See AO 2006-86(S)

Submitted by: Assemblymembers TRAINI, COFFEY, JENNINGS, SHAMBERG, STOUT, TESCHE
Prepared by: Assembly Counsel
For reading: May 23, 2006

ANCHORAGE, ALASKA
AO NO. 2006–86

AN ORDINANCE OF THE ANCHORAGE MUNICIPAL ASSEMBLY REPEALING AND REENACTING ANCHORAGE MUNICIPAL CODE CHAPTER 16.65, PROHIBITION OF SMOKING IN PUBLIC PLACES, TO EXTEND SECONDHAND SMOKE CONTROL.

WHEREAS, by Anchorage Ordinance 2000-91(S), effective December 31, 2000, the Anchorage Assembly enacted AMC 16.65, prohibiting smoking in certain public places; and

WHEREAS, since passage of AMC 16.65 in 2000, the harmful effects of secondhand smoke have become more widely known, substantiated, and appreciated, calling for further preventive action;

THE ANCHORAGE ASSEMBLY ORDAINS:

Section 1. Anchorage Municipal Code Chapter 16.65, Smoking in Public Places, is hereby repealed and reenacted as follows, and as required under AMC § 1.05.050B, the existing text of AMC Chapter 16.65 is appended.

16.65.001 Title and Purpose.

A. This chapter shall be known as "The Secondhand Smoke Control Ordinance".

B. The purposes of this chapter are to:

1. Protect the public health, safety and general welfare by eliminating exposure to secondhand smoke in public places, places of employment, and places where child care is offered.

2. Acknowledge the need of nonsmokers, especially children, to breathe smoke-free air, recognizing the danger to public health which secondhand smoke causes.

3. Recognize that the need to breathe air free of the disease-causing toxins in secondhand smoke should have priority over the desire and

convenience of smoking in public places, places of employment and childcare.

4. Recognize the right and benefit to municipal residents and visitors to be free from unwelcome secondhand smoke in public places and places of employment.

16.65.005 Definitions.

In this Chapter:

Business means any natural person or legal entity (such as, without limitation, a business-for-profit corporation, nonprofit corporation, partnership, limited liability company or trust) that undertakes to provide goods or services to the public or to persons who are members of a private group that is eligible to obtain the goods or services, regardless of whether the business exists or is conducted for the purpose of making a profit.

Employee means any person who is employed by any business for compensation or works for a business as a volunteer without compensation.

Enclosed area means all interior space within a building or other facility between a floor and a ceiling that is enclosed on all sides by walls, windows, or doors extending from the floor to the ceiling.

Place of employment means any area, under the control of any employer, that employees may frequent during the course of employment, including, but not limited to, work areas, employee lounges, restrooms, conference rooms, classrooms, cafeterias, hallways, and vehicles.

Private club means an organization (whether a legal entity or an informal association of persons) that is the owner, lessee, or occupant of a building or portion thereof used exclusively for club purposes at all times, which is operated solely for a recreational, fraternal, social, patriotic, political, benevolent, or athletic purpose, but not for pecuniary gain, and has been granted an exemption from the payment of federal income tax as a club under 26 U.S.C. Section 501.

Public place means any enclosed area to which the public is invited or into which the public is permitted, including but not limited to, educational facilities, entertainment, food and beverage service, offices, retail stores, and transportation facilities and vehicles accessible to the general public.

Smoking means inhaling, exhaling, burning or carrying any lighted tobacco product.

Sports arena means any sports pavilion, gymnasium, health spa, boxing arena, swimming pool, roller and ice rink, bowling alley and other similar place where members of the general public assemble either to engage in physical activity, participate in athletic competition, or witness sports events.

16.65.010 Prohibition of smoking.

A. Smoking is prohibited at the following places:

1. All enclosed public places within the Municipality of Anchorage, including, but not limited to, all businesses visited by the public, transportation facilities, waiting areas of public transit depots, buses, taxicabs, sports arenas, and other enclosed areas open to the public.

2. All enclosed areas that are places of employment.

3. All enclosed areas on properties owned or controlled by the Municipality of Anchorage, including the Anchorage School District, and including every room, chamber, place of meeting or public assembly under the control of any municipal board, council, commission, committee, or municipal authority.

4. All areas within 50 feet of each entrance to enclosed areas on properties owned or controlled by the Municipality of Anchorage including the Anchorage School District, and including every room, chamber, place of meeting or public assembly under the control of any municipal board, council, commission, committee, or municipal authority.

5. All areas within 50 feet of each entrance to a hospital or medical clinic.

6. All premises offering child care by person(s) other than the child's parent.

7. Outdoor seating areas of arenas, stadiums, and amphitheaters.

B. Smoking is prohibited on any property not listed in subsection A of this section, with or without enclosure, if the owner, operator, manager, or other person having control of the property chooses to prohibit smoking.

16.65.020 Reasonable distance.

To ensure that smoke does not enter any enclosed area where smoking is prohibited through entrances, windows, ventilation systems or any other means, smoking shall occur only at a reasonable distance outside any enclosed public place or place of employment where smoking is prohibited. Unless otherwise stated under this chapter, or increased by the owner, operator, manager, or other person having control of the property, the minimum reasonable distance is 20 feet.

16.65.030 Exceptions; areas where smoking is not prohibited.

A. Smoking is not prohibited in the following places:

1. A maximum of twenty-five percent of hotel and motel sleeping rooms rented to guests designated as smoking rooms if the hotel or motel designates at least 75% of its guest rooms as permanently nonsmoking.

2. Private clubs that are not places of employment, when not being used for a purpose, event, or function to which the general public is invited.

3. Outdoor areas of places of employment except the outdoor areas identified under AMC 16.65.010.

4. Private residences, unless child care is offered on the premises by person(s) other than the child's parent.

B. Nothing in this chapter shall be construed or interpreted to provide any person a right to smoke on premises or property owned, leased or under the legal control of another.

16.65.040 Obligations of property owners and employers.

A. "No Smoking" signs or the international "No Smoking" symbol (consisting of a pictorial representation of a burning cigarette enclosed in a red circle with a red bar across it) shall be clearly, sufficiently, and conspicuously posted by the owner, operator, manager, or other person having control of a building or other area where smoking is prohibited by this chapter.

B. Every public building owned or controlled by the Municipality of Anchorage

shall have posted at every entrance a conspicuous sign clearly stating that smoking is prohibited within 50 feet of the entrance to the building and within the building.

C. Every hospital and health care facility to which this chapter applies shall have posted at every entrance a conspicuous sign clearly stating that smoking is prohibited within 50 feet of the entrance to the building and within the building.

D. All ashtrays and other smoking paraphernalia shall be removed by the building owner, operator, manager, or other person having control of a building or other area where smoking is prohibited by this chapter.

E. It shall be the responsibility of employers to provide a smoke-free workplace, and neither an employer nor person having legal control of the premises may permit an employee, customer, or other person to smoke inside enclosed areas that are places of employment.

F. Each employer within the Municipality of Anchorage shall adopt, implement and maintain a written smoke-free policy by which smoking shall be prohibited within enclosed areas at places of employment. The smoke-free policy required by this subsection shall be communicated to all existing employees and to all prospective employees upon their application for employment.

16.65.050 Violations and penalties.

A. It shall be unlawful for any person to smoke in any area where smoking is prohibited and for any person who owns, manages, operates, or otherwise controls the use of premises subject to this chapter to fail to comply with the provisions of this chapter.

B. A person who smokes in an area where smoking is prohibited by the provisions of this chapter shall be subject to a fine of $100.

C. A person, owner, manager, employer, or operator who controls an enclosed area or place of employment or child care in violation of this chapter shall be subject to the following penalties:

1. A fine not exceeding $100 for a first violation;

2. A fine not exceeding $200 for a second violation; and

3. A fine not exceeding $500 for each additional violation.

D. Any person aggrieved by a violation or threatened violation of this chapter may bring a civil action under AMC 1.45.010.B to enjoin the violation and to obtain the relief described in that section.

