In this issue,

we place the tobacco industry in an historical context, examining how the industry has strategically targeted different demographic audiences over time to retain and build its customer base, shifting from an early focus on the well-heeled to its current targeting of America’s working class; the toll tobacco is taking on the health and economic well-being of blue-collar and service workers; and steps unions are taking to reduce the harm tobacco causes union members and their families.

Over many decades, tobacco companies have provided jobs for thousands of unionized workers involved in the manufacture, transport, marketing, distribution and sale of tobacco products, and have provided financial support for much-valued programmatic work of union-affiliated organizations. Knowing this history, and knowing that many union members still smoke or chew tobacco, some union leaders have been reluctant to address tobacco’s impact on union members. Why should unions care about tobacco prevention?

Blue-collar and service workers, many of whom are union members, are disproportionately impacted by tobacco. Compared to white collar workers, they are substantially more at risk for workplace exposure to smoke and tobacco-related medical conditions, diseases, and death.1,2 Armed with information on the health and economic harms that tobacco causes, union leaders are partnering with public health advocates to reduce workers’ exposure to tobacco smoke and to ensure that all workers who want to quit have ready access to comprehensive smoking cessation coverage. This guide provides numerous resources you can use to conduct outreach to your union’s members.
Advocating for Worker Health & Safety

The movement toward smoke-free workplaces is not about job elimination. It is about the right of every worker to breathe clean air. It is about improving workers’ health and safety on the job, improving productivity, and reducing health care and other tobacco-related costs. The movement toward smoke-free workplaces is about enhancing and extending workers’ lives by reducing or eliminating workplace exposure to secondhand smoke, a lethal occupational workplace hazard. It is about ensuring that every worker who chooses to quit tobacco has ready access to effective, affordable cessation programs.

Tobacco is the most preventable cause of death in Minnesota and in the U.S. Smoking kills more than 440,000 Americans each year from diseases caused by smoking or exposure to secondhand smoke, more than alcohol, legal and illegal drugs, motor vehicle crashes, homicide and suicide combined. In Minnesota, 1 in every 7 deaths, or 5,600 deaths per year, is attributable to smoking.

Blue-collar and service sector workers, many of whom are union members, are disproportionately impacted by tobacco. Compared to white-collar workers, blue-collar, service and hospitality workers are substantially more at risk for workplace exposure to smoke and tobacco-related medical conditions, diseases, and death.

In a survey of Minnesota union members conducted by WorkSHIFTS in 2003, 30% of union members polled identified themselves as smokers. Members who worked in smoke-free settings, had children under age 18 residing with them, and who worked indoors were significantly less likely than other members to report being current smokers. Females were less likely than males to report smoking. Also, 76% of smokers reported they had tried to quit at least one time.

Unions can make critical contributions toward improving their members’ health and safety and reducing existing disparities by advocating on behalf of their members for smoke-free workplaces and improved access to much-needed cessation benefits for those who want to quit. Tobacco use is a monumental epidemic, yet it is one that can be stopped.

voices of labor

[At LIUNA], we believe that every worker is entitled to a safe working environment and to information that will promote a healthier lifestyle. At our union we have accepted the challenge of addressing our members’ health issues head on. Our programs in this area demonstrate that unions can take on tobacco control and cancer prevention in ways that make sense within a union environment…the message we get out is this: smoking not only can ruin your health, it can shorten your career and endanger your ability to provide for your family.

Terence M. O’Sullivan, General President
Laborers’ International Union of North America (LIUNA)

In 2001, tobacco companies spent more than $11 billion—more than $30 million per day—in the U.S. alone for direct marketing and promotion of cigarettes (over $200 per smoker, more than 46 cents for every pack sold). Promotion allowances, in the form of payments to retailers to facilitate sales, account for more than 40% of total marketing expenditures. In Minnesota, in 2001, the industry spent an estimated $196 million to recruit new smokers, increase consumption, and retain customer loyalty.

Tobacco companies contend that advertising does not increase the overall quantity of tobacco sold and merely enhances market shares of existing brands without recruiting new smokers; however, a convincing body of evidence demonstrates that tobacco advertising plays a critical role in encouraging nonsmokers to begin smoking and is a particularly important factor in influencing young people to smoke.

In the document quoted above, Philip Morris predicted a dismal future for the industry, vis-à-vis smoke-free workplace policies, and suggested strategies, including the formation of “strategic alliances with those who exercise social control, e.g., personnel managers, owners of catering establishments, trade unions...we can only fight those systems through those who manage them.” Yet, here we are, a decade later, and the industry’s dire predictions have yet to come true. Why?

Cigarettes are among the most heavily marketed products in the world, with global marketing expenditures in the tens of billions of dollars per year.
Marketing Tobacco: An Historical Perspective

The following examples illustrate how the industry’s target populations have shifted over time.

**Early targets: The well-heeled**

Decades before the release of the landmark 1964 Surgeon General’s report on the health risks associated with tobacco use, which also identified secondhand smoke as harmful to nonsmokers, industry ads catered to middle- and upper-middle class consumers, including doctors and high-society women. Today, those with the most social and economic power have the lowest smoking rates.  

Just a century ago, smoking among women was taboo. A woman could be arrested for smoking in public. In 1921, federal legislation was proposed to ban women from smoking in Washington, D.C. A marketing shift occurred during and after World War I, when many women entered the work force to help with the war effort and were granted the right to vote. By the 1920s, the tobacco industry had begun exploiting ideas of liberation and power to design advertisements to attract women smokers, characterizing smoking as respectable, sociable, feminine, a symbol of independence, emancipation and success, and a way to avoid gaining weight.  

Today, one of every five women in the U.S. is a smoker. Lung cancer is the leading cancer killer among women. In 2000, the number of chronic obstructive pulmonary disease (COPD) deaths among women exceeded those among men for the first time.  

Current rates of cigarette smoking are roughly equivalent among young males and females. The increase in young girls’ tobacco use has been attributed mainly to aggressive marketing aimed at girls that portrays smoking as fashionable, feminine and a way to stay slim, in contrast to marketing to boys that portrays smoking as a way to be macho and tough.

Women and the ‘torch of freedom’

THE MARLBORO MAN UNMASKED

The hard-smoking working man’s champion, the Marlboro Man, was the top ad icon of the 20th Century, according to Advertising Age. But did you know that Marlboro was first marketed in the 1920s as a premium cigarette for women?

Marlboro sales exploded in the 1950s when the company began marketing Marlboros to men and introduced the Marlboro Man, a rugged, masculine symbol of freedom and individual power. Today, Marlboro remains the most popular U.S. brand of cigarettes.
Today, smoking in the U.S. is highest among men, American Indians, low income adults and those with low levels of education.³

Tobacco ads and other promotions target those Americans who still smoke—working class women, men and youth in the prime of life, many of whom are union members in blue-collar, service and hospitality jobs. These are today’s smokers.

Ads lure new customers and retain brand loyalty among existing customers by portraying smokers as young, hip, rebellious, fit, strong, sexy, fun and relaxed, wearing blue jeans and cowboy boots, hanging out at bars, the pool hall and the racetrack. Young adults and underage youth are particularly receptive to these messages.

Today’s targets:
Working class men, women, and youth

Industry documents from the 1960s reveal that between 1965 and 1969, RJ Reynolds spent more than $5 million tailoring ads to Black, Hispanic and Jewish special markets.

The strategy for advertising to the Negroes through their media is to create ‘Negro upscale situations’ and to make these consumers feel that the advertising is directed to them…

RJ Reynolds, Negro Market Study, September 1969
Bates No. 501989230/9469

A telling 1996 RJ Reynolds marketing research report shows how the industry targeted populations by clustering them into groups of similar socio-economic status, lifestyle, educational level, neighborhoods and interests and assigning them entertaining nicknames to differentiate them, including: "Kids & Cul-de-Sacs," "Shotguns & Pickups," "Hispanic Mix," "Norma Rae-ville," "God’s Country," and "Hard Scrabble." (Bates No. 516598872/8914)

Tobacco & Troops

During World Wars I and II, as well as the Korean and Vietnam wars, the U.S. government distributed free cigarettes in soldiers’ daily rations, and family members were urged by the tobacco industry to support the troops by sending even more.

Cigarettes were portrayed as a companion that soldiers could find solace in during pre-combat anxiety and loneliness, a form of smart marketing by the industry, building a huge future customer base under the cloak of patriotism.¹²

Today, despite decades of efforts by the military’s top brass to weaken the links between troops and tobacco, smoking rates among military personnel are substantially higher than the general public’s.¹⁸
Sports sponsorships give high visibility

Auto racing is the second most-watched sport on television. In 1999 alone, racing sponsorships provided tobacco companies with more than $122 million worth of television exposure. Tobacco company sponsorships of sport events, like NASCAR auto races, cater to working class values, conveying an image of corporate generosity while linking tobacco products with having a good time.

Survey research conducted in 2001 discovered that 4.9 million Sports Illustrated readers were under age 18. In 2000, Sports Illustrated reaped close to $40 million in ad revenue from tobacco ads, according to Competitive Media Reporting, an organization that monitors magazine advertising.

In the 1999 NASCAR Winston Cup Series, Winston received more than 19 hours of in-focus brand display on TV, plus over 3,300 on-air brand mentions for more than $94 million worth of television exposure.
Targeting youth

As part of the historic legal settlements with U.S. states, tobacco companies promised to stop targeting youth in advertising, promotion or marketing, directly or indirectly. As a result, Joe Camel ads and other cartoon-like marketing images have been removed from the marketplace. Still, despite terms that were intended to prevent advertisements from appearing in magazines with more than 15% youth readership or more than 2 million readers under the age of 18, tobacco ads continue to appear in magazines like Rolling Stone, People, Sports Illustrated, Glamour, Cosmopolitan and Vogue. Young people are also consistently exposed to pro-tobacco images in movies and on television.

Targeting young adults

The importance of young smokers to the short- and long-term growth of the cigarette market is not lost on tobacco companies. Promotions of tobacco products in bars and nightclubs have become important mechanisms that tobacco companies use to create and maintain brand images. These promotions are generally targeted at young adult audiences and portray smoking as being part of a lifestyle that includes socializing at nightclubs or bars. A recent example is the Camel Casbah Clubs promotion, which creates a close link between the Camel brand name and entertainment aimed at the young adult market, picking up where Joe Camel left off.

Marlboro, Camel and Newport, the three most heavily advertised U.S. brands of cigarettes, are the three brands smoked most frequently by underage youth.

A 1985 RJ Reynolds document that analyzed the future cigarette market eyed the importance of young smokers to future market potential: YAS [young adult smokers] are critical to short and long term growth…They represent the most important area of opportunity for new RJR brands…Less educated and more downscale smokers will become even more important to the cigarette marketplace in the future.

industry speak

When asked to comment on continuing concerns about youth exposure to tobacco ads in magazines, an RJ Reynolds spokesperson stated that there was only one way to ensure that underage readers not be exposed to such ads: That would be to ban all cigarette advertising in magazines…We never agreed to that.

Jan Smith, RJ Reynolds, in NY Times, 8–15-2001 Tobacco Industry Still Advertises in Magazines Read by Youth, by Alex Kuczynski
Buying Political Influence

The tobacco industry spends millions of dollars each year trying to influence public policy by bankrolling lobbyists, making major contributions to political parties and political candidates, making large investments in sophisticated public relations campaigns, and funding civic, educational and cultural organizations.

