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(FORM UPDATED: 08/11/2010)

WISCONSIN STATE LEGISLATURE ...
PUBLIC HEARING - COMMITTEE RECORDS

2009-10
(session year)

Senate
(Assembly, Senate or Joint)

Committee on ... Health, Health Insurance, Privacy, Property Tax Relief, and Revenue (SC-HHIPPTRR)

COMMITTEE NOTICES ...

- Committee Reports ... **CR**
- Executive Sessions ... **ES**
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INFORMATION COLLECTED BY COMMITTEE FOR AND AGAINST PROPOSAL

- Appointments ... **Appt** (w/Record of Comm. Proceedings)
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- Hearing Records ... bills and resolutions (w/Record of Comm. Proceedings)
  (**ab** = Assembly Bill) (**ar** = Assembly Resolution) (**ajr** = Assembly Joint Resolution)
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- Miscellaneous ... **Misc**

* Contents organized for archiving by: Stefanie Rose (LRB) (June 2012)

To the Committee on Health, Health Insurance, Privacy, Property, and Tax Relief and Revenue:

My name is Sandy Bernier and I live at 831 Minnesota Ave North Fond due Lac. Thank you to all the members of the committee for the opportunity to speak to you to day in support of SB 181.

This Sunday is Mother's Day, the last time I had an opportunity to spend Mother's Day with my mother was 25 years ago, May 1984, just three months before she was diagnosed with pancreatic cancer due to a lifetime addiction of smoking at least two packs of cigarettes a day,

Beatrice McCabe was her maiden name, she was a strong-willed, independent, self determined woman who ran her own restaurant for years, worked as a nurses aid for a time, had the voice of an angel which came in handy on long road trips. We all preferred her Amazing Grace to any song on the radio. She died a painful death where no amount of morphine could ease the pain. I was only 26-years-old when she left me, wondering how would I remember her face, her scent, her soft skin, her hands that held me from birth through all the ups and downs of a life that was meant to be shared with a woman who would face any hardship to protect and care for her children.

In 1996, my brother Jeff, a heavy smoker, never woke when his alarm went off for an early job interview; he had a massive heart attack. Jeff also worked in the bar/restaurant business for years.

In 2003, my oldest brother, David, was an entertainer. He grew up in the restaurant business, worked in the bar business and was a heavy smoker. He actually ran a bar here for a while in Madison. I wasn't 21 at the time, so I never was able to visit the bar here, but he loved Madison, the people, the atmosphere. David later moved to Naples and worked year round as a musician. The last time I saw David, was just before he died, he was sitting in a wheel chair smoking a cigarette. He also died of pancreatic cancer.

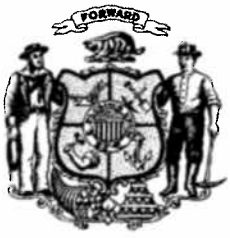
They are gone, but I am here today. I am their voice; I have to find their words to say to you. Their words would not be 'it's an adult choice, a right, or a freedom'; those were and are the words of an industry that has put profits before the health of an entire nation. David told me before he died, "someone has to do something about this killer". Their words would be to support SB 181, today. Stepping outside saves lives, supports people who want to quit smoking, and ends substantial human suffering.

Sandy Bernier CSW

Sandy Bernier

American Cancer Society Volunteer

WISCONSIN STATE LEGISLATURE



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Public Policy Statement on Nicotine Addiction and Tobacco

(formerly Nicotine Dependence and Tobacco)

Background

Nicotine is the psychoactive drug in tobacco. Regular use of tobacco products leads to addiction in a high proportion of users.

Nicotine addiction is the most common form of addiction in the United States. The National Survey on Drug Use and Health database shows that one of every three first time cigarette users becomes dependent.[1]

Nicotine addiction is especially prevalent among those who suffer from alcoholism and from other drug dependencies.

Although the medical profession has traditionally viewed tobacco use as a risk factor for other diseases, instead of a primary problem in itself, this approach has impeded, rather than promoted, the development of optimal treatment methods for patients addicted to nicotine. Nicotine addiction is a primary medical problem deserving of thoughtful, ongoing attention from every responsible clinician. Diseases either caused by or made worse by tobacco use should be regarded as complications of nicotine addiction.

Nicotine addiction most often begins as a pediatric disease. In 2006, three million young people, aged 12-17 years, were current users of cigarettes.[2] Three thousand youth become regular users each day, one-third of whom will eventually die from a tobacco-caused disease.

Cigarettes cause an enormous burden of illness, disability and death. On average each year from 1997 to 2001, the cigarette caused more than 438,000 premature deaths in the United States[3] and more than 3 million worldwide. Globally 1 person dies every 7 seconds from smoking-related diseases, and a smoker loses an average of 13.8 years of life.[4] The 2004 Surgeon General's Report on The Health Consequences of Smoking found that children and adolescents who smoke are less physically fit and have more respiratory illnesses than their nonsmoking peers. In general, smokers' lung function declines faster that that of nonsmokers.

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[1] Family Practice News, 3/15/05

[2] 2006 National Survey on Drug Use and Health, Substance Abuse and Mental Health Administration.

[3] MMWR 2005;54(25):625-8

[4] Missouri Department of Health and Senior Services. *Smoking-Attributable Mortality in Missouri, 1999*

Smokeless tobacco use is epidemic among the young. Smokeless tobacco products, along with cigars and pipe tobacco, are causes of nicotine addiction and cancer, among other serious problems. Cigar smoke has been shown to cause lung cancer, emphysema and heart disease among the many users who inhale the smoke.

Nonsmokers, too, are harmed by tobacco use. Nonsmokers may themselves become ill with lung cancer, heart disease, lower respiratory ailments, worsening of asthma and other problems through exposure to environmental tobacco smoke (second hand smoke). Nonsmokers who are exposed to secondhand smoke at home or work increase their heart disease risk by 25–30% and their lung cancer risk by 20–30%. They suffer through the illnesses and premature deaths of family members, friends and associates. They also share unwittingly in the economic costs of tobacco use because of higher insurance and medical care costs. At least 50,000 deaths are due to secondhand smoke each year in the USA.[5] Almost 60% of U.S. children aged 3–11 years—or almost 22 million children—are exposed to secondhand smoke.

The nicotine addiction epidemic is fueled in part by the wide availability of industry-marketed discounts and discount internet sites, which evade some federal and state excise taxes and minimum age limits for sales to youth; the ready availability of tobacco products to those underage (despite laws to the contrary); and the enormous marketing campaigns for these products (campaigns that are often very seductive and attractive to the young). In 2003, the cigarette industry spent more than $15 billion on marketing. Even with restrictions placed on tobacco marketing since the early 1990s, the tobacco industry gets its message to potential new users quite effectively, including through unregulated Internet-based advertising.

Taxation is one means of raising the price of tobacco products, which has been shown to reduce the purchase/use of tobacco products by youth, who are particularly sensitive to changes in price. Tax increases imposed on a federal basis minimize inequities in tax structure in various states that create unbalanced markets affecting purchasers' travels across jurisdictional lines to purchase lower-price products; federal excise taxes also can be directed to increasing federal funding support for biomedical research regarding nicotine addiction and nicotine addiction treatment. Native American nations should be encouraged to equalize their retail prices for tobacco with those in surrounding jurisdictions and not create market loopholes which promote sales of lower-tax and thus lower-priced tobacco products, especially in outlets targeted to tobacco purchasers such as tribal-operated 'smoke shops.'

Changing public policy can happen via judicial initiatives, but usually happens via legislation, which is a political process. Lobbyists for the tobacco industry are active at national, state and local levels. Ideally, wise policy changes can be implemented on a national scale, but political realities sometimes get in the way. And state governments, which rely on tobacco taxes for revenue, may feel some conflict of interest in establishing policies that would reduce tobacco sales and, thence, tobacco tax revenues. Policy change should be implemented wherever it is possible to do so: if not at the national level, at the state level; if not at the state level, at the county or municipal level. Localities should not be dissuaded from advancing policy to improve the public health even if the adoption of policy changes at the state or federal level has not yet been attained.

