine addiction to drugs such as heroin and cocaine; and WHEREAS, the unrestricted use of tobacco in public and the workplace sends a mixed message to the youth of this country concerning the social acceptance of smoking and drug use; and WHEREAS, involuntary smoking from secondary smoke has shown to have detrimental effects on health; and WHEREAS, educating the American people of the health risks associated with smoking is a vital component of the effort to prevent disease by reducing cigarette use; and WHEREAS, tobacco use by children is associated with chronic and recurrent medical problems; and WHEREAS, the American Osteopathic Association members, as important role models for both children and adults, should be encouraged not to smoke or use tobacco products in the presence of their patients; and WHEREAS, men, women and children continue to smoke, despite the abundance of educational health programs focused on the life threatening circumstances of smoking; now, therefore, be it
RESOLVED, that the American Osteopathic Association supports a comprehensive education campaign on the hazards of smoking beginning at the elementary school level; and, be it further RESOLVED, that physicians be encouraged to inquire into tobacco use and exposure as part of both prenatal visits and every appropriate health supervision visit; and, be it further RESOLVED, that the AOA strongly recommends that all federal and state health agencies continue to take positive action to discourage the American public from using cigarettes and other tobacco products; and, be it further RESOLVED, that the AOA encourages its members to discuss the hazards of tobacco use with their patients; and, be it further RESOLVED, that the AOA encourages the elimination of federal subsidies and encourages increased taxation of tobacco products at both federal and state levels; that monies from the additional taxation could be earmarked for smoking-reduction programs and research for prevention of tobacco-related diseases; that municipal, state and federal executive agencies and lawmakers enact clean-indoor air acts, a total ban on tobacco product advertising, opposes cigarette vending machines in general and supports federal legislation to limit access to cigarette machines to minors, and the elimination of free distribution of cigarettes in the United States; and that grades K -12 should be encouraged to incorporate a curricular component that has been proven effective in preventing tobacco usage in its health education curriculum; and, be it further RESOLVED, that the AOA urges the development of anti-tobacco educational programs targeted to all members of society, with the ultimate goal of achieving a tobacco-free nation.

FEDERAL AND STATE AFFAIRS
Date 3-9-05
Attachment 10

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Testimony in Support of HB 2495
Before the Committee on Federal and State Affairs
By Judy Keller, Executive Director, American Lung Association of Kansas
March 9, 2005

Members of the Committee:

I write in support of House Bill 2495 which would provide safe and clean indoor air for residents of Kansas.

We all know that smokers have a markedly increased risk of cancer, heart disease, stroke, lung problems, and many other diseases.

BUT, DID YOU KNOW:

1. 15% of cigarette smoke is inhaled by the smoker and 85% of the cigarette smoke is released into the air.

2. Smoke in the air or second hand smoke is higher in tar, nicotine, carbon monoxide, and cancer-causing chemicals than the smoke inhaled through the cigarette.

3. Second hand smoke contains 4,000 substances, more than 40 of which are known to cause cancer in people and pets.

4. Second hand smoke, like asbestos, is classified by the United States Environmental Protection Agency as a Group A Carcinogen, meaning known to cause cancer in humans.

5. Second hand smoke causes 3,000 lung cancer deaths per year in nonsmokers.

6. Second hand smoke leads to 35,000 deaths per year related to heart disease in nonsmokers.

7. Second hand smoke impairs fertility with a 15% decreased chance of conception in women and a reduced sperm count in men.

8. In otherwise healthy babies younger than 18 months of age, second hand smoke contributes to 300,000 cases per year of bronchitis and pneumonia with up to 15,000 hospitalizations per year in this group.

9. In asthmatic children, second hand smoke worsens asthma in up to 1 million children.

10. Employees who are exposed to smoke have more illnesses and miss more work.

11. Studies have shown that going smoke-free has a neutral or positive impact on the profits of restaurants and bars.

We applaud your interest in protecting the rights of individuals to breathe clean air and look forward to comprehensive smoke free workplace protection for all Kansans.

Improving Life,
One Breath
at a Time

Please fight lung disease by rememberin

FEDERAL AND STATE AFFAIRS
Date 3-9-05
Attachment 11

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American Heart Association
Testimony in Support of HB 2495

House Federal and State Affairs Committee
Wednesday, March 9, 2005

Chairman Edmonds and Members of the Committee:

I appreciate the opportunity to submit written testimony in support of HB 2495 as I am unable to participate in today's hearing in person. I am Kevin Walker, Vice President of Advocacy for the American Heart Association.