From 1995-2000, tobacco companies donated more than $32 million in U.S. political campaign contributions to state and federal candidates and political parties. Over 80% of that amount went toward influencing federal elections and offices. Between 1995 and 2000, members of the U.S. Congress received more than $5 million in contributions from tobacco companies—nearly 6 out of 10 members accepted tobacco money. The industry has used its financial prowess to block OSHA, EPA and FDA smoking regulations and kill efforts to restrict smoking or regulate tobacco products in ways similar to other drugs or hazardous substances.\textsuperscript{23,24}

Minnesota’s 1998 tobacco lawsuit settlement with the industry requires tobacco giants Philip Morris, Brown & Williamson, RJ Reynolds and Lorillard to disclose annually any payment they make to a lobbyist or principal if they know or have reason to know that the payment will be used, directly or indirectly, to influence legislative or administrative action or the official action of Minnesota state or local government units relating in any way to tobacco products or their use.

In 2003 alone, the industry spent nearly $600,000—an average of roughly $2,700 per Minnesota state legislator—to push their corporate agenda. Paid lobbyist and principal organizations included: Minnesota Chamber of Commerce; Minnesota Wholesale Marketers Association; Minnesota Retail Merchants Association; Accommodation Coalition; Minnesota Agri Growth Council, Inc., and Legislative Demographic Services.\textsuperscript{25}

\textbf{voices of labor}

\begin{quote}
The tobacco industry tried to scare our members into thinking their employers would lose business due to the smoking ban and that they would lose their jobs. I’m proud to say our union members and many employers saw through these tactics and stood up for the right to a safe and healthy workplace.

Mike Casey, President UNITE HERE Local 2
San Francisco, California.
From letter of support, February 26, 2001
\end{quote}

\begin{quote}
One of the things I’ve always said about the tobacco industry is that they are much more foresighted than the government, a lot smarter than the government, and they are richer than the government so they can do anything they want, and they are clever at what they do.

Dr. C Everett Koop, former U.S. Surgeon General
From Smoking: Billions Spent on Lives Lost.
United Press International, January 2004
\end{quote}
Using front groups on grassroots campaigns

Tobacco companies use front groups skillfully—including trade associations, local citizen groups, hospitality associations, Chambers of Commerce and, at times, labor organizations—to oppose local and statewide smoking restrictions while staying in the shadows of controversial debates. Front groups are often paid by the tobacco industry to oppose proposed tobacco laws and push for the dilution of proposed legislation.

The Massachusetts Restaurant Association, a nonprofit trade organization that advocates for the interests of restaurants and bars, has worked with the tobacco industry since the mid-1970s to fight restrictions on smoking in public places, using two arguments:

1. Smoking restrictions will be bad for business and eliminate jobs; and
2. Smoking is legal and nonsmokers can choose not to visit smoky establishments.

To defeat a 1978 legislative initiative to restrict indoor smoking in Massachusetts, two U.S. tobacco corporations, both dues-paying members of the Massachusetts Restaurant Association, formed a political action committee (PAC) with the hotel and restaurant industry. The Massachusetts Restaurant Association, as the organization that led the effort to defeat this legislation, succeeded in masking the extent of the tobacco industry’s involvement.

I want to start by saying without qualification that Philip Morris USA cannot grow without a strong, well-organized and well-thought-out legislative program. We need that legislative program to prevent excise tax increases, marketing restrictions and smoking bans from making our products unaffordable, unpromotable and unacceptable.

...A legislator is never too busy to talk about things like political contributions, fundraising for a coming election campaign and programs to benefit his district.

Excerpted from Grasstops Government Relations, a presentation given by Tina Walls, Philip Morris, March 30, 1993, accessed at www.pmdocs.com and Minnesota Smoke-Free Coalition

Supporting anti-union agendas

Political contribution disclosures demonstrate that although industry funds have been flowing to both political parties, far more support has gone to the Republican party, its candidates and political action committees (PACs). Between 1995 and 2000, the tobacco industry gave $17.4 million in soft money donations to PACs and political parties, of which $2.5 million was contributed to Democratic PACs or candidates and $15 million was contributed to Republican PACs or candidates—many of whom are the same lawmakers who try repeatedly to eliminate prevailing wages, repeal the right to organize unions, and weaken workers’ compensation and health insurance benefits.
Labor Support for Tobacco Control

As unions in the U.S. and many other countries, among them Canada, Great Britain and other western European nations, and Australia, have become increasingly aware of the gravity of the tobacco epidemic and its toll on union members, union leaders have joined forces with public health organizations, community coalitions, and political leaders to take steps to reduce workers’ exposure to secondhand smoke and to improve workers’ access to effective cessation services.

Minnesota support for tobacco control

Twenty-four percent of employed Minnesota residents are blue-collar workers; 41% work in service or service-related industries.

Results of WorkSHIFTS’ survey of Minnesota union members in 2003 found that 32% of respondents supported 100% smoke-free workplace legislation and that 55% supported workplace smoking restrictions. Of those surveyed, 85% believed cessation programs were an important union benefit and 75% supported union bargaining for reasonable smoking restrictions.5

There are many ways unions can take action in support of tobacco prevention goals to improve the health and safety of rank and file union members. In Minnesota, WorkSHIFTS and union leaders are working hand-in-hand to develop and disseminate an array of educational tools and resources on tobacco use, secondhand smoke, and cessation coverage that can be tailored to meet the needs of different blue-collar and service unions. WorkSHIFTS also facilitates policy transitions and offers technical assistance with policy formation and implementation issues.

A study of 38 major occupations in 2004 found that only 43% of the country’s food-service and blue-collar workers are covered by smoke-free policies, while 90% of teachers are covered by such policies.28

Waiters and bartenders who have direct interaction with the public have far greater exposure to secondhand smoke than do those who work in kitchens.

The Bureau of Labor Statistics ranks food service as the 4th-largest occupation in the U.S., employing nearly 7 million people, and as one of the fastest-growing segments of the workforce.

Blue-collar workers:

- start to smoke earlier than other workers;
- are heavier smokers than white-collar workers;
- are more likely to be employed at sites where they are exposed to a number of other harmful chemicals that interact with and exacerbate the harmful effects from tobacco smoke, thereby multiplying their risk of disease; and
- are less successful in quitting tobacco, despite making multiple quit attempts.27

Death by cigarette smoke should not be a condition of employment.

Tom Rankin, President
California Labor Federation, AFL-CIO
Statement made in support of workplace smoke-free laws
1998, 2002

voices of labor
There are many possible ways for unions to take action to help reduce members’ exposure to secondhand smoke and improve their access to cessation services, including:

- Providing members with practical educational information on the health and economic harms associated with tobacco use and with exposure to secondhand smoke at work and at home.
- Advocating for workplace smoke-free policies that protect workers from harmful exposure to secondhand smoke.
- Advocating for improved access to effective cessation coverage and services to help workers and their families quit using tobacco products.
- Advocating on behalf of individual workers who are harmed by unwanted exposure to tobacco smoke in the workplace.
- Joining labor and community coalitions that support smoke-free worksite policies.

Sources

Sources, continued

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WorkSHIFTS is a collaborative labor outreach initiative of the Tobacco Law Center at William Mitchell College of Law, partnering with Minnesota’s labor community.

WorkSHIFTS’ goal is to provide practical tools and resources that support labor’s efforts to address tobacco-related workplace concerns through education, collective bargaining, policy initiatives and the assertion of workers’ rights to health and safety.

For information, please contact:
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sweisman@wmitchell.edu
www.workshifts.org
In this issue,
we address the relationship between tobacco and workplace toxins. We include critical information every worker should know about secondhand smoke, what it is and how it interacts with other workplace hazards and toxins to greatly multiply workers’ health risks. You will learn why smoke-free workplaces are essential to protect the health of all workers from the harmful impact of tobacco.

Most workers know that smoking and exposure to secondhand smoke is unhealthy, yet many remain unaware of the magnitude of their health risks. Secondhand smoke is something many people still think of as a mere annoyance, not as a cause of disease and death. All workers, particularly those who work in smoky environments or with hazardous materials, should understand the impact that smoking and exposure to secondhand smoke can have on their health and safety so that they can make informed choices about their personal behaviors, understand the rationales for policy changes, and exercise their rights in the workplace. Within these pages, you will find valuable resources to facilitate outreach to members.
What is Secondhand Smoke?

When tobacco is burned or smoked, it generates a complex and dangerous mixture of chemical particles and gases. Secondhand smoke, sometimes called environmental tobacco smoke, is a mixture of the smoke released from the burning end of a cigarette, pipe, cigar, or other smoking device (sidestream smoke) and the smoke exhaled by smokers (mainstream smoke).¹ The exposure of people to secondhand smoke is often referred to as involuntary or passive smoking because it involves the inhalation of the same carcinogens and other toxins that are inhaled by smokers.

The Environmental Protection Agency (EPA) has classified secondhand smoke as a Group A carcinogen, a classification reserved for substances known to cause cancer in humans.² There is no safe level of exposure to Group A carcinogens. Despite this knowledge, secondhand smoke is the only Group A carcinogen not regulated by the Occupational Safety and Health Administration (OSHA)—a sad testament to the tobacco industry’s substantial lobbying power.

What is in secondhand smoke?

Secondhand smoke contains over 4,000 chemicals, including more than 50 known cancer-causing agents (carcinogens) and hundreds of irritants and toxins that cause other severe health problems.³ Tobacco companies use additives to enhance the flavor of cigarettes and make them milder or easier to inhale.⁴ They also use additives to increase the level of free (easily absorbed) nicotine, which allows smoke to pass deeper into a smoker’s lungs, leading to a stronger addiction. The resulting lung damage leaves active smokers more susceptible to other toxins, including many hazardous workplace chemicals, and increases smokers’ health risks for many other diseases and illnesses.

voices of labor

[Talking about combining workplace chemicals with tobacco smoke] It wouldn’t have made a difference, especially when I was younger. I was invincible. Now, I think about it.

Minneapolis Blue-Collar Worker, Smoker, 2003

The multiplier effect

When workers are exposed to tobacco smoke in combination with exposure to other toxins or chemicals, a multiplier or synergistic health effect may occur. When this happens, the combined exposures result in substantially greater health risks than would occur with separate exposures. This happens because cigarette smoking transforms existing chemicals into more harmful ones, increases exposure to existing toxic chemicals, adds to the biological effects caused by certain chemicals and interacts synergistically with existing workplace chemicals.⁵ In 1985, the U.S. Surgeon General concluded that the combination of smoking with exposure to other hazardous substances at workplaces presents a serious health risk.⁶

Asbestos workers who smoke have 10 times the risk for developing lung cancer as asbestos workers who do not smoke.⁶

One-third of cancer cases among smokers exposed to asbestos on the job can be attributed to the combination of smoking and asbestos exposure.⁷

Death from asbestosis is three times higher among workers who smoke a pack of cigarettes or more a day than among nonsmokers.⁸
Smoke at Work Poses Serious Health Risks

Many chemicals in tobacco smoke are used frequently at job sites and are among the most hazardous materials regulated by OSHA. Yet, even though OSHA requires worker protection—respirators, body suits, gloves, safety glasses, face shields—against exposure to chemicals, and even though it regulates hazardous chemicals and workplace conditions to protect workers from unnecessary exposures, this agency still lacks meaningful authority to regulate workers’ exposure to secondhand smoke.

Under Minnesota’s Right to Know Act, employers must provide workers with training and information about chemicals they may have contact with, hazards associated with those substances, and measures required to protect workers against those hazards. Material Safety Data Sheets (MSDS) provide basic safety and ingredient information for chemicals or hazardous substances workers come into contact with at work, but no MSDS are required to alert workers to the health risks they face from exposure to tobacco smoke.

