LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

SMOKE-FREE AREAS (ENCLOSED PUBLIC PLACES) BILL 1993

# *CLEARING THE AIR*

**Report by the Standing Committee on Conservation, Heritage and Environment**

**May 1994**

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# PREFACE

The *Smoke-free (Enclosed Public Places) Bill* was introduced into the Legislative Assembly on 23 February 1993 and referred to the Standing Committee on Conservation, Heritage and Environment for inquiry and report by 21 April 1994.

The Bill, being accepted in principle by the Legislative Assembly, is endorsed by the Committee. The Committee, however, was concerned over the application of the legislation in a number of areas.

The Committee examined the effect of environmental tobacco smoke (ETS) on public health; the role of ventilation in reducing exposure to environmental tobacco smoke; occupational health and safety implications of the legislation; the potential economic impact of the legislation and the implications for the civil liberties of smokers and non-smokers alike.

The Committee concluded that environmental tobacco smoke can present a potential health hazard to people with respiratory afflictions and young children. Further, ventilation systems will not prevent a person encountering high concentration levels of ETS in enclosed public places when, for example, walking past a person smoking a cigarette. As these are chance encounters, little preventative action can be taken by the smoker, managers of enclosed public places or the non-smoker. The possibility of this occurring may cause some people susceptible to the harmful effects of, or annoyed by the presence of, ETS not to enter these areas.

The Committee therefore concluded that the most effective way to minimise exposure to ETS in enclosed public places is to set a goal for the removal of the source of contamination as far as possible.

The evidence concerning the economic impact of the legislation was inconclusive. The Committee concluded that, while a substantial number of restaurants in Canberra are smoke-free, the majority are not. This indicated that most restaurateurs would prefer to offer the choice of smoking and non-smoking areas to customers. The Committee concluded that, with modification of the legislation to allow smoking under certain conditions, restaurateurs could still offer this choice while complying with the spirit of the legislation.

The Committee found that there was broad public support for the legislation from smokers and non-smokers alike.

The Committee concluded that, should the amendments to the legislation recommended in this report be adopted, the coverage of the Bill could be expanded to include all enclosed public places within 30 months of the enactment of the legislation.

The Committee received 26 submissions, not including supplementary submissions. In addition, the ACT Alcohol and Drug Service made available to the Committee submissions received in response to the discussion paper on the proposed legislation, released by the Minister for Health in October 1993. The Committee also received 21 exhibits.

The Committee held a public hearing in the Legislative Assembly on 6 April 1994. Evidence was received from the ACT Government, representatives from medical organisations, including the Australian Medical Association, the ACT Cancer Council and the National Heart Foundation; the hospitality industry, including the Licensed Clubs Association, the Restaurant and Caterers Association of the ACT and the Australian Tourism Industry Association; and Canberra ASH. The Committee was also briefed by the Australian Hotels Association.

Ms Ellis and myself also met with New Zealand Department of Health officials in Wellington and discussed the operation of the Government of New Zealand's *Smoke-free Environments Act 1990.*

The Committee commenced the process of review of the evidence, and concluded that it could not discharge its reference by 21 April 1994. The Committee sought and was granted an extension of its reporting date until 19 May 1994.

I wish to thank all of those who gave their time and effort to contribute to the inquiry.

Michael Moore, MLA
Chair

May 1994

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# TERMS OF REFERENCE

On 23 February 1994, the ACT Legislative Assembly referred to the Committee to inquire into and report on:

The *Smoke-free Areas (Enclosed Public Places) Bill 1993*.

The purpose of the Bill is to empower the Minister to declare that tobacco smoking is prohibited in a specified enclosed public place, or part of such a place. Smoking can be absolutely prohibited, or prohibited at specific times or in specific circumstances.

# COMMITTEE MEMBERS

Mr M Moore (Chairman)

Ms A Ellis

Mr L Westende

**Secretary**

Richard Cavanagh

# ACRONYMS/ABBREVIATIONS

| | |
|---|---|
| ADS | ACT ALCOHOL AND DRUG SERVICE |
| AHA | AUSTRALIAN HOTELS ASSOCIATION |
| AMA | AUSTRALIAN MEDICAL ASSOCIATION |
| AS 1668.2-1991 | AUSTRALIAN STANDARD 1668.2-1991 |
| ASH | ACTION ON SMOKING AND HEALTH |
| ASHRAE | AMERICAN SOCIETY OF HEATING, REFRIGERATION AND AIR-CONDITIONING ENGINEERS |
| ATIA | AUSTRALIAN TOURISM INDUSTRY ASSOCIATION |
| EPA | ENVIRONMENT PROTECTION AGENCY |
| ETS | ENVIRONMENTAL TOBACCO SMOKE |
| FLAIE | FEDERATED LIQUOR AND ALLIED INDUSTRIES EMPLOYEES' UNION |
| HBI | HEALTHY BUILDINGS INTERNATIONAL PTY LTD |
| HEPA | HIGH EFFICIENCY PARTICULATE AIR FILTERS |
| MS | MAINSTREAM SMOKE |
| OH&S | OCCUPATIONAL HEALTH AND SAFETY |
| RSP | RESPIRABLE SUSPENDED PARTICLES |
| SS | SIDE STREAM SMOKE |

# RECOMMENDATIONS

*Overview*

**The intention of the Report is to provide a structure which adequately protects non smokers from the impact of passive smoking which is also known as Environmental Tobacco Smoke.**

**The structure proposed by the majority view of the Committee is:**

1. **An immediate ban on smoking in such places as shopping malls, schools, taxis, public transport, enclosed recreational and sporting facilities, waiting areas, lobbies, stairways and venues primarily used by people under the age of 18 years;**

2. **A twelve month restriction to 50% non smoking in restaurants;**

3. **At the end of this twelve month phase-in period restaurants:**

   - **will be non smoking, or**
   - **may apply for an exemption which would allow a minimum of 75% non smoking provided they meet ventilation standard AS 1668.2-1991; and**

4. **At the end of a 30 month period, all other venues including bars, taverns, hotels, licensed clubs, the Canberra Casino and similar places:**

   - **will be smoke free; or**
   - **may apply for an exemption which would allow a minimum of 50% non smoking provided they meet ventilation standard AS 1668.2-1991.**

**The minority report of the Committee concerning elements of this structure is at page 31.**

*Recommendation 1*

**The Committee recommends that the Legislative Assembly be informed of any intention by the Minister to issue a declaration under Section 5 of the Bill prior to that declaration taking effect.**

*Recommendation 2*

**The Committee recommends that Section 9(2)b of the Bill the amended to state that, where smoking occurs in a designated smoke-free area, the occupier's legal responsibilities in "taking reasonable steps" are to:**

- **request the smoker to stop smoking; and**
- **inform the smoker that it is an offence to smoke under the *Smoke-free Areas (Enclosed Public Places) Act.***

*Recommendation 3*

**The Committee recommends that:**

- **the ACT Occupational Health and Safety Council adopt AS 1668.2-1991 as the minimum air quality standard requirement in work areas where smoking by persons other than employees is permitted; and**

- **Section 5 of the *Smoke-free Areas (Enclosed Public Places) Bill 1993* be amended to include the clause: "where smoking is permitted under the Bill, occupiers must still conform to minimum air quality standards set out in OH&S guidelines relating to smoking in the workplace."**

*Recommendation 4*

**The Committee recommends that restrictions on smoking in restaurants should be introduced in two stages:**

**Stage 1: Following the enactment of the smoke-free areas legislation, a minimum of 50% of a restaurant should become smoke free; and**

**Stage 2: 12 months after the introduction of the legislation, restaurateurs may choose either to become entirely smoke free, or apply for a Certificate of Exemption.**

**The Certificate should require at least 75% of the premises to remain smoke-free and meet the ventilation requirements of AS 1668.2-1991.**

*Recommendation 5*

**The Committee recommends that the amended *Smoke-free Areas (Enclosed Public Places) Bill* immediately apply to:**

- **enclosed shopping malls;**
- **schools and educational facilities;**

- health care facilities;
- retail shops and all business premises where goods and services are sold or delivered;
- taxis, buses and other means of public transport, together with substantially enclosed ticketing, boarding and waiting areas;
- indoor sports and recreation facilities;
- exhibitions, displays and meeting areas;
- facilities used for exhibiting motion pictures, stage, drama, lecture, musical recital and other performances;
- parts of private residences when used for registered commercial child care;
- indoor service queues, counters, waiting areas, foyers, hallways, rest rooms and toilets;
- lobbies, hallways, stairs, lifts, dining areas and other common areas of multi-unit residential and commercial facilities; and
- places which are a venue primarily for people under the age of 18.

No Certificates of Exemptions should be granted for these areas. They are to be smoke free.

*Recommendation 6*

The amended *Smoke-free Areas (Enclosed Public Places) Bill* be extended to cover the following enclosed public places within 30 months of its enactment:

- bars, taverns, hotels, licensed clubs, the Canberra Casino and similar places where the primary business is other than the sale of food to be consumed on the premises; and
- separately enclosed areas of hotels, restaurants, clubs and similar premises when used exclusively for meetings and private functions where seating is under the control of a sponsor, not the occupier, and attendance is by invitation.

Certificate of Exemptions should require a minimum of 50% of these premises to remain smoke free and meet the ventilation requirements of AS 1668.2-1991.