The American Heart Association is in full support of clean indoor air efforts. Throughout the country we have been an active partner in bringing smoke-free air to local communities and entire states. We are encouraged by the progress being made throughout the country on this issue and applaud the Kansas Legislature for addressing this important topic.

Heart disease and stroke are the nation's first and third leading causes of disability and death, and the use of tobacco products contributes to these deadly diseases. Second hand smoke, or environmental tobacco smoke (ETS) as it is also known, has long been associated with heart disease because of tobacco smoke's overall effect on the cardiovascular system. Studies show that the inhalation of tobacco smoke causes blood vessels to contract, limits blood flow throughout the body, reduces a person's oxygen supply, damages arteries, lowers the "good" HDL cholesterol and increases the risk of clotting. Those exposed to ETS are 82 percent more likely to suffer a stroke and even occasional exposure to secondhand smoke increases the risk of developing heart disease by 58 percent. Unfortunately the effects of ETS result in a number of grim statistics including the death toll of approximately 37,000 cardiovascular deaths each year.

In addition to the human toll, there is an economic toll as well. Smoking related illnesses cost Americans an estimated $130 billion annually in medical care.

Both the U.S. Surgeon General and the National Institute of Occupational Safety and Health have both found that the simple separation of smokers and nonsmokers in the workplace or in public places does not provide adequate protection for nonsmokers. Or, let me use an analogy. The air we breathe in a restaurant can best be compared to water in a swimming pool; just as there is no way to have chlorinated and non-chlorinated sections of a pool, we all end up having to inhale deadly second-hand smoke while dining in, or working in a restaurant.

In a survey of American, non-smoking, working adults over the age of 17, nearly 48 percent reported being exposed to tobacco smoke at home or on the job. Researchers measuring the air in more than 400 restaurants and 600 homes found that restaurant workers were exposed to levels of secondhand smoke twice as high as other office workers and 1.5 times higher than

Please remember the American Heart Association in your will.

FEDERAL AND STATE AFFAIRS
Date 3-9-05
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persons living with a smoker. In bars, workers' secondhand smoke intake was at least four times higher than in offices and homes.

The American Heart Association regards the public's protection from secondhand smoke hazards an integral part of a comprehensive tobacco control policy. The very fact that the exposure appears to be irreversible and accelerates vascular disease associated with the development of high blood pressure and diabetes indicates the seriousness of the risk. Reducing secondhand smoke must be a high priority in preventing these diseases.

While I do offer our support for this legislation, I do believe it is important to point out that we stand ready to provide suggestions on a few provisions of the bill that, if modified, could make the bill even stronger and go further in protecting the health of Kansans.

On behalf of the American Heart Association I applaud your efforts with this bill and believe that tobacco use prevention policies – including clean indoor air laws – will make a positive difference in the lives of all Kansans.

Please remember the American Heart Association in your will.

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Testimony Re: HB 2495
House Federal and State Affairs Committee
Presented by Ronald R. Hein
on behalf of
Kansas Restaurant and Hospitality Association
March 9, 2005

Mr. Chairman, Members of the Committee:

My name is Ron Hein, and I am legislative counsel for the Kansas Restaurant and Hospitality Association. The KRHA is the Kansas professional association for restaurant, hotel, lodging and hospitality businesses in Kansas.

KRHA opposes HB 2495, which bans smoking in all indoor places, including bars and restaurants, and outdoor facilities for food service establishments or "licensed premises". This would make Kansas have the most far reaching smoking ban statute in the country.

KRHA is a firm believer in the right of a business owner, and a private property owner to determine these types of issues. There has already been significant governmental intrusion into the use of such private property with existing laws. This measure throws the concept of accommodation and least intrusion of government regarding private property rights and personal liberties out the window.

The private sector, under current law, is addressing this issue in a manner that protects the public health, and yet also protects private property rights and personal liberties. Already numerous facilities are smoke-free. And yet for those who would like to dine-out and smoke, reasonable accommodation is given to their personal rights.

KRHA is also concerned about the adverse economic impact on private businesses caused by smoking bans. You will hear testimony from others who have been directly impacted by smoking bans, but the KRHA recognizes that smoking bans definitely have an impact on businesses whose livelihood depends upon their smoking clientele. You may hear statistics that measure the total (macrocosm) impact of smoking bans, both positive and negative, depending upon who is supplying the statistics and how the study is configured. But, without doubt, in a microcosmic view, smoking bans definitely adversely impact current businesses who cater to a smoking clientele.

The fact that the government is considering prohibiting such customers, and businesses that cater to such customers, from exercising what they consider to be their personal right to consume a lawful product in a free society is indeed a frightening thought.