The general public is aware that tobacco use is harmful, but it seriously underestimates the magnitude of the harm which tobacco causes. At the same time, there is incomplete appreciation of the positive impact in several states achieved by the application of tobacco settlement funds to targeted education campaigns regarding the public health implications of

[5] California Air Resources Board [CAR], 2005

tobacco use. For example, the Virginia Tobacco Settlement Foundation announced in 2008 that the percentage of high school students who smoke in this tobacco-growing state declined from 29% in 2001 to 15.5% in 2007, nearly a 50% drop and below the national average. The Foundation claims that successful prevention efforts save the state $1.25 billion each year in smoking-related costs.[6]

Becoming abstinent from tobacco has been shown to have substantial beneficial effects on health and longevity. The treatment of nicotine addiction reduces the complications of this addiction. Many who successfully recover from another addiction die from a complication of nicotine addiction. The widespread notion that nicotine addiction is best left untreated during the course of treatment for other drug addiction lacks empiric support.

Although the addiction field has traditionally viewed tobacco smoking as almost normative and not central to the alcohol and other drug recovery process, attitudes and behaviors are shifting. Rather than viewing attention to a patient's smoking as 'defocusing' from their 'real' addictions, counselors are now addressing tobacco addiction in treatment plans. The New York State Office on Alcohol and Substance Abuse Services introduced Part 856 of its regulations governing certification of addiction treatment services, which requires programs to incorporate nicotine addiction in addiction services treatment plans for all nicotine addicted persons receiving alcohol or other drug addiction care; these landmark requirements became effective in mid-2008. All states should move in similar directions.

While the processes of Screening and Brief Intervention (SBI) by primary care physicians were developed by professionals to reduce smoking and its adverse health effects, momentum regarding SBI in the early 21st century has focused on using SBI to address drinking and the adverse health effects of alcohol use and addiction. SBI has even been proposed to address all emerging chemical addictions, including addiction to or misuse of prescription drugs. The emphasis on tobacco and the psychoactive drug it contains, nicotine, should not be diminished given the reality that more persons—including persons with alcohol addiction—die from nicotine addiction than from any other addiction. The U.S. Public Health Service 2008 publication, Clinical Practice Guideline Update: *Treating Tobacco Use and Dependence*, encourages all physicians to use the 5 A's of SBI (Ask, Advise, Assess Motivational Level, Assist, Arrange Follow-up) to intervene for tobacco use and addiction, employing techniques of SBIRT (Screening, Brief Intervention, and Referral to Treatment) to address nicotine addiction in patients they see in their regular workday. The 2008 Practice Guideline also encourages the use of pharmacotherapies to assist patients who desire to stop smoking.

Policy Recommendations

1. **The American Society of Addiction Medicine (ASAM) recognizes that nicotine is an addictive drug, and there is no safe level of consumption for tobacco products, in any age group, among any special populations. Abstinence from tobacco use should be the ultimate goal for clinical interventions regarding tobacco use and addiction. ASAM advocates and supports the development of policies and programs which promote the prevention and treatment of nicotine addiction. These include, but are not limited to, the following:**

[6] Virginia Tobacco Settlement Foundation. Virginia Youth Tobacco Survey, released September 8, 2008. http://www.vtsf.org/data/youth-tobacco-survey.asp

a) **The availability of tobacco products to the young should be controlled through the establishment of an enforced, national minimum age of 21 years for purchase of all tobacco products and the requirement that all sales of tobacco products be face to face encounters, eliminating vending machines, self-service, mail order, and—ideally—Internet sales. Efforts to reduce tobacco sales to minors should reserve punitive approaches to manufacturers, distributors and merchants and should not include measures that penalize underage possession or use of tobacco products. Punishment of the user perpetuates a counterproductive judicial approach. Underage persons who use tobacco products should instead be referred for educational or clinical services, as indicated.**

b) **Governmental policies regarding tobacco should be changed in several ways:**

- **The regulation of all nicotine-containing products intended for human consumption should be assigned to the Food and Drug Administration. In particular, ASAM vigorously supports the proposal made by the FDA in the Federal Register of August 11, 1995 to regulate cigarettes and smokeless tobacco products as nicotine delivery devices.**

- **State and federal excise taxes on tobacco products should be increased substantially in order to decrease the use of tobacco and tobacco products and the incidence of nicotine addiction among youth. Revenues generated from increased taxes should be used to fund sustained, integrated, multifaceted public health programs to reduce or eliminate tobacco consumption and to treat nicotine addiction, as well as to increase funding for biomedical research regarding nicotine addiction and nicotine addiction treatment.**

- **When federal policy reform has not yet been attained due to political realities at a given time, state governments should not be dissuaded from adopting policy reforms regarding tobacco use, sales, advertising, production, distribution, taxation, or the like. When federal or state-wide reforms have not yet been adopted, localities should be encouraged to advance tobacco policy reforms to promote public health goals.**

- **Tobacco product manufacturers should be required to publish and publicize the ingredients used in each brand they offer to the public and to publish and publicize the levels of toxic substances, including nicotine, that customers who consume each such product may reasonably expect to have delivered to their bodies via tobacco use.**

- **The sale of flavored tobacco products should be prohibited, including tobacco laced with fruit flavorings and menthol flavorings intended to attract specific subpopulations of consumers.**

- **Package inserts should be required in each tobacco product sold to a consumer. Such inserts would contain useful information about the harm of tobacco use, the benefits of stopping, and advice on how to stop.**

- **Warning labels on cigarettes and smokeless tobacco should be extended and the warning label system expanded to all other tobacco products so that the warnings are much more visible, easier to understand and explicitly describe the risks of addiction, disease and death from use of these products.**

- **All advertising and other promotional activities for nicotine-containing tobacco products should be eliminated, with a mandate that all packaging for tobacco products be plain packaging, in order to eliminate the allure provided by package design and brand-associated symbols.**

- **The ban against cigarette advertising in broadcast media should be enforced by directing the Justice Department to take action against cigarette brand and smokeless tobacco brand promotions and sponsorships in all professional sports including motor sports.**

- **Research and public health efforts funded through the various branches of government should be supported, including the Department of Defense, the NIH, CDC, SAMHSA, and state initiatives that contribute to (1) an understanding of nicotine addiction, its treatment and its prevention, and (2) controlling the epidemic, including research and programmatic assistance in understanding and dealing with the profound clinical interrelationships among nicotine, alcohol and other addictive drugs.**

- **Governmental edicts should be adopted, such as those in place in a few states and provinces, which prohibit pharmacies and stores with pharmacy departments from selling tobacco products or which ban smoking in vehicles with children.**

- **Subsidies and all other forms of governmental assistance which encourage the production of tobacco and tobacco products should be eliminated. Tobacco should be eliminated as an export crop and tobacco products as export products from the United States. Government assistance for tobacco product exports should be replaced with the export of medical and public health knowledge about tobacco and about how to control the tobacco epidemic.**

- **Transition programs for displaced workers should be funded when jobs now in the tobacco industry are eventually shifted to other parts of the economy as a result of the above and other measures.**

- **Alternative designs should be required to make cigarettes fire-safe, since these products are the leading cause of death in household fires.**

- **Tobacco should be excluded from international trade agreements (see ASAM Public Policy Statement on the Establishment of a Framework Convention on Alcohol Control and the Exclusion of Tobacco and Alcohol from Trade Agreements).**

c) **Because they increase overall smoking and tobacco use rates, the sale of low-cost cigarettes and other tobacco products by "smoke shops" or Internet sellers based on Native American Tribal lands is a significant public health problem. Such sellers should comply with all applicable laws relating to such sales, including Federal tax laws and the Jenkins Act, and should implement effective measures to block any sales to youth. With full respect for Tribal sovereignty and immunity rights, existing laws applicable to tobacco product sales from Tribal lands should be regularly enforced and new laws should be implemented, as needed.**

d) **Treatment for nicotine withdrawal and nicotine addiction should be broadly available and utilized.**