Although workers attend mandatory training sessions on the dangers and health risks associated with their exposure to a host of dangerous substances as part of apprenticeship programs, toolbox or other meetings, they receive little or no training on the health risks they face from smoking or exposure to smoke in combination with exposure to other workplace toxins. Ideally, information about the harms of tobacco and secondhand smoke should be included in mandatory worker occupational health and safety programs and fully integrated into existing health and safety materials and trainings.

We have a long way to go. Despite indisputable evidence that secondhand smoke causes over 3,000 lung cancer deaths and 35,000 heart disease deaths in the U.S. per year, and that even short-term exposure to secondhand smoke can be a direct health threat for those who already have heart or lung disease, most workers have not received occupational health and safety training that includes this critical information.

Examples of hazardous materials that present a serious health risk when combined with tobacco smoke include: Aromatic amines; asbestos; coal; cotton dust; grains; ionizing radiation; pesticides; petrochemicals; silica; and welding materials.

action steps

There are many possible ways unions can take action to help reduce members’ exposure to secondhand smoke, including:

- Providing union members with practical educational information about the serious health risks they face from smoking or inhaling tobacco smoke while working with other hazardous toxins. Examples include:
  - Integrating information about tobacco use, secondhand smoke, and cessation options into occupational health and safety materials and presentations; or
  - Inviting guest speakers, including doctors, nurses, or other health professionals to mandatory toolbox or union meetings and training sessions.

- Supporting workplace policies that substantially limit or eliminate smoking, with the goal of helping union members to improve their health and safety. Smoke-free policies promote worker health and safety and dramatically reduce workers’ exposure to toxic chemicals, thereby dramatically reducing workers’ health risks. They also help motivate workers to achieve the goal of quitting tobacco use.

- Advocating for improved access to effective cessation coverage and services to help workers and their families quit using tobacco products.
Sources


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In this issue, we examine the impact of tobacco use and exposure to secondhand smoke on the health of workers and their families. We show how working class men, women and children, in many ways, bear the brunt of the health harms and economic consequences associated with tobacco use. This unit provides straightforward information you can use to build awareness of the personal health risks union members face from tobacco use and exposure to secondhand smoke at work, at home, and at play.

Tobacco use is taking a terrible toll on America's working class. Among the workers most at risk are those who are employed in restaurants, bars and other hospitality settings where smoking is still permitted. Also at high risk are blue-collar and service workers who work in settings where smoking and chewing remain the norm. In keeping with labor's goal to ensure safe and healthy workplaces for all workers, there is much work left to be done to reduce the disproportionate impact that smoking and exposure to secondhand smoke have on these workers and their loved ones.

Armed with overwhelming evidence of the harmfulness of tobacco to blue-collar and service workers and the exorbitant costs associated with tobacco use and exposure to smoke in workplaces, unions are working hand in hand with the public health community to develop effective policy approaches that will help members quit using tobacco products and ensure healthful workplace environments for all workers. By utilizing opportunities to educate union members about tobacco-related health harms, union leaders can promote the health and economic benefits of a smoke-free workplace, help members make informed choices about their personal tobacco use, and support members' efforts to quit.
Tobacco Use: Number One Cause of Preventable Death

Although the issue of obesity has been getting a lot of media attention lately, tobacco use remains the leading preventable cause of death in the U.S. Cigarette smoking causes approximately 440,000 deaths per year, or about 1 out of every 5 deaths. Each year, primarily because of their exposure to secondhand smoke, more than 35,000 nonsmoking Americans die of heart disease and 3,000 die of lung cancer.

Not only do smoking and exposure to secondhand smoke cut short far too many lives, they also cause millions of people to live with debilitating conditions, including heart disease, respiratory diseases, and many forms of cancer. In workplaces that allow smoking, exposure to secondhand smoke affects all workers—smokers and nonsmokers—by increasing workplace injuries, absenteeism, maintenance expenses and healthcare costs. Among smokers, cigarette smoking causes more death and disability than any other workplace hazard.

Disproportionate Impact on America’s Working Class

Workers with Low SES and Educational Levels
Tobacco use in the U.S. today is strongly associated with low socio-economic status and lower educational levels. Adults below the poverty line have an average smoking rate of 31%, compared to 23% of all adults. Although tobacco use is declining within the population as a whole, it is not declining uniformly among different socio-economic levels. Between 1974 and 1990, declines in smoking were much greater among adults with higher educations. The smoking rate among adults with a high school diploma is now 26%, more than double the rate (12%) among adults with a college degree.

Blue-Collar, Hospitality and Service Workers
Workers employed in service, hospitality and blue-collar settings have substantially higher risks for health harms caused by tobacco compared to other workers. These workers are more likely to be exposed to secondhand smoke on the job than are white-collar workers, and are more likely to use tobacco products. They also have a harder time quitting and are least likely to be offered employer-based support to help them quit or cut back on smoking.

...tobacco is the only legally available consumer product which kills people when used entirely as intended.

did you know?

- Blue-collar workers:
  - Are heavier smokers and begin smoking earlier than white-collar workers.
  - Have lower quitting rates than other workers due in part to a lack of social support for quitting in their work environments.
Risks for Women of Childbearing Age

Every year, tobacco-related diseases kill more than 178,000 women in the U.S., making it the leading preventable cause of death among women.\(^1\) By age, smoking rates among women are highest among those between 18-24 and 25-44, placing at risk working women of childbearing age.\(^9\) For pregnant women, active smoking and exposure to secondhand smoke can have devastating results:

- **Low Birthweight.** Smoking during pregnancy increases the risk for pregnancy complications, premature delivery and low birthweight infants. Low birthweight leads to over 300,000 deaths per year among U.S. newborns.

- **Sudden Infant Death Syndrome (SIDS).** Babies exposed to secondhand smoke after birth have twice the risk for SIDS compared to other babies. Infants whose mothers smoked during pregnancy and after birth are 3 to 4 times more likely than other infants to die of SIDS.

- **Reduced Lung Function.** Mothers' smoking during pregnancy causes reduced lung function in babies.\(^14\)

In all, more than one out of every five adult women and more than one in four high school girls are current smokers.\(^9\) From 1995 to 1999, lost productivity and medical expenses attributable to female smoking totaled approximately $75 billion per year.\(^1\) When we take educational levels into account, we find that the higher the level of education attained, the lower the rate of smoking among women. In addition to putting their reproductive health at risk, women who smoke greatly increase their risks of developing heart disease, cancer and respiratory diseases.

### U.S. Smoking Rates by Occupation\(^11\)

<table>
<thead>
<tr>
<th>Occupation</th>
<th>Smoking Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transportation and material moving</td>
<td>.46%</td>
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<tr>
<td>workers</td>
<td>.45%</td>
</tr>
<tr>
<td>Waiters/waitresses</td>
<td>.45%</td>
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<tr>
<td>Construction laborers</td>
<td>.42%</td>
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<td>Construction trades</td>
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<td>Laborers, except construction</td>
<td>.39%</td>
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<td>Fabricators, assemblers, inspectors</td>
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<tr>
<td>Health service occupations</td>
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<tr>
<td>Sales and retail workers</td>
<td>.27%</td>
</tr>
<tr>
<td>Executives, administrators, managers</td>
<td>.24%</td>
</tr>
<tr>
<td>Secretaries</td>
<td>.21%</td>
</tr>
<tr>
<td>Teachers</td>
<td>.12%</td>
</tr>
</tbody>
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**Voices of labor**

*Three waitresses have died from lung cancer since I started, and another one who used to work here died around the same time. They were all smokers, and that scared the heck out of me and I tried to cut down. I can cut down to almost nothing, but then I turn around and I'm just like a chimney again.*

Minneapolis Waitress, Smoker, 2003
Summary of Tobacco-Related Diseases and Conditions

Smoking harms nearly every organ of the human body, causing many diseases and deaths and substantially limiting daily activities of millions who live with chronic diseases. Smoking harms fetuses, newborn babies, infants, young children, teens and adults of all ages, and is the leading cause of preventable death in the U.S. In Minnesota, one in seven deaths is caused by smoking. On average, a lifetime of smoking results in a 13- to 15-year shorter lifespan. More than 8.6 million people in the U.S. have at least one serious illness that is caused by smoking.

Compared to nonsmokers:
• Smokers are more likely to be absent from work and their illnesses last longer.
• Smokers tend to incur more medical costs, to see doctors more often, and to be admitted to hospitals more often and for longer periods.
• Smokers have lower survival rates after surgery and are at greater risk for complications following surgery.

**did you know?**

You know, the reality is that people need to be considerate of each other. We need to breathe air…. We can't survive without it….If a person wants to smoke, and I understand it because I smoked for 25 years, you have a choice where you can smoke. The person next to you doesn't have a choice about breathing your cigarettes.

Duluth Hospitality/Service Worker, Ex-smoker, 2003

**voices of labor**

**Adult Smoking Patterns in the U.S. By Gender and Ethnicity**

- 25% of adult men and 21% of adult women are smokers.
- 22% of adult African Americans are smokers (28% of men and 18% of women).
- 33% of adult American Indians and Alaska Natives are smokers (34% of men and 32% of women).
- 17% of Hispanic adults are smokers (22% of men and 12% of women).
- 12% of Asian American adults are smokers (19% of men and 6% of women).

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Diseases & Conditions Caused By Smoking

Coronary Heart Disease
- Coronary heart disease is the leading cause of death in the U.S.
- Cigarette smoking is associated with sudden cardiac deaths of all types in both women and men.
- More than 2,600 Americans die every day because of cardiovascular diseases, about one death every 33 seconds.

Cancers
- Cancers are the second leading cause of death in the U.S.
- Among the types of cancer caused by smoking are: Acute myeloid leukemia; bladder cancer; cervical cancer; esophageal cancer; kidney cancer; laryngeal cancer; lung cancer; oral cancers; pancreatic cancer; stomach cancer; and throat cancers.
- Cigarette smoking causes most cases of lung cancer, which is the leading cause of cancer deaths. Smoking causes about 90% of all lung cancer deaths among men and almost 80% among women.
- Compared to nonsmokers, men who smoke are about 23 times more likely to develop lung cancer and women who smoke are about 13 times more likely.
- The risk for cancers caused by smoking generally increases with the number of cigarettes smoked and the number of years of smoking and generally decreases after quitting completely.

Strokes
- Strokes are the third leading cause of death in the U.S., numbering about 600,000 cases per year.
- The one-year fatality rate for strokes is about 30%.
- The risk for stroke decreases steadily after quitting smoking.

Respiratory Diseases
- In 2001, COPD was the fourth leading cause of death in the U.S., leading to more than 118,000 deaths. More than 90% of these deaths were attributed to smoking.
- About 10 million people in the U.S. live with chronic obstructive pulmonary disease (COPD), which includes chronic bronchitis and emphysema.
- COPD is one of the ten most common chronic health conditions in the U.S. and one of the ten most common conditions that limit daily activities.
- Smoking contributes to chronic coughing and wheezing, which damage the airways and alveoli of the lungs and can lead eventually to COPD.
- According to the American Cancer Society’s second Cancer Prevention Study, female smokers are nearly 13 times as likely and male smokers are nearly 12 times as likely to die from COPD as their nonsmoking counterparts.

Oral Diseases
- Smoking is a cause of periodontitis, a serious gum disease that can result in loss of teeth and bones.

Vision
- Cataracts are the leading cause of blindness worldwide.
- Smokers in the U.S. have two to three times the risk for developing cataracts as do nonsmokers.

Bones
- Smoking decreases bone density among postmenopausal women.
- Smoking increases the risk for hip fractures among men and women.
- Every year in the U.S., over 300,000 hip fractures occur among seniors over age 65. Persons with a hip fracture are 12% to 20% more likely to die than those without a hip fracture. The estimated costs related to hip fractures range from $7 billion to $10 billion per year.