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The philosophical question involved in this type of legislation is whether the government should force all businesses to conform to a credo or philosophy to which some people ascribe. Which "right" is greater? The right of an individual customer to force ALL businesses to conform to a standard that such customer deems to be appropriate, whether or not that customer ever frequents that business. The right of the property owner to cater to his or her customer base, even if they are participating in a behavior that some feel is inappropriate. The right of another individual to participate in a behavior that some feel is inappropriate in a facility where the owner of the property is willing to accommodate and even welcome that individual. Which "right" is greater?

HB 2495 would outlaw a business which is owned by a person who smokes and is willing to serve customers who smoke, and which is operated by employees who smoke and are willing to work around smokers, and which is frequented only by smokers who are willing to be with other smokers, solely for the purpose of appeasing another individual who does not smoke, who doesn't like smoking, and who would never frequent that business, but who wants to prohibit such conduct.

This is another example of government protecting people from themselves. Current law on smoking in public facilities is, for the most part, based in personal responsibility. If one doesn't want to be around smokers at a restaurant, they can go to a restaurant that is smoke free. Many restaurants have separate sections or rooms that accomodate both smokers and non-smokers.

KRHA would question where this type of legislation might go from here? Bans on wearing of perfumes, which can have adverse physical affects on certain people? (We understand that such a restriction has been adopted in Nova Scotia.) Bans on serving of certain food products, such as msg, salt, grapefruit that may be harmful to some? Banning of pork or other foods that certain ethnic groups feel are inappropriate?

Lastly, we would question whether there is a taking of property by the government for businesses that have spent money to meet current laws to accommodate smokers.

KRHA would respectfully request the committee defeat HB 2495.

Thank you very much for permitting me to testify, and I will be happy to yield to questions.

March 9, 2005
Regarding HB 2465

My name is Chuck Magerl, and I have a curious experience with the questions of smoking accommodation, since one of my restaurants in Lawrence, WheatFields bakery, was non smoking, and one of them, Free State Brewery was open accommodation. My academic training was as a scholarship student in pre-med science disciplines, as well as civil engineering and water resources. Those studies confirmed for me the need to search for connections in science and public health and safety issues. As a disclaimer, I have smoked perhaps a dozen cigarettes in my life, and have neither paid money to, nor received money from any tobacco company. I've never allowed the sale of tobacco at any of the businesses I have operated in Lawrence for the past 25 years. I have made sure that my retirement funds are not invested in tobacco companies. I am not just a nonsmoker, but also anti-smoking, though certainly not anti-smoker. With this background I was selected as one of 7 members on the Lawrence Task Force on Smoking. As you may guess, it was a massive undertaking.

My personal belief is that smoking stinks, it burns your eyes, irritates your nasal passages and fouls your hair, and for smokers, it cuts your life expectancy by 7 to 10 percent. If smokers quit, the health of Lawrence will improve, but it most likely won't have much of any impact on the mortality of us nonsmokers, and therein lies my opposition to this bill.

The reality behind the Lawrence smoking ban is that it is designed to abate the nuisance for us nonsmokers, and hopefully entice a few smokers to quit, so they can reap the health benefits of a nonsmoking lifestyle. Government has no role in accommodating personal preferences at the expense of private businesses, especially when a person has many options to enjoy a smoke free environment if that is important to him.

I'm the father of two girls, who have spent many hours over the years at my restaurants, healthy, intelligent kids, the oldest has been on the principal's honor roll at junior high every semester. To suggest that I would risk their health, my wife's health, my health or the health of the 115 employees I care for, is simply wrong.

I take great pride in my Kansas heritage, although the past has some embarrassing moments. I think HL Mencken may have been thinking of the Carry Nation era of Kansas with his definition of Puritanism - "the haunting fear that someone, somewhere, may be happy"

I appreciate Mr. Edmonds providing a forum for the second hand smoke issue facing our state. This consideration is an example of one of the wonderful features of Kansas: true, broad based care for the future of our state. Sometimes wise and principled individuals may find themselves in disagreement on plans of action, and the smoking ban issue is a grand example. I believe that our democracy is posited on a Socratic "educated masses", not a deferral to a Platonic "enlightened ruler".

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My assumption is that members of this committee and myself both want the same thing, responsible hospitality and healthy lifestyles. We want moderation, we want healthy citizens. My commitment is to life, liberty and the pursuit of happiness, and the individual's right to make personal choices based on informed decisions.

I am not a tobacco user, and as a member of the Mayor's Task Force, I've had quite a bit of exposure to the implications and problems associated with tobacco use. I also am an advocate of programs promoting abstinence from tobacco products as a healthy and better choice for members of our society, especially youth. I have instructed my smoking employees on the real dangers of a smoking lifestyle.