- **Physicians and other health care providers should engage in Screening, Brief Intervention, and Referral for Treatment (SBIRT) for tobacco use and nicotine addiction. People who screen for nicotine addiction should also screen for all other substance use and addiction.**

- **Physicians and other health care professionals should utilize evidence-based pharmacotherapies and psychosocial and behavioral interventions for tobacco use and nicotine addiction, as outlined in the 2008 Clinical Practice Guideline Update: *Treating Tobacco Use and Dependence* (U. S. Public Health Service).**

- **All hospitals and medical schools should address nicotine addiction on a par with other chemical dependencies. Physicians and all clinicians should be trained to screen for nicotine addiction when they do medical evaluations, including assessments for other chemical dependencies. When nicotine addiction is present for a patient, the treatment plan should address the patient's nicotine addiction as it would address any other addiction, and appropriate medication should be offered to address nicotine withdrawal while the patient is hospitalized.**

- **Accreditation and regulatory agencies at the state and national level (such as the Joint Commission on Accreditation of Healthcare Organizations) should take steps to assure that hospitals include interventions for nicotine withdrawal and nicotine addiction whenever the patient's clinical condition so indicates.**

- **ASAM encourages policy changes that lead to the integration of evidence-based nicotine addiction treatment into mental health and addiction services. Addiction treatment services should address nicotine addiction on a par with other chemical addictions. Counselors should be trained to assess for nicotine addiction when they do assessments for other chemical addictions. When nicotine addiction is present for a patient, the treatment plan should address the patient's nicotine addiction as it would address any other addiction. Addiction treatment service providers should make their facilities and grounds smoke-free environments for patients, staff and visitors alike.**

- **All addiction treatment professionals who recommend Alcoholics Anonymous or other self-help participation by their patients should recommend to their patients that they seek out smoke-free 12-step meetings and consider selecting a non-smoking AA sponsor. For their patients who accept the recommendation to make a quit attempt, counselors should advise attendance at Nicotine Anonymous meetings as an option.**

- **All private and government health insurance plans should cover the costs of treatment for nicotine withdrawal and addiction on a par with treatment for other medical-surgical conditions. There should not be discriminations against payment for treatment for nicotine-related health conditions, including addiction; nicotine replacement therapies and other pharmacotherapy for nicotine withdrawal and addiction should be covered by health insurance plans.**

- **Health care delivery systems should build systems for identifying and treating cases of nicotine addiction as well as patient education regarding nicotine addiction and other health consequences of smoking and smokeless tobacco use.**

2. **Research, professional education, and clinical expertise in the areas of nicotine addiction should receive increased emphasis through the following measures:**

   a) **Promote research in universities and other institutions into the causes, prevention, and treatment of nicotine dependence, including organizational and cultural change efforts.**

   b) **Train all health professionals to regard nicotine addiction as a primary medical problem, including training in the management of nicotine addiction on the part of physician specialists in addiction medicine, primary care physicians, clinical psychologists, and all alcohol and other drug counselors. This training should also include information on the ways the tobacco industry perpetuates the epidemic and undermines efforts aimed at reducing the problem and on ways health care professionals can help counter these influences.**

   c) **Teach about the addiction process and about the management of nicotine addiction in CME courses and other professional education programs.**

   d) **Teach that nicotine addiction and withdrawal needs to be diagnosed and treated along with other drug addictions.**

   e) **Explore mechanisms for third party reimbursement for the treatment of nicotine addiction by qualified health professionals who use clinically recognized methods.**

   f) **Refuse funding from the tobacco industry and its subsidiaries by medical schools, other research institutions and individual researchers to avoid giving tobacco companies an appearance of credibility.**

   g) **Encourage all institutions involved in health care to divest from the tobacco industry since investments in this industry are profitable only to the extent that measures to control the epidemic fail.**

3. **Public education about tobacco should be enhanced by additional measures:**

   a) **Establish primary and secondary schools as tobacco-free zones with clinical support made available as a benefit of enrollment or employment for those students and staff who want assistance in dealing with nicotine addiction.**

   b) **Teach youth in the schools about the risks of addiction, other disease and death from tobacco use and about the cynical efforts of the tobacco industry to recruit new customers from among their peers.**

   c) **Counter-market tobacco products, including advertisements and other efforts, to offset the seduction of tobacco advertising imagery and to educate the public about the hazards of tobacco and about methods of quitting or of not starting tobacco use.**

4. **Tobacco-free policies should be implemented in all workplaces and places of public accommodation, including all hotels, motels, restaurants and taverns. (See ASAM Public Policy Statement on Clean Indoor Air.)**

5. **All hospitals, other health-care facilities, and medical schools should establish not only completely tobacco-free buildings but also tobacco-free grounds throughout their entire campuses. Smoke and tobacco-free grounds regulations should apply to all patients, staff, volunteers and visitors alike.**

6. **Elected officials should refuse to accept support from tobacco companies so that they can more easily work to control the epidemic caused by tobacco.**

7. **Legal action against the tobacco industry should be supported, including law suits by states, private insurers and others seeking to recover money spent on medical care of tobacco-caused disease, consumer protection actions seeking to better inform the public about tobacco or to stop industry practices which harm the public health, and product liability suits brought by individuals who have been harmed by tobacco products. In cases where a settlement agreement exists which directs tobacco firms to pay monies to governments to recoup governmental expenditures spent on treating tobacco-related illnesses, settlement funds should be directed to nicotine addiction treatment, prevention, research, or education and not diverted to other uses. ASAM supports litigation, if necessary, to ensure that tobacco settlement proceeds are not directed away from such public health uses.**

8. **ASAM should actively participate in a liaison network with other groups on issues of mutual interest related to tobacco.**

Adopted by ASAM Board of Directors (then the American Medical Society on Alcoholism) April 1988; **rev.** September 1989; **rev.** April 1996; **rev.** October 1996; **rev.** October 2008.

American Society of Addiction Medicine

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ASAM

American Society of Addiction Medicine

Public Policy Statement on Clean Indoor Air Policy

Background

Much progress has been made in Clean Indoor Air policy since ASAM decreed -- two decades after the Surgeon General's Report on Tobacco and Health of 1964 -- that there would be no smoking or tobacco use allowed during sessions of the annual ASAM Medical-Scientific Conference.[1]

As we near the 50th Anniversary of that Surgeon General's Report, virtually all hotels, convention centers, and publicly-owned buildings in North America are 'smoke-free'--except, ironically, for some health care facilities (nursing homes or psychiatric or addiction units of hospitals). The dangers of tobacco use to persons actively addicted to tobacco are universally known and accepted. The health aspects of passive exposure to environmental tobacco smoke are also known and widely accepted, and have led city councils to establish clean indoor air standards for cities, and legislatures to consider such standards for entire states. Many major cities in Europe and some entire nations have adopted clean indoor air laws that apply to all publicly and privately owned structures where the public may consort, including restaurants, taverns, and at times open-air stadiums and public parks.

But resistance remains in some areas to universal prohibition of smoking outside of private homes and privately-owned vehicles. This resistance is often presented by advocacy groups that are covertly funded by tobacco manufacturers. Exceptions proposed include taverns, restaurants, and even addiction and psychiatric units of hospital-based or residential treatment facilities. Such exceptions fail to respect the health of employees of such facilities as well as clientele.