Adapted from The Health Consequences of Smoking: A Report of the Surgeon General, 2004.15
Impact of Smoking on Family Members

Nonsmoking family members who live with a smoker are more likely to be exposed to secondhand smoke than other nonsmokers. Even relatively little exposure can lead to serious health risks.\(^{17}\) Prolonged exposure to secondhand smoke (at work or at home) almost doubles the risk for a heart attack.\(^{18}\)

Spouses and Partners
We now know that secondhand smoke causes lung cancer among those who have never smoked. Nonsmoking spouses of smokers are at increased risk for lung cancer, by roughly 20% for women and 30% for men.\(^{19}\) Those exposed to the heaviest smokers for the longest times have the highest risks.\(^{20}\) Exposure to secondhand smoke is also associated with nighttime chest tightness and loss of breath after physical activity.\(^{21}\)

Children
Young children are far more vulnerable to secondhand smoke than are adults because their lungs are not fully developed. Exposure to secondhand smoke increases the risk for sudden infant death syndrome (SIDS), asthma, bronchitis, middle ear infections, and pneumonia in young children.\(^{14}\)

Approximately 15 million U.S. children and teenagers per year live in households where they are exposed to secondhand smoke. Of those under the age of 18, about 22% are exposed to secondhand smoke within their homes. Of those under the age of six, over 40% live in households where someone smokes.\(^{25}\) In Minnesota, over 280,000 children (22%) face regular exposure to tobacco smoke in their homes.

About 8,000-26,000 new asthma cases in children per year are associated with secondhand smoke.\(^{26}\) In addition, every year, 150,000-300,000 new cases of bronchitis and pneumonia in children less than 18 months of age are associated with exposure to secondhand smoke. Of these, 7,500-15,000 will require hospitalization.\(^{26}\) Secondhand smoke not only increases the risk for asthma, it also increases the number and severity of asthma attacks.

**did you know?**

- A nonsmoker who is exposed to a pack-a-day-smoker inhales the equivalent of 3 cigarettes a day—or nearly 55 packs a year.\(^{13}\)
- 63% of current Minnesota smokers report having a spouse, parent, friend, or other person close to them who also smokes cigarettes or uses other forms of tobacco. In contrast, only about 32% of former and 30% of never smokers report having someone close to them who uses tobacco.\(^{22}\)
- Children whose parents smoke are twice as likely to become smokers themselves.\(^{23}\)
- The majority of deaths due to smoking occur at ages 35-69 years.\(^{24}\)
Pets
Seldom do we think of secondhand smoke as being harmful to family pets but, like children, pets also face serious health risks due to their exposure to secondhand smoke. Studies on family pets and tobacco smoke have found that:

- Dogs exposed to indoor secondhand tobacco smoke are 2 to 2.5 times more likely than other dogs to develop canine nasal cancer.28
- Cats with any exposure to household secondhand smoke are 2.5 times more likely than cats that are not exposed to develop malignant lymphoma—cats with five years’ exposure are 3 times more likely to have the disease.29

Youth and Tobacco

- 80% of all smokers have their first cigarette before age 18.
- 90% of all smokers begin smoking before age 20.
- One-third of all smokers begin smoking before the age of 14.
- Each day, nearly 5,000 American youth between 12 and 17 try a cigarette for the first time.
- Between one-third and one-half of youth who try a cigarette will become daily smokers.
- Daily smoking is highly associated with addiction.

From American Legacy Foundation27

did you know?

I'm not really happy being a smoker. I'm not supposed to be smoking. Last year my sister passed away of cancer, so that should've stopped me right there. My husband has a heart problem and I have high blood pressure so my doctors tell me to stop, stop, stop. I have never tried to stop, so I don't know how to start.

Minneapolis Waitress, Smoker, 2003

voices of labor

My wife and I, we don't smoke in our vehicles, we don't smoke in the house, we don't smoke around our kids. The only place we do smoke is outside. I can go a weekend without smoking a cigarette, but get me in a social situation and I can smoke them up, three or four packs at a shot, you know, easy.

Duluth Hospitality Worker, Smoker, 2003
Quitting—A Family Affair

Nationally, at least 70% of current smokers report that they want to quit and have repeatedly tried to do so. Many describe their quit attempts as the hardest thing they have ever done. Quitting can be even more difficult when a family member or friends with whom one spends time continue to smoke.

Restricting or prohibiting smoking at home is one of the most effective strategies for quitting. Smokers who accept a total or partial ban on smoking at home are more likely to try to quit smoking and are more likely to succeed. The success rate increases if a spouse or partner who also smokes agrees to attempt to quit at the same time or if the smoker avoids smoking at work or in social settings that can trigger smoking.

Smokers can protect their loved ones from secondhand smoke by not smoking around them, by agreeing to make the interior of their homes, garages, and vehicles smoke-free zones, by quitting or attempting to quit smoking, and by helping a friend or family member in their attempts to quit smoking. Not smoking around spouses, partners, children and friends will protect their health and may save their lives.

voices of labor

I've got two kids and I really should quit. I feel so guilty. Every Christmas that's the first thing on their lists—Quit Smoking.

Duluth Hospitality/Service Worker, Smoker, 2003

voices of labor

I don't smoke around my kids. Well, we smoke in the basement. We like to think that's different, but we know we are not really fooling ourselves. But we never smoke in the vehicle with the kids in the car. We try to respect them.

Duluth Hospitality/Service Worker, Smoker, 2003
After quitting, a smoker's risk of...

- **Stroke** is reduced to that of a person who never smoked after 5 to 15 years
- **Cancers of the mouth, throat, and esophagus** are halved after 5 years
- **Cancer of the larynx** is reduced
- **Coronary heart disease** is cut in half after 1 year and is nearly the same as someone who never smoked after 15 years
- Death by **chronic obstructive pulmonary disease** is reduced
- **Lung cancer** drops by as much as half after 10 years
- **Ulcer** drops
- **Bladder cancer** is halved after a few years
- **Peripheral artery disease** goes down
- **Cervical cancer** is reduced after a few years
- **A low birthweight baby** drops to normal if the smoker quits before pregnancy or during the first trimester


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**voices of labor**

I started smoking when I was 12, peer-pressure, more or less. Now I'm 48. I quit once for nine days. My wife and I, we made a bet. I quit for nine days, then I walked into the garage and saw her with a cigarette in her hand, and I started up again.

Rochester Blue-Collar Worker, Smoker, 2003

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**did you know?**

- Smokers who have a ban on smoking in their home are five times more likely to try quitting than smokers with no home restrictions and are more than twice as likely to succeed.³¹
- Even smokers who do not quit entirely are much more likely to smoke fewer cigarettes if smoking is banned or restricted within their homes.³¹
- Banning smoking at home reduces 90% of exposure to teenagers. Partial bans, those restricting smoking to certain times, or when children are away, reduce children’s exposure by 60%.³¹
There are many possible ways unions can take action to help reduce members’ exposure to secondhand smoke and improve their access to cessation services, including:

- Providing union members with practical educational information about the serious health risks they face from smoking or inhaling tobacco smoke while working with other hazardous toxins, for example, by:
  - Integrating information about tobacco use, secondhand smoke, and cessation options into occupational health and safety materials and presentations; or
  - Inviting guest speakers, including doctors, nurses, or other health professionals to mandatory toolbox or union meetings and training sessions.

- Providing information and updates about tobacco issues and cessation services via union websites, newsletters and other communication vehicles to ensure members gain knowledge that can help them make informed choices about tobacco use and options for quitting.

- Offering union-sponsored incentives to help motivate members to quit, such as recognition in the union newsletter.

- Linking union websites to Internet-based cessation support services, such as the free service offered by quitplan.com, as well as to tobacco prevention organization websites.

- Supporting workplace policies that substantially limit or eliminate smoking, with the goal of helping union members improve their health and safety. Smoke-free policies promote worker health and safety and dramatically reduce workers' exposure to toxic chemicals, thereby reducing workers' health risks. They also help motivate workers to achieve the goal of quitting tobacco use.

- Advocating for improved access to effective cessation coverage and services to help workers and their families quit using tobacco products.

- Partnering with the public health community on tobacco prevention initiatives.

- Endorsing public campaigns for smoke-free legislation.
Sources


**Photo Credits**

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WorkSHIFTS is a collaborative labor outreach initiative of the Tobacco Law Center at William Mitchell College of Law, partnering with Minnesota’s labor community.

WorkSHIFTS’ goal is to provide practical tools and resources that support labor’s efforts to address tobacco-related workplace concerns through education, collective bargaining, policy initiatives and the assertion of workers’ rights to health and safety.

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www.workshifts.org

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www.workshifts.org • 651.290.7506
In this issue, you will learn about cessation services and resources available to Minnesota union members, the effectiveness of different cessation approaches, common barriers to quitting, and benefits of quitting. This unit builds on labor’s rich tradition of fighting for the health and safety of workers by equipping unions with tools to help members gain access to effective cessation services.

Although much progress has been made in reducing smoking rates among the public at large, the progress to date has not impacted all population groups equally. Smoking rates remain substantially higher among blue-collar and service workers, when compared to other adults. This holds true within Minnesota.¹

Not only do blue-collar and service workers have higher rates of smoking than white-collar workers, they are also more likely to be exposed to tobacco smoke on the job.² Blue-collar and service workers are less likely than other workers to have health insurance that covers cessation services and are less likely to know about the range of available services, which services are most effective, or how to get the help and support they need to quit.

At a time when health care costs are spiraling out of control, providing workers with access to proven cessation options is both smart and cost-effective. Smoke-free workplace policies, coupled with the provision of cessation services, lower the percentage of smokers in workplaces, as well as the amount of tobacco consumed per continuing smoker, reduce absenteeism, increase productivity, and lower health care costs. In fact, tobacco cessation is the single most effective health service that can be provided to employees.³ Unions can play important roles in helping members achieve the goal of quitting.
Unions & Cessation

Many unions are actively involved in promoting a healthy workforce. Advocating for smoke-free workplace policies and the provision of cessation services that meet particular workforce needs can serve as strong complements to existing worksite health promotion programs and initiatives.

When unions are partners in shaping smoking policies and cessation programs, policy outcomes are more likely to incorporate employee perspectives and priorities and to result in greater acceptance of policy changes and greater utilization of program services.

By working together to adopt smoke-free workplace policies and improve workers’ access to effective cessation services, unions and employers can provide employees with the critical motivation and support they need to quit successfully, while at the same time reduce absenteeism, productivity and health care costs.

Cost Savings & Benefits

Providing tobacco cessation benefits is the single most cost-effective preventive service that employers can provide to employees.³ Although employers incur initial costs when providing cessation benefits, they can see a quick return on their investments. Cost analyses estimate that about one-third of the cost of an employer-paid cessation program is returned in the first year and that the entire cost is fully recovered in three years.⁴,⁵

Employer savings include reductions in: the number of health problems among employees, rates of absenteeism and lost productivity, and the cost of life and health insurance coverage.

• Compared to a smoker who quits, the average smoker incurs $1,041 in additional annual health care expenses over a period of five years.⁶

• Smokers are subject to more disciplinary actions and are at greater risk of occupational injuries than are nonsmokers.⁷

• Very few smokers are able to quit cold turkey. Only 3 to 7% of smokers succeed in quitting without some source of help or support.⁸

• Most smokers who succeed in quitting do not succeed on the first try and make multiple attempts before achieving their goals.⁹

• Approximately 85% of Minnesota union members believe smoking cessation programs are important benefits that unions should negotiate, according to the results of a survey conducted by WorkSHIFTS in 2003.¹

• Almost two-thirds of current adult smokers in Minnesota who have made recent quit attempts did not use any assistance in their last attempt to quit. This finding suggests that many Minnesota smokers may lack critical information about successful quit methods and personal cessation options, and need greater support.¹⁰

voices of labor

For too long the tobacco industry has wreaked havoc in the lives of working people by targeting them as a vulnerable market. The consequence has been that workers die and are made sick at a rate far in excess of other groups in the population. At the same time, unions are asked to pay for the ravages of this toxic drug in the form of higher health care insurance costs.