*Recommendation 7*

**The Committee recommends that:**

- **an occupier of a premises who wishes to provide a smoking area may apply for a Certificate of Exemption from the Act;**
- **in order to qualify for a Certificate of Exemption the smoking area must be fitted with air cleaning equipment that will maintain air quality as stipulated in AS 1668.2-1991, and the occupier must agree to regular check of this equipment and monitoring of air quality by inspectors appointed under the Act to ensure that air cleaning equipment is operating efficiently and air quality is maintained;**
- **the Certificate should only allow for smoking to be permitted within a limited area of the premises;**
- **the premises granted an exemption be placed on a Register of Exempted Premises, administered by ACT Alcohol and Drug Service;**
- **the Certificate of Exemption will be provided for a fee, sufficient to cover administration costs. This fee should not exceed cost recovery;**
- **where a decision made by the ACT Alcohol and Drug Service is disputed, the claimant may appeal to the Administrative Appeals Tribunal; and**
- **failure to comply with the conditions of the Certificate of Exemption be punishable by revocation of the Certificate and a fine of $1000 in the case of an individual, and $5000 in the case of a body corporate.**

# CHAPTER 1.

# THE LEGISLATION

1.1. The *Smoke-free Areas (Enclosed Public Places) Bill 1993* was introduced into the Legislative Assembly on 23 February 1993. The object of the Bill is to promote public health by reducing exposure to environmental tobacco smoke (ETS).[1]

1.2. The Bill gives the Minister for Health the power to prohibit smoking in a specified public place:

- absolutely;
- at specified times or in specified circumstances; or
- in accordance with specified or prescribed conditions.[2]

1.3. The Bill defines a public place as:

> "A place which the public, or a section of the public, is entitled to use or which is open to, or used by, the public ... "[3]

1.4. An enclosed place is defined as:

> "a public place that has a floor and a ceiling or roof and is, except for doors and passageways, completely or substantially enclosed by walls or windows ..."[4]

1.5. Although it was not included in the Bill the Government intends to apply the legislation "in the first instance"[5] to 13 areas:

- enclosed shopping malls;
- schools and educational facilities;
- health care facilities;
- retail shops and all business premises where goods and services are sold or delivered;
- restaurants, cafes, coffee lounges cafeterias, snack bars, take aways and other eating houses or dining areas, whether free standing or contained within other premises such as hotels or clubs;
- taxis, buses and other means of public transport, together with substantially enclosed ticketing, boarding and waiting areas;
- indoor sports and recreation facilities;
- exhibitions, displays and meeting areas;
- facilities used for exhibiting motion pictures, stage, drama, lecture, musical recital and other performances;
- parts of private residences when used for registered commercial child care;

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[1] *Smoke-free Areas (Enclosed Public Places) Bill 1993*, s.4
[2] ibid., s.5
[3] ibid., s.3
[4] ibid.
[5] Minister for Health: Submission 9 p 2

- indoor service queues, counters, waiting areas, foyers, hallways, rest rooms and toilets;
- lobbies, hallways, stairs, lifts, dining areas and other common areas of multi-unit residential and commercial facilities; and
- places which are a venue primarily for people under the age of 18.[6]

1.6. The Government does not intend "initially"[7] to prohibit smoking in:
- bars, taverns, licensed clubs and other places where the primary business is other than the sale of food to be consumed on the premises;
- separately enclosed areas of hotels, restaurants, clubs and similar premises when used exclusively for meetings and private functions where seating is under the control of a sponsor, not the occupier, and attendance is by invitation; and
- areas of hotels, motels, hostels, boarding houses and other multi-unit residential facilities that are not common areas (such as people's bedrooms).[8]

1.7. Under section 5(3) of the Bill, the Legislative Assembly can overturn a smoking ban declared by the Minister.[9]

1.8. Other key elements of the Bill are:
- the appointment of inspectors to ensure compliance with the legislation;
- the provision of a $500 fine for smoking in a prohibited area;
- the provision of a $1000 fine for the occupier of an area where an offence has taken place (increased to $5000 where the occupier is a body corporate); and
- the provision of penalties for persons obstructing or preventing inspectors from performing their duty.[10]

1.9. In framing the legislation, the Government wishes to be in tune with community attitudes. Community opinion, in the view of the Government, supports the proposed smoking bans in the nominated public places, and the legislation will serve to reinforce the decreasing level of acceptance of smoking as a social activity.[11]

1.10. The Committee notes that the Legislative Assembly has accepted the Bill in principle, and consequently it endorses the objective of restricting, and in some places banning, smoking in public places. The interest of the Committee is, however, over the application of the legislation.

## APPLICATION OF THE LEGISLATION

1.11. The Committee received over 26 submissions. In addition, it received as evidence submissions made to the ACT Alcohol and Drug Service (ADS) in response to the discussion paper on the proposed Bill released in October 1993.

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[6]ibid., pp 2-3
[7]ibid.
[8]ibid.
[9]*Smoke-free Areas (Enclosed Public Places) Bill 1993*, s.5(3)
[10]*Smoke-free Areas (Enclosed Public Places) Bill 1993*, Ss 6-10
[11]Minister for Health: Submission 9 p 1

1.12. The submissions support the introduction of the Bill, although the inclusion of retirement and nursing homes and restaurants as "smoking prohibited" areas caused some controversy.

1.13. The Council of the Ageing (ACT) indicated to the Committee that many residents of nursing homes spend all, or nearly all, of their time in enclosed places, and some may have smoked for many years. The Council considered that a smoking ban in these areas may cause unnecessary distress for these residents.[12]

1.14. The Committee notes that the New Zealand smoke-free environments legislation incorporates a provision exempting incapacitated residents of nursing homes or hospitals from the Act, providing steps are taken to ensure that other people in the vicinity will not be adversely affected by the smoke.[13]

1.15. The Government has stated that there will be flexibility in the application of the legislation to aged care hostels and nursing homes. Residential facilities may incorporate smoking permitted common areas, but only where non-smoking common areas are also provided.[14]

1.16. The inclusion of restaurants as enclosed public places for the purposes of the legislation will be dealt with in Chapter 5.

1.17. The Committee notes that the legislation, in its current form, gives the Minister the power to either restrict or ban smoking in enclosed public places, but does not specify which places will be affected. Further, this power can be exercised by Ministerial declaration, although the declaration can be disallowed or amended by the Assembly.

1.18. The Committee notes that the intention of the legislation is to "initially" exclude bars, taverns and a number of other areas from the operation of the legislation. The Committee considers that the powers granted to the Minister may be used to include these areas by declaration, without adequate public debate.

1.19. Although the Assembly will have the power to overturn the declaration, this will be a retrospective action and can only be done when the Assembly is in session. A situation may arise, for example, where a declaration is made immediately after the Assembly rises for a recess and consequently would be in effect for some time before the Assembly has the opportunity to debate the matter.

1.20. The Committee considers that any extension of the legislation should only occur after adequate public debate.

*Recommendation 1*

**The Committee recommends that the Legislative Assembly be informed of any intention by the Minister to issue a declaration under Section 5 of the Bill prior to that declaration taking effect.**

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[12]Council On The Ageing (ACT): Submission 4 p 1
[13]*Smoke-free Environments Act 1990*, s.6(1), Government of New Zealand
[14]ACT Alcohol and Drug Service: Submission 16 p 14

ENFORCEMENT

1.21. Submissions from the hospitality industry expressed concern over the role of hospitality staff in enforcing compliance with the Bill.

1.22. The Australian Hotels Association (AHA) stated:

> "To employ 'smoke police' or to expect hoteliers to divert staff time into policing bans must be considered as a vast waste of resources, over what can only be described as a petty issue.
>
> The AHA rejects the notion that the industry should become 'smoke police' monitoring and instructing patrons in their activities."[15]

1.23. The Australian Tourism Industry Association (ATIA) saw the enforcement issue in terms of staff training:

> "It is unreasonable to expect that the relatively young 'front of house' staff employed in the tourism industry will be able to enforce the requirements of the legislation without the appropriate training."[16]

1.24. The ADS takes the view that, in order for the legislation to be effective, compliance must be on the whole voluntary. The ADS also considers that a high level of compliance will occur due to the following factors:

- relatively low compliance costs;
- high visibility of violations;
- high levels of public support and lack of sympathy for people smoking in restricted areas; and
- growing acceptance of people generally and by people who smoke of the health risks of ETS to others.[17]

1.25. The Committee accepts the point being made by the ADS that a high degree of compliance is likely, given the experience of the adoption of smoke-free policies in Commonwealth Government and other public service workplaces. The Committee notes that Section 9(2) of the Bill provides for a defence for occupiers of places should smoking occur in a prohibited place.

1.26. However, this misses the point being made by the hospitality industry - that hospitality staff will have a primary enforcement role. The Committee considers that this role should be more properly defined, to ensure that both occupiers and their staff are aware of their responsibilities, and do not inadvertently contravene the law themselves by not properly enforcing the law.

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[15]AHA: Submission 17 p 6
[16]ATIA: Submission 21 p 4
[17]ACT Alcohol and Drug Service: Submission 16 p 11

1.27. The Committee notes that in other jurisdictions, smoke-free ordinances are designed and implemented in a way to minimise confrontation between smokers and hospitality staff. The City of Aspen, for example, relies on adequate signage to advertise the law and its penalties, and restaurant owners have no obligation to enforce the law other than to inform patrons of the city law if they smoke.[18]

1.28. The Committee considers that a similar approach should be adopted by the ADS to minimise the enforcement role of hospitality staff.

1.29. While the ADS acknowledges that civil disobedience may occur if smoking prohibitions are extended into bars, taverns and licensed clubs, it should also recognise that civil disobedience by restaurant owners and staff may occur if enforcement responsibilities are too onerous.

*Recommendation 2*

**The Committee recommends that Section 9(2)b of the Bill the amended to state that, where smoking occurs in a designated smoke-free area, the occupier's legal responsibilities in "taking reasonable steps" are to:**

- **request the smoker to stop smoking; and**
- **inform the smoker that it is an offence to smoke under the *Smoke-free Areas (Enclosed Public Places) Act*.**

[18] ACT Cancer Council: Exhibit 20 p 2

## OVERSEAS LEGISLATION

1.30. Legislation proscribing smoking in enclosed public places has been enacted in over 450 overseas communities, principally in the United States, Canada and New Zealand. Often the legislation allows for up to 50% of the enclosed public place to be set aside for smoking. The measures contained in the legislation range from restrictions on where smoking can occur in public places to outright bans. Generally, administrators of smoking control legislation have found that there is a high degree of voluntary compliance with the legislation, and little need for coercive measures.[19]

1.31. The New Zealand Government enacted smoke-free legislation in 1990. The legislation covered a wide variety of enclosed areas, including workplaces, hospitals and rest homes, aircraft, ships and trains, passenger terminals, and restaurants. The legislation does not apply to licensed premises which are "set aside primarily for the consumption of liquor by patrons."[20]

1.32. The Committee Chair and Ms Ellis met with New Zealand Department of Health officials in Wellington and discussed the operation of the Act.

1.33. In reporting to the Committee on their observations in New Zealand the Committee Chair and Ms Ellis drew attention to their observation that Australian restaurants and offices had achieved a similar level of compliance (and in some cases better) without resort to legislation. Community attitudes are seen as more significant than legislation, although the two are clearly complimentary.

1.34. In addition to the legislation in operation throughout New Zealand, the Wellington Health Board has a number of people dedicating to assisting restaurateurs and others to establish effective techniques to assist them to control smoking.

1.35. The proposed legislation for the A.C.T. goes considerably further than that which has been enacted in New Zealand.

1.36. Mr Westende, in conversation with a relative who owns a cocktail bar/restaurant in Redlands, California, was informed that currently there is no State legislation which bans smoking in enclosed public places. However, we understand that there may be some local government restrictions in this area.