The two thoughts that seem to encapsulate this discussion most completely come from some highly esteemed gentlemen. The first came on a recent NPR broadcast with the noted surgeon Dr. Michael DeBakey. The summation of his lengthy interview was the thought, "I hope we realize that our health and our freedom are the two most valuable things we have." The other item that resonates with this discussion is the often quoted English Prime Minister Benjamin Disraeli's quip, "there are three kind of lies: lies, damned lies and statistics."

As I reviewed these statistics and reports for the Task Force, several perplexing questions arose about the threat level of second hand smoke. The first thing I noted is the fact that of the 18 developed nations with a greater life expectancy than the US, 15 have greater rates of smoking, and by extension, greater exposures of secondhand smoke (sometimes much greater, e.g. Japan). Something else may be a factor in the US life expectancy than secondhand smoke?

Additionally, there was the troubling report of a huge drop in heart attacks in Helena, Montana during a brief smoking ban. It was reported that heart attacks dropped 60 percent (later changed to 40 percent). According to the U.S. Centers for Disease Control and Prevention, smoking accounts for about one-fifth of heart disease deaths. So even if every smoker in Helena quit (which no one claims happened), you would not get anything like the drop that was attributed to the ban.

If smoking bans cut heart attacks in half, it's odd that no one had noticed it before, especially in big cities such as Los Angeles and San Francisco, where an effect of such magnitude should have been obvious. Indeed, why didn't the authors study hospital data in places within the State of California where the samples would have been much bigger and the results more meaningful, instead of focusing on what one author calls "a tiny little community in the middle of nowhere"?

California's ban on smoking in workplaces took effect in 1995; it was extended to bars in 1998. Yet according to CDC data, the number of heart disease deaths in California did not drop substantially in either year. If smoking bans cut heart attacks in half, surely the effect would have shown up in these numbers.

In my own community of Lawrence, when I extrapolated the often repeated number of 50-60,000 deaths each year from ETS, it suggests that in my 30 years in Lawrence there were 500-600 people who died from second hand smoke. I've known people who have been murdered, people who have drowned, people who have been killed in car accidents, but not one who died from second hand smoke. My doctor, who has practiced in Lawrence longer than 30 years, could not cite any cases either.

I am not a card carrying Libertarian. I believe government has a legitimate role in health and safety issues. I accept that appropriate government intervention must be considered in regards to worker health and secondhand smoke. In fact, a specific government agency is responsible for all these concerns, and is mandated to seek action to remedy safety and health problems. That agency, however, is not our hard working citizen legislators of the Kansas House, but rather the expert staff of the Occupational Safety and Health Administration of the Federal government.

For five years OSHA reviewed studies and testimony on the workplace impact of secondhand smoke. They factored the components of smoke exposure based on their tabulated data for air contaminant substances, and the established Permissible Exposure Levels. Their conclusion? "Field studies of environmental tobacco smoke indicate that under normal conditions, the components in tobacco smoke are diluted below existing Permissible Exposure Levels. It would be VERY RARE to find a workplace with so much smoking that ANY individual PEL would be exceeded."

As continued calls came to OSHA from state and local governments seeking information on the workplace threat of secondhand smoke, OSHA reiterated their findings in 2003. "Although OSHA has no regulation that addresses tobacco smoke as a whole, 29 CFR 1910.1000 limits employee exposure to several of the main chemical components found in tobacco smoke. In normal situations, exposures would not exceed these PELs." It's within the scope of this legislative body to act as you wish, but you should know that some well informed experts disagree with the ban approach.

As a responsible and caring business owner, I am concerned about the employees, guests and my family, who frequent my businesses. Using the best data from KDHE, CDC and the American Cancer Society, the statistics suggest the possibility of a case of lung cancer with a non-smoking employee for every 949 years we are in business. I know some people would suggest that the precautionary principle applies here, but please review this.

Everything in life involves a risk of some kind. Throughout our evolution and development we have sought to minimize and manage risk, but not to eliminate it. Even if this were possible, it would undoubtedly be undesirable. A culture in which people do not take chances, where any form of progress or development is abandoned 'just to be on the safe side', is one with a very limited future. The very nature and structure of all human societies are what they are because individuals, in co-operation with each other, have taken their chances - seeking the rewards of well-judged risk-taking to the

enervating constraints of safe options. Had the precautionary principle been applied, the Pilgrim Fathers would never have set sail for America in their fragile ships.

As an individual facing risks, the only sane response is to analyze the risk factors and make your own decisions based on the concerns you value.