Joel Shufro, Executive Director
New York Committee for Occupational Safety and Health
Excerpts from NYCOSH Update on Safety and Health,
January 8, 2003
Minnesota’s major health plans offer no-cost telephone counseling to help members quit smoking.

- Blue Cross and Blue Shield of Minnesota
  1–800–835–0704

- HealthPartners
  1–800–311–1052

- Medica Commercial
  1–800–952–3455

- Medica Medicare and Medicaid
  1–800–292–2336

- Metropolitan Health Plan
  1–800–292–2336

- PreferredOne Community Health Plan
  1–800–292–2336

- UCare Minnesota
  1–888–642–5566

A stop-smoking telephone service, the QUITPLAN Helpline, is available at no charge to uninsured Minnesota residents or to those who do not have access to quitting assistance through their health plans. QUITPLAN Helpline offers personalized phone counseling with follow-up calls to help the caller through the quitting process. Research has shown that smokers who use telephone helplines increase their chances of quitting successfully compared to smokers who try to quit without such assistance.

QUITPLAN Helpline:

- English speakers
  1–888–354–PLAN (that’s 7526)

- Spanish speakers
  1–877–266–3863

- Hearing impaired TTY line
  1–877–777–6534

- For online assistance
  www.quitplan.com
Barriers to Quitting

Quitting tobacco is difficult for individuals because:

- Nicotine is one of the most addictive substances known to humankind.

- The social environments in which smokers spend their time—at home, at work, or at leisure—tend to support smoking.

- For workers whose workplaces permit smoking, workplace exposure to secondhand smoke is both harmful to their health and a major impediment to their personal attempts to quit.

- Workers face numerous challenges that can be barriers to quitting, including work organization issues like increased hours, intensification of work due to downsizing, and changes in technologies and work processes. These issues have been associated with ergonomic hazards, repetitive strain injuries, stress, workplace violence and even fatalities.

- Tobacco use can function as an escape from the stress or the tedium of work. Studies show that former smokers sometimes start to smoke again during particularly stressful times. To quit successfully, smokers and chewers need to learn new ways to cope with stress.

- Time constraints can be serious barriers to quitting, too. Workers who hold multiple jobs, work night shifts, have transportation challenges, or face other, equally challenging obstacles, may be unable to participate in cessation programs unless they are telephone-based or are made available at their worksites during work hours.

- The perceived cost of cessation programs, combined with workers’ self-perceptions about their abilities to quit, may also be barriers to quitting.

voices of labor

…You know—‘Hey, we’re going out for a smoke.’ ‘Okay, let’s go.’

So, we all go out for a smoke…we follow everyone…and we have a good time and then we go back to work.

A couple of hours later, ‘Hey, smoke break.’ ‘Okay.’ ‘Let’s get away from the job.’

Duluth Service/Hospitality Workers, Smokers, 2003

NICOTINE

Nicotine has a powerful effect on the body that causes changes in mood, alertness and energy. Nicotine helps people cope with difficult emotions, including stress, discomfort, anger, and anxiety. These physical and emotional effects make it hard for many persons to stop using tobacco.

Nicotine’s effects on the brain are similar to those of heroin and cocaine. Smokers become addicted to nicotine physically and psychologically and must overcome both of these dependencies, as well as learn alternative coping strategies, to quit successfully and stay smoke-free.
Benefits of Quitting

For individuals and those around them, the benefits of quitting are many and varied.

It’s never too late to quit

The earlier a smoker quits, the less likely he or she will be to incur a smoking-attributable disease.

- Former smokers live longer than continuing smokers. People who quit before age 50 cut in half their risk of dying within 15 years compared to people who continue to smoke.

- Lung cancer claims more lives than any other cancer. Smoking causes nearly 90% of all lung cancer deaths in the U.S. Since 1987, lung cancer deaths have surpassed breast cancer deaths among women. Quitting decreases the risk of lung cancer and other cancers.

- Quitting reduces the risk of coronary heart disease, hypertension, heart attacks, strokes and chronic obstructive pulmonary disease (COPD). Smokers with gastric and duodenal ulcers who quit greatly improve their recovery from these diseases, compared to those who continue to smoke.

- Helping pregnant women stop smoking has enormous health benefits. Smokers who quit before becoming pregnant or during the first three to four months of pregnancy reduce their risks of having low birthweight babies to levels equal to that of nonsmokers. Smoking increases the chances of miscarriage, premature births and several other complications. Quitting can also help reduce the number of admissions to neonatal intensive care units, infant deaths from perinatal disorders and sudden infant death syndrome (SIDS).

(Adapted from NCI, 2004)
Components of Cessation Programs

Successful employee cessation programs combine multiple approaches to quitting and include three key components:

- Information and educational materials
- Access to Nicotine Replacement Therapy (NRT), like patches or gum
- Counseling options: Individual or group counseling, in-person or by phone

The most effective programs place no limits on the number of times a person can attempt to quit and require no deductibles or co-payments. Even very small co-payments can result in much lower participation rates.

Important considerations

Creating a supportive workplace environment by adopting a smoke-free policy and providing incentives for quitting increases the likelihood that smokers will ultimately succeed in quitting.\(^\text{12}\)

Providing individuals with access to all forms of treatment will achieve the greatest success rates in smoking cessation. Success rates double when counseling and drug therapies are applied together.

Providing smoking cessation services as a fully covered benefit by a health plan is more likely to result in utilization; smoking prevalence within the health plan is more likely to decrease, too.

In a trial cessation program for blue-collar workers insured under Taft Hartley Funds, counseling in combination with medications proved most effective, resulting in quit rates of approximately 30\%.\(^\text{13}\)

Six recognized types of cessation tools

1. Self-help materials, such as booklets, quit kits, or videotapes, are attractive to some smokers because of the privacy and flexibility they afford. Good self-help materials help people understand their smoking patterns, set a quit date, identify and resist smoking cues, explore alternatives to smoking, control weight gain, manage stress and prevent relapse.

2. Group and individual counseling programs offer smokers support by providing practical counseling, problem-solving and skills training.

3. Telephone-based counseling programs offer counseling support that is private and convenient for many smokers. This approach has proven effective with construction workers. Some health and welfare funds contract with private providers to offer telephone-based counseling. Minnesota’s QUITPLAN Helpline offers free telephone-based counseling to all Minnesota adults who do not have access to this type of service through their health insurance provider or employer.

4. Nicotine Replacement Therapy (NRT) products provide individuals with low doses of nicotine. The nicotine is absorbed more slowly than when someone smokes, lessening the urge to smoke and helping with withdrawal. NRT includes nicotine gum, patches, inhalers, nasal sprays and lozenges. Many of these products are available without a prescription or, to receive benefits through a health plan, a prescription may be required.

5. Medications that require a prescription, such as Zyban and Wellbutrin, contain bupropion SR, a type of medication that helps some people with withdrawal symptoms and lessens the urge to smoke.

6. Special incentives can motivate workers to try to quit. Even small rewards or recognition for quitting, such as being noted in a union’s newsletter, can help smokers succeed.
There are many possible ways for unions to take action to help reduce members’ exposure to secondhand smoke and improve their access to cessation services, including:

- Negotiating for a written no-smoking policy if none exists at a worksite or negotiating to strengthen an existing policy.

- Negotiating for comprehensive cessation services in members’ health care benefits, including a variety of service options and opportunities for multiple quit attempts.

- In consultation with management, conducting a survey of members to help gauge what types of cessation services to offer, by determining: How many employees smoke or use smokeless tobacco products; how many employees want to quit and/or have tried to quit; how do employees feel about pending policies or services; what kind of support do they like or expect; and, how many employees are interested in using the types of support services the employer plans to offer.

- Encouraging employers to provide incentives, either monetary or non-monetary, to help motivate smokers to quit.

- Offering union-sponsored incentives to help motivate members to quit, such as recognition in the union newsletter.

- Inviting guest speakers, including doctors, nurses, or other public health professionals, to mandatory tool-box or union meetings, classes or training sessions to give tailored presentations about the impact of tobacco use on employee health and to discuss options for quitting.

- Integrating information about tobacco use, secondhand smoke, and cessation into workplace occupational health and safety materials and presentations. When tested in a workplace setting, integrating tobacco use and smoking cessation messages with occupational health and safety efforts has yielded impressive quit rates among blue-collar smokers.

- Providing information and updates about work-related tobacco issues and cessation options to members via union websites, union newsletters, and other communication vehicles, to ensure members gain knowledge that will help them make informed choices about tobacco use and their options for quitting.

- Linking union websites to Internet-based cessation support services, such as the free service offered by quitplan.comSM, as well as to tobacco prevention organization websites.

- Adopting resolutions in support of smoke-free policies and cessation coverage.

- Endorsing public campaigns for smoke-free legislation, such as ordinance campaigns.

- Partnering with the public health community on tobacco prevention initiatives.
Sources


Photo Credits

Cover photos: Sam Hollenshead, Labor Research Association.
Photos pages 3–5: David Parker, Minnesota Historical Society.

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WorkSHIFTS’ goal is to provide practical tools and resources that support labor’s efforts to address tobacco-related workplace concerns through education, collective bargaining, policy initiatives and the assertion of workers’ rights to health and safety.

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In this issue,
we address the economic costs associated with tobacco use and exposure to secondhand smoke in the workplace. You will find pertinent information within these pages about how smoking affects employers’ costs of doing business and how employer-provided cessation coverage and smoke-free workplace policies can provide economic benefits. Perhaps most importantly, this issue identifies possible steps unions can take to lessen the burden of tobacco-related costs on union members.

As the cost of healthcare continues to skyrocket, unions are finding it increasingly difficult to secure decent wage increases and health insurance benefits for their members. The question of how to stem the tide of rapidly escalating healthcare costs has become one of the most pressing issues facing unions today.

Economic data show that tobacco-related healthcare and related workplace costs are primary drivers of the rapid escalation of healthcare costs. In both Minnesota and the U.S. as a whole, approximately two-thirds of all deaths are caused by chronic diseases, and smoking is the leading cause of many of these diseases. The state of Minnesota, alone, loses billions of dollars every year on healthcare expenditures and lost productivity as a direct result of smoking.

The good news is that tobacco-related healthcare costs can be reduced dramatically when employers provide comprehensive cessation services and implement smoke-free workplace policies. In fact, the most cost-effective health insurance benefit an employer can provide to adult employees is to support their quit attempts by paying for access to comprehensive cessation services. This issue provides practical resources and suggested action steps to help your union negotiate for smoke-free workplaces and employer-provided cessation benefits.
Costs of Smoking

The impact of smoking on rising healthcare costs is huge and cannot be ignored. In less than ten years, Minnesota’s healthcare costs have increased over 70%, from $12 billion in 1993 to almost $22 billion in 2001. The chief drivers of the cost increases have been hospital care, physician services, prescription drugs, and other healthcare spending. Five chronic diseases—heart disease, cancer, chronic obstructive pulmonary disease (COPD), and strokes—account for 62% of all Minnesota deaths and 68% of all U.S. deaths, and smoking is the leading cause of four of these five chronic diseases.

In all, Minnesota loses over $1.6 billion each year on healthcare-related costs that are directly attributable to smoking and more than $1 billion per year in lost productivity as a direct result of smoking. Approximately 20% of the adult population of the city of Minneapolis and the state of Minnesota smoke cigarettes.