When local jurisdictions adopt prohibitions against smoking and neighboring ones do not, it is argued that clientele may cross jurisdictional lines in order to continue to use tobacco products, for instance while dining or drinking. One of the arguments used against adoption of local anti-smoking ordinances is the

[1] See ASAM Public Policy Statement on Clean Air Policy for ASAM Conferences (formerly Clean Air Policy), originally passed in 1986 and revised in 2008 to incorporate a policy of sponsoring ASAM conferences only in locales which have adopted comprehensive smoke-free policies, except in certain specific circumstances.

creation of competitive disadvantages for local business or the creation of a patchwork of jurisdictional differences.

ASAM affirms that regular tobacco use usually occurs in the context of the chronic disease of nicotine addiction, which frequently causes serious morbidity and mortality among those who use tobacco, as well as those who are exposed to environmental smoke from its use. Tobacco smoke is harmful in that it causes symptoms, illnesses, and death, and it affects healing from other health conditions. Smoke-free and tobacco-free environments provide people who would like to quit with an opportunity to practice not smoking and not using other forms of tobacco. Tobacco smoke is a Class A carcinogen, and removal of tobacco smoke from all workplaces, including those in the food service and hospitality industries, is an important step in promoting occupational health.[2]

Recommendations

The American Society of Addiction Medicine recommends:

1. **that all states, commonwealths, provinces, districts and territories of the United States and Canada should adopt area-wide bans on smoking in public places so that ideally there are no municipal differences in regulations within a state/province, and no differences from one jurisdiction to another in such regulations. When state-wide or comparable reforms have not yet been adopted, counties should not be dissuaded from adopting bans on smoking in public places; when county-wide reforms have not yet been adopted, localities should not be dissuaded from adopting bans on smoking in public places;**

2. **that bans on smoking in commercial establishments should make no exceptions for restaurants or taverns;**

3. **that bans on smoking in health care facilities should make no exception for inpatient, outpatient, or residential addiction or psychiatric treatment facilities; and**

4. **that environmental tobacco smoke should be subject to regulation by federal agencies such as the Environmental Protection Agency, the Occupational Safety and Health Administration, the Food and Drug Administration, the Indian Health Service, and the Department of Veterans Affairs.**

Adopted by the ASAM Board of Directors October 2008.

[2] For further detail on ASAM's recommendations for federal, state and local action to reduce nicotine addiction, see ASAM's Public Policy Statement on Nicotine Addiction and Tobacco (formerly Nicotine Dependence and Tobacco), revised in October 2008.

American Society of Addiction Medicine

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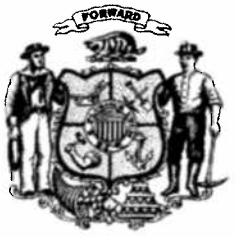
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HEALTH EFFECTS OF SMOKE-FREE BARS IN WISCONSIN

Karen Palmersheim PhD, Mark Wegner MD MPH, Patrick Remington MD MPH

INTRODUCTION

Exposure to secondhand smoke has increasingly become an issue of concern to the public health community. Indeed, a heightened awareness has followed the release of the 2006 report of the US Surgeon General,[1] which reviewed and critiqued numerous studies investigating the relationship of passive smoking with various disease processes. The report concluded that children and infants exposed to secondhand smoke are at increased risk of lower respiratory illnesses, middle ear disease, and sudden infant death syndrome (SIDS).[1] Exposure to secondhand smoke has also been associated with an increased risk for coronary heart disease among both men and women, and an increase in lung cancer risk among lifetime non-smokers.[1] Further, the Surgeon General concluded that nasal irritation is causally related to secondhand smoke exposure, and evidence is suggestive of a causal relationship between secondhand smoke and other acute respiratory symptoms including cough, wheeze, chest tightness, and difficulty breathing --- among both healthy persons and persons with asthma.[1]

Summary

Objective – To assess the impact of a smoke-free workplace ordinance on bartenders' exposure to secondhand smoke and upper respiratory tract symptoms.

Methods – Data were collected from bartenders working in Appleton and Madison, Wisconsin employing a cross-sectional research design. Pre-ordinance data were collected 2 months before the July 1, 2005 ordinance; post-ordinance data were collected approximately one year later. Findings were extrapolated to the statewide population of bartenders.

Findings – Bartenders' mean level of exposure to secondhand smoke at work decreased from 20.7 hours during pre-ordinance to 1.6 hours during post-ordinance; exposure in other places decreased from 8.2 hours to 4.1 hours; home exposure decreased from 3.9 hours to 2.8 hours. The prevalence of eight upper respiratory symptoms was significantly lower during the post-ordinance period among non-smoking bartenders. Smokers reported a significant reduction of two symptoms.

Implications – A smoke-free workplace ordinance was associated with reduced exposure to secondhand smoke and fewer related upper respiratory symptoms among bartenders. Statewide, smoke-free establishments could lead to similar health improvements among many more employees and bar patrons.

The number of workplaces that are smoke-free has been steadily increasing --- via the enactment of smoke-free laws and by the voluntary implementation of smoke-free policies by employers and businesses. However, individuals working in the restaurant and hospitality industry (e.g., wait staff, bartenders) are among those least likely to work in smoke-free environments,[1,2] and previous research has found mean serum cotinine levels (a measure of secondhand smoke exposure) highest among people working in these settings.[2] These findings suggest that individuals employed in these types of occupations would be at an increased risk of developing conditions associated with secondhand smoke, and accordingly, would benefit most from the elimination of such exposure.

The purpose of this research was to assess change in mean level of exposure to secondhand smoke among bartenders affected by the establishment of smoke-free ordinances in two Wisconsin cities. In addition, upper respiratory tract symptoms were assessed prior to, and approximately one year after, the implementation of the smoke-free ordinances. These findings were then used to estimate the potential impact of smoke-free policies on bartenders statewide.

METHODS

The University of Wisconsin Tobacco Surveillance and Evaluation Program, in collaboration with the Wisconsin Tobacco Prevention and Control Program, conducted two cross-sectional studies to assess secondhand smoke exposure and upper respiratory symptoms among bartenders working in two Wisconsin cities that implemented smoke-free workplace ordinances on July 1, 2005. The first study was conducted two months prior to the ordinance, and the second study was conducted approximately one year after its establishment, during May through July of 2006. Details of data collection, inclusion criteria, and analytic methods for the full study can be found at http://www.medsch.wisc.edu/mep/.

Overall, 1,528 bartenders were included in the current study, 793 in the pre-ordinance group, and 735 in the post-ordinance group. However, the samples were stratified by bartender smoking status to control for the effects of active smoking. In the current report, findings presented for upper respiratory health symptoms were limited to bartenders that reported being non-smokers, because exposure at work is likely to be their main source of inhaled cigarette smoke. Independent-samples t-tests were employed to compare pre-ordinance scores to post-ordinance scores on measures

of secondhand smoke exposure. Pearson Chi-square analyses were used to test levels of upper respiratory symptoms. These findings were then extrapolated to the estimated number of non-smoking bartenders working in Wisconsin as follows. According to the Wisconsin Department of Workforce Development, approximately 23,000 individuals are employed as bartenders in the state of Wisconsin.[3] Calculating an average across the two study samples suggests that approximately 45% of bartenders currently smoke. Thus, an estimated 12,650 bartenders would be non-smokers (55% of 23,000). The estimated number of non-smoking bartenders was then applied to the absolute percent difference in each symptom, pre- to post-ordinance, to predict the number whose physical symptoms might be improved if all bars in the state were smoke-free.

RESULTS

Sample characteristics of bartenders who participated in the pre-ordinance and post-ordinance studies are presented in Table 1. Table 2 displays the mean estimates of exposure to secondhand smoke in the home, at work, and other places, during pre-ordinance and at post-ordinance. Exposure was self-reported as the number of hours exposed during the past 7 days. Mean exposure to secondhand smoke in the home decreased from 3.9 hours at pre-ordinance to 2.8 hours at post-ordinance. Exposure to secondhand smoke at work decreased from 20.7 hours at pre-ordinance to 1.6 hours at post-ordinance, and mean exposure in other places decreased from 8.2 hours to 4.1 hours. T-test analyses revealed the mean reported decreases in exposure were statistically significant for all three areas assessed.

