**Policy Statement**

**CLHO Committee:** Health Promotion & Prevention

**Policy Statement:** The Oregon Coalition of Local Health Officials supports a statewide, comprehensive smoke and vape-free workplace law with no exemptions or preemption of local ordinances. Tobacco use costs Oregonians $2.5 billion a year in medical expenses, lost productivity and early death.[[1]](#endnote-1)

**Policy Positions:** CLHO supports a strong Indoor Clean Air Act that:

* Makes no exemptions for smoking or vaping indoors, including places such as certified smoke shops and cigar bars
* Makes no exemptions for smoking or inhaling cannabis and cannabinoid products
* Does not include preemption that restricts local governments from enacting stronger smoke and vape-free workplace laws
* Protects employees, youth and Oregonians from second-hand exposure

**Public Health Issue that Policy Statement is Addressing:**

* Smoking prevalence
* Exposure to secondhand smoke and aerosol
* Youth initiation of tobacco products
* Cannabis and youth initiation to cannabis

**Justification (data supporting the need to work on this issue):**

Tobacco use is the number one preventable cause of death and disease in Oregon. Annually, tobacco use leads to nearly 8,000 deaths as well as costs the state $2.5 billion in medical expenses and lost productivity.1 In Oregon, smoking rates are higher among African Americans (33%) and American Indians and Alaska natives (35%) than among whites (21%).1 More than one in three Oregonians who make less than $15,000 per year smoke (39%), compared to one in 10 who make more than $50,000 per year (9%).1 Additionally, Oregonians with less than a high school education are nearly four times more likely to smoke, compared to those with a college degree (33% vs. 7%).1

Secondhand Smoke

Secondhand tobacco smoke causes more than 7,300 lung cancer deaths among U.S. nonsmokers each year. It also causes health problems in infants and children, including asthma attacks, respiratory infections, ear infections and sudden infant death syndrome (SIDS).[[2]](#endnote-2),[[3]](#endnote-3) An estimated 625 deaths occur annually as a result of secondhand smoke in Oregon.[[4]](#endnote-4)

Smokefree policies have been shown to protect nonsmokers from secondhand smoke exposure. These policies have also been shown to motivate and help smokers to quit, increasing cessation and reduce smoking prevalence. There is also evidence that these policies may also reduce youth smoking initiation.[[5]](#endnote-5)

More than one in 10 Oregonians are exposed to secondhand smoke at work, despite expanding the places where employees are protected from secondhand smoke.1 Additionally, the Indoor Clean Air Act still contains exemptions for certified smoke shops and cigar bars, allowing smoking inside the premises if retailers abide by specific requirements.[[6]](#endnote-6)

E-cigarettes and Vaping

E-cigarette use among Oregon 11th graders increased three-fold from 2013 to 2015 from 5% to 17%.1 While youth e-cigarette use is associated with future use of combustible tobacco, the reverse is not true. Smoking combustible tobacco products is not associated with future youth use of e-cigarettes.[[7]](#endnote-7) In 2017, 49% of Oregon 11th graders who had ever used tobacco tried vaping products as their first product used.1 The acceptance of e-cigarette use in public is challenging the strong normative pressure against smoking achieved in recent years. Allowing the sampling of vaping products indoors, and the associated marketing and advertising, further increases the acceptance of e-cigarette use among youth. The vaping industry is interested in carving out a space for indoor sampling of vape products, despite the prohibition of the use of inhalant delivery systems in the Indoor Clean Air Act.[[8]](#endnote-8)

Exemptions allowing vaping indoors also pose a challenge to enforcement of the Indoor Clean Air Act. Local Public Health Departments work with the Oregon Health Authority to enforce the Indoor Clean Air Act by responding to complaints and conducting site visits to determine if a business is in violation of the law. Exemptions to the Indoor Clean Air Act will increase the burden of enforcement on Local Public Health Departments in two primary ways. First, Local Public Health Department staff would need to determine whether vaping products used indoors contain nicotine or cannabinoids. This determination would be time consuming and difficult, if even possible. Second, as e-cigarette retailers are not licensed under Oregon law, there is the potential for any business to allow vaping indoors if the Indoor Clean Air Act is weakened with these types of exemptions. The responsibility for determining compliance would again fall on Local Public Health Departments. A strong Indoor Clean Air Act, with no exemptions, provides broad protections for the public, is clear for business owners to follow, and is straightforward for local public health to enforce. Introducing exemptions puts the strengths of Oregon’s current law at risk.