1.37. However, it is intended that, at the next State election in November 1994, a referendum will be held asking if smoking should be banned in eating areas unless suitable ventilation/extraction systems are in place.[21]

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[19] See for example: Submission 16; Exhibits 4, 6

[20] Section 12 *Smoke-free Environments Act 1990*, Government of New Zealand

[21] See also *Tobacco giant fires up attack*, Australian Financial Review, 17 May 1994, p 16

# CHAPTER 2.

# PUBLIC HEALTH AND ENVIRONMENTAL TOBACCO SMOKE

## HEALTH EFFECTS OF ENVIRONMENTAL TOBACCO SMOKE

2.1. In discussing the need for smoke-free legislation, the ADS stated that:

> "In addition to the impact of smoking on those who smoke, the health risks of passive, or 'involuntary' smoking, are borne by the community generally, and particularly by certain vulnerable groups such as infants, young children, babies during pregnancy and people suffering from pre-existing ailments and conditions.
>
> There is growing acceptance of the danger of environmental tobacco smoke (ETS) to non-smokers. However, this awareness which is linked to the appearance of scientific and medical information dating from the mid-1970s, has not yet translated into systematic protection for people who are involuntarily exposed to ETS".[22]

2.2. In support of this position, the ADS cited a 1993 study conducted by the United States Environmental Agency (EPA). The study titled *Respiratory Health Effects of Passive Smoking: Lung Cancer and Other Disorders - Report of the U.S. Environmental Protection Agency* concluded that:

> "In adults environmental tobacco smoke:
>
> - is a human lung carcinogen, responsible for approximately 3,000 lung cancer deaths annually in U.S. non-smokers; and
> - has subtle but significant effects on the respiratory health of non-smokers, including reduced lung function, increased coughing, phlegm production and chest discomfort.
>
> In children environmental tobacco smoke exposure is causally associated with an increase:
>
> - of lower respiratory tract infections such as bronchitis and pneumonia;

[22]ACT Alcohol and Drug Service: Submission 16 p 1

- in the prevalence of fluid in middle ear, symptoms of upper respiratory tract infection and a small but significant reduction in lung function; and
- in episodes of and increased severity of symptoms in children with asthma.

Environmental tobacco smoke exposure is a risk factor for new cases of asthma in children who have not previously displayed symptoms."[23]

2.3. The potential risk to public health posed by ETS is due to both its chemical mix, and existence in both solid (particulate) and gas phases. According to the EPA, ETS is:

"a dynamic complex mixture of over 4000 compounds found in both vapour and particle phases. Efforts to characterise the physical and chemical properties of ETS have found that:

- MS (Mainstream Smoke) and SS (Side Stream Smoke) emissions are qualitatively very similar in their chemical composition , containing many of the same carcinogenic and toxic compounds;
- several of these compounds, including five known human carcinogens, nine probable human carcinogens three animal carcinogens and several toxic agents, are emitted at higher levels in SS than MS ... ; and
- emission of these notable air contaminants demonstrate little variability among brands of cigarettes."[24]

2.4. The key conclusion of this study is that a link can be established between exposure to tobacco smoke and the incidence of lung cancer.

2.5. This study was the principal medical evidence cited by the ADS. Their submission does not, however, refer to any medical evidence which deals with the possible health implication of ETS on the Australian population.

2.6. Other information presented to the Committee stated that the number of lung cancer deaths in Australia attributable to ETS vary between 1650 and 2000 annually.

2.7. The ACT Cancer Society and Canberra ASH stated that:

"Every year smoking related disease kills about 20,000 Australians ... one in five deaths in Australia in 1992 were caused by drug use of which tobacco accounted for over 72%. ... Passive smoking is increasingly recognised as a major cause

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[23]ibid., pp v-vi

[24]U.S. Environmental Protection Agency: *Respiratory Health Effects of Passive Smoking: Lung Cancer and Other Disorders - Report of the U.S. Environmental Protection Agency*, National Institutes of Health, January 1993

> of tobacco related deaths. ... Somewhere in the order of 1650 Australians die each year because of passive smoking ...".[25]
>
> "The first thing we have to get through is that smoking is a health issue. ... there are around 2000 Australians die each year from the effects of passive smoking."[26]

2.8. However, the Committee notes that the results of the studies used by the EPA and others to form these conclusions have been disputed. The Tobacco Institute, for example, cited criticism by Alvan Feinstein, Professor of Medicine and Epidemiology at Yale Medical School, Yale University. Professor Feinstein is reported to have stated that the EPA study "simply ignored the inconvenient results and emphasised those ... that are helpful.".[27]

2.9. The Tobacco Institute also cited a study conducted by Peter Lee in 1992 which came to the opposite conclusion to that of the EPA, namely that:

> "Considered in its entirety the epidemiological evidence does not convincingly demonstrate that exposure to ETS increases risk of lung cancer among non-smokers."[28]

2.10. The Committee received a submission from David Lewis who disputed the findings of a number of key studies conducted in ETS, claiming that a close analysis of the data showed that there was no link between passive smoking and cancer.[29]

2.11. The Committee's attention was also drawn to the Burswood Casino case where the Casino faced prosecution by the Western Australian Department of Occupational Health, Safety and Welfare over the health risk faced by employees from ETS exposure.

2.12. The claims against the Casino were dismissed on the grounds that:

> "Whilst ETS is annoying and of discomfort to non-smokers it has not been proved at the required standard, or at all, in this prosecution, that it is a risk to the health of the employees of the Casino."[30]

2.13. The Committee notes that the conclusions of the study conducted by the EPA were based primarily on the incidence of cancer and other diseases in never smoking women married to smokers, a group that would be exposed to high doses of ETS over many years. In extrapolating the overall public health risk of ETS from this study, the ETS stated:

> "The 3000 figure is a composite value from estimates of varying degrees of uncertainty. ... there is a high degree of confidence in the estimates derived for female never smoker.

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[25]Bowcock, G, Executive Director, ACT Cancer Society: Transcript p 62
[26]Shroot, Dr A, President, Canberra ASH: Transcript p 70
[27]Tobacco Institute of Australia: Exhibit 7.73 p 6
[28]ibid., p 4
[29]David H Lewis: Submission 23
[30]ibid., p 5

> The figures for male never smokers and former smokers of both sexes are subject to more uncertainty because more assumptions were necessary for extrapolation from the epidemiological results. ... Based on statistical variations, estimates as low as 400 and as high as 7000 are possible. However, where specific assumptions were made, we believe that they were generally conservative, and we expect that the actual number may be greater than 3000.
>
> Thus, the confidence in these estimates is judged to be medium to high. In summary, the evidence demonstrates that ETS has a very substantial and serious health impact."[31]

2.14. The Committee notes the conclusion of the EPA that, while the EPA's confidence in its own analysis is "medium to high", it nevertheless draws the conclusion that ETS has a "substantial" health impact.

2.15. In relation to the figures cited for Australia, Dr A Shroot, President, Canberra ASH stated that:

> "Some of the actual figures may be a little bit difficult where there are multi-factors involved, but these are the best statistics we have got ... the various figures quoted are between 800 and 2000 but it is very significant."[32]

2.16. In reviewing the medical evidence the Committee accepts the finding of the US EPA that ETS is a substance which contains carcinogens, and as such, can pose a health risk. The Committee also accepts the findings of the EPA in relation the role of ETS in aggravating existing respiratory and related disorders.

2.17. Further, the Committee accepts the findings of the EPA of an increased risk of cancer in non-smoking women with smoking spouses, but notes the qualifications used by the EPA in relation to its analysis when presenting its conclusions in relation to the wider population.

2.18. The Committee considers that, while a link between lung cancer and long term exposure to high levels of ETS by non-smoking spouses of smokers can be established, it does not necessarily follow that the same level of risk can be applied, or is encountered by, the general public in the course of their daily lives.

2.19. This does not mean, however, that there is no risk associated with ETS encountered in indoor environments. ETS has been classified as a Class A carcinogen by the EPA, and consequently the risk presented by ETS should not be ignored.

2.20. While this debate continues, however, caution must be exercised in dealing with ETS. While the bulk of evidence dealt with ETS as a cause of disease, there was little argument with the finding of the EPA that ETS can aggravate existing respiratory afflictions.

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[31]U.S. Environmental Protection Agency: op cit., p 196, 200-201
[32]Shroot, Dr A, President, Canberra ASH: Transcript p 75

2.21. The Committee therefore concludes that ETS does have a role in aggravating existing respiratory afflictions and as such should be considered as a health hazard to people with respiratory ailments and a potential health hazard to children.

## EXPOSURE RISK IN ENCLOSED PUBLIC PLACES

2.22. In examining the medical evidence concerning ETS and health, it was clear that a critical factor in assessing the health implications was the cumulative exposure of a person to ETS.

2.23. As with evidence concerning the direct impact of ETS on public health, contradictory evidence was presented to the Committee as to the acceptable level of exposure to ETS. The ACT Cancer Council, for example, stated that "there was no safe level of exposure to tobacco smoke."[33]

2.24. Alternately, the Tobacco Institute presented the evidence cited above concerning the Burswood Casino case which stated that there was no risk to health from ETS exposure.

2.25. The Licensed Clubs Association of the ACT sought to place the potential health hazard posed by ETS within the context of the indoor environment: "Despite much controversial discussion to date there is no evidence that passive smoking is any more or less the cause of health related problems than a whole host of other substances occurring naturally or artificially in the working environment."[34]

2.26. In 1993 the Victorian Environment Protection Agency conducted a study of indoor air quality and identified five locations where exposure to contaminants may occur:

- the home;
- during travelling;
- the workplace;
- other public enclosed places; and
- the open air.[35]

2.27. The study stated that: "For individuals the central issue is the total exposure over all situations" encompassing ambient, home and workplace. The study found that the proportion of time spent in different indoor environments are:

| | |
|---|---|
| • home | 68.0% |
| • work | 18.0% |
| • other | 6.1%[36] |

[33]ACT Cancer Council: Submission 15 p 2
[34]The Licensed Clubs Association of the ACT Inc: Submission 2 p 3
[35]Environment Protection Agency: *Indoor Air Quality in Domestic Premises in Victoria: A Review*, State Government of Victoria, September 1993 p 2
[36]ibid., p 3

2.28. The conclusion could be drawn from this that the level of exposure to ETS in enclosed public places is low, and, of itself, may not present a substantial risk to the general public. In relation to this matter Mr Martin Derkley stated to the Committee:

> "Now, that may seem fairly trivial and the majority of us who are in good health will recover from that sort of exposure. However, for children, for people with particular respiratory and circulatory diseases like cystic fibrosis, this can mean exclusion from a lot of the public areas of daily life."[37]

2.29. A number of submissions referred to the relatively low level of exposure faced by the general public in enclosed public places, and recommended to the Committee that ventilation systems may reduce the level of exposure to ETS to an acceptable level. This will be dealt with further in the next chapter.