Study participants were also asked to report how often they experienced a number of upper respiratory symptoms over the past 4 weeks. Data were dichotomized (collapsed into yes/no categories) for the current analyses. Table 3 presents the percentage of non-smoking bartenders that reported experiencing the eight upper respiratory symptoms before and after the establishment of the smoke-free ordinance. The second column designates the percentage of bartenders that reported having experienced each of the eight symptoms during the pre-ordinance study, and the third column shows the prevalence at post-ordinance. For example, 31% of non-smoking bartenders reported 'wheezing or whistling in chest' during the pre-ordinance study, whereas 16% reported this symptom at post-ordinance. This represents an absolute percent decrease of 15%. The fourth column, presenting the results from the Chi-square analysis which compares the sample proportions, shows that the change was statistically significant. The final column shows the estimated number of non-smoking bartenders statewide who could see improvement in the reported symptom were a smoke-free policy extended to all Wisconsin bars. For example, we could expect approximately 1,900 fewer non-smoking bartenders to experience wheezing or whistling in the chest.

COMMENTS

The findings from this study reveal that the establishment of a smoke-free workplace ordinance can reduce exposure to secondhand smoke among bartenders – both at work and in other places. These latter findings suggest that when bartenders are not at work, they may be spending more of their time in establishments that have also become smoke-free. The lower level of exposure to secondhand smoke in the home reported in the post-ordinance study may reflect, in part, the lower percentage of smokers in the post-ordinance sample, as smokers are more likely to live with other smokers. Or, the impact of the smoke-free workplace ordinances may have carried over into the home environment.

Analyses suggest that the reduced level of exposure to secondhand smoke corresponds with a reduction in the prevalence of upper respiratory symptoms among these workers. In particular, among non-smoking bartenders, the prevalence of all eight symptoms was significantly lower after the establishment of the smoke-free ordinances compared to that reported prior to the ordinances. These findings suggest that an improvement in upper respiratory health symptoms could be experienced by a significant number of non-smoking bartenders in Wisconsin if all bar work environments in the state were smoke-free. In addition, even bartenders that were current smokers reported a significantly lower prevalence of two symptoms one year post-ordinance (data not shown), and thus could be expected to see a tangible improvement in health. Finally, although this study examined only the health effects of these policies on bartenders, others who work or recreate in bars might also see similar improvements in health.

These findings are similar to those reported by Eisner et al.[4] in a cohort study of bartenders in San Francisco, and a second study conducted by Menzies et al.[5] in Scotland. However, due to relatively smaller sample sizes, results in the previous two studies were reported as groups of symptoms. In addition, the Menzies study only included non-smokers. The current study had ample power by which to analyze each symptom independently, in addition to stratifying the sample by smoking status.

Morever, the current study extends the findings from a previously reported longitudinal study of bartenders in Madison and Appleton.[6] That study involved comparing baseline data, collected 2 months before the July 1, 2005 ordinance, to follow-up data collected only 3-5 months post-ordinance. Within the cohort of 403 bartenders studied, mean level of exposure to secondhand smoke decreased significantly at work and in other places. In addition, the prevalence of all eight upper respiratory symptoms decreased significantly from baseline to follow-up among non-smoking bartenders, and smokers reported a significant reduction of two symptoms. The strength of the current study is that similar findings have now been found in two much larger cross-sectional samples.

PROGRAM/POLICY IMPLICATIONS

This study revealed a significant reduction in exposure to secondhand smoke in the workplace, as well as in other places, one year after the implementation of a smoke-free workplace ordinance in two Wisconsin cites. In addition, bartenders working in establishments impacted by the ordinances reported significantly fewer upper respiratory tract symptoms. Thus,

it appears the elimination of smoking in workplaces such as bars and restaurants can have beneficial effects on the acute respiratory health of those who work in such settings. These acute symptoms may serve as the warning signs of impending, more serious chronic conditions such as emphysema, lung cancer, and heart disease. Hence, in addition to reducing the immediate, short-term consequences associated with exposure to the chemicals present in secondhand smoke, smoke-free environments should contribute to a reduced risk of more serious long-term conditions.

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6. Palmersheim KA, Remington PL, Gundersen DF. The impact of a smoke-free ordinance on the health and attitudes of bartenders. Tobacco Surveillance and Evaluation Program, University of Wisconsin Comprehensive Center, Madison, WI: February, 2006. Available at: http://www.medsch.wisc.edu/mep/.

Suggested Citation: Palmersheim, et al. Health Effects of Smoke-Free Bars in Wisconsin. Surveillance Brief. UW Paul P. Carbone Comprehensive Cancer Center. 2007; 3-1.

TABLE 1. Sample Characteristics – Pre-Ordinance and Post-Ordinance

	Pre-Ordinance (n=793)	Post-Ordinance (n=735)
City (n)		
Madison	621	510
Appleton	172	225
Age (years)		
Range	19-80	19-76
Mean	35	35
Median	32	31
Gender (%)		
Female	52	54
Race/Ethnicity (%)*		
White	95	96
Other	6	5
Hispanic	2	3
Education (%)		
Less than high school	2	1
High school diploma	18	16
Some college (no degree yet)	38	39
Associate's degree	12	12
Bachelor's degree	24	26
Graduate or Professional degree	5	5
Months bartending at current bar (#)		
Mean	64	61
Median	36	35
Hours working in current bar per week (#)		
Mean	24	23
Median	22	20
Current smoker (%)	48	41
Cigarettes smoked per day (#)		
Mean	13	11
Median	10	10

* Because respondents could check more than one race, totals may not add to 100.

TABLE 2. Level of Exposure to Secondhand Smoke at Home, Work and Other Places – Pre-Ordinance and Post-Ordinance

Place of Exposure	Pre-Ordinance (mean hours/past 7 days)	Post-Ordinance (mean hours/past 7 days)
Home*	3.9	2.8
Work***	20.7	1.6
Other***	8.2	4.1

Independent-samples t-test, 2-tailed; *p<.05, **p<.01, ***p<.001.

TABLE 3. Percent Reporting Upper Respiratory Symptoms – Pre-Ordinance and Post-Ordinance (Non-Smokers)

	Percent Reporting Symptom			
Upper Respiratory Symptoms (past 4 weeks)	Pre-Ordinance (n=409)	Post-Ordinance (N=433)	p-value[a]	Number of Non-Smoking Bartenders Potentially Affected by Statewide Smoke-Free Policy[b]
Wheezing or whistling in chest	31	16	.000	1,900
Shortness of breath	40	27	.000	1,600
Cough first thing in the morning	44	24	.000	2,500
Cough during the rest of the day/night	50	29	.000	2,700
Cough up any phlegm	50	32	.000	2,300
Red or irritated eyes	72	41	.000	3,900
Runny nose/irritation, sneezing	76	53	.000	2,900
Sore or scratchy throat	62	38	.000	3,000

a Comparison of Pre-Ordinance to Post-Ordinance; Pearson Chi-square Analyses, 2-tailed

b Calculated as (percent with symptom pre-ordinance – percent with symptom post-ordinance) x 12,650 (rounded to the nearest hundred)

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Wisconsin's Comprehensive Cancer Control Program

Prevention • Screening & Detection • Treatment • Quality of Life • Palliative Care

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Funded by a grant through the Wisconsin Partnership Fund for a Healthy Future.

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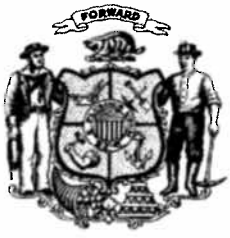
In This Issue:

HEALTH EFFECTS OF SMOKE-FREE BARS IN WISCONSIN


WISCONSIN STATE LEGISLATURE


FORWARD

Mr. Chairman & Committee Members,

I am one of the few individuals that you will hear from today that will be able to give you firsthand knowledge of the TRUE effect of a smoking ban.