16.65.060 Public education.

A. The Department of Health and Human Services shall engage in a continuing program of education about the public health purposes, benefits and requirements of this chapter for municipal residents and visitors and to guide owners, managers, employers, and operators concerning the requirements of this chapter.

B. The continuing education program may include publication of a brochure for affected businesses and individuals explaining the provisions of this chapter, the requirement to post "No Smoking" signage, the obligation to provide a smoke-free work place, and other actions consistent with AMC 16.65.040, to property owners, managers, employers, and operators.

16.65.070 Non-retaliation and non-discrimination.

No person or employer shall discharge, refuse to hire, or in any other manner retaliate or discriminate against any employee, applicant for employment, or customer because such employee, applicant for employment or customer insists upon compliance with any requirement of this chapter.

Section 2. This ordinance shall become effective sixty (60) days after its passage and approval by the Assembly, except that subsection 16.65.040.F shall take effect ninety (90) days after passage and approval by the Assembly.

PASSED AND APPROVED by the Anchorage Assembly this _____day of _____, 2006.

_____
Chair

ATTEST:

_____
Municipal Clerk

MUNICIPALITY OF ANCHORAGE
ASSEMBLY MEMORANDUM
NO. AM 365–2006

Meeting Date: May 23, 2006

From: Assemblymembers Coffey and Traini

Subject: **AO 2006–86 AN ORDINANCE OF THE ANCHORAGE MUNICIPAL ASSEMBLY REPEALING AND REENACTING AMC CHAPTER 16.65, PROHIBITION OF SMOKING IN PUBLIC PLACES, TO EXTEND SECONDHAND SMOKE CONTROL.**

By Anchorage Ordinance 2000-91(S), effective December 31, 2000, the Anchorage Assembly enacted AMC 16.65, prohibiting smoking in certain public places. Since passage of AMC 16.65 in 2000, the harmful effects of secondhand smoke have become more widely known, substantiated, and appreciated. We know the following:

- There is no benefit to secondhand smoke, only harm.
- In the wane of availability of health care insurance, it is a Hobson's Choice many workers face in maintaining employment, when not all workplaces are required to be smoke-free.
- The Surgeon General, the U.S. Center for Disease Control and Prevention, the National Cancer Institute, the National Research Council and the United States Environmental Protection Agency have all reported on the serious harm to health caused to nonsmokers from exposure to secondhand smoke.
- Secondhand smoke contains more than 50 known carcinogens and is estimated to cause 50,000 deaths in the United States annually from cancer, heart disease and other illnesses, making secondhand smoke a leading cause of preventable death nationally, and in Alaska.
- There is no safe level of secondhand smoke, and even short duration of exposure can increase the risk of heart attack, making workers exposed to secondhand smoke at their place of employment subject to a serious and needless health threat.
- The American Society of Heating Refrigerating and Air-Conditioning Engineers (ASHRAE) has officially recognized that ventilation systems cannot control the health harms from secondhand smoke, and ASHRAE endorses complete elimination of indoor smoking as the only effective means to protect health.

- Hundreds of local governments throughout the United States have now adopted comprehensive smoke-free workplace laws, to include restaurants and bars. This is in addition to at least thirteen states, nine Canadian provinces, and ten entire nations.

- Published review of available studies on the economic impact of smoke-free workplace laws conclude that all the best designed studies have identified either no impact or a positive economic impact to the hospitality industry from comprehensive smoke-free workplace, restaurant and bar laws; and

- The Anchorage Assembly prohibited smoking in restaurants, and subsequent study of the economic effect of the ordinance by the University of Alaska found no adverse economic impact to the Anchorage hospitality industry.

AO 2006-86 repeals and reenacts AMC 16.65 as the "Secondhand Smoke Control Ordinance" to provide smoke-free public places, smoke-free places of employment, and smoke-free premises offering child care. AO 2006 – extends the coverage and protections from secondhand smoke to bars and any other business having employees. For public buildings controlled by the Municipality, smoking within 50 feet of the building entrance is prohibited. This same rule applies to hospitals and medical clinics.

Prepared by:

Julia Tucker, Assembly Counsel

Respectfully submitted

Assemblymember Dan Coffey, Section 4

Assemblymember Dick Traini, Section 4

Chapter 16.65 PROHIBITION OF SMOKING IN PUBLIC PLACES*

*Editor's note: AO No. 2000-91(S), § 3, provides as follows: "Within one year after the initial implementation of this ordinance, the Mayor, in conjunction with the Health and Human Services Department and the Anchorage Police Department, shall review the ordinance and report and make recommendations to the Municipal Assembly and the Health and Human Services Commission concerning the effectiveness of the ordinance. The report shall specifically include the following information:
1. Effectiveness of the continuing public education program and ongoing efforts to work with affected businesses and individuals.
2. Effect on reducing secondhand smoke exposure.
3. Practicality of enforcing the ordinance and any problems with enforcement.
4. Number of violations and amount of penalties.
5. Any needed revisions to the ordinance.
6. Overall economic impact.

16.65.005 Definitions.
16.65.010 Application of chapter to municipal facilities.
16.65.015 Prohibition of smoking in public places.
16.65.020 Prohibition of smoking in places of employment.
16.65.025 Reasonable distance.
16.65.030 Where smoking not regulated.
16.65.035 Posting of signs.
16.65.040 Non-retaliation.
16.65.045 Violations and penalties.
16.65.050 Public education.
16.65.055 Other applicable laws.

16.65.005 Definitions.

In this chapter:
Bar means a premise licensed under AS 04.11.090 which does not employ any person under the age of 21 and which does not serve any person under the age of 21 unless accompanied by a parent or legal guardian, and where tobacco smoke cannot filter into any other area where smoking is prohibited through a passageway, ventilation system, or other means.
Business means any sole proprietorship, partnership, joint venture, corporation or other business entity formed for profit-making purposes, including retail establishments where goods or services are sold as well as professional corporations and other entities where legal, medical, dental, engineering, architectural or other professional services are delivered.
Employee means any person who is employed by any employer in the consideration for direct or indirect monetary wages or profit, and any person who volunteers his or her services for a nonprofit entity.
Employer means any person, partnership, corporation, including a municipal corporation, or nonprofit entity, who employs the services of one or more individual persons.
Enclosed area means all space between a floor and ceiling which is enclosed on all sides by solid walls or windows (exclusive of door or passage ways) which extend from the floor to the

ceiling, including all space therein screened by partitions which do not extend to the ceiling or are not solid, "office landscaping" or similar structures.
Place of employment means any enclosed area under the control of a public or private employer which employees normally frequent during the course of employment, including, but not limited to, work areas, employee lounges and restrooms, conference and classrooms, employee cafeterias and hallways. A private residence is not a "place of employment" unless it is used as a child care, adult care or health care facility.
Public place means any enclosed area to which the public is invited or in which the public is permitted, including but not limited to, banks, educational facilities, health facilities, laundromats, public transportation facilities, reception areas, restaurants, retail food production and marketing establishments, retail service establishments, retail stores, theaters and waiting rooms. A private residence is not a "public place."
Restaurant means any coffee shop, cafeteria, sandwich stand, private and public school cafeteria, and any other eating establishment which gives or offers for sale food to the public, guests, or employees, as well as kitchens in which food is prepared on the premises for serving elsewhere, including catering facilities.
Retail tobacco store means a retail store utilized primarily for the sale of tobacco products and accessories and in which the sale of other products is merely incidental.
Service line means any indoor line at which one or more persons are waiting for or receiving service of any kind, whether or not service involves the exchange of money.
Smoking means inhaling, exhaling, burning or carrying any lighted tobacco product.
Sports arena means sports pavilions, gymnasiums, health spas, boxing arenas, swimming pools, roller and ice rinks, bowling alleys and other similar places where members of the general public assemble either to engage in physical exercise, participate in athletic competition, or witness sports events.
(AO No. 2000-91(S), § 1, 12-31-00)

16.65.010 Application of chapter to municipal facilities.
All enclosed facilities owned by the Municipality of Anchorage, including the Anchorage School District, shall be subject to this chapter.
(AO No. 2000-91(S), § 1, 12-31-00)

16.65.015 Prohibition of smoking in public places.
A. Smoking is prohibited in all enclosed public places within the Municipality of Anchorage including, but not limited to, the following places:
1. Elevators.
2. Restrooms, lobbies, reception areas, hallways, and any other common-use areas.
3. Buses, taxicabs, and other means of public transit under the authority of the Municipality of Anchorage, and ticket, boarding, and waiting areas of public transit depots.
4. Service lines.
5. Retail stores.
6. All areas available to and customarily used by the general public in all businesses and nonprofit entities patronized by the public, including but not limited to, attorneys' offices and other offices, banks, laundromats, hotels, and motels.
7. Restaurants.
8. Public areas of aquariums, galleries, libraries and museums when open to the public.