That what we have to do in our businesses every day as well. The bar and restaurant business is fiercely competitive, and the people running venues are smart enough to do everything they can to increase their bottom line. If banning smoking really were good for their business, wouldn't they have discovered it by now, and wouldn't that make laws mandating bans unnecessary?

Numerous studies have been undertaken in an attempt to determine economic impact after smoking ban laws are placed into effect. Most "community-wide" statistical studies appear to show little or no overall negative impact when laws are passed restricting smoking in restaurants. However, non-smoking ordinances have been found to have significant impact on the sales and profits of individual restaurants in certain cases.

It appears the proponents of restaurant smoking restrictions concentrate on the "macro" economic impact of these laws. In other words, their studies tend to show that taken as a whole, restaurant sales in a community do not decline after passage of "smoke-free" ordinances. Opponents of smoke-free restaurant laws tend to rely more on the "micro" economic impact. They may report business opinions of lost revenue, or have anecdotal reports of individual businesses declining or failing. On an aggregate basis, an industry category subject to a ban may show no net effect on sales even though one-half of firms showed gains and the other half exhibited losses. It is not particularly useful to conclude that nothing occurred.

The most recent data from the Kansas Department of Revenue tracks the reporting of Liquor Drink Tax from Drinking Establishments in Lawrence. In the six months preceding the ban, a reviving economy had resulted in a 6.13 percent growth in beverage sales at restaurants and bars. In the months since the July 1st ban, beverage sales have dropped by an average of 8.07 percent. Some of this, to be sure, is a measure of the local economy. Lawrence has lagged the State in growth in retail sales for quite some time. We certainly haven't enjoyed the growth of communities such as Wichita or Topeka, let alone the amazing growth of Manhattan or Bonner Springs.

Another item to recognize is that smoking bans do not impose identical economic effects on all businesses. Bars are more than twice as likely to experience revenue drops than restaurants. Similarly, losses are more likely in restaurants that are more "bar-like" (sports bars, pubs) than other restaurants. Chain restaurant franchises are also less likely to experience revenue reduction. Fast food outlets and other carryout type establishments typically see an increase in revenues as restaurant customers rearrange their purchasing patterns.

Several of the studies from California localities indicate that although the revenues from restaurant sales continued to increase, they did not keep pace with inflation and population growth, even in the mid 1990's boom economy. U.S. Department of Commerce data reports that in the 1993 – 1998 period spanning the enactment of the restaurant smoking ban in California, the position of the industry in the state did not keep pace with the growth in other states. Prior to the ban, 9 of the top 50 metropolitan per capita restaurant sales locations were in California. After the ban, that number had fallen to 4 of the top 50. The rate of restaurant sales growth in California cited in the most noted study (Glantz, et.al.) was 29% below our rate of growth in Lawrence during the same period.

A newspaper article from the college community of Greeley, Colorado is indicative of the co-existence of the conflicting perspectives on the economic impact of smoking bans.

> "Overall, the report shows a healthy 16.9 percent increase in December restaurant and tavern sales compared to the same month last year. But that increase reflects sales from new restaurants such as Outback Steakhouse that opened after December 2002.
>
> The December sales picture is a lot less rosy for several bars and restaurants that used to be smoker hangouts.
>
> The city compared December 2002 and 2003 sales at several former smoker hangouts and found that revenues were down 5 percent -15 percent this year." (Greeley Tribune)

This article notes sales are up based on overall tax reports. However, as in many reports, it's unclear whether these reports control for differences in tourism, weather and employment growth, all of which could influence businesses. And though the aggregate numbers are positive, the negative reports of declining sales are confirmed on an individual case basis.

Could we have done a better job of abating the smoke nuisance at Free State Brewery? Absolutely. One of the most positive aspects of my year of research with the Task Force has been my understanding of the advancements in ventilation and filtration technology that would greatly enhance the comfort level of our guests and staff. I was prepared to invest $30-40,000 in updated heat recovery ventilation systems to make the Brewery a more hospitable and relaxing environment for people to enjoy our food and beer. And that would benefit us all, since we know moderate alcohol consumption decreases heart disease by 40 percent.

For some very legitimate reasons, some activists have declared war on tobacco companies. Unfortunately, frustrated with losing the direct confrontations, they have taken a different attack. This bill would conscript hundreds of small, independent Kansas businesses in a proxy war against the tobacco companies. And that's too bad. It's not really our war.