What I am going to tell you is not information from a study or survey. What I am going to tell you is FACT.

I own and operate a bowling center in the city of Madison.

I have been smoke free for almost 4 years.

After having 5 straight years of revenue increases, the Madison ban took effect. I immediately lost 25% of my business. These were customers that wanted to patronize my business, but since they could no longer smoke while bowling, they decided to just stay home.

As a result, I had to lay off 6 employees, one of them being a well paid manager. To this date, he still has not been able to find a job that pays as well as I did. This former Employee recently lost his home to foreclosure.

4 Years later, my business has only recouped 7% of this lost revenue.

All of these claims can be verified with my sales tax returns.

I can only imagine the devastating effects of a smoking ban in a bowling center given today's economy. Just imagine owning a Bowling Center in Beloit, Janesville or Kenosha.

In an attempt to keep as many of my smoking customers as possible, I constructed an outdoor smoking patio. At a cost of over $80,000, this

patio was necessary to allow bowlers to have a cigarette between games.

As you may know, bowling shoes can be damaged if worn outdoors or if they become wet. Given Wisconsin winters, I needed a facility where bowlers could smoke, not damage their shoes and risk injury.

This patio has a roof with walls that are 50% open to the outside. I do have pictures here for your review. What I need to know, will this facility still be allowed under this bill???

If the true intent of the bill is to protect my Employees and Non Smokers, then I have already accomplished your goals and my smoking patio should be allowed.

I believe that reasonable provisions will be necessary for Wisconsin Bowling Centers to survive the current economy in addition to a Smoking Ban.

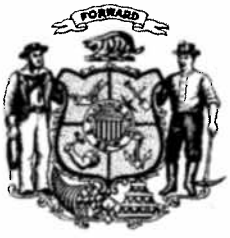
At the same time that you are trying to protect the health of bowling center employees, you may be taking away their ability to provide for themselves and their families.

Please keep this in mind.

Thank you for your time.

ROBIN FOWLBERG
DREAM LANES
(608) 221-3596


WISCONSIN STATE LEGISLATURE

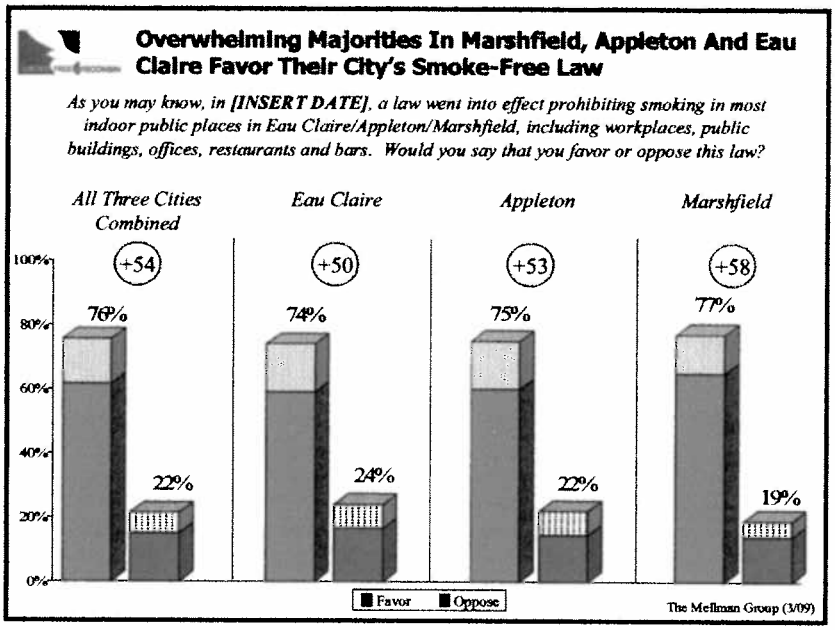

FORWARD

SB181

THE MELLMAN Group RESEARCH BASED STRATEGY

TO: Smoke Free Wisconsin
FROM: The Mellman Group, Inc.
RE: Surveys In Smoke-Free Communities In Wisconsin
DATE: April 3, 2009

The Mellman Group conducted citywide surveys of 400 registered voters in Marshfield and 400 likely voters in Appleton and Eau Claire. The polls were conducted by telephone February 23-25 in Appleton and Eau Claire, and March 21-24, 2009 in Marshfield, using registration-based samples. The margin of error for each survey is +/-4.9%, at the 95% level of confidence. The margin of error is larger for subgroups.



Voters In Smoke-Free Cities Overwhelmingly Support Their Smoke-Free Laws

In April 2008, we conducted a statewide survey of likely voters in Wisconsin, in partnership with Republican polling firm Public Opinion Strategies, showing that 69% favor a statewide smoke-free law that prohibits smoking in most indoor public places, including all workplaces, public buildings, offices restaurants and bars, and that only 28% oppose such a law.

This year, instead of conducting another statewide survey, we measured support for already existing smoke-free laws in Appleton, Marshfield and Eau Claire, which have each implemented comprehensive smoking restrictions in the last four years. We found that support for the smoke-free laws in these three cities is actually stronger than support for a statewide smoke-free law. Indeed, 74% of voters in Eau Claire, 75% of voters in Appleton and 77% of voters in Marshfield all favor their cities prohibition on smoking in indoor public places. This suggests that, contrary to the doomsday predictions put forth by some opponents of these laws, smoking restrictions have been enthusiastically embraced in cities that have implemented them.

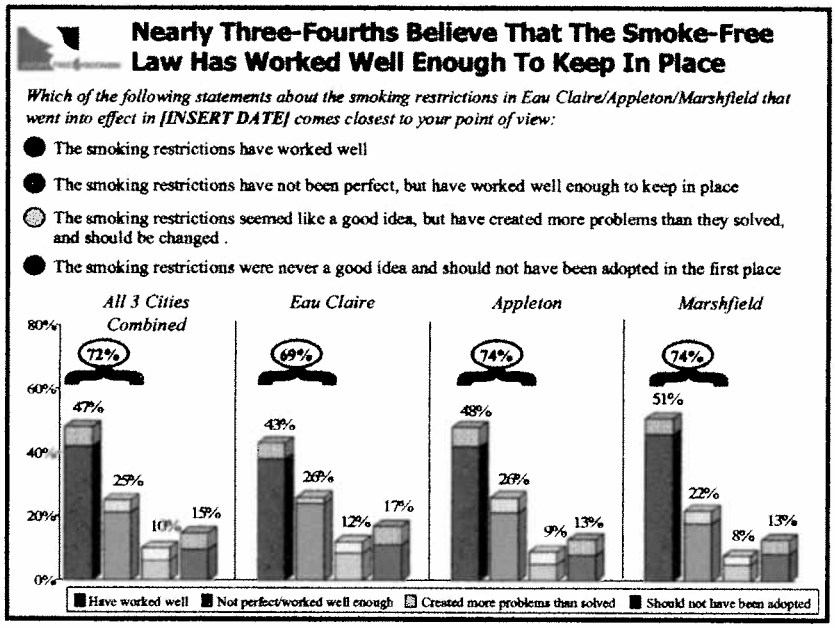
% Favor/Oppose Smoke-Free Law
(Appleton, Marshfield & Eau Claire Combined)

	Favor	Oppose
Total	76%	22%
Men	74%	23%
Women	77%	20%
Democrat	76%	21%
Independent	75%	22%
Republican	76%	22%
18-39	77%	21%
40-59	73%	23%
60+	77%	20%
Current/Occas Smoker	48%	48%
Former Smoker	79%	19%
Never Smoked	85%	12%
HS or Less	68%	28%
Some College	74%	24%
College Grad+	81%	16%

In order to gain a better understanding of support for smoke-free laws across demographic subgroups, we combined the results for all three cities into one data set. Support for the smoke-free law is especially strong among those who go out to restaurants and bars most frequently. Among those who go out once a week or more, 78% favor the law, while only 19% oppose it. A similar number of those who go out a few times a month (77% favor, 20% oppose) favor the law. Indeed, only among those who go out less than once a month or never is support a bit less robust (61% favor, 32% oppose), though even among these voters, a sizable majority favor their city's smoke-free law.