9. Any facility which is primarily used for exhibiting any motion picture, stage, drama, lecture, musical recital or other similar performance, except performers when smoking is a part of stage production.
10. Sports arenas and convention halls, including bowling facilities and pool halls.
11. Every room, chamber, place of meeting or public assembly, including school buildings under the control of any board, council, commission, committee, including joint committees, or agencies of the Municipality of Anchorage or any political subdivision of the state during such time as a public meeting is in progress, to the extent such place is subject to the jurisdiction of the Municipality of Anchorage.
12. Waiting rooms, hallways, wards, and semiprivate rooms of health facilities, including, but not limited to, hospitals, clinics, physical therapy facilities, doctors' offices, and dentists' offices.
13. Lobbies, hallways, and other common areas in apartment buildings, condominiums, trailer parks, retirement facilities, nursing homes, and other multiple-unit residential facilities.
14. Polling places.
B. Notwithstanding any other provision of this chapter, any owner, operator, manager or other person who controls any establishment or facility may declare that entire establishment or facility as a nonsmoking establishment.
(AO No. 2000-91(S), § 1, 12-31-00)

16.65.020 Prohibition of smoking in places of employment.
A. It shall be responsibility of employers to provide a smoke-free workplace for all employees, but employers are not required to incur any expense to make structural or other physical modifications to discharge this responsibility.
B. By the effective date of this chapter, each employer having an enclosed place of employment located within the Municipality of Anchorage shall adopt, implement, make known and maintain a written smoking policy which shall contain the following requirements:
Smoking shall be prohibited in all enclosed facilities within a place of employment without exception. This includes common work areas, auditoriums, classrooms, conference and meeting rooms, private offices, elevators, hallways, medical facilities, cafeterias, employee lounges, stairs, restrooms, vehicles, and all other enclosed facilities.
C. The smoking policy shall be communicated to all employees within three weeks of its adoption.
D. All employers shall supply a written copy of the smoking policy upon request to any existing or prospective employee.
(AO No. 2000-91(S), § 1, 12-31-00)

16.65.025 Reasonable distance.
To ensure that tobacco smoke does not enter the area through entrances, windows, ventilation systems or any other means, smoking may occur, when otherwise prohibited by the property owner, only at a reasonable distance outside any enclosed area within which smoking is prohibited.
(AO No. 2000-91(S), § 1, 12-31-00)

16.65.030 Where smoking not regulated.
A. Notwithstanding any other provision of this chapter to the contrary, the following areas shall not be subject to the smoking restrictions of this chapter:
1. Private residences, including private residences used as places of employment, except during hours used as a child care, adult care or health care facility.

2. Places of employment with four or less employees. For the purpose of this exception, the four or less employee limit includes on-site business owner(s), with the exception that in all uses cited in AMC 16.65.015 smoking shall not be permitted.
3. Twenty-five percent of hotel and motel rooms rented to guests.
4. Retail tobacco stores.
5. Restaurants, hotel and motel conference or meeting rooms and public and private assembly rooms while these places are being used for private functions.
6. Bars.
7. Bingo halls and pull tab establishments where a non-smoking section which is an enclosed area is also offered to its patrons.

B. Notwithstanding any other provision of this section, any owner, operator, manager or other person who controls any establishment described in this section may declare that entire establishment as a nonsmoking establishment.

(AO No. 2000-91(S), § 1, 12-31-00)

16.65.035 Posting of signs.

A. "No Smoking" signs or the international "No Smoking" symbol (consisting of a pictorial representation of a burning cigarette enclosed in a red circle with a red bar across it) shall be clearly, sufficiently and conspicuously posted in every building or other area where smoking is prohibited by this chapter, by the owner, operator, manager or other person having control of such building or other area.

B. Every public place where smoking is prohibited by this chapter shall have posted at every entrance a conspicuous sign clearly stating that smoking is prohibited.

C. All ashtrays and other smoking paraphernalia shall be removed from any area where smoking is prohibited by this chapter by the owner, operator, manager or other person having control of such area.

(AO No. 2000-91(S), § 1, 12-31-00)

16.65.040 Non-retaliation.

No person or employer shall discharge, refuse to hire or in any manner retaliate against any employee, applicant for employment, or customer because such employee, applicant, or customer exercises any right to a smoke-free environment afforded by this chapter.

(AO No. 2000-91(S), § 1, 12-31-00)

16.65.045 Violations and penalties.

A. It shall be unlawful for any person who owns, manages, operates or otherwise controls the use of any premises subject to regulation under this chapter to fail to comply with any of its provisions.

B. It shall be unlawful for any person to smoke in any area where smoking is prohibited by the provisions of this chapter.

C. In addition to the penalties and remedies available under AMC 1.45.010 of this Code and as allowed under AMC 16.02.040, any person aggrieved by a violation or threatened violation of this chapter may bring a civil action under AMC 1.45.010(B) to enjoin that violation and to obtain the relief described in that section.

(AO No. 2000-91(S), § 1, 12-31-00)

16.65.050 Public education.

The department of health and human services shall engage in a continuing program to explain and clarify the purposes and requirements of this chapter to citizens affected by it, and to guide owners, operators and managers in their compliance with it. Such program may include publication of a brochure for affected businesses and individuals explaining the provisions of this chapter.
(AO No. 2000-91(S), § 1, 12-31-00)

16.65.055 Other applicable laws.
This chapter shall not be interpreted or construed to permit smoking where it is otherwise restricted by other applicable laws.
(AO No. 2000-91(S), § 1, 12-31-00)

Municipality of Anchorage
MUNICIPAL CLERK'S OFFICE

Agenda Document Control Sheet

AO 2006-86

(SEE REVERSE SIDE FOR FURTHER INFORMATION)

1	SUBJECT OF AGENDA DOCUMENT PROHIBITION OF SMOKING IN PUBLIC PLACES	DATE PREPARED 5/19/06
		Indicate Documents Attached [X] AO [ ] AR [X] AM [ ] AIM
2	DEPARTMENT NAME Assembly	DIRECTOR'S NAME Dan Sullivan, Chair
3	THE PERSON THE DOCUMENT WAS ACTUALLY PREPARED BY Julia Tucker - Assembly Counsel	HIS/HER PHONE NUMBER 343-4419

4	COORDINATED WITH AND REVIEWED BY	INITIALS	DATE
	Mayor		
	Municipal Clerk		
	Municipal Attorney		
	Employee Relations		
	Municipal Manager		
	Cultural & Recreational Services		
	Fire		
	Health & Human Services		
	Merrill Field Airport		
	Municipal Light & Power		
	Office of Management and Budget		
	Police		
	Port of Anchorage		
	Public Works		
	Solid Waste Services		
	Transit		
	Water & Wastewater Utility		
	Executive Manager		
	Community Planning & Development		
	Finance, Chief Fiscal Officer		
	Heritage Land Bank		
	Management Information Services		
	Property & Facility Management		
	Purchasing		
	Other		

5 **Special Instructions/Comments**

Addendum _ Consent Agenda -Introduction

6	ASSEMBLY HEARING DATE REQUESTED 5/23/06	7	PUBLIC HEARING DATE REQUESTED ~~6/6/06~~ 7/11/06

MUNICIPALITY OF ANCHORAGE
ASSEMBLY INFORMATION MEMORANDUM
NO. AIM 70-2006

Meeting Date: July 11, 2006

From: Assemblymembers Traini and Coffey
Subject: Summary of Economic Effects for AO 2006-86

Attached to this memo is the Summary of Economic Effects for AO 2006-86, regarding an ordinance of the Anchorage Municipal Assembly repealing and reenacting AMC Chapter 16.65, prohibition on smoking in public places, to extend secondhand smoke control.