If this committee believes that smoking is devastating to the health of smokers, and that tobacco smoke is devastating to the health of non-smokers, then I urge you to have the courage to ban the sale of tobacco in Kansas. Banning smoking in businesses will not address the greatest venue for second hand smoke exposure, private homes and automobiles. Why take timid, half way measures? This is not a new idea for Kansas, we banned tobacco for several decades in the Carry Nation years, we could do it again. Take the stance of forsaking the $190 million in revenue that Kansas gathers from tobacco sales. If you can't accept the idea of banning the product, then please have the respect and decency to allow Kansas businesses and Kansas citizens the personal intelligence to decide how to balance the use of a legal product on private property. The innovations of Kansas businesses should not be underestimated.

My regard for cigarette smoking in restaurants is highlighted in the swimming pool analogy. Having a non-smoking area in a restaurant is like having a non-peeing area in a swimming pool or lake. It may be obnoxious, it may be gross, but it's something we have all been exposed to, and the health risk is virtually non-existent. Filtration and dilution is a wonderful thing. Like they taught us in pre-med biology, the poison is in the dose.

Thanks for taking the time to consider my thoughts. I truly do not envy the task ahead of you, and I wish you extraordinary wisdom and courage in the weeks to come.

Chuck Magerl
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The Committee on Federal and State affairs

House Bill No. 2495

Dear Members of the committee:

My name is Rod Anderson and I own and operate two Hereford House Restaurants in the state of Kansas. I am a non smoker.

Currently we employ 165 people in our two restaurants down from a high of 185. This drop in employees is almost totally attributable to the decrease in traffic in our Lawrence location since the total smoking ban was implemented July 1, 2004. The Lawrence Hereford House employed 78 people before the smoking ban and currently employs 61.

I do not believe the Hereford House is alone with respect to the drop in business since the smoking ban was enacted in Lawrence. We have adjusted to the downturn in business and are aggressively attacking the market with a new enthusiasm. We are committed to the Lawrence Market and we will operate profitably although at a lower sales volume.

The issue at hand is the rights of individuals to smoke, as well as, the rights of individuals not to be exposed to smoke. The market forces will typically dictate how many smoking and non smoking tables that operators will make available in restaurants and bars. Smoking ordinances have been passed in Overland Park and Leawood that have grand fathered existing establishments and were applied only to new construction and extensive renovations. This ordinance has been effective and has made newer establishments a far better place to be for smokers and non smokers alike. This has had a positive effect on the constituents as well as protecting the investments of individuals who had invested in the community long before the push for non smoking establishments started.

The compromise worked out in Overland Park is a tribute to Mayor Eilert who's comment to the advocates of non smoking in restaurants and bars was to say "do not go and you will force the owners of these establishments to make a choice of whether or not to be a smoking establishment". However for those advocates of non smoking this ultimately has not been seen as a victory for both sides but only as a step towards the complete elimination of smoking anywhere but your house or car.

House Bill No. 2495 goes further than the Lawrence non smoking bill and eliminates smoking in outdoor patios and at doorways. As owners we are to enforce these clauses and if we do not we will obligated to pay a fine that can be as high as $500. If you enact this bill I would encourage your committee to find an outlet to smoke legally for the 20% of the population that continues to smoke legally today. As smoking has not been made illegal you must find a way to accommodate the smoker so as not to make a law abiding

citizen commit a crime for taking part in a legal substance and for owners of businesses to become the smoke police.

I close by saying that I believe many bars and restaurants will suffer wherever the ban is enacted. Most will survive , although some will not, and those that do will eventually thrive. This ordinance should not be enacted city by city or county by county. It should actually go way beyond the borders of each state to create a fair and level playing field for all establishments. The restaurants on the state line in Kansas will most likely suffer if Missouri does not support a similar ban. The commissioners in Lawrence believe they had the best interests of the citizens foremost in their minds. I would like to ask the 17 people that are no longer employed at the Hereford House in Lawrence if they feel that their best interests are being taken care of.

We had an employee just recently who got angry during a shift and walked off the job. His employment was immediately terminated. He came back the next day to apologize for his actions. He came to see us because he said it was hard to get another restaurant job in Lawrence right now. We did not hire him back because we hired someone the day he walked off the job. We have a stack of applications from people who want to work in Lawrence but the Hereford House as well as many other establishments are not adding employees at this time.

The Lawrence market is an example of what happens when a smoking ban is enacted in a small community surrounded by other larger communities that allow smoking. I asked a non smoker who is an advocate of non smoking in restaurants and bars this question. What would you do if one person in your group smoked and you had a choice of a restaurant that allowed smoking and one that didn't? The answer was we would go to the smoking restaurant and sit in the non smoking section. They would accommodate the smoker by choosing a restaurant where smoking is permitted , but choose to sit in a non smoking section not encumbered by smoke.