As the chart at left indicates, support for the smoke-free law crosses party lines and demographic groups. Democrats, Independents and Republicans favor the law by nearly identical margins, suggesting that there is little, if any, partisan polarization around this issue. Support is also very strong across gender, age, and education groups.

Surprisingly, even those who say they are current or occasional smokers (21% of our sample) are evenly split on the law, with 48% of this group supporting it and 48% opposing it. However, the smoking restrictions garner overwhelming support among the much larger number of non-smokers, including former smokers (79% favor, 19% oppose), and those who have never smoked (85% favor, 12% oppose).



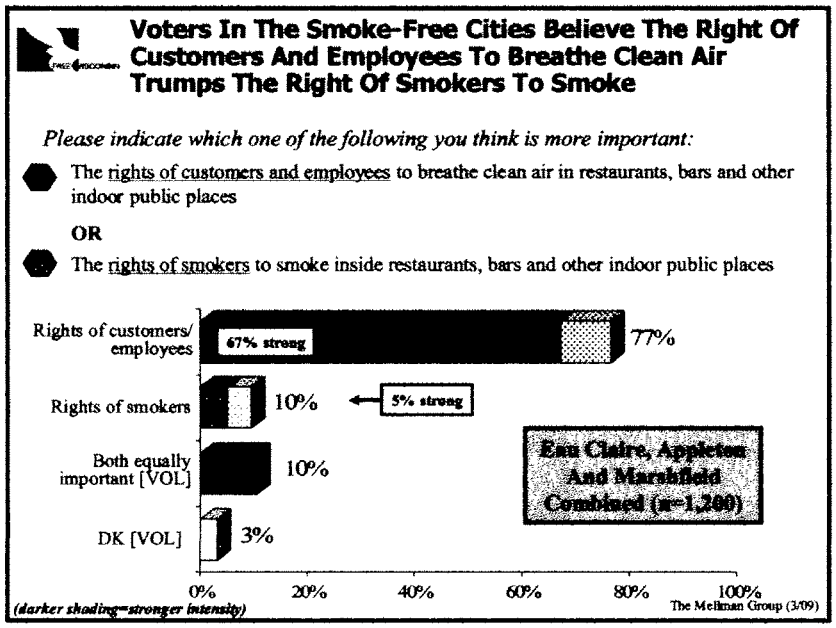
Most Believe The Smoke Free Law Has Worked Well Enough To Keep It In Place

More than 7 in 10 voters in the three cities where smoke-free laws have been implemented believe that the smoking restrictions have worked well and should be kept in place, while only 25% believe that the law should either be changed or should have not been adopted in the first place. Just under half (47%) believe that the restrictions have worked well, and another 25% believe that, while the restrictions have not been perfect, they have worked well enough to keep in place. By contrast, only 15% believe that the smoke-free law should never have been adopted in the first place. Seventy-two percent (72%) of Democrats, 71% of independents, and 75% of Republicans believe the law has worked well, or at least well enough to keep in place. Likewise over three-fourths (76%) of those who go out to restaurants weekly or more have a positive reaction to the smoking restrictions.

Support for keeping the smoking restrictions in place is consistently strong in each of the three cities, with 69% of Eau Claire voters, 74% of Appleton voters and 74% of Marshfield voters believing that the smoking restrictions have either worked well, or despite imperfections, have worked well enough to keep in place.

The Positive Reaction To These Smoke-Free Laws Is Rooted In The Perceived Danger Posed By Secondhand Smoke And The Belief That The Right To Clean Air Trumps Smokers' Rights

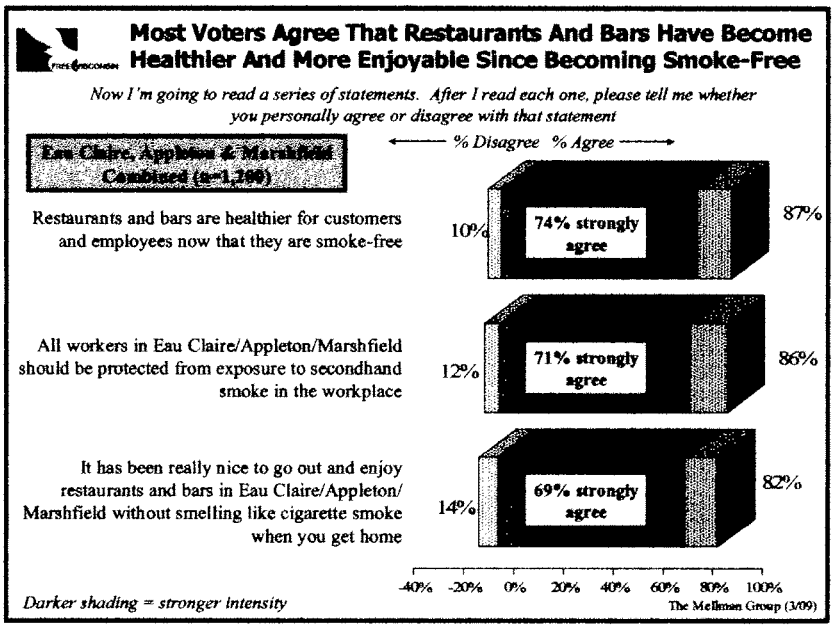
Overwhelming support for these smoke-free laws is a function of concern about the dangers of secondhand smoke and the priority accorded to the rights of customers and employees over those of smokers. Overall, 83% of voters in the three cities believe secondhand smoke is at least a "moderate" health hazard, with a sizable majority (62%) saying it constitutes a "serious health hazard." Only 14% believe secondhand smoke to be a "minor health hazard" or "not a health hazard at all." Eighty-three percent (83%) of Eau Claire voters, 83% of Appleton voters and 84% of Marshfield voters consider secondhand smoke to be a serious or moderate health hazard.



Voters in these cities attach greater priority to the right to breathe clean air in restaurants and bars over the right of smokers to smoke inside those establishments. Seventy-seven percent (77%) say "the rights of customers and employees to breathe clean air in restaurants, bars and other indoor public places" takes precedence, while only 10% attach higher priority to "the rights of smokers to smoke inside restaurants and bars." Even a majority of smokers (51%) agree that the rights of customers and employees to breathe clean air in restaurants trump their right to smoke in restaurants and bars. More than three-quarters of the voters in all three cities believe that the right to smoke-free air trumps the right of smokers to smoke.

Voters In The Smoke-Free Cities Strongly Agree With The Rationale Behind A Smoke-Free Law

Voters in Eau Claire, Appleton and Marshfield are strongly on board with the rationale behind passing the cities' smoke-free laws. When read several statements about smoking in public places, voters in these cities overwhelmingly agree that all workers should be protected from exposure to secondhand smoke, that restaurants and bars are healthier now that they are smoke-free, and that it has been nice going out to restaurants and bars in their respective cities without smelling like cigarette smoke. The reaction to these statements is consistent across all three cities, with over 80% of the voters in each agreeing with each of the three statements

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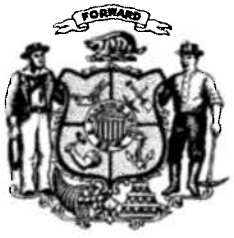
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FOR IMMEDIATE RELEASE
APRIL 28, 2009
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Young Adults Want a Smoke-Free Wisconsin

Student survey shows overwhelming support for Tobacco Control

[OSHKOSH, WI]— In an effort to give a voice to young adults on the issue of statewide smoke-free air, the Tobacco-Free & Drug-Free Coalition of Winnebago County partnered with a group of UW Oshkosh Nursing students for the "18-24 YO Project." Part of the project included a survey of this age group about statewide smoke-free air, the tobacco tax proposed in the State Budget and current smoking rates.