Prepared By: Steven B. King, Utility Budget Analyst
Reviewed By: Barbara E. Gruenstein and Guadalupe Marroquin
Submitted By: Assemblymembers Traini and Coffey

MUNICIPALITY OF ANCHORAGE
Summary of Economic Effects -- General Government

An ordinance of the Anchorage Municipal Assembly repealing and reenacting AMC Chapter 16.65, prohibition on smoking in public places, to extend secondhand smoke control.

AO Number: 2006-86 Title:

Sponsor: Assemblymember Traini and Coffey
Preparing Agency: Assembly
Others Impacted:

CHANGES IN EXPENDITURES AND REVENUES:	(In Thousands of Dollars)				
	FY06	FY07	FY08	FY09	FY10
Operating Expenditures					
1000 Personal Services	$ -	$ -	$ -	$ -	$ -
2000 Non-Labor	-	-	-	-	-
3900 Contributions					
4000 Debt Service					
TOTAL DIRECT COSTS:	$ -	$ -	$ -	$ -	$ -
Add: 6000 Charges from Others					
Less: 7000 Charges to Others					
FUNCTION COST:	$ -	$ -	$ -	$ -	$ -
REVENUES:					
CAPITAL:					
POSITIONS: FT/PT and Temp					

PUBLIC SECTOR ECONOMIC EFFECTS:

There is no clear indication that this ordinance would have a significant public sector economic effect. However, some research suggest that similar laws often encourage individuals to cease smoking or to smoke less. If this be the case, there would be a reduction of public health costs associated with smoking. In addition, public sector organizations would see a reduction in work time lost due to smoke related ailments as well as a potential decrease in employee health insurance rates.

There is also a potential that public employees who smoke would take longer breaks in order to travel a greater distance from their place of employment in order to find an appropriate smoking location. This could lead to increased inefficiency within the public sector workplace.

PRIVATE SECTOR ECONOMIC EFFECTS:

There is also no clear indication that this ordinance would have a significant private sector economic effect. Some research, mostly anecdotal, suggest that business will suffer if they cease to allow customers to smoke within their premises. This research states that individuals who smoke will choose not to enter non-smoking facilities.

However, the preponderance of research suggests that there is no reduction in a private organizations economic viability based solely on a smoking ban. Some research even suggests that an increased customer base will emerge after the smoking ban is enacted. The few patrons that an organization may lose could be compensated for (or even increased) by individuals who had avoided the location previously due to the congested environment.

Prepared by: Steven B. King, Utility Budget Analyst Telephone: 343-4714
Reviewed by: Barbara Gruenstein and Guadalupe Marroquin Telephone: 343-4311 and 343-4376

Municipality of Anchorage
MUNICIPAL CLERK'S OFFICE

Agenda Document Control Sheet

AIM 70 -2006

(SEE REVERSE SIDE FOR FURTHER INFORMATION)

1	SUBJECT OF AGENDA DOCUMENT SEE FOR AO 2006-86	DATE PREPARED 5/30/06
		Indicate Documents Attached ☐ AO ☐ AR ☐ AM ☒ AIM
2	DEPARTMENT NAME Assembly	DIRECTOR'S NAME Dan Sullivan, Chair
3	THE PERSON THE DOCUMENT WAS ACTUALLY PREPARED BY Steven B. King, Utility Budget Analyst	HIS/HER PHONE NUMBER 343-4714

4	COORDINATED WITH AND REVIEWED BY	INITIALS	DATE
	Mayor		
	Municipal Clerk		
	Municipal Attorney		
	Employee Relations		
	Municipal Manager		
	Cultural & Recreational Services		
	Fire		
	Health & Human Services		
	Merrill Field Airport		
	Municipal Light & Power		
	Office of Management and Budget		
	Police		
	Port of Anchorage		
	Public Works		
	Solid Waste Services		
	Transit		
	Water & Wastewater Utility		
	Executive Manager		
	Community Planning & Development		
	Finance, Chief Fiscal Officer		
	Heritage Land Bank		
	Management Information Services		
	Property & Facility Management		
	Purchasing		
	Other		

5 **Special Instructions/Comments**

NEW PUBLIC HEARINGS - REF. AO 2006-86

6	ASSEMBLY HEARING DATE REQUESTED 7/11/06	7	PUBLIC HEARING DATE REQUESTED 7/11/06

MUNICIPALITY OF ANCHORAGE
ASSEMBLY MEMORANDUM
NO. AM 457–2006

Meeting Date: July 11, 2006

From: Assembly Members Traini and Coffey
Subject: **AO 2006–86 – AN ORDINANCE OF THE ANCHORAGE MUNICIPAL ASSEMBLY TO EXTEND SECONDHAND SMOKE CONTROL.**

AO 2006-86 was introduced on May 23, 2006, with Assembly Memorandum 365-2006. On Tuesday, June 27, 2006, Richard Carmona, M.D., M.P.H., F.A.C.S, Surgeon General, issued a 685-page report addressing the health consequences of involuntary exposure to secondhand smoke. The Surgeon General's report conclusively supports timely action by the Anchorage Assembly in extending secondhand smoke control under AO 2006-86. While inclusion of the full report is impracticable, AM 365-2006 is supplemented by this memorandum and attached excerpts from the Surgeon General's report.
Commentary offered by the Surgeon General in the *Preface* includes:

> Today, massive and conclusive scientific evidence documents adverse effects of involuntary smoking on children and adults . . . As this report documents, exposure to secondhand smoke remains an alarming public health hazard. . . . We now have substantial evidence on the efficacy of different approaches to control exposure to secondhand smoke. Restrictions on smoking can control exposures effectively, but technical approaches involving air cleaning or greater exchange of indoor with outdoor air cannot. Consequently, nonsmokers need protection through the restriction of smoking in public places and work places and by a voluntary adherence to policies at home, particularly to eliminate exposures of children. . . . Because of the high levels of exposure among young children, their exposure should be considered a significant pediatric issue. . . . An environment free of involuntary exposure to secondhand smoke should remain an important national priority in order to reach the *Healthy People 2010* objectives.

Significant Conclusions by the Surgeon General include:

- Secondhand smoke causes premature death and disease in children and in adults who do not smoke.
- The scientific evidence indicates that there is no risk-free level of exposure to secondhand smoke.
- Establishing smoke-free workplaces is the only effective way to ensure that secondhand smoke exposure does not occur in the workplace.
- Total bans on indoor smoking in hospitals, restaurants, bars, and offices substantially reduce secondhand smoke exposure, up to several orders of magnitude with incomplete compliance, and with full compliance, exposures are eliminated.
- Separating smokers from nonsmokers, cleaning the air, and ventilating buildings cannot eliminate exposures of nonsmokers to secondhand smoke.

- The operation of a hearing, ventilating, and air conditional system can distribute secondhand smoke throughout a building.
- The extent to which workplaces are covered by smoke-free policies varies among worker groups, across states, and by sociodemographic factors. Workplaces related to the entertainment and hospitality industries have notably high potential for secondhand smoke exposure.
- Workplace smoking restrictions are effective in reducing secondhand smoke exposure.