[37]Derkley, M, Director, ACT Alcohol and Drug Service: Transcript p 3

# CHAPTER 3.

# VENTILATION AND ENVIRONMENTAL TOBACCO SMOKE

3.1. ETS presents a major challenge to ventilation engineers. Smoke does not spread evenly around a room, levels of contamination may vary according to the number of smokers and concentration levels are higher near smokers.

3.2. ETS also exists in gaseous and particulate phase, requiring different technologies to effectively clean contaminated air.

3.3. Healthy Buildings International Pty Ltd (HBI) stated that, in dealing with ETS:

> "Equipment marketed specifically for the removal of tobacco smoke components from room air includes electrostatic precipitators, activated charcoal filters and high efficiency filters such as HEPA (High Efficiency Particulate Air) filtration units. The electrostatic and HEPA filters are very efficient at removing the fine so-called respirable suspended particles (RSP) from the air. Correctly sized, well serviced electrostatic precipitators or HEPA filters can remove 90 to 98% of these airborne particles. Neither of these filters, however, can remove gaseous components. here we need the use of adsorbent filters using activated charcoal, potassium permanganate impregnated aluminium oxide pellets or other proprietary adsorbents. These, again presupposing they are sized correctly and serviced regularly, can remove substantial amounts of ... gases, nicotine etc.
>
> The most effective devices for removing perceived signs ... of tobacco smoke appear to be a combination of a 'roughing' filter followed by an electrostatic precipitator or HEPA unit, followed by an adsorbent filter. Several proprietary designs are of this combination are readily available worldwide."[38]

3.4. This evidence was disputed by the ADS:

> "While ventilation may decrease the overall ambient particulate and gaseous matter on average, the concentration of ETS near a person smoking may be much higher and still effect non-smokers nearby.

[38]Healthy Buildings International Pty Ltd: Exhibit 7.11 p 6

> Systems which rely on filtering or trapping small particles are either not adequate or prohibitively expensive for removing ETS, due to the small size of ETS gas particles. ... Also highlighted [are] the deficiencies of air conditioning and air cleaning equipment in relation to maintenance, down-time, and the potential release of contaminants into the indoor environment when systems are restarted.
>
> Ventilation and air conditioning are ineffective in removing ETS.".[39]

3.5. HBI pointed out that ETS is one of many indoor air pollutants which have to be controlled through mechanical heating and ventilation equipment. Further, HBI stated that, in their opinion, ETS is not a major indoor contaminant.

3.6. In a study of indoor air quality covering 953 buildings world wide, HBI found that tobacco smoke was a major factor in poor air quality in only 2.8% of all buildings. The major indoor pollutants were allergenic fungi (33.4% of all buildings), airborne dust (26.6% of all buildings) and formaldehyde gas (8.5% of all buildings).[40]

3.7. A key finding of this study was that 51% of the buildings surveyed were inadequately ventilated.[41] This finding supports the view of ADS that the air conditioning equipment in most ACT buildings would not be capable of meeting existing air quality standards.

## INDOOR AIR QUALITY STANDARDS

3.8. Indoor air quality standards of all mechanically ventilated buildings must conform to Australian Standard (AS) 1668.2-1991. This standard sets the minimum requirement for preventing " an excess accumulation of airborne contaminants.". Tobacco smoke is included in this definition of contaminants.[42]

3.9. In discussing this standard, Mr Clive Broadbent, adviser to the ADS, stated that the standard dealt with comfort levels of contaminants for occupants of a building and "had nothing to do with health".[43]

3.10. This statement is not entirely accurate. The Australian Standard is based on the American Society of Heating, Refrigeration and Air-Conditioning Engineers (ASHRAE) Standard 62. This seeks to:

> "specify minimum ventilation rates and indoor air quality that will be acceptable to human occupants and are intended to avoid adverse health effects. For substantive information on

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[39]ACT Alcohol and Drug Service; Submission 16 pp 8-9
[40]Healthy Buildings International Pty Ltd, op cit., p 2
[41]ibid.
[42]*AS 1668.2-1991: Australian Standard: The use of mechanical ventilation and airconditioning in buildings; Part 2: Mechanical ventilation for acceptable indoor air quality*, Standards Australia, Sydney 1991 p 5, 33, 36
[43]Broadbent, C, Adviser to the ACT Alcohol and Drug Service: Transcript p 8

health effects, the Standard must rely on recognised authorities and their specific recommendations. Therefore, with respect to tobacco smoke and other contaminants, this Standard does not, and cannot, ensure avoidance of all possible adverse health effects, but it reflects recognised consensus and criteria.".[44]

3.11. Further, an analysis of AS 1668.2 by Mr E M West, Director, Gutteridge Haskins and Davey Pty Ltd directly contradicted Mr Broadbent. Mr West states specifically that "this Standard [AS 1668.2-1991] would not address comfort but confine itself to health".[45]

3.12. In developing the Standard, Mr West noted that:

> "based on the work of Wanner, Weber and Johansson, a limit of 1 ppm of CO was considered necessary and to achieve this for one cigarette requires 66 cubic metres of outdoor air. Assuming moderate smoking at a rate of two cigarettes/hr/smoker and heavy smoking at a rate of 3 cigarettes/hr/smoker, outdoor air flow rates can be estimated as follows:
>
> For moderate smoking
>
> 2 cig/hr x 0.33 x 66m$^3$/cigarette = 43.5m$^3$/hr/person = 12 L/s/person where 0.33 represents fraction of smokers in enclosure
>
> For heavy smoking
>
> 3 cig x 0.5 x 66m$^3$/cigarette = 99m$^3$/hr/person = 28 L/s/person where 0.5 represents fraction of smokers in the enclosure.[46]

3.13. The Standard set the following minimum air flow rates for mechanically ventilated buildings where smoking may occur:

- heavy smoking 20 L/s/person
- moderate smoking 15 L/s/person[47]

3.14. AS 1668.2 is incorporated into the Building Code of Australia, and as such stipulates the **mandatory minimum** air quality requirement for mechanically ventilated buildings in all Australian states and territories.[48]

3.15. In discussing the issue of ventilation, the Minister for Health stated that the Smoke-free Bill deliberately did not address the issue of air quality standards in relation to ETS. In

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[44]*ASHRAE 62-1989: ASHRAE STANDARD: Ventilation for acceptable indoor air quality*, American Society of Heating, Refrigeration and Air-Conditioning Engineers Inc, Atlanta GA 1989 p 1

[45]West, E: *Revised Australian Standard AS 1668 pt 2, Mechanical ventilation of acceptable indoor air quality*: Exhibit 21 p 2

[46]ibid., p 3

[47]ibid., p 4

[48]Spry, P: Transcript p 23

the view of the Minister, any judgement made in relation to air quality and ETS may become a de facto air quality standard:

> "it is obviously in the interests of the health of patrons and workers in places where smoking is not prohibited to have ETS reduced. ... However, it would be concerned about setting an arbitrary standard for air purity.
>
> Should the ACT set arbitrary air quality standards, through the Mutual Recognition Act, this may become the de facto national standard. Furthermore, should legal action be taken against the occupiers who reached this standard, by people who have suffered adverse health consequences, the ACT Government may be required to explain why it had set a level which, in the face of available evidence, was not safe.".[49]

3.16. The Committee notes the views expressed in the Minister's submission, but considers that an air quality standard for ETS has already been set. The Committee accepts that conformity with AS 1668.2 will not eliminate ETS from indoor air, but will reduce the level of contamination. This will obviously leave some contaminants in the air which may impact on the health of some occupants.

3.17. The Committee considers, however, that AS 1668.2 should achieve a balance between the health and comfort needs of occupants and the technical problems of eliminating all contaminants. The aim of the Committee is to minimise the health risks involved.

3.18. Further, the Committee notes that all Australian Standards are periodically reviewed, with input from the National Health and Medical Research Council, consequently, should this Standard not be effective in reducing the hazard posed by ETS, filtration requirements can be re examined.

## MONITORING AIR QUALITY

3.19. Monitoring levels of ETS contamination presents technical challenges. Mr Broadbent described these problems as:

> "I think from the point of view of monitoring we really have a difficult job monitoring gases whereas we will not have quite such a difficult job monitoring particulates.
>
> If we monitor gases we have got to think about which gas. ... all the constituents of ETS are very, very unstable and break down very quickly, and it is very, very difficult to monitor a particular gas.

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[49]Berry, W, Minister for Health: Submission 9 p 5

> I think if we were going down a monitoring track we would probably think about the solid particles, the particulates and we would think about devices to be able to measure down at this particular size range, what is called respirable size particles. That does now exist, that sort of equipment."[50]

3.20. Monitoring devices, however, come at some cost:

> "A sensor, for example, which could be used in a restaurant or a bar or some facility like that would cost $6000 plus tax ... You could add another $3000 for circuitry, and $2000 (for an alarm system) there is a total of $11,000 just to monitor the particles."[51]

3.21. In addition to the cost of monitoring a particular establishment, Mr Broadbent also pointed out that ACT Health would also need equipment to carry out independent testing of air quality. This equipment could cost up to $20,000 per unit, with a requirement for 2 or 3 units.[52]

3.22. The Committee considers that attempting to monitor all gases and all particulate sizes of ETS would be an uneconomic exercise. However, other information presented to the Committee indicated that effective monitoring of air quality could be achieved in a more cost effective manner. This method is based on identifying and monitoring levels of a chemical, such as nicotine, unique to ETS.[53]

3.23. HBI indicated that a complimentary approach to monitoring air quality would be to incorporate checks on the maintenance and operation of ventilation systems.[54]

3.24. The existence of air quality standards and monitoring procedures will not have any effect if they are not applied. The Committee notes with concern the finding of the HBI that, of over 900 buildings surveyed, 51% were inadequately ventilated. The Committee has no reason to believe that these results would not be representative of buildings in Canberra.

3.25. The Committee therefore considers that, while air quality standards may provide for the removal of a major proportion of ETS from an indoor environment, ventilation systems may not be performing efficiently enough to meet that standard. Consequently, contaminants may reach a level which could cause some irritation and harm to non smokers.