Data for the survey was collected at local bars, restaurants, bowling alleys and Reeve Union on April 4 and April 14. 200 people participated. All participants were between 18-24 years old. 74% are non-smokers; 26% are smokers. Results of the survey include:

- 70% preferred to go to a non-smoking bar.
- 72% are in support of a statewide smoking ban in all workplaces and public places.
- 69% support a smoking ban on the UW Oshkosh campus.
- 53% support the 75-cent tax increase on cigarettes.

Along with the survey, participants could express themselves thought a photogram, a statement about why they want a smoke-free Wisconsin along with their picture. Meghan B. from Hortonville says, "I prefer my lungs pink." And Ashley C. from Kenosha says, "I would rather not die from something I don't do."

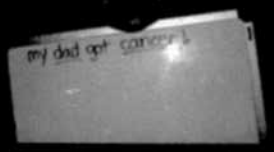
By sharing their story, these young adults hope to make their voices heard by their lawmakers as a stand-alone Smoke-Free Air Bill is moving forward in the WI State Legislature. Smoke-Free Air also remains in the State Budget Bill at this time. For full details on the survey and photogram project, please contact Emily Dieringer, edieringer@co.winnebago.wi.us or 920-232-3021.

####

The Tobacco-Free Coalition of Winnebago County is supported in part by a grant from the State of Wisconsin Department of Health Services to the Health Departments of Winnebago County (Cities of Oshkosh, Neenah, Menasha and Winnebago County).
The Drug-Free Communities Coalition of Winnebago County is supported in part by a grant to Winnebago County Health Department #1H79SP0114699 from ONDCP and SAMHSA.

These coalitions could not exist without the support and participation of our community partners.

18-24 year olds are the largest group of smokers (27.3%)



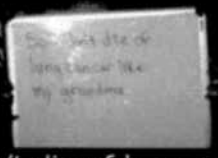
"My dad got cancer!"

"I won't die early from lung cancer!" Molly W. (Appleton)

- "Younger adult smokers have been the critical factor in the growth and decline of every major brand and company over the last 50 years." *Published by RJ Reynolds Tobacco Co.*
- Tobacco companies target 18-24 year olds by using sport sponsorships, music sponsorships, price breaks, selling sexiness, and more.

Wisconsin Tobacco Prevention and Control Program. *Students for a Smoke-Free Wisconsin Toolkit (2009).*

An executive at RJ Reynolds Tobacco Co. said, "We reserve the right to smoke for the young, the poor, the black and the stupid." This is what they think of their target audience. PRETTY ALARMING, Huh?



"So I don't die of lung cancer like my grandma." Danielle M. (Madison)

"Healthier Environment" Flavio L (Sao Paulo, Brazil).

"We don't like making our pillow cases smell like smoke when we go home." Kari H. (Kiel)

"Let my lungs breathe health air!"

Wisconsin Tobacco Prevention and Control Program. *Students for a Smoke-Free Wisconsin Toolkit (2009).*

18-24 YO Tobacco Project

Brittany Watring, Kate Hoerth, Erin Folstad
UW Oshkosh Senior I Nursing Students
with Emily Dieringer, Health Educator
Winnebago County Health Dept

Our groups surveyed workers, students, and customers at restaurants, bars, UWO Reeve Union, and a bowling alley.




The Workers

- Everyone deserves the right to breathe clean air in public and at work.
- People shouldn't have to sacrifice their health just to earn a paycheck!!!!!

"I love non-smokey clothes" Chad R. (Oshkosh)

"I don't want to cough up a lung!" Chris A. (Lakeville,MN)

The Workers (cont)

"Smoking is gross!" Meghan K. (Milton)

"I don't want to do laundry after work." Mike J. (Oshko

"Smoke makes me sad." Janelle L. (Oshkosh)

"Because smoking does NO ONE any good!!" Alana K. (Oshkosh)

The Customers

"I prefer my lungs pink."
Meghan B. (Hortonville)

"I would rather not die from something I don't do."
Ashley C. (Kenosha)

- Secondhand smoke kills and is proven to cause serious health problems.
- Secondhand smoke contains over 4,000 chemicals. 69 of these chemicals cause cancer.

Wisconsin Tobacco Control Board, *Second Hand Smoke Campaign (2002)*; American Lung Association.

Customers (cont)

"So we aren't smelly." Melissa R. (Niagara) and Megan A. (Oconomowoc)

"Girls dig the non-smoker" Tim S. (Sheboygan) and Eric V. (Waukesha)

"Smoke smells bad"

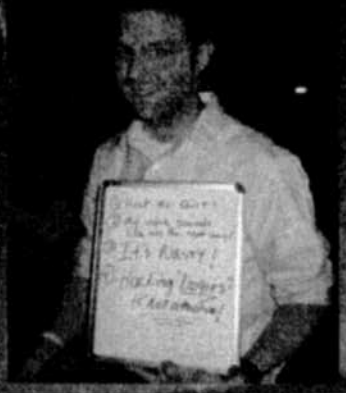
"Cigarettes are from the devil"

The results of the Survey....

- **200 people participated in the survey. All were between 18-24 years old.**

- 74% are non-smokers
- 26% are smokers

- 53% Support the 75-cent tax increase on cigarettes.



"Help me quit, my voice sounds like ass the next day, it's nasty, hocking loogies is not attractive." Joe K. (Oshkosh)

"I actually want to be able to breathe in the morning." Erik Z. (Oshkosh)

Results of the Survey

- 70% preferred to go to a non-smoking bar.
- 72% are in support of a statewide smoking ban in all workplaces and public places.
- 69% support a smoking ban on the UW-Oshkosh campus.

"I don't want to smell like an ashtray." Shane S. (Fond du Lac)

"Smoke *sad face*, non-smoking *happy face*" Nick B. (Oshkosh)

Quotes

- "My grandmother died of lung cancer and my grandfather developed emphysema after 40 years of NOT smoking."
- "Makes me mad when people get smoke breaks at work."
- When I'm at a place that has excellent food, smoking looses the essence of each succulent flavor."
- "Restaurants are hurting the community by allowing poison in the food."
- "I don't like to eat around smoke even though I smoke."

"My grandma died of cancer." Andrea C.

"Non-smokers shouldn't pay for other people's actions." Kate H. (Chilton)

Quotes

- "My grandpa had his lung removed because he was a smoker."
- "People could breathe easier."
- "There would be a cleaner environment and less cases of cancer."
- "It would be an incentive for people to stop smoking and for kids to never start."
- "Kids inhale it and can get cancer like my dad."

"My hair smells right now!" Liz R. (Hartford)

"I hate laundry" Brittany W. (Pleasant Prarie)

Dangerous Facts

- Secondhand smoke causes approximately 3,000 lung cancer deaths each year to people that DON'T smoke.
- If you smoke around your children, they can inhale the equivalent of 102 PACKS of cigarettes by age 5.

"There are a lot of reasons"

"I am tired of my hair smelling bad in the morning." Stefani R. (Waukesha) and Alexis B. (Fairbanks, Alaska)

Wisconsin Tobacco Control Board, *Second Hand Smoke Campaign (2002)*

Secondhand smoke is never safe, no matter what the amount!

"What's the worst that could happen? People stop smoking!" Tim B (Appleton)

"I don't want black lung." Kate [illegible] (New Glarus)

"Cleaner air for those who don't want to breathe in poison!"

"Smoke free is the way to be" Mike C. (Dalton, MN)