For ease of reference, pages 11, 92, 158, 400–401, 649, the index to the 10 chapters of the full report, and a listing of all chapter conclusions at pages 12-16 have been attached.

There are no identifiable mandatory brick and mortar conversion costs for businesses to physically remove ashtrays and ban smoking on the premises. Concerning potential adverse economic impact related to clientele, the Surgeon General's report at page 649 concludes "Evidence from peer-reviewed studies shows that smoke-free policies and regulations do not have an adverse economic impact on the hospitality industry." A decrease in tobacco product sales might be anticipated, if overall consumption decreases as a secondary effect of extending secondhand smoke control. When weighed against the adverse affects of secondhand smoke to children and nonsmoking adults, as documented in the Surgeon General's report, the potential down-line negative economic impact to the tobacco industry is not a persuasive economic consideration. As to a corollary potential down-line impact to municipal revenues derived from tobacco product taxes, municipal revenues are within local control and can be managed.

The private and public economic impact attributable to health care costs associated with death and illness caused by secondhand smoke appears significant as more data is developed. In the Forward to the Surgeon General's Report released June 27, 2006, Dr. Gerberding, Director of the Centers of Disease Control and Prevention, recounts a partial death toll attributable to secondhand smoke: "In 2005, it was estimated that exposure to secondhand smoke kills more than 3,000 adult nonsmokers from lung cancer, approximately 46,000 from coronary heart disease, and an estimated 430 newborns succumbed to sudden infant death syndrome."

The Surgeon General reports that the most recent data suggest that children aged 3 through 11 subjected to secondhand smoke have nicotine byproduct levels of "more than twice as high as in nonsmoking adults" (Chapter 4, page 158).

Given the enormous potential harm to children from tobacco exposure, the World Health Organization has affirmed in interpreting the UN Convention on the Rights of the Child the governmental duty "to take all necessary legislative and regulatory measures to protect children from tobacco and ensure that the interest of children take precedence over those of the tobacco industry."

The Americans With Disabilities Act has deemed impaired respiratory function to be a disability. Places of employment should be deterred from exposing employees to unnecessary risks of disability.

AO 2006-86 accomplishes a baseline of workplace protection from secondhand smoke. Education and public awareness are needed to effectuate the Surgeon General's call for voluntary adherence to policies at home. Prohibiting smoking in child care facilities and other places within municipal control are steps the Assembly can take to better protect the health interests of children in our community from exposure to secondhand smoke.

Upon passage of AO 2006-86 and any amendment, the fine schedule in AMC 14.60.030 related to chapter 16.65 will be amended to reflect current violations and fines prior to implementation.

Prepared by:

Julia Tucker, Assembly Counsel

Respectfully submitted:

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Assembly Member Dan Coffey, Section 4

The Health Consequences of Involuntary Exposure to Tobacco Smoke

A Report of the Surgeon General

2006

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service
Office of the Surgeon General
Rockville, MD

Major Conclusions

This report returns to involuntary smoking, the topic of the 1986 Surgeon General's report. Since then, there have been many advances in the research on secondhand smoke, and substantial evidence has been reported over the ensuing 20 years. This report uses the revised language for causal conclusions that was implemented in the 2004 Surgeon General's report (USDHHS 2004). Each chapter provides a comprehensive review of the evidence, a quantitative synthesis of the evidence if appropriate, and a rigorous assessment of sources of bias that may affect interpretations of the findings. The reviews in this report reaffirm and strengthen the findings of the 1986 report. With regard to the involuntary exposure of nonsmokers to tobacco smoke, the scientific evidence now supports the following major conclusions:

1. Secondhand smoke causes premature death and disease in children and in adults who do not smoke.

2. Children exposed to secondhand smoke are at an increased risk for sudden infant death syndrome (SIDS), acute respiratory infections, ear problems, and more severe asthma. Smoking by parents causes respiratory symptoms and slows lung growth in their children.

3. Exposure of adults to secondhand smoke has immediate adverse effects on the cardiovascular system and causes coronary heart disease and lung cancer.

4. The scientific evidence indicates that there is no risk-free level of exposure to secondhand smoke.

5. Many millions of Americans, both children and adults, are still exposed to secondhand smoke in their homes and workplaces despite substantial progress in tobacco control.

6. Eliminating smoking in indoor spaces fully protects nonsmokers from exposure to secondhand smoke. Separating smokers from nonsmokers, cleaning the air, and ventilating buildings cannot eliminate exposures of nonsmokers to secondhand smoke.

Conclusions

1. Current heating, ventilating, and air conditioning systems alone cannot control exposure to secondhand smoke.

2. The operation of a heating, ventilating, and air conditioning system can distribute secondhand smoke throughout a building.

Implications

These conclusions suggest that control strategies for indoor exposure to secondhand smoke cannot use approaches based on HVAC system design and operation. The benefits from HVAC systems include a number of critical functions that help to maintain a healthful and comfortable indoor environment. This review of their functioning shows, however, that current HVAC systems cannot fully control exposures to secondhand smoke unless a complete smoking ban is enforced. Furthermore, unless carefully controlled, HVAC operations can distribute air that has been contaminated with secondhand smoke throughout a building. Simple predictions cannot be made about the consequences of these operations because they vary with the building and with the HVAC characteristics. However, to develop models that assess the effects of indoor secondhand tobacco smoke exposures, it is necessary to first develop an understanding of HVAC systems and their effectiveness in a particular structure. However, this review indicates that a complete ban on indoor smoking is the most efficient and effective approach to control exposures to secondhand smoke. Additional implications of these findings are considered in Chapter 10, Control of Secondhand Smoke Exposure.

Conclusions

1. The evidence is sufficient to infer that large numbers of nonsmokers are still exposed to secondhand smoke.
2. Exposure of nonsmokers to secondhand smoke has declined in the United States since the 1986 Surgeon General's report, *The Health Consequences of Involuntary Smoking*.
3. The evidence indicates that the extent of secondhand smoke exposure varies across the country.
4. Homes and workplaces are the predominant locations for exposure to secondhand smoke.
5. Exposure to secondhand smoke tends to be greater for persons with lower incomes.
6. Exposure to secondhand smoke continues in restaurants, bars, casinos, gaming halls, and vehicles.

Overall Implications

Exposure to secondhand smoke remains a serious public health problem in the United States, with exposure of almost 60 percent of children aged 3 through 11 years and more than 40 percent of nonsmoking adults. Since the publication of the 1986 Surgeon General's report, measured levels of exposure in the United States have declined significantly. However, the proportional decrease has been larger among adults than among children, and the most recent data suggest that children aged 3 through 11 years have serum cotinine concentrations that are more than twice as high as those among nonsmoking adults. Data suggest that the home remains the most important target for reducing exposures to secondhand smoke, particularly for children but also for middle-aged and older adults. Although progress has been made to protect nonsmoking workers, continuing efforts are needed to protect these workers, and particularly younger workers, in all occupational categories.

Research questions remain regarding exposure to secondhand smoke. As noted in the 1986 report, no indicator has been developed that can objectively estimate long-term exposure or early-life exposure. Secondhand smoke exposure from "shared air spaces" within a building is also of concern, as a significant proportion of the population lives in apartment buildings or condominiums where smoking in another part of the building might increase tobacco smoke exposure for households of nonsmokers.

Implications

Lung growth continues throughout childhood and adolescence and is completed by young adulthood, when lung growth peaks and then begins to decline as a result of aging, smoking, and other environmental factors. The evidence shows that parental smoking reduces the maximum achieved level, although not to a degree (on average) that would impair individuals. Nonetheless, a reduced peak level increases the risk for future chronic lung disease, and there is heterogeneity of the effect so that some exposed children may have a much greater reduction than the mean. In addition, children of smokers are more likely to become smokers and thus face a future risk for impairment from active smoking.