Nationally, among adults, the economic cost of lost work time due to premature deaths related to smoking rose from $47 billion in 1990 to $84 billion in 1999. These calculations are low estimates, in that they do not include productivity losses that result from absenteeism, breaks, performance declines, early retirements, terminations due to smoking-related illnesses or disabilities, or training to replace workers who leave a job or die from smoking. These estimates also do not include the costs associated with deaths that are caused by workers’ exposure to secondhand smoke or smoking-related fires.

Union members feel the pain of escalating healthcare costs when, in contract negotiations, their employers seek to raise healthcare co-payments, eliminate or reduce healthcare coverage, or give smaller or no wage increases to offset rising healthcare and productivity costs. All Minnesotans pay higher taxes and higher insurance premiums to cover tobacco-related health costs. These costs are not abstract—they directly affect a union’s ability to negotiate higher wages, maintain health insurance benefits, and meet families’ needs.

Attitudes of Minnesota Union Members Toward Smoking-Related Healthcare Costs

- 77% of union members agree that smoking increases healthcare costs.
- 72% believe that reducing smoking will reduce healthcare costs.
**Minnesota Industry and Occupation Employment Statistics**

<table>
<thead>
<tr>
<th>Occupation</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blue-collar workers</td>
<td>24%</td>
</tr>
<tr>
<td>Service or service-related workers</td>
<td>41%</td>
</tr>
<tr>
<td>Manufacturing workers</td>
<td>16%</td>
</tr>
<tr>
<td>White-collar workers</td>
<td>36%</td>
</tr>
</tbody>
</table>

**Minnesota Levels of Educational Attainment: 16 years and Older**

<table>
<thead>
<tr>
<th>Educational Level</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than high school</td>
<td>12%</td>
</tr>
<tr>
<td>High school graduate</td>
<td>29%</td>
</tr>
<tr>
<td>Some college</td>
<td>24%</td>
</tr>
<tr>
<td>Associate's degree</td>
<td>8%</td>
</tr>
<tr>
<td>Bachelor's degree or higher</td>
<td>27%</td>
</tr>
</tbody>
</table>

**U.S. Smoking Rates by Occupation**

<table>
<thead>
<tr>
<th>Occupation</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transportation and material moving occupations</td>
<td>46%</td>
</tr>
<tr>
<td>Waiters/waitresses</td>
<td>45%</td>
</tr>
<tr>
<td>Construction laborers</td>
<td>42%</td>
</tr>
<tr>
<td>Construction trades</td>
<td>40%</td>
</tr>
<tr>
<td>Laborers, except construction</td>
<td>39%</td>
</tr>
<tr>
<td>Fabricators, assemblers, inspectors</td>
<td>37%</td>
</tr>
<tr>
<td>Health service occupations</td>
<td>35%</td>
</tr>
<tr>
<td>Sales and retail workers</td>
<td>27%</td>
</tr>
<tr>
<td>Executives, administrators, managers</td>
<td>24%</td>
</tr>
<tr>
<td>Secretaries</td>
<td>21%</td>
</tr>
<tr>
<td>Teachers</td>
<td>12%</td>
</tr>
</tbody>
</table>

**Employer Costs Attributable to Smoking**

In a 1994 report, the Congressional Office of Technology Assessment estimated that each worker who smokes costs an employer between $2,000 and $5,000 per year in increased healthcare and fire insurance premiums, absenteeism, lost productivity and property damage. A more recent 2002 report by the Centers for Disease Control (CDC) estimated that each adult smoker costs employers $3,400 per year in lost productivity and excess medical expenditures.

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**How much does tobacco cost employers?**

Determining an employer’s smoking-related costs is difficult because many factors and variables can influence the calculation. Based on the CDC’s estimate that each adult smoker costs employers $3,400 per year, the following formula may provide a useful starting point in determining the cost of smoking to a particular employer in your occupational setting.

**Step 1:** Multiply the total number of employees times the estimated percentage of employees who smoke. To calculate the percentage of employees who smoke, enter either the percentage of adult Minnesotans who smoke (20%), or the percentage of smokers within your occupation (from the occupation table). The resulting number provides an estimate of the total number of smokers within a workplace.

\[
\text{Total number of employees} \times \text{Estimated } \% \text{ of employees who smoke} = \text{Total # of smokers}
\]

**Step 2:** Multiply the total number of smokers times the CDC estimate of the cost per smoker ($3,400).

\[
\text{Total # of smokers} \times \$3,400 = \text{Employer’s estimated cost of smoking per year}
\]
### Smoking-Attributable Employer Costs

- Increased absenteeism
- Decreased productivity
- Increased health and life insurance premiums and claims
- Increased level of early retirements
- Increased cleaning and maintenance expenses, property damage and related expenses
- Increased fire insurance premiums and costs of fires caused by smoking
- Increased potential legal liability
  - Where smoking is permitted, nonsmoking employees have received workers' compensation settlements, unemployment compensation benefits and disability benefits based on claims of exposure to secondhand smoke.

### Investing in Tobacco Cessation Cuts Employer Costs

**Short-term benefits:**
- Increased productivity
- Savings on fire insurance premiums
- Savings on ventilation services, property upkeep and repair

**Long-term benefits:**
- Reduced healthcare costs
- Reduced absenteeism
- Increased productivity
- Reduced life insurance costs

---

Smoking cessation treatment is referred to as the 'gold standard' of preventative interventions.
Cost Benefits of Smoke-Free Workplace Policies

Among our nation’s health goals for the year 2010 is to reduce the rates of current smoking among adults to 12% or less; however, unless cessation programs and other tobacco control efforts are expanded, this 2010 national health objective will not be achieved. This is because unless smoking cessation among current smokers increases quite rapidly, the rate of smoking-attributable deaths is not expected to decline substantially for many years. Unions can help reduce the rate of current smoking by working with employers to develop smoke-free workplace policies and negotiate the provision of cessation coverage.

Reducing the number of smokers in the workplace is cost-effective, even for cash-strapped budgets. Cessation programs are relatively low-cost, and studies show that they yield financial returns for employers over the short- and long-term that far outweigh their costs. In fact, tobacco cessation is the single most cost-effective clinical preventive service that employers can provide to employees, costing considerably less than other disease prevention interventions, such as treatment of hypertension and high blood cholesterol. A theoretical model for the U.S. estimates the potential net benefit of a smoking cessation program in a manufacturing workforce of 10,000 to be about $4.7 million after 25 years.

How Much Does Cessation Coverage Cost?

- Providing a comprehensive tobacco cessation benefit costs between 10 and 40 cents per member per month. Costs vary based on utilization and dependent coverage.
- Cost analyses have shown tobacco cessation benefits to be either cost-saving or cost-neutral. Generally, cost/expenditure to employers equalizes at 3 years; by 5 years, benefits exceed costs.
- Tobacco use treatment doubles quitting success rates.
- Working in a smoke-free workplace is associated more strongly with successful quitting than either physician advice or use of nicotine replacement products.
- The smoking rate among Union Pacific Railroad employees decreased from 40% to 25% in a 7-year period during which the employer offered a cessation benefit as part of a comprehensive cessation program.
- Smokers employed in smoke-free workplaces smoke fewer cigarettes per day, are more likely to be considering quitting, and quit at greater rates than smokers employed in workplaces that allow smoking.
- If all workplaces became smoke-free, the per-capita consumption of cigarettes across the U.S. would decrease by 4.5% per year.
- Minnesota can save $9.2 million in Medicaid costs per year by expanding and funding programs that reduce tobacco use by only 25%.
- Employers with smoke-free workplaces may be able to negotiate reduced insurance rates for life, fire or health insurance. Some insurers have offered up to 45% discounts on life insurance for nonsmokers.
Negotiating Health Insurance Benefits

Among the key strengths of unions is the power to negotiate benefits for members, including the negotiation of affordable, high-quality healthcare insurance. Fully-funded, comprehensive tobacco prevention programs save both lives and money. They are cost-effective and provide the best long-term solution to the negative impacts of smoking.24

Approximately 2,500 Taft Hartley Funds provide group healthcare benefits for 33 million Americans, most of whom are blue-collar workers and their dependents.24 Results of a recent trial smoking cessation program for one Fund, the Carpenters Health and Security Trust of Western Washington, estimated the compounded savings in reduced lifetime tobacco-related medical costs for participants who quit were 15 times the cost of the program—yielding a 28% annual return on the investment.24

As representatives of large segments of the U.S. workforce, including a large portion of blue-collar and service workers, unions have the responsibility to advocate on behalf of their members’ best interests. The rapid escalation of healthcare and health insurance costs has become a primary concern for union representatives, employers, and employees. By working together to establish smoke-free workplace policies and negotiate the provision of smoking cessation coverage, unions and employers can promote cost-effective preventative measures. These measures will help reduce the rate of smoking among workers, the incidence rate of smoking-related illnesses, smoking-attributable medical expenses, and associated employer expenses.

With a nonsmoking population, the length of life as well as the length of a disability-free life will be extended.8
action steps

There are many possible ways unions can take action to help reduce the rate of smoking among workers, as well as the rate of exposure to secondhand smoke:

1. **Support Smoke-Free Union Halls.** Unions may wish to begin by supporting tobacco control close to home by choosing to make their union meeting halls smoke-free in an effort to protect every member from secondhand smoke.

2. **Develop Workplace Smoking Policies.** Union leaders can work together with employers to develop reasonable workplace smoking policies, with the goal of creating safe, smoke-free work environments for all workers.

3. **Advocate for Cessation Services.** Unions can advocate for employer-provided, comprehensive smoking cessation services that include:
   - Behavioral interventions (such as telephone, internet, face-to-face or group counseling programs)
   - Nicotine Replacement Therapy (NRT) products
   - Follow-up cessation services to prevent relapses

4. **Provide Support and Motivation for Members Who Use Tobacco.** Unions can offer support and motivation for smokers and ex-smokers by providing members and their families with a credible source of information and referrals for preventing or stopping tobacco use. Quitting is never easy, but with support and solidarity from multiple sources, an individual's chances increase greatly.

5. **Partner with Public Health Advocates.** By working in partnership with tobacco control and public health advocates, unions can help ensure that the needs of smoking and nonsmoking union members are met with regard to workplace smoking policies and cessation services. Possible action steps include:
   - Developing and implementing a tobacco control research agenda that addresses the needs of unionized workers,
   - Joining or forming advocacy coalitions with tobacco control and public health organizations around shared goals—for example, the allocation of tobacco settlement dollars toward cessation programs for workers, and
   - Working with tobacco control organizations to provide ongoing technical assistance on union-relevant topics—for example, to address how to establish workplace smoking policies and cessation programs in unionized settings.

Sources

Sources, continued


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In this issue,
you will learn about the breadth of union support for smoke-free workplace policies, reasons smoke-free policies are the most effective types of workplace smoking policies, and how labor and management, by working together, can achieve reasonable and effective workplace policies with the highest levels of acceptance among workers.

Unions have always fought hard for workplace health and safety protections for their members and yet, until recently, labor leaders have often refrained from advocating for smoke-free workplaces, perceiving workplace smoking issues to be divisive. As labor leaders have become increasingly aware of and concerned about tobacco’s harmful and disparate impact on blue-collar and service workers, perceptions of smoking policies have changed. Labor leaders have become vocal supporters of smoke-free workplace policies, recognizing that successful policy implementation eliminates members’ workplace exposure to secondhand smoke, increases their awareness of the health hazards and economic costs associated with smoking and secondhand smoke, and helps them quit using tobacco.