Emerging research also shows that the aerosol users breathe and exhale from the device can contain potentially harmful substances, including nicotine, flavoring such as diacetyl (a chemical linked to a serious lung disease), volatile organic compounds, ultrafine particles that can be inhaled deep into the lungs, cancer-causing chemicals such as formaldehyde, and heavy metals such as nickel, tin, and lead.[[9]](#endnote-9)

Marijuana

The legalization of marijuana in Oregon also presents new challenges to the Indoor Clean Air Act. Public use of marijuana is currently illegal in Oregon; however, other jurisdictions with legalized marijuana are examining carving out areas in their clean indoor air laws by providing exemptions for indoor marijuana consumption. For example, jurisdictions in California are permitted to allow the smoking and vaporizing of cannabis products on the premises of a business.[[10]](#endnote-10) In fact, a cannabis consumption lounge recently opened in San Francisco allowing smoking indoors; other jurisdictions are accepting applications for consumption lounges.[[11]](#endnote-11),[[12]](#endnote-12)

Secondhand marijuana smoke contains THC (tetrahydrocannabinol), the chemical responsible for most of marijuana’s psychological effects, and many of the same toxic chemicals in smoked tobacco.[[13]](#endnote-13),[[14]](#endnote-14), [[15]](#endnote-15) Marijuana has many of the same cancer-causing substances as smoked tobacco, and there are unanswered questions around secondhand marijuana smoke exposure and its impact on chronic diseases such as heart disease, cancer, and lung diseases.[[16]](#endnote-16) The Indoor Clean Air Act should not be weakened to allow exemptions for smoking or inhaling cannabis and cannabinoid products.

Preemption

The Indoor Clean Air Act should not include preemption that restricts local governments from enacting stronger smoke and vape-free workplace laws. State preemption language prevents local governments from passing stronger, more comprehensive regulations regulating smoking indoors to reduce secondhand smoke exposure.

Historically, the tobacco industry supports preemptive state laws as a way to reverse existing local tobacco control ordinances and prevent future enactment of such ordinances. The tobacco industry's leading legislative strategy against local tobacco control laws has been preemptive state laws.[[17]](#endnote-17) Keeping preemption out of a state smoke-free workplace law allows local public health to be responsive to its community, allowing for the strongest indoor clean air laws possible.

**Role of Local Public Health (promising practice/evidenced-based work):**

Local public health departments are charged with protecting the health of all people in Oregon. Evidence shows that comprehensive clean indoor air laws are an effective strategy to reduce exposure to secondhand smoke; reduce prevalence of tobacco use; reduce tobacco consumption and increase quit rates among tobacco users; reduce initiation of tobacco use among young people; and reduce tobacco-related death and disease.13 These reductions, in turn, lead to lower health care and medical costs for Oregonians. For every $1 spent on prevention in Oregon, an estimated $4 is saved in medical costs alone. The savings is even greater for those enrolled in Medicaid, with a $7 savings for every $1 spent.[[18]](#endnote-18)

For decades, the strongest most innovative policies to reduce tobacco use have emerged at the local level before ultimately being adopted at the state or federal levels.[[19]](#endnote-19) For example, 12 Oregon communities passed local smokefee workplace laws before the Indoor Clean Air Act was passed at the state level. Although the Indoor Clean Air Act allows exemptions for certified smoke shops and cigar bars, several local jurisdictions have already removed this exemption, further protecting employees and the public from secondhand smoke and vapor exposure. By continuing to advocate for no preemption at the state level, local governments can continue to innovate and create reponsive regulations that lead to statewide reductions to secondhand smoke exposure and tobacco use.

**Connection to Modernization Manual Foundaional Programs/Capabilities:**

Foundational Programs:

Health Promotion & Prevention

Foundational Capabilities:

Policy & Planning

Health Equity

1. Oregon Health Authority Public Health Division, Health Promotion and Chronic Disease Prevention Section. 2018. Oregon tobacco facts. Available at <https://public.health.oregon.gov/PreventionWellness/TobaccoPrevention/Pages/pubs.aspx> [↑](#endnote-ref-1)
2. U.S. Department of Health and Human Services. The health consequences of smoking — 50

   years of progress: A report of the surgeon general. Atlanta: U.S. Department of Health and

   Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease

   Prevention and Health Promotion, Office on Smoking and Health, 2014. Available at