Conclusions

Lower Respiratory Illnesses in Infancy and Early Childhood

1. The evidence is sufficient to infer a causal relationship between secondhand smoke exposure from parental smoking and lower respiratory illnesses in infants and children.

2. The increased risk for lower respiratory illnesses is greatest from smoking by the mother.

Middle Ear Disease and Adenotonsillectomy

3. The evidence is sufficient to infer a causal relationship between parental smoking and middle ear disease in children, including acute and recurrent otitis media and chronic middle ear effusion.

4. The evidence is suggestive but not sufficient to infer a causal relationship between parental smoking and the natural history of middle ear effusion.

5. The evidence is inadequate to infer the presence or absence of a causal relationship between parental smoking and an increase in the risk of adenoidectomy or tonsillectomy among children.

Respiratory Symptoms and Prevalent Asthma in School-Age Children

6. The evidence is sufficient to infer a causal relationship between parental smoking and cough, phlegm, wheeze, and breathlessness among children of school age.

7. The evidence is sufficient to infer a causal relationship between parental smoking and ever having asthma among children of school age.

Childhood Asthma Onset

8. The evidence is sufficient to infer a causal relationship between secondhand smoke exposure from parental smoking and the onset of wheeze illnesses in early childhood.

9. The evidence is suggestive but not sufficient to infer a causal relationship between secondhand smoke exposure from parental smoking and the onset of childhood asthma.

Atopy

10. The evidence is inadequate to infer the presence or absence of a causal relationship between parental smoking and the risk of immunoglobulin E-mediated allergy in their children.

Lung Growth and Pulmonary Function

11. The evidence is sufficient to infer a causal relationship between maternal smoking during pregnancy and persistent adverse effects on lung function across childhood.

12. The evidence is sufficient to infer a causal relationship between exposure to secondhand smoke after birth and a lower level of lung function during childhood.

Overall Implications

The extensive evidence considered in this chapter causally links parental smoking to adverse health effects in children. The association between parental smoking and childhood respiratory disease is stronger at younger ages, a pattern plausibly explained by a higher level of exposure to secondhand smoke among infants and preschool-age children for any given level of parental smoking. In general, associations with maternal smoking are stronger than with paternal smoking, but for several outcomes, associations were found for smoking by the father in homes where the mother does not smoke. This finding argues strongly for an independent adverse effect of a postnatal involuntary (environmental) exposure to secondhand smoke in the home. There may be an additional hazard related to prenatal exposure of the fetus to maternal smoking during pregnancy (USDHHS 2001, 2004). The published evidence does not adequately separate the independent effects on childhood respiratory health of prenatal versus postnatal exposure to maternal smoking. This unresolved research issue should not detract from the public health message that smoking by either parent is potentially damaging to the health of children.

Interpretation of the evidence is perhaps most complex in relation to childhood asthma, which is a term generally applied to a mixed group of clinical phenotypes. Recurrent wheeze illnesses are common among young children, and there is controversy about whether these illnesses should all be classified as "asthma." Cohort studies show that symptoms do not persist for many children beyond the first few years of life. The balance of evidence strongly supports a causal relationship between parental smoking and the incidence of wheeze illnesses in infancy, the prevalence of wheeze and related symptoms among schoolchildren, and the relative severity of disease among children with physician-diagnosed asthma. These are all important indicators of a substantial and potentially preventable public health burden.

The evidence related to the wheeze illnesses can be separated to an extent from that related to a clearer clinical phenotype of asthma, a chronic condition of variable airflow obstruction with a heightened susceptibility to environmental triggers of bronchospasm. The evidence is less clear as to whether parental smoking initiates the disease among previously healthy children. Because the clinical diagnosis of asthma relies to a large extent upon a history of recurrent wheeze attacks or other chest illnesses, any exposure (including parental smoking) that increases the incidence of such episodes will tend to be associated with an apparent increase in the incidence of diagnosed "asthma," even if secondhand smoke exposure does not contribute to the incidence directly. Studies of nonspecific bronchial responsiveness, a surrogate for the asthma phenotype, offer some insights into the long-term susceptibility that underlies chronic asthma. Secondhand smoke exposure is linked to an increase in responsiveness, beginning with in utero exposure. However, bronchial responsiveness is also nonspecifically and transiently increased following respiratory tract infections. For this reason, the conclusion regarding parental smoking as a cause of childhood asthma has been phrased in less definite terms than the conclusions relating to asthma prevalence and severity.

Conclusions

1. Workplace smoking restrictions are effective in reducing secondhand smoke exposure.
2. Workplace smoking restrictions lead to less smoking among covered workers.
3. Establishing smoke-free workplaces is the only effective way to ensure that secondhand smoke exposure does not occur in the workplace.
4. The majority of workers in the United States are now covered by smoke-free policies.
5. The extent to which workplaces are covered by smoke-free policies varies among worker groups, across states, and by sociodemographic factors. Workplaces related to the entertainment and hospitality industries have notably high potential for secondhand smoke exposure.
6. Evidence from peer-reviewed studies shows that smoke-free policies and regulations do not have an adverse economic impact on the hospitality industry.
7. Evidence suggests that exposure to secondhand smoke varies by ethnicity and gender.
8. In the United States, the home is now becoming the predominant location for exposure of children and adults to secondhand smoke.
9. Total bans on indoor smoking in hospitals, restaurants, bars, and offices substantially reduce secondhand smoke exposure, up to several orders of magnitude with incomplete compliance, and with full compliance, exposures are eliminated.
10. Exposures of nonsmokers to secondhand smoke cannot be controlled by air cleaning or mechanical air exchange.

Overall Implications

Total bans on indoor smoking in hospitals, restaurants, bars, and offices will substantially reduce secondhand smoke exposure, up to several orders of magnitude with incomplete compliance, and, with full compliance, exposures will be eliminated. Absent a ban, attempts to control secondhand smoke exposure of nonsmoking occupants or patrons have mixed results. Uncontrolled air currents, mixed return air and ventilation air, and the lack of complete physical barriers lead to persistence of some secondhand smoke exposure with partial restriction strategies. The few studies that claim unrestricted smoking in offices meets ASHRAE standards do not provide convincing evidence that exposures of nonsmokers to secondhand smoke were adequately reduced (ASHRAE 1999). Specially designed smoking areas inside a building can effectively isolate secondhand smoke, but effectiveness depends on engineering

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Chapter Conclusions

Chapter 2. Toxicology of Secondhand Smoke

Evidence of Carcinogenic Effects from Secondhand Smoke Exposure

1. More than 50 carcinogens have been identified in sidestream and secondhand smoke.

2. The evidence is sufficient to infer a causal relationship between exposure to secondhand smoke and its condensates and tumors in laboratory animals.

3. The evidence is sufficient to infer that exposure of nonsmokers to secondhand smoke causes a significant increase in urinary levels of metabolites of the tobacco-specific lung carcinogen 4-(methylnitrosamino)-1-(3-pyridyl)-1-butanone (NNK). The presence of these metabolites links exposure to secondhand smoke with an increased risk for lung cancer.

4. The mechanisms by which secondhand smoke causes lung cancer are probably similar to those observed in smokers. The overall risk of secondhand smoke exposure, compared with active smoking, is diminished by a substantially lower carcinogenic dose.

Mechanisms of Respiratory Tract Injury and Disease Caused by Secondhand Smoke Exposure

5. The evidence indicates multiple mechanisms by which secondhand smoke exposure causes injury to the respiratory tract.

6. The evidence indicates mechanisms by which secondhand smoke exposure could increase the risk for sudden infant death syndrome.