The most effective type of workplace smoking policy is one that does not allow smoking in any indoor areas of a workplace and is paired with employer-provided cessation options for workers who want to quit smoking. Following implementation of a smoke-free policy, smokers are more likely to consider quitting, quit at increased rates and consume fewer cigarettes per day than smokers employed in a workplace with a less restrictive policy or no policy in place.

Reports show that employees—both smokers and nonsmokers—support reasonable smoke-free workplace policies. Even workers who oppose workplace smoking restrictions tend to comply with a reasonable policy after it is implemented. To achieve success, labor and management should work together to develop and implement a policy, conduct outreach to employees, provide ample notice, and offer opportunities for smokers to obtain cessation services. This guide provides valuable resources to support the development and implementation of effective policies.
Smoke-Free Policies Benefit All Workers

Smoke-free workplace policies impact workers and workplaces in many ways. They eliminate workers’ exposure to secondhand smoke while at work; help lower smoking rates among workers; improve the health, attendance and productivity of the workforce; and reduce many additional costs associated with tobacco use, including health care costs.

A smoke-free workplace policy is most effective in helping smokers quit smoking and in reducing cigarette consumption among workers who continue to smoke. This is particularly relevant for blue-collar and service-sector unions because not only are smoking rates among blue-collar and service workers much higher than for U.S. adults, in general, but these workers are also less likely than white-collar workers to be covered by a smoke-free workplace policy or to know about or have access to comprehensive services to help them quit smoking.

Smoke-free policies benefit smokers and nonsmokers by protecting all workers from unhealthy exposure to secondhand smoke and providing a supportive environment that helps smokers cut back or quit smoking for good. An overwhelming majority of U.S. adult smokers want to quit but have not yet succeeded in doing so. The reality is, most smokers succeed in quitting only after they have accessed multiple types of cessation services and made multiple quit attempts.

Studies show that smokers who work in smoke-free workplaces smoke fewer cigarettes per day (about 50 packs less per year for the average smoker), consider quitting more often, and quit at increased rates compared to smokers whose workplaces have weak policies or no policies in place. Smoke-free policies have the greatest impact on worker populations with the highest smoking rates.

70% of U.S. adult smokers have tried to quit at least once.
76% of Minnesota union workers who smoke have made at least one attempt to quit.

The bottom line is that smoke-free workplaces make a critical difference in the ability of many smokers to achieve their personal goals of quitting. This holds true for multiple demographic groups and in nearly all industries. Requiring all workplaces to be smoke-free would lower overall rates of smoking by approximately 5 to 10 percent.
Education Builds Support for Policy Change

While it may be true that most people know smoking is harmful to health, many remain unaware of the magnitude of the personal health risks to themselves, their co-workers and family members from tobacco use or exposure to secondhand smoke.⁷

By providing workers with pertinent information about the health, safety and economic benefits of smoke-free workplaces, labor and management representatives can help to resolve workers’ concerns about the implementation of a smoke-free workplace policy.

Most importantly, by integrating educational information about tobacco use and exposure to secondhand smoke with other health and safety issues relevant to union members, labor and management can achieve support for and acceptance of a new policy, resulting in substantial health and economic benefits for both workers and employers.⁸

Union Members Support Smoke-free Policies

In 2003, WorkSHIFTS surveyed Minnesota union members about their knowledge and attitudes concerning workplace smoking issues and policies. Results showed that 55% of survey respondents supported limiting smoking to designated areas and 32% agreed smoking should be totally banned at workplaces. Three-quarters of union members surveyed supported having their unions negotiate "reasonable" smoking restrictions and 51% supported having their unions negotiate for smoke-free indoor workplace policies.⁷

When asked who should initiate workplace smoking policies, many union members surveyed preferred that management take the lead. This preference for management action may reflect members’ awareness of labor-management past practices when implementing and enforcing smoking policies or it may indicate the tendency of some to view secondhand smoke as merely an annoyance, rather than as a recognized workplace health and safety hazard.

Studies show that regardless of workers’ pre-implementation concerns about smoking policies, most workplaces report increases in support for smoking policies following implementation.²

Attitudes of Minnesota Union Members Toward Workplace Smoking Restrictions

Support union negotiating reasonable workplace smoking restrictions ................75%*

Support union negotiating for total bans on smoking at the workplace ................51%*

Believe management should take lead in initiating smoking policies ......................43%

*Among workers who did not already work in smoke-free workplaces⁷

California’s Smoke-Free Workplace Law has benefited millions of workers over the past several years by protecting them from the deadly effects of secondhand smoke. We hope California serves as an example to other cities, states and countries that a smoking ban is good for workers, employers and the public.

Tom Rankin, President
California Labor Federation, AFL-CIO
“Support for Smokefree Bars Skyrockets in California,” Business Wire, November 20, 2002

Education Builds Support for Policy Change
**Minnesota Workplace Smoking Policies**

The Minnesota Clean Indoor Air Act (MCIAA) currently prohibits smoking in some, but not all, workplaces. Certain types of workplaces, including restaurants, bars, casinos, resorts, hotels and motels, are less restricted under the Minnesota Clean Indoor Air Act. In a growing number of communities, including the cities of Bloomington, Duluth, Cloquet, Minneapolis, Moose Lake and the counties of Hennepin, Ramsey, Olmsted and Beltrami, ordinances have been enacted that exceed the requirements of state law, extending protection to employees in workplaces where smoking is still allowed under state law, such as restaurants and, in some instances, bars.

Below is a brief overview of types of smoking policies in Minnesota workplaces, starting with the most effective type, a smoke-free policy.

**Smoke-free workplace policies**

Smoke-free workplace policies prohibit smoking in all indoor areas of a workplace and may prohibit smoking on part, or all, of the grounds of a workplace, as well as in company vehicles. Smoke-free workplace policies protect all employees from workplace exposure to secondhand smoke and reduce the number of smokers and the extent of smoking among workers. They help smokers quit by providing them with a supportive workplace environment that is conducive to quitting. Smoke-free policies also lower employers’ costs of doing business by reducing absenteeism, increasing worker productivity, and lowering health care and maintenance costs.  

**Outdoors-only smoking policies**

Outdoors-only smoking policies prohibit smoking inside workplace buildings, but allow employees to smoke in designated outdoor areas on company grounds. This type of policy has not been associated with reduced rates of smoking nor successful cessation among workers.

**Designated indoor area smoking policies**

Policies that allow a designated smoking-permitted area, such as a smoking-permitted break room, attempt to isolate smokers from nonsmokers. To accomplish this purpose, the Minnesota Clean Indoor Air Act (2002) requires that every designated smoking area must be at a negative pressure, compared to nonsmoking areas. The air from a smoking-permitted area must not re-circulate into nonsmoking areas and must be exhausted directly to the outdoors. Every smoking-permitted area must have: A wall with closed doors, except to permit necessary entry and exit, that separates the smoking-permitted area from non-smoking areas; or, a ventilation system that ensures that all air that crosses the boundary between the nonsmoking and smoking-permitted areas flows only from the nonsmoking area to the smoking-permitted area.

Numerous additional requirements apply to smoking-permitted break rooms or lunch rooms in offices, factories, warehouses or similar places of work. [Please refer to the companion piece, A Union Guide to Tobacco: Legal Issues, for a detailed description of these requirements, or contact WorkSHIFTS, at 651-290-7506, for information.]

Like outdoors-only smoking policies, designated indoor area policies are less effective than smoke-free policies because they do not prevent all workers from exposure to secondhand smoke and do not reduce smoking rates among smokers. They also tend to be difficult to enforce. In addition, the ventilation systems on which these policies depend are expensive to install, update and maintain, and cannot eliminate all health risks from secondhand smoke.

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**Restaurants, bars and lodging establishments**

Food service workers, such as waiters, waitresses, cooks, bartenders and counter help, are least likely to work in smoke-free environments. These and other types of workers exposed to secondhand smoke have up to a 50% increase in risk of heart disease and lung cancer compared to those in other occupations.
Shaping Effective Policies

Today, smoking in the workplace is either prohibited altogether, limited to designated areas, or unrestricted. Policies that allow smoking in designated areas, indoors or outdoors, do not protect all workers from exposure to secondhand smoke and are less effective than smoke-free policies in helping current smokers quit using tobacco.

The health impact of workplace smoking restrictions diminishes as smoking is allowed in designated areas. Workplaces that adopt smoke-free indoor policies see declines in smoking that are twice as great as workplaces that allow smoking in designated indoor areas.\(^1\)

The worldwide trend is toward 100% smoke-free workplace policies—those that prohibit smoking in all indoor and outdoor areas of a workplace, including company vehicles when more than one person is present. As the public becomes more knowledgeable about tobacco’s harmful health and economic impact on workers, co-workers, their families and friends, smoke-free workplaces are becoming the norm.

For more information about the laws in effect in a particular community or how existing or proposed laws affect your workplace, please contact WorkSHIFTS at 651-290-7506.

Smoke-Free Policy Goals

A goal of every smoke-free workplace policy is to promote a healthy and productive work environment for all workers—smokers and nonsmokers alike. A worker-friendly policy should clearly communicate an employer’s concern for the health and well-being of all employees and be designed to treat all workers fairly, without attacking smokers or promoting anti-smoker messages. To achieve the best policy implementation results, smokers and chewers should be provided with access to comprehensive cessation services.

In a workplace that employs union labor, the employer and union should work together to shape an effective smoking policy or to modify an existing policy. To begin this process, union representatives may find it useful to ask the following questions: Under the existing contract, do employees have the right to smoke at the workplace?; How does the collective bargaining process affect the development and implementation of smoking restrictions?; Is a focus on secondhand smoke perceived as a diversion from addressing other occupational hazards?\(^18\)

Sample Employee Survey

- Do you currently smoke at work?
- Do you think existing smoking restrictions are appropriate? Why or why not?
- Does smoking by others bother you at work?
- Which of the following would you like to see implemented:
  - A complete ban on indoor smoking?
  - A complete ban on indoor and outdoor smoking?
  - Smoking allowed only in designated areas indoors? Outdoors?
  - If you are a smoker and want to quit, what could the employer do to assist you?

Adapted from WHO, *Tobacco in the Workplace: Meeting the Challenges*.\(^17\)
Sample Smoke-Free Workplace Policy*

To fully comply with the Minnesota Clean Indoor Air Act (MCIAA) (or insert reference to local ordinance if the local provision is more restrictive than the MCIAA), and in the interest of providing a safe and healthy environment for both employees and the public, smoking restrictions have been established.

**Purpose**
A smoke-free policy has been developed to comply with current state (or local) regulations (insert specific legislative provisions) and to protect all employees and visitors from secondhand smoke, an established cause of cancer and respiratory disease. The policy set forth below is effective [date] for [organization name and location].

**Smoke-Free Areas**
All areas of the workplace are now smoke-free, without exception. Smoking is not permitted anywhere in the workplace, including all indoor facilities and company vehicles with more than one person present. Smoking is not permitted in private enclosed offices, conference and meeting rooms, cafeterias, lunchrooms, or employee break rooms or lounges.

**Sign Requirements**
"No smoking" signs must be clearly posted at all entrances and on bulletin boards, bathrooms, stairwells and other prominent places. No ashtrays are permitted in any indoor area.

**Compliance**
Compliance with the smoke-free workplace policy is mandatory for all employees and persons visiting the company, with no exceptions. Employees who violate this policy are subject to disciplinary action.

Any disputes involving this policy should be handled through the company’s established procedures for resolving other work-related problems. If the problem persists, an employee can speak to [company department, name and phone number for complaints] or lodge an anonymous complaint by calling the [insert local government unit’s complaint line or the state’s indoor air unit complaint line or web address, where applicable].