3.26. As stated in the previous chapter exposure rates to ETS in public places, while not affecting most people, may cause harm to people with respiratory diseases or aggravate pre-existing condition.

3.27. Further, concentration levels of ETS differ widely throughout enclosed public places, making ETS reduction difficult. Ventilation systems will not prevent a person encountering

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[50]Broadbent, C, Adviser to the ACT Alcohol and Drug Service: Transcript p 10
[51]ibid.
[52]ibid., p 11
[53]BESCA: Submission 26 p 3
[54]Healthy building International: Exhibit 7.11 p 10

high concentration levels of ETS when, in a shopping centre for example, walking past a person smoking a cigarette. As these are chance encounters, little preventative action can be taken by the smoker, the shopping mall manager or the non-smoker. As the Government stated, the possibility of this occurring may cause some people susceptible to the harmful effects of, or annoyed by the presence of, ETS not to enter these areas.

3.28. The Committee concurs with the Government's view that the most effective way to minimise exposure to ETS in enclosed public places is to set a goal for the removal of the source of contamination as far as possible. To achieve this goal will require a staged process.

# CHAPTER 4.

# OCCUPATIONAL HEALTH AND SAFETY

4.1. In addition to the Smoke-free Areas Bill, Occupational Health and Safety (OH&S) guidelines are currently being prepared by the government to control exposure to ETS in the workplace.

4.2. As many areas defined as enclosed public places under the Bill are also workplaces, there will be an overlap in the regulation of exposure to ETS. A number of submissions expressed concern that an anomaly may arise between one set of OH&S guidelines applying to staff of a premises, and a different set of guidelines applying to customers under the Bill.

4.3. Under the Occupational Health and Safety Act, employers have "a responsibility to eliminate all occupational health and safety hazards emanating from air contaminants (of which environmental tobacco smoke is one element)".[55]

4.4. The key principle in the Draft Code of Practice, as circulated in September 1993 which was made available to the Committee, is the introduction of smoke-free workplaces, in three steps:

- **Step 1:** immediate nomination of particular areas as non-smoking;
- **Step 2:** designation of work areas as non-smoking; and
- **Step 3:** signage to indicate the presence of a non-smoking area.[56]

4.5. An updated version of the Draft Code of Practice was made available by the Minister for Industrial Relations at the Committee's request.

4.6. The Committee notes that the key strategy for controlling exposure to passive smoking is the establishment of smoke-free areas, with the overall aim of banning smoking in the workplace.

4.7. An anomaly could arise, therefore, between the move towards establishing smoke-free work areas in places where smoking will not be prohibited, such as bars, taverns and nightclubs.

4.8. This was recognised by the Federated Liquor and Allied Industries Employees' Union (FLAIE), who stated:

> "The difficulty presents itself is that, in many industries, the distinction between a public place and a workplace is difficult, if not impossible to make. For this reason the existence of two separate proposed regulatory frameworks to deal with

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[55] *Draft Code of Practice for Passive Smoking in the Workplace*, Australian Capital Territory Occupational Health and Safety Council, 1993 p 8

[56] ibid., p 12

> essentially the same mater would be counterproductive, confusing, likely to lead to litigation and easy target for those who complain about 'over regulation'."[57]

4.9. The FLAIE pointed to the control strategies adopted by the Workcover Authority of NSW. Workcover states that

> "In order to reduce the exposure to environmental tobacco smoke in enclosed spaces, it is necessary to provide effective ventilation and filtration systems in the occupied area. The increased ventilation and filtration requirements of the 1991 issue of AS 1668, part 2 must be considered for existing buildings in order to aid in effectively controlling ETS."[58]

4.10. The Trades and Labour Council also advocates the adoption of AS 1668.2 in Workcover regulations as the **minimum requirement** for controlling exposure to ETS.[59]

4.11. The Committee considers that, where the Smoke-free Areas Bill prohibits smoking in enclosed public places, there will be no conflict between OH&S standards and the operation of the Bill.

4.12. The application of the OH&S passive smoking code to places where smoking will not be prohibited may result in some difficulties for employers in catering to smoking patrons and minimising staff exposure to ETS. Workcover NSW has utilised AS 1668.2 as a key mechanism for controlling exposure to ETS by employees in these situations.

4.13. The Committee considers that the ACT OH&S Council should consider the adoption of this standard as a **minimum requirement** to reduce exposure to ETS in the workplace. Further, in order to ensure that there is no conflict with the Smoke-free Areas Bill, section 5 of the legislation should be amended to include a further clause stating that, where smoking is permitted under the Bill, occupiers must still conform to minimum air quality standards set out in OH&S guidelines relating to smoking in the workplace.

*Recommendation 3*

**The Committee recommends that:**

- **the ACT Occupational Health and Safety Council adopt AS 1668.2-1991 as the minimum air quality standard requirement in work areas where smoking by persons other than employees is permitted; and**

- **Section 5 of the *Smoke-free Areas (Enclosed Public Places) Bill 1993* be amended to include the clause: "where smoking is permitted under the Bill, occupiers must still conform to minimum air quality standards set out in OH&S guidelines relating to smoking in the workplace."**

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[57]Federated Liquor and Allied Industries Employees' Union: Exhibit 7.62 pp 4-5
[58]ibid., Appendix 1 p 2
[59]Trades and Labour Council: Exhibit 7.86 p 2

# CHAPTER 5.

# ECONOMIC IMPACT OF SMOKE-FREE AREAS LEGISLATION

5.1. Tourism and the hospitality industry are major industries in the ACT, generating $584 million in 1993 and providing 9,400 jobs. 83% of tourists are from interstate (mainly Sydney and Melbourne). Overseas tourists are, however, are increasingly the focus of tourist attraction programs. An estimated 254,000 international tourists came to the ACT in 1992-93.[60]

5.2. In discussing the economic impact of the smoke-free areas Bill, Mr Martin Derkley, Director, ADS stated:

> "I believe we will find that there will be no overall economic impact either positive or negative in the short term related to tourism, economic activity and so forth."[61]

5.3. ADS cited a number of studies conducted in California indicating that there was little economic impact on the hospitality industry in areas where smoke-free legislation had been introduced.[62]

5.4. This view was not shared by the hospitality industry. The Australian Hotels Association (AHA) stated that:

> "We believe that a ban on smoking and the unrealistic imposition of certain conditions will threaten the viability of the majority of hotels, taverns, restaurants and licensed premises in the ACT. The flow on effects to employment and investment could be so great that it has the potential to permanently damage the tourism industry in the ACT."[63]

5.5. In support of this position the AHA pointed to the experience of licensed premises in airport terminals following the introduction of smoking bans:

> "research undertaken in consultation with the brewing industry, and independently audited, has established a dramatic and continuing fall-off in sales parallelling the introduction of those bans."[64]

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[60]Falvey, C: *They're capital attractions*, Australian Financial Review, 20 April 1994 p 40; ATIA: Submission 21 p 5

[61]Derkley, M, Director, ACT Alcohol and Drug Service: Transcript p 5

[62]See Submission 16 pp 10-11

[63]AHA: Submission 17 p 3

[64]Australian Hotels Association: Submission 17 p 9

5.6. The AHA also noted that the Californian experience has had "disastrous" economic consequences, although did not provide any information to support this statement.[65]

5.7. The AHA referred the Elephants Foot Hotel in Surrey Hills, Sydney. The licensee introduced a smoking ban, but within two months trade had declined by 25%, and the ban was lifted.[66]

5.8. In other evidence the Canberra Tradesmen's Union Club estimates that a smoking ban in its premises could cost the club between 30% and 50% of its total income - a figure of $4.5 to $6.5 million per year.[67]

5.9. In examining this evidence the Committee notes that the key concern is the potential impact of the Bill on licensed premises, which will be excluded from the operation of the legislation.

5.10. Smoking bans will extend to eating establishments. Evidence concerning the economic impact of smoking bans on restaurants is less clear. The President of the Restaurant and Catering Association of the ACT, Ms Fiona Wright, stated to the Committee that: "we cannot survive as an industry if we ban smoking in our restaurants".[68]

5.11. However, when asked specifically how the ban would impact on small restaurants, such as her own, Ms Wright replied that she "could not tell [the Committee]" as no work had been done to study the economics of small establishments, and model the impact of a smoking ban.[69]

5.12. Canberra ASH disputed the claim that restaurants would suffer financial disadvantage as a result of a smoking ban. Dr Shroot, President, Canberra ASH, claimed that restaurants may find business increasing as more non-smokers would be likely to patronise smoke-free establishments.[70]

5.13. Canberra ASH provided the Committee with a list of restaurants that have already adopted a smoke-free policy,[71] and stated that currently over 100 eateries are smoke-free, with many more providing both smoking and non-smoking areas.[72]These ranged from cafes and takeaways through to family and fine dining establishments.

5.14. The ACT Cancer Society provided the Committee with the findings of a study conducted in California to examine the impact of smoking bans on restaurants. The study, titled *The Impact of Tobacco Control Ordinances on Restaurant Revenues in California* conducted in January 1994, compared the economic performance of restaurants in cities with smoke-free ordinances against restaurants in nearby cities where smoking was permitted.

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[65]ibid.
[66]ibid.
[67]Canberra Tradesmen's Union Club: Exhibit 7.85 p 1
[68]Wright, F, President, Restaurant and Catering Association of the ACT: Transcript p 45
[69]ibid., pp 48-49
[70]Shroot, Dr A, President, Canberra ASH: Transcript p 71
[71]See Exhibit 3
[72]Shroot, Dr A, op cit., p76

5.15. The study found that:

> "[non-smoking] ordinances had no systematic impact on restaurant revenues, regardless of the percentage of no-smoking seating required. Surrounding cities without ordinance restrictions exhibited patterns of effects that were indistinguishable from those of ordinance cities ..."[73]

5.16. The Committee also received evidence that many licensed establishments other than restaurants are taking active steps either to provide smoke-free areas or reduce ETS levels. This is partially a response to OH&S requirements, but also a result of the desire of an increasing number of customers to use the facilities in a less smoky atmosphere.

## INTERNATIONAL TOURISM

5.17. The ATIA stated to the Committee that the introduction of smoking bans may have an impact of the perception of Canberra as a tourist friendly destination. The ATIA stated:

> "Australia (and the ACT) has targeted the ... expanding markets of Asia ... as countries offering tourism potential. ... Many of these Asian nations still have rates of smoking amongst the adult population in excess of 50%, and show little indications of pursuing the type of smoking policy currently endorsed in the ACT."[74]

5.18. The Committee reiterates the point made by the Government that the proposed legislation will exempt some premises from the Bill, reducing the potential negative message that could be sent to overseas tourists.