Ladies and gentleman I appreciate the opportunity to makes my comments and to answer any further questions you may have.

Sincerely

Rod Anderson

Testimony Presented to

the House Judiciary Committee

Re: HB 2495

by Joni Bocelewatz

KCK Drinking Establishment Owner

March 9, 2005

Thank you, Mr. Chairman, for allowing me the opportunity to speak to the committee today. My name is Joni Bocelewatz. My husband and I own two bars on Strawberry Hill, a historic area in downtown Kansas City, Kansas. This is an economically depressed area that has begun to turn around with the arrival of new businesses, old storefront buildings being renovated, condos being built in the old City Hall, and younger people purchasing homes in the area for renovation. It's becoming a neighborhood again. We also have purchased a 105-year-old house within two blocks of each of the bars that we're renovating so we can move to this area of KCK from Johnson County.

House Bill 2495 seeks a state-wide ban on cigarettes in public areas. The Lawrence newspaper has reported that several of the bars there have reported a 20% loss in business since the implementation of the city wide smoking ban. There are bars outside that city where people will go, knowing they can smoke. This bill is going to effect businesses along the state line corridors in the same manner. The state-wide bill is not going to effect commerce in most of Kansas to a great degree because the interior of the state would be immune from people simply getting in their cars and driving to another location. If there's a smoking ban in Kansas City, people will travel across the line to Kansas City, Missouri. The nearest bar in Missouri from my location of business is less than two miles across the Lewis and Clark Viaduct which connects the cities. Pittsburg, Coffeyville, Liberal, and other border towns will face the same problem as KCK due to their close proximity to the state line. At a time when we're trying to bring a viable economy to downtown KCK, this would be an economic disaster

for the bar owners, in addition to losing valuable Kansas tax dollars to surrounding states.

I do not smoke cigarettes, nor have I ever smoked. Some of my customers smoke, some do not. We know what environment we are entering when we open the door. It is our choice whether to enter and perhaps suffer the deleterious effects of secondhand smoke. Personal choice of this nature needs to remain with the individual. If one does not want to be in a smoke-filled environment, they have the choice of going to a smoke-free venue. In addition, many of the bars are equipped with filtration devices designed to clean the smoke out of the air. We are attempting to provide as safe an environment for our patrons as possible without limiting their personal choice of whether they wish to smoke or not.

Enforcement of this bill is another issue. As bar owners and bartenders, are we to be burdened with the task of enforcing this bill? If someone lights up a cigarette, who is responsible for giving them a citation? It should not be the bar that gets fined because someone else makes the choice to break this law. Is it enough that we display the appropriate signage? More and more, small business owners are forced to act as morality police rather than concentrate on running a profitable business.

If House Bill 2495 is an attempt to stop the public from smoking, its effectiveness is questionable because people who smoke will do so somewhere else. It is also my understanding that the local communities can opt out of the state ban with a vote of the people. If that is the case, then let the local communities decide whether they with to institute a smoking ban to begin with, and keep it out of the state legislature. Forcing local communities to hold an election on this matter is a waste of city resources at a time when cities are already strapped for funds.

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Testimony re: HB 2495
House Federal and State Affairs Committee
Presented by Ronald R. Hein
on behalf of
R. J. Reynolds Tobacco Company
March 9, 2005

Mr. Chairman, Members of the Committee:

My name is Ron Hein, and I am legislative counsel for R. J. Reynolds Tobacco Company (RJRT).

RJRT is unequivocally opposed to HB 2495 which proposes a total ban on smoking in all indoor places - including bars and restaurants. HB 2495 also bans smoking on all outdoor patios or other facilities for any food service establishments or "licensed premises" making it the most extreme smoking ban statute in the country. This bill goes further than California and New York or any other state in the country. The reasons for RJRT's opposition are numerous, but I've set out a few of the most salient points.

HB 2495 seems to assume that restaurant and bar customers and employees are forced to be exposed to cigarette smoke whenever they wish to go out or look for employment. This is simply not true. Here in Kansas, and across the country, the free market is addressing the smoking/smoke-free issue. Smoke-free dining choices are easily found at restaurants throughout Kansas and the U.S. Those wishing to work in smoke free environments may avail themselves of multiple potential employment opportunities.

In non-hospitality related workplaces, smoking is virtually non-existent. In fact, the Occupational Safety and Health Administration (OSHA) in Washington declined to issue workplace smoking rules, in part, because of that fact. In America and in Kansas, the free market is already deciding this issue. Government intervention into what should be a private property right decision is unnecessary and unwarranted.