   <http://www.surgeongeneral.gov/library/reports/50-years-of-progress/> [↑](#endnote-ref-2)
3. U.S. Department of Health and Human Services. Let’s make the next generation tobacco-free:

   Your guide to the 50th anniversary surgeon general’s report on smoking and health. [PDF–795

   KB] Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and

   Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on

   Smoking and Health, 2014. Available at https://www.surgeongeneral.gov/library/reports/50-years-

   of-progress/consumer-guide.pdf [↑](#endnote-ref-3)
4. Oregon Health Authority Public Health Division, Health Promotion and Chronic Disease Prevention Section. 2017. Tobacco Prevention and Education: Expanding our reach for a healthier Oregon. Available at <http://www.oregon.gov/oha/PH/PREVENTIONWELLNESS/TOBACCOPREVENTION/Documents/TPEP%20Report%202015%20to%202017.pdf> [↑](#endnote-ref-4)
5. <https://www.cdc.gov/tobacco/data_statistics/fact_sheets/secondhand_smoke/protection/reduce_smoking/index.htm> [↑](#endnote-ref-5)
6. Oregon Health Authority. Public Health Division, Health Promotion and Chronic Disease Prevention Section. Tobacco Prevention and Education Program. Indoor Clean Air Action. Smoke Shop and Cigar Bar Certification.http://www.oregon.gov/oha/PH/PREVENTIONWELLNESS/TOBACCOPREVENTION/SMOKEFREEWORKPLACELAW/Pages/certification.aspx [↑](#endnote-ref-6)
7. Bold KW, Kong G, Camenga DR, et al. Trajectories of E-Cigarette and Conventional Cigarette Use Among Youth. Pediatrics. 2018;141(1):e20171832 [↑](#endnote-ref-7)
8. 2017 Oregon Legislative Session. Senate Bill 799 [↑](#endnote-ref-8)
9. US Department of Health and Human Services. [E-cigarette use among youth and young adults: a report of the Surgeon General [PDF–8.47 MB]](https://www.cdc.gov/tobacco/data_statistics/sgr/e-cigarettes/pdfs/2016_sgr_entire_report_508.pdf" \t "_blank). Atlanta, GA: US Department of Health and Human Services, CDC; 2016 [↑](#endnote-ref-9)
10. SB 94, Chapter 27, SEC. 102, 26200(a)) [↑](#endnote-ref-10)
11. <https://www.usnews.com/news/business/articles/2018-03-15/san-francisco-one-of-few-us-cities-with-marijuana-lounges> [↑](#endnote-ref-11)
12. <https://www.bloomberg.com/news/articles/2018-05-31/cannabis-lounges-will-soon-light-up-west-hollywood-s-bar-scene> [↑](#endnote-ref-12)
13. Moore, C., et al. (2011). Cannabinoids in oral fluid following passive exposure to marijuana smoke. *Forensic Sci Int,* 212(1-3): p. 227-30 [↑](#endnote-ref-13)
14. Cone, E.J., et al. (2015) Non-smoker exposure to secondhand cannabis smoke. I. Urine screening and confirmation results*. J Anal Toxicol,* 39(1): p. 1-12 [↑](#endnote-ref-14)
15. Zarfin, Y., et al. (2012) Infant with altered consciousness after cannabis passive inhalation*. Child Abuse Negl*, 36(2): p. 81-3 [↑](#endnote-ref-15)
16. Centers for Disease Control and Prevention. Marijuana and Public Health. Health Effects. Marijuana: How Can It Affect Your Health? <https://www.cdc.gov/marijuana/health-effects.html> [↑](#endnote-ref-16)
17. Community Preventive Services Task Force. Reducing Tobacco Use and Secondhand Smoke Exposure: Smoke Free Policies. Document last updated Jun3 3, 2013. https://www.thecommunityguide.org/sites/default/files/assets/Tobacco-Smokefree-Policies.pdf [↑](#endnote-ref-17)
18. Solet D, Boles M. The health and economic benefits of public health modernization in Oregon. Program Design and Evaluation Services. Prepared for the Oregon Health Authority Public Health Division. 2016 Sept 6. Available at: healthoregon.org/modernization [↑](#endnote-ref-18)
19. Tobacco Control Legal Consortium. Fact Sheet. Why Preemption is Bad for Tobacco Control. (Updated Oct. 2014). Available at http://www.publichealthlawcenter.org/sites/default/files/resources/tclc-fs-why-preemption-bad-tobacco-control-2014.pdf [↑](#endnote-ref-19)