5.19. In examining this issue, the Committee concludes that there is not enough evidence to clearly predict the impact of the legislation on the hospitality industry, and Canberra's economy as a whole. While overseas evidence points to the apparent acceptance of smoking bans in restaurants in California, the findings of these studies would not necessarily apply to Canberra restaurants, and overseas and domestic tourists visiting the ACT.

5.20. The existence of a substantial number of smoke-free restaurants in Canberra does support the argument that there would be little adverse impact from the proposed legislation.

5.21. However, the fact that a majority of restaurants offer smoking areas indicates that most restaurateurs would prefer the option of providing a choice of smoking and non-smoking areas to customers.

5.22. The Committee, as stated in Chapter 1, accepts the objective of the Bill which is to reduce public exposure to ETS. The Committee therefore considers that, as a general

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[73]ACT Cancer Society: Exhibit 20 p 10
[74]ATIA: Submission 21 p 5

principle, restaurants and other eating establishments should be included as enclosed public places for the purposes of the Bill.

5.23. Owners of restaurants may wish to provide a choice of smoking and non-smoking areas. The Committee therefore considers that the Smoke-free Areas (Enclosed Public Places) Bill be amended to incorporate a Certificate of Exemption for occupiers of premises to allow smoking under certain conditions.

5.24. The Certificate, however, should not allow for smoking throughout a premises. The choice should be offered in such a way as to minimise the exposure non-smoking customers to ETS and not contravene OH&S guidelines in relation to passive smoking.

5.25. The Committee therefore considers that restrictions on smoking in restaurants should be introduced in two stages:

Stage 1: Following the enactment of the smoke-free areas legislation, a minimum of 50% of a restaurant should become smoke free; and

Stage 2: 12 months after the introduction of the legislation, restaurateurs may choose either to become entirely smoke free, or apply for a Certificate of Exemption.

5.26. The Certificate should only allow for smoking to be permitted within a limited area of the premises, and at least 75% of the premises should remain smoke-free and meet the ventilation requirements of AS 1668.2-1991.

5.27. As stated in Chapter 3 AS 1668.2-1991 provides a basic minimum standard for air quality in areas where smoking occurs. The Certificate of Exemption should, therefore, be based on this standard.

5.28. Under the Certificate of Exemption Scheme, the ADS would establish and administer a Register of Exempted Premises. The ADS would have the power to issue and revoke Certificates of Exemption, and enforce compliance with the requirements of the Certificate.

5.29. In order to qualify for a Certificate of Exemption:

- premises must have ventilation and filtration equipment capable of providing clean air to the standard proscribed in AS 1668.2-1991;
- occupiers regularly maintain this equipment; and
- occupiers agree to regular inspections of ventilation and filtration equipment and periodic inspection of air quality by inspectors appointed under the legislation.

5.30. Holders of Certificates should be charged a fee to cover the administration costs of the scheme. Penalties for not adhering to the conditions of the scheme should be the same as those applying to occupiers under Section 9 of the legislation. This fee should not exceed cost recovery.

5.31. Where a decision made by the ACT Alcohol and Drug Service relating to the issue of a Certificate, or breach of the conditions of the Certificate, is disputed the claimant may appeal to the Administrative Appeals Tribunal.

*Recommendation 4*

**The Committee recommends that restrictions on smoking in restaurants should be introduced in two stages:**

**Stage 1: Following the enactment of the smoke-free areas legislation, a minimum of 50% of a restaurant should become smoke free; and**

**Stage 2: 12 months after the introduction of the legislation, restaurateurs may choose either to become entirely smoke free, or apply for a Certificate of Exemption.**

**The Certificate should require at least 75% of the premises to remain smoke-free and meet the ventilation requirements of AS 1668.2-1991.**

5.32. The Committee further considers that the Certificate of Exemption scheme, if adopted, should be extended to include all enclosed public places, including all premises holding a liquor licence: e.g. clubs, the Canberra Casino and areas in enclosed public places used for meetings and private functions. The Certificate should require a minimum of 50% of these premises to remain smoke free and meet the ventilation requirements of AS 1668.2-1991.

5.33. The Committee considers that such as extension should take place within 30 months of the enactment of the legislation.

*Recommendation 5*

**The Committee recommends that the amended *Smoke-free Areas (Enclosed Public Places) Bill* immediately apply to:**

- **enclosed shopping malls;**
- **schools and educational facilities;**
- **health care facilities;**
- **retail shops and all business premises where goods and services are sold or delivered;**
- **taxis, buses and other means of public transport, together with substantially enclosed ticketing, boarding and waiting areas;**
- **indoor sports and recreation facilities;**
- **exhibitions, displays and meeting areas;**
- **facilities used for exhibiting motion pictures, stage, drama, lecture, musical recital and other performances;**
- **parts of private residences when used for registered commercial child care;**
- **indoor service queues, counters, waiting areas, foyers, hallways, rest rooms and toilets;**

- lobbies, hallways, stairs, lifts, dining areas and other common areas of multi-unit residential and commercial facilities; and
- places which are a venue primarily for people under the age of 18.

No Certificates of Exemptions should be granted for these areas. They are to be smoke free.

*Recommendation 6*

The amended *Smoke-free Areas (Enclosed Public Places) Bill* be extended to cover the following enclosed public places within 30 months of its enactment:

- bars, taverns, hotels, licensed clubs, the Canberra Casino and similar places where the primary business is other than the sale of food to be consumed on the premises; and
- separately enclosed areas of hotels, restaurants, clubs and similar premises when used exclusively for meetings and private functions where seating is under the control of a sponsor, not the occupier, and attendance is by invitation.

Certificate of Exemptions should require a minimum of 50% of these premises to remain smoke free and meet the ventilation requirements of AS 1668.2-1991.

*Recommendation 7*

The Committee recommends that:

- an occupier of a premises who wishes to provide a smoking area may apply for a Certificate of Exemption from the Act;
- in order to qualify for a Certificate of Exemption the smoking area must be fitted with air cleaning equipment that will maintain air quality as stipulated in AS 1668.2-1991, and the occupier must agree to regular check of this equipment and monitoring of air quality by inspectors appointed under the Act to ensure that air cleaning equipment is operating efficiently and air quality is maintained;
- the Certificate should only allow for smoking to be permitted within a limited area of the premises;
- the premises granted an exemption be placed on a Register of Exempted Premises, administered by ACT Alcohol and Drug Service;
- the Certificate of Exemption will be provided for a fee, sufficient to cover administration costs. This fee should not exceed cost recovery;
- where a decision made by the ACT Alcohol and Drug Service is disputed, the claimant may appeal to the Administrative Appeals Tribunal; and

- **failure to comply with the conditions of the Certificate of Exemption be punishable by revocation of the Certificate and a fine of $1000 in the case of an individual, and $5000 in the case of a body corporate.**

5.34. The Committee recognises that smaller eating houses may not be able to install air cleaning equipment sufficient to meet the requirements of AS 1668.2-1991. The Committee considers that owners of these premises may not be in a position to ensure that non-smoking customers will not be affected by exposure to ETS. In such cases, smoking should not be allowed.

# CHAPTER 6.

# CIVIL LIBERTIES

6.1. A key issue raised in a number of submissions concerned smokers vs non-smokers rights. The opposing views on this issue were best expressed by the AHA and the Australian Medical Association (AMA). The AHA stated that:

> "The underlying issue is freedom of choice. The people of the ACT should be allowed to make their own decisions as to whether they patronise smoking or non-smoking establishments."[75]

6.2. The AMA took the view that:

> "the general public (the vast majority of whom are non-smokers) should have the right to enter public places without the risk or unpleasantness of environmental tobacco smoke generated by the few who smoke."[76]

6.3. The central issue, therefore, becomes one of the extent to which the wishes of the majority override the those of the individual. This decision has already been made in relation to smoking in a number of areas, such as public service workplaces, food preparation areas, airport terminals, public transport etc.

6.4. The City of Albany stated, in relation to this issue that: "the health problems created for non-smokers were more severe than the restriction on civil liberties of smokers to smoke where they pleased without considering how they affected those nearby."[77]

6.5. The ADS considers that the response of smokers to initiatives to curb active smoking and exposure to ETS is to take a more responsible attitude to smoking in public places. Further, smokers are willing to comply with the restrictions on smoking:

> "I think that smokers generally are responsible people who would like to have clear guidelines about where they should smoke and where they should not and do not like the idea that their habits would affect the health of other people."[78]

6.6. The willingness of smokers to comply with restrictions on their activities is also based on changing community attitudes towards where smoking should and should not occur. The ADS referred to a recent study which showed that most people supported, or were neutral

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[75]AHA: Submission 17 p 3
[76]AMA: Submission 22 p 1
[77]ACT Cancer Society: Exhibit 20 p 11
[78]Derkley, M, Director, ACT Alcohol and Drug Service: Transcript p 15

towards, a ban on smoking in shops and restaurants, but did not support smoking bans in pubs and clubs.[79]

6.7. The Committee also notes a separate study which has shown that a majority of non-smokers, and a substantial percentage of smokers, did not like exposure to ETS. The study, reported in the Canberra Times, found that:

> "85% of people who never smoked were bothered slightly or a lot by other people's smoke, compared to 55% of ex-smokers and 38% of smokers."[80]

6.8. In examining this issue the Committee considers that the point should be made that cigarettes are a legally available drug to adults over 18 years of age. The Bill seeks to restrict the number of areas where the drug can legally be consumed, rather than proposing an outright ban.

6.9. The Committee considers that, while cigarettes are legally available, they should be able to be legally consumed in public and private. This is also recognised by the ADS in exempting certain places from smoking bans imposed under the Bill.

6.10. The Committee acknowledges that community attitudes towards smoking have changed from a general approval of smoking to that of approval of smoking in locations where non-smokers will not be affected by this activity, or where a non-smoker has exercised a choice to enter such a location.

6.11. The Committee therefore considers that the Bill acts a mechanism to clarify the civic responsibilities of smokers in such a way that will have the support of the non-smoking population.

Michael Moore

Michael Moore, MLA
Chair

19 May 1994

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[79]ACT Alcohol and Drug Service: Submission 16 p 4
[80]*Fumes get up smokers' noses, too*: Canberra Times, 2 May 1994 p 3

## Standing Committee on Conservation, Heritage and Environment

## Enquiry into *Smoke-free Areas (Enclosed Public Places) Bill 1993*

## Dissenting comments from Ms Annette Ellis, MLA

**Introduction**

The intention of the *Smoke-free Areas (Enclosed Public Places) Bill 1993* is to extend guarantees of protection to members of the community from involuntary exposure to environmental tobacco smoke (ETS). ETS has been recognised as a health risk since at least the mid-1980s, and information has been mounting since that time about the extent and nature of this risk. It is not about if people smoke, it is about where people smoke.