Some proponents of measures such as this have stated that smoking bans have no economic impact on private businesses, especially in bars and restaurants. Those statements do not bear accurate witness to the facts. One has to look only as far as Lawrence to see the impact of draconian smoking bans. In a July 8, 2004 article in the *Lawrence Journal-World*, the business editor reports that a survey conducted by the paper indicates an average 25% decrease in business.

One restaurant owner in Lawrence is quoted as saying the ban has "killed" his business.

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Another reported his business is down 20%.

The loss of business that Lawrence restaurant and bar owners are experiencing is seen wherever business owner's rights are taken away by smoking bans. In New York, a study by the New York Nightlife Association and the Empire State Restaurant Association shows 2,000 jobs have been lost along with almost $30 million in wages and salary payments since a statewide smoking ban took effect in 2003. In Dallas, Texas, the Dallas Restaurant Association reports sales of alcoholic beverage have declined $11.7 million following the passage of citywide smoking bans.

Just last month the Restaurant Association of Maryland reported that one county that passed a smoking ban (Talbot County) has seen not only a decrease in sales but a decrease in the number of actual businesses with alcohol licenses. Specifically the organization reports that, according to sales tax figures from the Maryland Comptroller, May through December 2004, sales at Talbot County restaurants/bars with liquor licenses declined by $2,906,100 (or 11 percent) when compared to the same period in 2003. Moreover, the total number of Talbot County restaurants/bars with liquor licenses (per state sales tax records) declined from a high of 39 establishments in November 2003 to a low of only 29 by the end of December 2004.

Business owners are not the only ones to suffer economically. Smoking ban bills are ostensibly meant to protect restaurant and bar workers. In reality, workers are oftentimes financially damaged by smoking bans. Tips are down for numerous employees in numerous areas since smoking bans were enacted. Without a doubt smoking bans hurt those they are meant to protect.

Philosophically, this legislation is the epitome of government infringing on the personal property rights of the state's citizens and the state's businesses. Ironically this bill would take away private business owners' rights to make decisions for themselves and their properties at the same time that businesses are providing more and more smoke-free dining options. We underestimate the power of a free-market to determine these issues.

RJR would respectfully request the committee to defeat HB 2495.

Thank you very much for permitting me to submit this written testimony.

Kansas Licensed Beverage Association

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Tom Intfen

Secretary/Treasurer
Tammy Davis

Vice Presidents
Robert Farha
Glenda Dewey
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Testimony on HB-2495, March 9, 2005
House Federal and State Affairs Committee

Mr. Chairman, and Representatives of the Committee,

I am Philip Bradley representing the Kansas Licensed Beverage Assn., the men and women, in the hospitality industry, who own and manage bars, clubs, caterers, restaurants, breweries and hotels where beverage alcohol are served. These are the places you frequent, enjoy and that are glad to serve you. Thank you for the opportunity to speak today.

We oppose HB-2495.

First, if this is an air quality issue, why are we not addressing air quality. There are many more air contaminates that environmental smoke and if it is the desire of this body to protect all citizens from them then an air quality standard bill would be in order. This would set a level playing field and allow all businesses to meet this standard for all the air particulates and gasses. This is the fair and most effective way to address the issue and removes the emotional element. This way allows for the advancement of science and the creative capabilities of industry to work and continually improve lives and living conditions. If however the real goal is to get rid of all smoking then the legislature should propose the prohibition of smoking and vote on that issue and the subsequent loss to the general fund revenue. Please do not make the hospitality establishments the unwitting victims in a battle between the anti-tobacco activists and the tobacco industry!

Second, this is an issue of the rights of private businesses to serve their customers. Smoking is a legal activity and the establishments that are targeted in this bill are places that all persons have a choice, wheat her or not they enter and frequent. All are very responsive to their customers and if their customers were to stop coming due to conditions at the venue, then owners would change their place to accommodate and re-win those customers or they would soon be out of business. There are options of non-smoking venues.

Third, if you believe you must pass this bill we ask for an exemption for businesses licensed for on-premise liquor sales. You already allow an exemption for smoke-shops, based upon the belief that those that work or frequent these smoke shops have a reasonable expectation of being exposed to environmental smoke and have made a choice. We believe that the same is true for licensed establishments with proper signage. Further that with that expectation and choice that individuals are taking responsibility for their own actions and whatever risks, if any, that are present.

Fourth, if you still must include licensed establishments, we ask you to ammend this bill to include a class of establishment that would be a "Smoking Establishment". With a separate permit and requirements for adequate signage to make sure all who approach and enter have the information to make a rational choice knowing that by entering or working here they have the expectation of being exposed to environmental smoke.

As always we are available for questions. Thank you for your time.

Philip B. Bradley
Executive Director

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