Mechanisms of Secondhand Smoke Exposure and Heart Disease

7. The evidence is sufficient to infer that exposure to secondhand smoke has a prothrombotic effect.

8. The evidence is sufficient to infer that exposure to secondhand smoke causes endothelial cell dysfunctions.

9. The evidence is sufficient to infer that exposure to secondhand smoke causes atherosclerosis in animal models.

Chapter 3. Assessment of Exposure to Secondhand Smoke

Building Designs and Operations

1. Current heating, ventilating, and air conditioning systems alone cannot control exposure to secondhand smoke.

2. The operation of a heating, ventilating, and air conditioning system can distribute secondhand smoke throughout a building.

Exposure Models

3. Atmospheric concentration of nicotine is a sensitive and specific indicator for secondhand smoke.

4. Smoking increases indoor particle concentrations.

5. Models can be used to estimate concentrations of secondhand smoke.

Biomarkers of Exposure to Secondhand Smoke

6. Biomarkers suitable for assessing recent exposures to secondhand smoke are available.

7. At this time, cotinine, the primary proximate metabolite of nicotine, remains the biomarker of choice for assessing secondhand smoke exposure.

8. Individual biomarkers of exposure to secondhand smoke represent only one component of a complex mixture, and measurements of one marker may not wholly reflect an exposure to other components of concern as a result of involuntary smoking.

Chapter 4. Prevalence of Exposure to Secondhand Smoke

1. The evidence is sufficient to infer that large numbers of nonsmokers are still exposed to secondhand smoke.

2. Exposure of nonsmokers to secondhand smoke has declined in the United States since the 1986 Surgeon General's report, *The Health Consequences of Involuntary Smoking.*

3. The evidence indicates that the extent of secondhand smoke exposure varies across the country.

4. Homes and workplaces are the predominant locations for exposure to secondhand smoke.

5. Exposure to secondhand smoke tends to be greater for persons with lower incomes.

6. Exposure to secondhand smoke continues in restaurants, bars, casinos, gaming halls, and vehicles.

Chapter 5. Reproductive and Developmental Effects from Exposure to Secondhand Smoke

Fertility

1. The evidence is inadequate to infer the presence or absence of a causal relationship between maternal exposure to secondhand smoke and female fertility or fecundability. No data were found on paternal exposure to secondhand smoke and male fertility or fecundability.

Pregnancy (Spontaneous Abortion and Perinatal Death)

2. The evidence is inadequate to infer the presence or absence of a causal relationship between maternal exposure to secondhand smoke during pregnancy and spontaneous abortion.

Infant Deaths

3. The evidence is inadequate to infer the presence or absence of a causal relationship between exposure to secondhand smoke and neonatal mortality.

Sudden Infant Death Syndrome

4. The evidence is sufficient to infer a causal relationship between exposure to secondhand smoke and sudden infant death syndrome.

Preterm Delivery

5. The evidence is suggestive but not sufficient to infer a causal relationship between maternal exposure to secondhand smoke during pregnancy and preterm delivery.

Low Birth Weight

6. The evidence is sufficient to infer a causal relationship between maternal exposure to secondhand smoke during pregnancy and a small reduction in birth weight.

Congenital Malformations

7. The evidence is inadequate to infer the presence or absence of a causal relationship between exposure to secondhand smoke and congenital malformations.

Cognitive Development

8. The evidence is inadequate to infer the presence or absence of a causal relationship between exposure to secondhand smoke and cognitive functioning among children.

Behavioral Development

9. The evidence is inadequate to infer the presence or absence of a causal relationship between exposure to secondhand smoke and behavioral problems among children.

Height/Growth

10. The evidence is inadequate to infer the presence or absence of a causal relationship between exposure to secondhand smoke and children's height/growth.

Childhood Cancer

11. The evidence is suggestive but not sufficient to infer a causal relationship between prenatal and postnatal exposure to secondhand smoke and childhood cancer.

12. The evidence is inadequate to infer the presence or absence of a causal relationship between maternal exposure to secondhand smoke during pregnancy and childhood cancer.

13. The evidence is inadequate to infer the presence or absence of a causal relationship between exposure to secondhand smoke during infancy and childhood cancer.

14. The evidence is suggestive but not sufficient to infer a causal relationship between prenatal and postnatal exposure to secondhand smoke and childhood leukemias.

15. The evidence is suggestive but not sufficient to infer a causal relationship between prenatal and postnatal exposure to secondhand smoke and childhood lymphomas.

16. The evidence is suggestive but not sufficient to infer a causal relationship between prenatal and postnatal exposure to secondhand smoke and childhood brain tumors.

17. The evidence is inadequate to infer the presence or absence of a causal relationship between prenatal and postnatal exposure to secondhand smoke and other childhood cancer types.

Chapter 6. Respiratory Effects in Children from Exposure to Secondhand Smoke

Lower Respiratory Illnesses in Infancy and Early Childhood

1. The evidence is sufficient to infer a causal relationship between secondhand smoke exposure from parental smoking and lower respiratory illnesses in infants and children.

2. The increased risk for lower respiratory illnesses is greatest from smoking by the mother.

Middle Ear Disease and Adenotonsillectomy

3. The evidence is sufficient to infer a causal relationship between parental smoking and middle ear disease in children, including acute and recurrent otitis media and chronic middle ear effusion.

4. The evidence is suggestive but not sufficient to infer a causal relationship between parental smoking and the natural history of middle ear effusion.

5. The evidence is inadequate to infer the presence or absence of a causal relationship between parental smoking and an increase in the risk of adenoidectomy or tonsillectomy among children.

Respiratory Symptoms and Prevalent Asthma in School-Age Children

6. The evidence is sufficient to infer a causal relationship between parental smoking and cough, phlegm, wheeze, and breathlessness among children of school age.

7. The evidence is sufficient to infer a causal relationship between parental smoking and ever having asthma among children of school age.

Childhood Asthma Onset

8. The evidence is sufficient to infer a causal relationship between secondhand smoke exposure from parental smoking and the onset of wheeze illnesses in early childhood.

9. The evidence is suggestive but not sufficient to infer a causal relationship between secondhand smoke exposure from parental smoking and the onset of childhood asthma.

Atopy

10. The evidence is inadequate to infer the presence or absence of a causal relationship between parental smoking and the risk of immunoglobulin E-mediated allergy in their children.

Lung Growth and Pulmonary Function

11. The evidence is sufficient to infer a causal relationship between maternal smoking during pregnancy and persistent adverse effects on lung function across childhood.

12. The evidence is sufficient to infer a causal relationship between exposure to secondhand smoke after birth and a lower level of lung function during childhood.

Chapter 7. Cancer Among Adults from Exposure to Secondhand Smoke

Lung Cancer

1. The evidence is sufficient to infer a causal relationship between secondhand smoke exposure and lung cancer among lifetime nonsmokers. This conclusion extends to all secondhand smoke exposure, regardless of location.

2. The pooled evidence indicates a 20 to 30 percent increase in the risk of lung cancer from secondhand smoke exposure associated with living with a smoker.

Breast Cancer

3. The evidence is suggestive but not sufficient to infer a causal relationship between secondhand smoke and breast cancer.

Nasal Sinus Cavity and Nasopharyngeal Carcinoma

4. The evidence is suggestive but not sufficient to infer a causal relationship between secondhand smoke exposure and a risk of nasal sinus cancer among nonsmokers.

5. The evidence is inadequate to infer the presence or absence of a causal relationship between secondhand smoke exposure and a risk of nasopharyngeal carcinoma among nonsmokers.

Cervical Cancer

6. The evidence is inadequate to infer the presence or absence of a causal relationship between secondhand smoke exposure and the risk of cervical cancer among lifetime nonsmokers.

Chapter 8. Cardiovascular Diseases from Exposure to Secondhand Smoke

1. The evidence is sufficient to infer a causal relationship between exposure to secondhand smoke and increased risks of coronary heart disease morbidity and mortality among both men and women.

2. Pooled relative risks from meta-analyses indicate a 25 to 30 percent increase in the risk of coronary heart disease from exposure to secondhand smoke.