Following the US Environmental Protection Agency Report of 1993 confirming ETS as a Class A carcinogen, numerous businesses in North America have responded by eliminating smoking from their premises, and many communities are enacting legislation which designates indoor environments in public places as smoke-free. Even prior to this time, numerous overseas jurisdictions had enacted various forms of smoke-free environments legislation.

Two members of the Committee met recently with a range of officials in New Zealand, where a system similar to that proposed by the committee is in place. They reported considerable dissatisfaction among proprietors, customers and public health authorities. Their comments urged the ACT not to go down this track, but to enact legislation which is simple, fair and effective, rather than unwieldy, complex, confusing, confrontational, and fails to provide public health protection. In fact they were envious of the opportunity the ACT has to start off with a simple and equitable system.

My concerns therefore focus on the effect that some of the Committee's recommendations would have on actually extending a reasonable degree of protection from ETS, and the effect that others would have by committing the Government to forcing certain changes, within an inappropriate or questionable timeframe, in places where other strategies, such as occupational health and safety, should be particularly relevant.

**Public Health**

While studies may be on-going concerning the precise extent and nature of the ill effects of ETS, what we know now is sufficient to warrant the adoption of measures designed to protect people from ETS - a toxic substance which can be eliminated from a wide range of indoor environments without great cost or difficulty.

**Exemptions**

I do not accept that there are sufficient grounds for exempting individual premises which would otherwise be covered by the legislation. The rationale for the legislation is the creation, insofar as possible, of a level playing field. The Government has also indicated that it intends that smoking would not be prohibited in places, or parts of places, where the primary business is gaming or the consumption of alcohol (subject to prescribed conditions). This is not only reasonable, providing the necessary flexibility within the social environment, but also acknowledges that certain patterns of smoking behaviour will be more difficult to change.

The result of the Committee's recommendation that individual exemptions be granted based on the capacity of the business to meet an air conditioning standard, would be destructive and confrontational. In addition, there would be serious implications for social equity, given that smoking would be permitted only in financially well-off places which could afford to buy the exemption. Only people who could afford to go to these (up-market) places could smoke.

The need for exemptions is eliminated by the Government's proposal to not prohibit smoking in night-clubs, bars, gaming areas and in bar areas of bistros. I would prefer to see this given a chance to work, with co-operation from businesses, industry groups and occupational health and safety authorities.

**Use of AS1668.2**

I disagree with the Committee's application of AS1668.2, which relates to ventilation requirements. I do not accept that the Committee has been provided with sufficient evidence for it to conclude that this Standard was intended for, or can be reasonably used for, the public health regulation of ETS exposure in indoor environments.

Use of the standard will reduce the exposure to ETS, but not to safe levels - particularly where the US Environmental Protection Agency has clearly defined a number of the constituents of ETS as class A carcinogens, where a zero level of exposure is the safe level.

The Standard relates only to mechanically ventilated buildings; many buildings in the ACT do not fall into this category. In addition, many restaurants conduct business in premises owned or controlled by someone other than the restaurateur. This makes it impractical, if not impossible, in many instances, for alterations to air conditioning and ventilation systems to be carried out. We should also note the smaller establishments where installation of appropriate equipment may not be physically possible. In any case, the use of air conditioning and ventilation systems to minimise or remove an airborne substance implies:

- that the accepted hierarchy of control has been gone through, whereby engineering controls are used only after eliminating the pollutant at the source, before it enters the environment, has been attempted;

- the imposition of significant financial burden on businesses, with no guarantees in terms of achieving the desired health outcome;

- that a relevant standard exists against which to measure ETS.

While I accept the use of AS1668.2 as a reasonable standard for ventilation for all mechanically ventilated buildings, I also conclude, from evidence presented to the Committee, that it would be inappropriate to rely on AS1668.2 as a health-based standard with reference to ETS. We heard evidence to the effect that the Standard is a design standard primarily set by results from experiments relating to odour, or comfort. I do not believe that convincing evidence has been presented to indicate that the Standard is intended to minimise the risk of disease from specific airborne irritants and carcinogens such as are present in ETS. I therefore conclude that the specific application of AS 1668.2 to the control of ETS exposure would constitute a misuse of the Standard and would create unnecessary inequities.

**Extension of Smoking Restrictions to Other Premises**

I do not support the Committee's recommendation that, within 30 months of gazettal of the legislation, smoking prohibitions should be extended to areas set aside for gaming and the consumption of alcohol. This would be an unwise and unwarranted commitment which fails to take into account the need to work with businesses in these sectors to create more fertile ground for changes to occur. It also fails to acknowledge the role of occupational health and safety measures in these establishments, a role which is likely to be strengthened following the introduction of the proposed code of practice for workplaces.

While I recognise that a harm minimisation approach to ETS exposure in these premises will not result in the immediate elimination of the dangers to health, I am convinced that locking the Government into an inappropriate or questionable timeframe will result in smoke-free environments not receiving the strong level of support which currently exists for other types of enclosed public places, including restaurants.

Harm minimisation is an important aspect of protecting people who use alcohol, tobacco and other drugs from additional harm which may be imposed upon them through unsafe drug usage or inappropriate social reactions and controls. When harm results to others from alcohol, tobacco or other drug usage, the community must set higher standards, as it has done in other public health legislation and as it is attempting to do in the creating of smoke free public environments. One hundred years ago, spitting remnants of chewing tobacco was acceptable practice. Spittoons were to be seen in public places. When spitting was identified as a public health hazard following the post World War I influenza outbreak, spitting was banned.

I am of the view that the Assembly has lost a great opportunity. As AMA Federal President, Brendan Nelson, said "the ACT is in a position to lead Australia with landmark public health legislation...smokers can choose not to smoke but non smokers can't give up breathing...The whole Assembly now needs to back this sensible, practical and crucial public health measure."

In conclusion, some have regarded the smoke-free environments proposal as an attack on people who smoke. It is not. It is a question not of if you smoke but where you smoke.

ANNETTE ELLIS, MLA
18 May, 1994

# APPENDIX I
# CONDUCT OF THE INQUIRY

The *Smoke-free (Enclosed Public Places) Bill* was introduced into the Legislative Assembly on 23 February 1993 and referred to the Standing Committee on Conservation, Heritage and Environment for inquiry and report by 21 April 1994.

The Committee advertised the inquiry on 26 February 1994, and sought submissions directly from relevant Government Ministers, medical organisations and representatives from the hospitality industry.

The Committee has received 26 submissions (not including supplementary submissions) which are listed at Appendix III. In addition, the ACT Alcohol and Drug Service made available to the Committee submissions received in response to the discussion paper on the proposed legislation, released by the Minister for Health in October 1993.

The Committee also received 20 exhibits, and these are listed at Appendix IV.

The Committee held a public hearing in the Legislative Assembly on 6 April 1994. Evidence was received from the ACT Government, representatives from medical organisations, including the Australian Medical Association, the ACT Cancer Council and the National Heart Foundation; the hospitality industry, including the Licensed Clubs Association, the Restaurant and Caterers Association of the ACT and the Australian Tourism Industry Association; and Canberra ASH. The Committee was also briefed by the Australian Hotels Association. The witnesses who appeared before the Committee are listed at Appendix II.

The Committee Chair and Ms Ellis met with New Zealand Department of Health officials in Wellington and discussed the operation of the Government of New Zealand's *Smoke-free Environments Act 1990.*

The Committee commenced the process of review of the evidence, and concluded that it could not discharge its reference by 21 April 1994. The Committee sought and was granted an extension of its reporting date until 19 May 1994.

# APPENDIX II
# LIST OF HEARINGS AND WITNESSES

**Canberra, 6 April 1994**

ACT Department of Health Alcohol and Drug Service
Mr Martin Dirkley, Director
Mr Clive Broadbent, Engineering Consultant

Private Citizen
Mr Paul Spry

Licensed Clubs Association
Mr Alan Ray, President
Mr Peter Russell, Executive Director

Restaurant and Catering Association of the ACT
Ms Fiona Wright, President

Australian Tourism Industry Association
Mr Keith Young, President
Mr Steven Holle, Executive Director, Canberra Region Chapter

ACT Cancer Society
Mr Geoff Bowcock, Executive Director

Canberra ASH
Dr Alan Shroot, President

Australian Medical Association
Mr Mark Hurwitz, President
Dr Robert Allan, Immediate Past President

ACT Division of General Practitioners
Dr Brian Richards, Executive Director

National Heart Foundation
Dr Paul Magnus, Medical Director
Mr A James Morris, Executive Director, ACT Division

# APPENDIX III
# LIST OF SUBMISSIONS

| Submission No. | Date | Person or Organisation |
|---|---|---|
| 1. | Undated | Identical letters signed by employees of Telopea Park Motel, Waffles, The Private Bin and The Brassey Hotel |
| 2. | Undated | Mr Peter Russell<br>Licensed Clubs Association of the ACT Inc |
| 3. | 7 March 1994 | Ms Christine James |
| 4. | 9 March 1994 | Mrs Phyllis Montgomerie<br>Council On The Ageing (ACT) |
| 5. | 3 March 1994 | Dr Howard Peak OAM<br>The ACT Cardiovascular Health Council |
| 6. | 11 February 1994 | Mr A James Morris<br>National Heart Foundation of Australia (ACT Division) |
| 7. | 10 March 1994 | Mr M Costigan<br>Tobacco Interagency Committee ACT |
| 8. | 12 March 1994 | Ms Kay Hann |
| 9. | 16 March 1994 | The Hon Wayne Berry, MLA<br>Minister for Health and Minister for Sport |
| 10. | 11 March 1994 | Mr A James Morris<br>National Heart Foundation of Australia (ACT Division) |
| 11. | 14 March 1994 | Dr Brian Richards<br>ACT Division of General Practitioners |
| 12. | 14 March 1994 | Ms Leesa Croke<br>Health Advancement Services |
| 13. | 14 March 1994 | Ms Geraldine Spencer<br>Canberra ASH |

| | | |
|---|---|---|
| 14. | 15 March 1994 | Ms Fiona Wright<br>Restaurant and Catering Association of ACT |
| 15. | 10 March 1994 | Mr Geoff Bowcock<br>ACT Cancer Society |
| 16. | 16 March 1994 | Mr Martin Dirkley<br>ACT Health Alcohol and Drug Service |
| 16.1 | 17 March 1994 | Supplementary to Submission 16 |
| 16.2 | Undated | Supplementary to Submission 16 |
| 16.3 | Undated | Supplementary to Submission 16 |
| 17. | 21 March 1994 | Mr Gregory Weller<br>Australian Hotels Association |
| 18. | 11 March 1994 | Mr J Reavall |
| 19. | 9 March 1994 | Ms V Holland |
| 20. | 23 March 1994 | Mr John Miller<br>Canberra Visitor Attractions Association |
| 21. | 23 March 1994 | Mr John Milton<br>Australian Tourism Industry Association |
| 22. | 22 March 1994 | Dr Mark Hurwitz<br>Australian Medical Association |
| 23. | 23 March 1994 | Mr David Lewis |
| 24. | Undated | Residents,<br>Sundown Motor Village |
| 25. | Undated | Mr Paul Spry |
| 26. | 11 April 1994 | Mr Ken Collins<br>BESCA Engineers |

# APPENDIX IV
# LIST OF EXHIBITS

| Exhibit No. | Title/Document |
|---|---|
| 1. | Attachment to Submission No. 13 - *Ashes to Dust*, Newsletter of Canberra ASH Incorporated, Vol 10(4), November 1993 |
| 2. | Attachment to Submission No. 13 - *Ashes to Dust*, Newsletter of Canberra ASH Incorporated, Vol 9(4), November 1992 |
| 3. | Attachment to Submission No. 13 - *Smokefree eateries in Canberra*, dated 14 March 1994 |
| 4. | Attachment to Submission No. 13 - letter from Dr Alan Shroot, President, Canberra ASH Incorporated to Mr Wayne Berry, MLA, Minister for Health, Industrial Relations and Sport dated 3 February 1993 |
| 5. | Letter from Mr Paul Lopez, Centre Manager, Westfield Shopping Centre Management Co (ACT) Pty Ltd to T Henderson, dated 1 March 1994 |
| 6. | Copy of Capital Regional District, Victoria, British Columbia, Canada, By Laws relating to prevention of involuntary exposure to tobacco smoke, dated 8 March 1994 |
| 7. | Submissions received by the ACT Department of Health in response to the discussion paper "Legislative proposals for Smoke-free Enclosed Public Places in the ACT" |
| 8. | Brochures provided by Mr Bob Tacy for MINIRAM ( Miniature Real-Time Aerosol Monitor) |
| 9. | *The Human Equation: Health and Comfort*, Extract of proceedings of the ASHRAE/SOEH Conference IAQ 89, April 17-20, 1989, San Diego, California |
| 10. | Document titled *Do you have air quality complaints*, undated |
| 11. | Copies of overhead transparencies provided by Mr Clive Broadbent at the public hearing on 6 April 1994 |
| 12. | Speaking notes used by Mr Martin Dirkley at the public hearing on 6 April 1994 |

13. Document titled *Estimation of Environmental Tobacco Smoke Exposure*, undated

14. Letter from Mr Geoff Bowcock, Executive Officer, ACT Cancer Society to The Secretary, Standing Committee on Conservation, Heritage and Environment, Legislative Assembly for the ACT, dated 10 March 1994

15. Speaking notes used by Mr Geoff Bowcock at the public hearing on 6 April 1994

16. Press articles and other documents provided by Mr John Reavell, dated 30 March 1994

17. Press articles and other documents provided by Mr John Reavell, dated 5 April 1994

18. Letter from Mr Joe Robertson, Managing Director, Healthy Buildings International Pty Ltd to Ms Kate Carnell, Leader of the Opposition, Legislative Assembly of the ACT, dated 5 April 1994

19. *Ethical Considerations relating to health care resource allocation decisions: Report of the Australian Health Ethics Committee*, National Health and Medical Research Council, November 1993

20. Maroney, N, Sherwood, D, Stubblebine, W: *The Impact of Tobacco Control Ordinances on Restaurant Revenues in California*, The Clairmont Institute for Economic Policy Studies, The Clairmont Graduate School, January 1994 and related documents

21. West, T: *Revised Australian Standard AS 1668 pt 2, Mechanical ventilation of acceptable indoor air quality*, undated

# APPENDIX V
# SMOKE FREE AREAS (ENCLOSED PUBLIC PLACES) BILL 1993

1993

THE LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

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(As presented)

(Minister for Health)

# Smoke-free Areas (Enclosed Public Places) Bill 1993

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## A BILL

FOR

**An Act to prohibit or restrict tobacco smoking in certain enclosed public places, and for related purposes**

The Legislative Assembly for the Australian Capital Territory enacts as follows:

**Short title**

**1.** This Act may be cited as the *Smoke-free Areas (Enclosed Public Places) Act 1993*.

**Commencement**

**2.** (1) Sections 1, 2, 3 and 4 commence on the day on which this Act is notified in the *Gazette*.

(2) The remaining provisions commence on a day, or respective days, fixed by the Minister by notice in the *Gazette*.

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83100 1993/189 (T100/93)

(3) If a provision referred to in subsection (2) has not commenced before the end of the period of 6 months commencing on the day on which this Act is notified in the *Gazette*, that provision, by force of this subsection, commences on the first day after the end of that period.

**Interpretation**

3. In this Act, unless the contrary intention appears—

"enclosed", in relation to a public place, means a public place that has a floor and a ceiling or roof and is, except for doors and passageways, completely or substantially enclosed by walls or windows;

"occupier", in relation to an enclosed public place, means a person having the management or control, or otherwise being in charge, of that place;

"public place" means a place which the public, or a section of the public, is entitled to use or which is open to, or used by, the public or a section of the public (whether on payment of money, by virtue of membership of a body, or otherwise);

"smoke" means smoke, hold, or otherwise have control over, an ignited tobacco product;

"tobacco product" means a cigarette, cigar or any other product a substantial ingredient of which is tobacco.

**Object of Act**

4. The object of this Act is to promote public health by reducing exposure to environmental tobacco smoke.

**Declarations**

5. (1) The Minister may, by notice published in the *Gazette*, declare that smoking in a specified enclosed public place, or in a specified part of such a place, is prohibited—

(a) absolutely;

(b) at specified times or in specified circumstances; or

(c) except in accordance with specified or prescribed conditions.

(2) A notice under subsection (1) may be expressed to take effect on and from a specified date.

(3) A notice under subsection (1) is a disallowable instrument for the purposes of section 10 of the *Subordinate Laws Act 1989*.

**Inspectors**

**6.** (1) The Minister may, by instrument, appoint persons to be inspectors for the purposes of this Act.

(2) An inspector shall perform such duties as the Minister directs for the purpose of promoting compliance with this Act and the regulations.

(3) The Minister shall issue to each inspector an identity card that specifies the name and appointment of the inspector and on which appears a recent photograph of the inspector.

(4) A former inspector shall not, without reasonable excuse, fail to return his or her identity card to the Minister.

Penalty for contravention of subsection (4): $100.

**Powers of inspectors**

**7.** (1) Subject to subsections (2) and (3), an inspector has power to do all things necessary or convenient to be done in the performance of his or her duties.

(2) For the purpose of performing his or her duties, an inspector may at all reasonable times enter an enclosed public place that he or she is not, but for this subsection, entitled to enter.

(3) An inspector who enters an enclosed public place pursuant to subsection (2) is not entitled to remain in that place if, on request by the occupier of that place, the inspector does not produce his or her identity card.

(4) Where an inspector has reason to believe that a person is committing or has committed an offence against this Act or the regulations, he or she may, on producing his or her identity card—

(a) if the person is contravening section 8—direct the person to cease the contravention; and

(b) require the person to furnish his or her name and usual address.

**Offence by smoker**

**8.** (1) A person shall not smoke in an enclosed public place or a part of such a place—

(a) if smoking in that place or part is prohibited by a declaration under paragraph 5 (1) (a);

(b) at a time when, or in circumstances in which, smoking in that place or part is prohibited by a declaration under paragraph 5 (1) (b); or

(c) otherwise than in accordance with conditions applicable to that place or part by virtue of a declaration under paragraph 5 (1) (c).

(2) A person who is contravening subsection (1) shall not, without reasonable excuse, fail to comply with a direction by—

(a) an inspector; or

(b) an occupier of the enclosed public place, or the part of such a place, where the contravention is occurring or an employee or agent of such an occupier;

to cease the contravention.

Penalty: $500.

**Offence by occupier**

**9.** (1) If a person contravenes subsection 8 (1), an occupier of the enclosed public place, or the part of such a place, where the contravention occurred is guilty of an offence punishable on conviction by a fine not exceeding—

(a) in the case of a natural person—$1,000; or

(b) in the case of a body corporate—$5,000.

(2) It is a defence to a prosecution under subsection (1) if the defendant establishes that he or she—

(a) was not aware, and could not reasonably be expected to have been aware, that the contravention was occurring; or

(b) took reasonable steps to avoid the contravention or a continuation of the contravention.

(3) An occupier of an enclosed public place in respect of which a declaration under subsection 5 (1) is in force shall not, without reasonable excuse, fail to display, in the prescribed manner (if any), the prescribed signs within that place.

Penalty:

(a) if the offender is a natural person—$500;

(b) if the offender is a body corporate—$2,500.

**Obstruction**

**10.** A person shall not, without reasonable excuse—

(a) fail to comply with a requirement under paragraph 7 (4) (b); or

(b) hinder or obstruct an inspector in the exercise of his or her powers, or the performance of his or her duties, under this Act or the regulations.

Penalty:

(a) for a contravention of paragraph (a)—$500;

(b) for a contravention of paragraph (b)—$5,000 or imprisonment for 6 months, or both.

**No right to smoke**

**11.** Nothing in this Act shall be construed as creating or preserving the right of a person to smoke in an enclosed public place.

**Regulations**

**12. (1)** The Executive may make regulations, not inconsistent with this Act, prescribing matters—

(a) required or permitted by this Act to be prescribed; or

(b) necessary or convenient to be prescribed for carrying out or giving effect to this Act.

(2) Without limiting the generality of subsection (1), the regulations may make provision for—

(a) the displaying of signs within enclosed public places relating to smoking;

(b) the content, dimensions and location of those signs;

(c) the requirements to be observed by occupiers of enclosed public places to facilitate compliance with this Act and the regulations; and

(d) penalties, not exceeding a fine of $500 in the case of a natural person and $2,500 in the case of a body corporate, for offences against the regulations.

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