3. The evidence is suggestive but not sufficient to infer a causal relationship between exposure to secondhand smoke and an increased risk of stroke.

4. Studies of secondhand smoke and subclinical vascular disease, particularly carotid arterial wall thickening, are suggestive but not sufficient to infer a causal relationship between exposure to secondhand smoke and atherosclerosis.

Chapter 9. Respiratory Effects in Adults from Exposure to Secondhand Smoke

Odor and Irritation

1. The evidence is sufficient to infer a causal relationship between secondhand smoke exposure and odor annoyance.

2. The evidence is sufficient to infer a causal relationship between secondhand smoke exposure and nasal irritation.

3. The evidence is suggestive but not sufficient to conclude that persons with nasal allergies or a history of respiratory illnesses are more susceptible to developing nasal irritation from secondhand smoke exposure.

Respiratory Symptoms

4. The evidence is suggestive but not sufficient to infer a causal relationship between secondhand smoke exposure and acute respiratory symptoms including cough, wheeze, chest tightness, and difficulty breathing among persons with asthma.

5. The evidence is suggestive but not sufficient to infer a causal relationship between secondhand smoke exposure and acute respiratory symptoms including cough, wheeze, chest tightness, and difficulty breathing among healthy persons.

6. The evidence is suggestive but not sufficient to infer a causal relationship between secondhand smoke exposure and chronic respiratory symptoms.

Lung Function

7. The evidence is suggestive but not sufficient to infer a causal relationship between short-term secondhand smoke exposure and an acute decline in lung function in persons with asthma.

8. The evidence is inadequate to infer the presence or absence of a causal relationship between short-term secondhand smoke exposure and an acute decline in lung function in healthy persons.

9. The evidence is suggestive but not sufficient to infer a causal relationship between chronic secondhand smoke exposure and a small decrement in lung function in the general population.

10. The evidence is inadequate to infer the presence or absence of a causal relationship between chronic secondhand smoke exposure and an accelerated decline in lung function.

Asthma

11. The evidence is suggestive but not sufficient to infer a causal relationship between secondhand smoke exposure and adult-onset asthma.

12. The evidence is suggestive but not sufficient to infer a causal relationship between secondhand smoke exposure and a worsening of asthma control.

Chronic Obstructive Pulmonary Disease

13. The evidence is suggestive but not sufficient to infer a causal relationship between secondhand smoke exposure and risk for chronic obstructive pulmonary disease.

14. The evidence is inadequate to infer the presence or absence of a causal relationship between secondhand smoke exposure and morbidity in persons with chronic obstructive pulmonary disease.

Chapter 10. Control of Secondhand Smoke Exposure

1. Workplace smoking restrictions are effective in reducing secondhand smoke exposure.

2. Workplace smoking restrictions lead to less smoking among covered workers.

3. Establishing smoke-free workplaces is the only effective way to ensure that secondhand smoke exposure does not occur in the workplace.

4. The majority of workers in the United States are now covered by smoke-free policies.

5. The extent to which workplaces are covered by smoke-free policies varies among worker groups, across states, and by sociodemographic factors. Workplaces related to the entertainment and hospitality industries have notably high potential for secondhand smoke exposure.

6. Evidence from peer-reviewed studies shows that smoke-free policies and regulations do not have an adverse economic impact on the hospitality industry.

7. Evidence suggests that exposure to secondhand smoke varies by ethnicity and gender.

8. In the United States, the home is now becoming the predominant location for exposure of children and adults to secondhand smoke.

9. Total bans on indoor smoking in hospitals, restaurants, bars, and offices substantially reduce secondhand smoke exposure, up to several orders of magnitude with incomplete compliance, and with full compliance, exposures are eliminated.

10. Exposures of nonsmokers to secondhand smoke cannot be controlled by air cleaning or mechanical air exchange.

REVISED

MUNICIPALITY OF ANCHORAGE
Summary of Economic Effects -- General Government

AO Number: 2006-86

Title: An ordinance of the Anchorage Municipal Assembly repealing and reenacting AMC Chapter 16.65, prohibition on smoking in public places, to extend secondhand smoke control.

Sponsor: Assemblymember Traini and Coffey
Preparing Agency: Assembly
Others Impacted:

CHANGES IN EXPENDITURES AND REVENUES: **(In Thousands of Dollars)**

	FY06	FY07	FY08	FY09	FY10
Operating Expenditures					
1000 Personal Services	$ -	$ -	$ -	$ -	$ -
2000 Non-Labor	-	-	-	-	-
3900 Contributions					
4000 Debt Service					
TOTAL DIRECT COSTS:	$ -	$ -	$ -	$ -	$ -
Add: 6000 Charges from Others					
Less: 7000 Charges to Others					
FUNCTION COST:	$ -	$ -	$ -	$ -	$ -
REVENUES:					
CAPITAL:					
POSITIONS: FT/PT and Temp					

PUBLIC SECTOR ECONOMIC EFFECTS:

There is no clear indication that this ordinance would have a significant public sector economic effect. However, some research suggests that similar laws often encourage individuals to cease smoking or to smoke less. This being the case, there would be a reduction of public health costs associated with smoking. In addition, public sector organizations would see a reduction in work time lost due to smoke related ailments. There would also be a potential decrease in employee health insurance rates. These public health costs have been explored in the recent (6/27/06) Surgeon General's report.

This reduction in smoking could also have a negative economic impact on state and local treasuries. This effect may result in some reduction of the nearly $16 million collected by the Municipality every year on the taxes associated with tobacco sales.

PRIVATE SECTOR ECONOMIC EFFECTS:

The preponderance of peer-reviewed research suggests that there is no reduction in a private organizations economic viability based solely on a smoking ban. The Surgeon General's Report issued 6/27/06, provides a thorough review of research on this topic . The report found no evidence in peer-reviewed scientific literature of negative economic effects of smoking restrictions on the hospitality industry.

Some research, mostly non-scientific and based on subjective measures, suggests that business will suffer if they cease to allow customers to smoke within their premises. This research states that individuals who smoke will choose not to enter non-smoking facilities.

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Municipality of Anchorage
MUNICIPAL CLERK'S OFFICE

AM 457-2006

Agenda Document Control Sheet

(SEE REVERSE SIDE FOR FURTHER INFORMATION)

1	SUBJECT OF AGENDA DOCUMENT: TO EXTEND SECONDHAND SMOKE CONTROL	DATE PREPARED: 7/3/06
		Indicate Documents Attached: ☐ AO ☐ AR ☒ AM ☐ AIM
2	DEPARTMENT NAME: Assembly	DIRECTOR'S NAME: Dan Sullivan, Chair
3	THE PERSON THE DOCUMENT WAS ACTUALLY PREPARED BY: Julia Tucker - Assembly Counsel	HIS/HER PHONE NUMBER: 343-4419

4	COORDINATED WITH AND REVIEWED BY	INITIALS	DATE
	Mayor		
	Municipal Clerk		
	Municipal Attorney		
	Employee Relations		
	Municipal Manager		
	Cultural & Recreational Services		
	Fire		
	Health & Human Services		
	Merrill Field Airport		
	Municipal Light & Power		
	Office of Management and Budget		
	Police		
	Port of Anchorage		
	Public Works		
	Solid Waste Services		
	Transit		
	Water & Wastewater Utility		
	Executive Manager		
	Community Planning & Development		
	Finance, Chief Fiscal Officer		
	Heritage Land Bank		
	Management Information Services		
	Property & Facility Management		
	Purchasing		
	Other		

M.O.A.
2006 JUN 33 AM 8:10
CLERKS OFFICE

5 **Special Instructions/Comments**

REF. AO 2006-86, NEW PUBLIC HEARINGS

Revised SFE attached

CLERKS OFFICE
2006 JUL -3 AM 8:11
M.O.A.

6	ASSEMBLY HEARING DATE REQUESTED: 7/11/06	7	PUBLIC HEARING DATE REQUESTED: 7/11/06