**Smoking Cessation Opportunities**
[Company name] encourages all employees who smoke to quit smoking. The [insert the company department, e.g., worksite wellness program] offers a number of cessation services for employees who want to quit smoking or chewing tobacco. Smoking cessation information is available from the QUITPLAN HelplineSM for uninsured Minnesota residents and from major health plans for their members:

- English speakers: 1-888-354-PLAN (that’s 7526)
- Spanish speakers: 1-877-266-3863
- Hearing impaired: 1-877-777-6534

**Questions**
Any questions regarding the smoke-free policy should be directed to [company department/union representative, including phone number(s) for handling inquiries].

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*Every workplace is unique. This sample policy may require modifications to meet the needs of specific workplaces. Please contact WorkSHIFTS for more information at 651-290-7506.

Adapted from a smoke-free policy developed by the American Cancer Society\(^5\)
Developing a Smoke-Free Workplace Policy

Unions and employers can work together to shape an effective workplace smoke-free policy by:

1. **Establishing a working group.** By involving representatives from all parts of the organization, a working group can communicate the importance of smoking as a workplace issue. To be effective, a working group should consult with employees and management about workplace issues and policy development and advocate for policies that address workplace tobacco issues. The composition of a working group should reflect the diversity of the organization. Participants should include senior management, union and occupational health representatives, employees, human resources, safety officers and work committees or councils.

2. **Assessing current practices.** An assessment of current practices helps to determine their strengths and weaknesses, an essential step in guiding policy development. An evaluation of current worksite practices may include: Review of a company’s existing tobacco policy (if any); review of the types, patterns, and extent of tobacco use within a company; review of current state or local legal restrictions on smoking in the workplace; review of provided cessation services for employees who use tobacco; and, development of a timeline for the new policy creation and implementation.

3. **Involving and informing employees.** Open communication between employees and management is crucial to gaining initial and long-term support for a new policy and will help ensure that all employees are aware of the policy changes and their implications. Supervisors and mid-level managers need to know what to expect when implementing a new policy so that enforcement will be fair and consistent. Maintaining open communication will help to reduce potential problems, such as misuse of break time or development of tensions between smokers and nonsmokers.

   One way to involve employees in the development of a new policy is by conducting a short survey to learn about behaviors and opinions related to the proposed policy. In a unionized workplace, unions should be involved in the development of employee surveys. Gathering opinions of all employees—smokers and nonsmokers—is important and can help to determine potentially effective ways for smokers to quit.

4. **Developing a written policy.** A written smoking policy needs to clearly identify its goals and the steps necessary to meet those goals. Policy goals should be achievable, even if they cannot all be achieved immediately. If, for example, the ultimate goal is to make a workplace entirely smoke-free, full policy implementation might best be phased in over the course of several months or a year or more. Whenever possible, the new policy should be integrated with other programs and procedures on health and safety in the workplace to achieve the greatest effect.

   A written policy should include:  
   - Purpose of the policy  
   - A link between the policy and company values  
   - Time frame for implementation  
   - A clear statement of whether smoking is allowed on the premises, and if so, where  
   - Number and duration of acceptable smoking breaks (not to exceed those for nonsmokers)  
   - Details of support, such as counseling and cessation services, available for smokers  
   - Disciplinary actions or consequences of non-compliance  
   - Names of contact persons who can answer questions related to the policy

5. **Providing support for smokers.** Smoke-free workplace policies should include active and multiple types of support for employees who are smokers or chewers. For many workers, being restricted from access to tobacco during the workday may be very difficult because of their addiction to nicotine, one of the most addictive substances on earth. Examples of accommodations that employers can provide to help employees who are most in need of assistance include: Employer-paid cessation options and incentives; information about cessation support and treatment options; flexibility in scheduling cessation services; and, allowing support groups to meet during working hours.
Sources

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WorkSHIFTs’ goal is to provide practical tools and resources that support labor’s efforts to address tobacco-related workplace concerns through education, collective bargaining, policy initiatives and the assertion of workers’ rights to health and safety.

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In this issue,

you will learn about laws, legal principles and issues that may come into play in a unionized workplace when management seeks to modify an existing smoking policy, introduce a new policy, or address problems that arise following implementation of a policy.

Smoking policy issues can be contentious in workplace settings, especially when a company imposes a new policy or modifies an existing one unilaterally. When a union opposes an employer’s unilateral implementation of a smoking policy, it is more likely to oppose the process by which a policy change has been made than the content of the policy itself. This is because the National Labor Relations Act requires that, in an organized workplace, an employer must bargain with a union over changes in terms and conditions of employment. Careful planning, involving participation of all stakeholders—labor and management—will help yield the best policy with the highest level of acceptance among workers. The bottom line is that when new rules, including smoking policies, are negotiated in good faith, employers, employees, and unions will be best served.

Within these pages, you will learn about smoking policies as a mandatory subject of bargaining, the scope of management’s bargaining authority under management rights clauses and the application of the just cause standard to smoking violations by employees. A succinct summary of state and federal laws and regulations that address smoking and exposure to secondhand smoke in workplace settings is also included.
Bargaining Authority & Related Policy Implementation Issues

Two core legal concepts come into play when an employer seeks to introduce a new workplace smoking policy or make changes to an existing policy:

- The obligation to negotiate a mandatory subject of bargaining; and
- The authority granted to an employer under a contract’s management rights language.

The obligation to negotiate a smoking policy as a mandatory subject of bargaining under the NLRA

The National Labor Relations Board (NLRB), which is charged with enforcing the National Labor Relations Act (NLRA), has ruled fairly consistently that a smoking policy is a mandatory subject of bargaining. In the absence of clear contract language to the contrary, any proposed change to an existing workplace smoking policy can be implemented unilaterally only if both parties have bargained to impasse and have reached a good-faith deadlock on the policy issue. A union’s remedy for an employer’s failure to bargain in good faith is to file an ‘unfair labor practice’ (ULP) charge under Section 8(a)(5) of the NLRA. Examples of other mandatory bargaining issues include wages, health insurance, vacation days and shift differential pay.

- Union action required: Notice of intent to bargain
  A union is in the strongest position to argue against an employer’s unilateral implementation of a smoking policy when it states its intent to bargain over the policy to an employer as soon as learning of the employer’s intent to take action—before a policy change is implemented. Unions have been found to have waived their rights to bargain by waiting too long to give notice of the intent to bargain or by never making a proper request. Please note that this differs from several other types of policy grievances wherein a grievance is filed after actual harm is incurred.

- The impact on negotiations of a legislative mandate for a workplace smoking policy
  When legislation mandates a change to an existing smoking policy or the establishment of a new policy, such as when changes are required as the result of recent amendments to the Minnesota Clean Indoor Air Act or a municipality’s adoption of a new smoke-free workplace ordinance, a union has a right to request to bargain over the employer’s new smoking policy terms, to the extent that all proposed terms remain within the bounds of law. The NLRB has held that an employer may implement a smoking policy unilaterally as long as the policy change is mandated by legislation that does not allow any discretion in implementation of the policy. If discretion is allowed in the implementation of the law, the union retains the right to bargain over the implementation of, but not the substance of, the policy.

The scope of an employer’s authority to make unilateral changes in smoking policies

Almost every labor-management contract contains a management rights clause that grants management the authority to make policy changes unilaterally under certain conditions. Employers often attempt to expand their authority under management rights clauses, while unions try to limit employers’ authority under these clauses. When questioning whether management rights apply, it is essential to remember that every management rights clause is unique and must be examined independently.

- Unilateral implementation
  Disputes over an employer’s right to implement a new smoking policy almost always occur when an employer attempts to implement a new policy unilaterally. When this happens, a union is apt to file a grievance, questioning whether a specific contract’s management rights clause gives an employer this right. In contrast to unfair labor practice charges that are reviewed by the NLRB, smoking policy grievances are usually resolved through a grievance-arbitration process.

- Duty of fair representation
  Unions have an obligation to represent smokers and nonsmokers and to enforce contracts. An employer may be able to argue successfully that a union’s failure to grieve the unilateral implementation of a smoking policy constitutes a waiver of the union’s right to bargain over the smoking policy change, thereby ceding to management the right to implement the change.
• **Grievance proceedings inquiries**

As a guideline in grievance proceedings, arbitrators examine the scope of an employer’s authority under the existing contract’s management rights clause and inquire whether the policy in question is reasonable. Unions may charge that the employer failed to fulfill its obligation to bargain, lacked authority to implement the policy change unilaterally, or was prohibited from doing so by specific contract language or past practice. They also may charge that the policy itself is unreasonable in that it is not implemented fairly, is discriminatory, creates undue hardship, or the like.

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**What authority does an employer retain under a management rights clause?**

An arbitrator may elect to sustain management’s right to implement a smoking policy unilaterally if:

1. The management rights clause of the contract in question gives an employer the right to promulgate work rules and the rules are reasonable.

2. The applicable contract language obligates management to provide a safe or a safe and healthy workplace. To sustain such a claim, an employer may be required to document that smoking, as well as exposure to secondhand smoke, are hazardous to employees or to the safe operation of the employer’s facility.

3. The policy prohibits smoking in workplace interior spaces only. Arbitration outcomes have been mixed when employers have sought to unilaterally prohibit smoking on a company’s entire premises.

Generally speaking, arbitrators try to weigh an employer’s obligation to maintain a safe workplace, including the corresponding right to promulgate reasonable work rules, against a union’s arguments in favor of past practice, and make decisions based on the weight of evidence provided to substantiate each claim. Increasingly, rulings appear to favor employers’ arguments that new scientific data demonstrating the hazards of secondhand smoke should overrule past practices.

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**Is the policy related to a legitimate business interest?**

Smoking policies have been upheld when they are reasonably related to a legitimate business interest. A smoking policy may prevail when an employer can show successfully that the policy will have a positive impact on employee productivity, absenteeism and health, or reduce safety hazards or workers’ exposure to secondhand smoke. The latter rationale has met with greater success recently, in response to growing public awareness of the magnitude of the health risks caused by the presence of secondhand smoke in workplace settings.

Arbitrators apply conventional standards of reasonable work rules to smoking policies, asking:

- **Is the rule justified?** Is the smoking policy justified by demonstrable safety, health, and productivity concerns?

- **Is the rule balanced?** Does the policy attempt to address the interests and rights of both smokers and nonsmokers?

- **Is the rule fair?** Is the smoking policy arbitrary and capricious? Does it target specific workers for reasons other than smoking? Is the policy overly burdensome?
Other contract language that may be disputed

Although most contractual disputes over smoking policies involve interpretations of management rights clauses, other contract provisions may be disputed, too. Each contract is unique and must be examined independently. Below are examples of additional contract provisions that may be disputed.

- **Specific smoking provisions.** Contracts may contain specific smoking language. Typically, the presence of specific contract language would suffice to prohibit an employer from implementing a change unilaterally, unless new legislation mandates that a change be made to the provision in question.

- **Safety committee provisions.** Some contracts establish a safety committee that is run jointly as a labor-management partnership. Safety committee language may apply to a smoking policy, especially when an employer’s rationale for implementing a policy is to protect employee safety.

- **Break language.** Break language within a contract may grant employees certain rights to use company premises during their breaks. In such a case, a smoking policy that permits smoking during breaks, but limits where smoking breaks may occur, may violate the existing contract in question.

- **Past practice.** Unions often charge that a new smoking policy violates past practice. Employers respond by arguing that what was once considered a legitimate past practice must now be understood differently in light of new scientific data, demonstrating the dangers of second-hand smoke. Arbitrator rulings on past practice issues have been mixed. Unions have prevailed in some disputes in which contracts have contained specific maintenance of existing conditions language.
Disciplining Employees for Smoking Policy Violations

Employers may discipline or terminate employees for violating smoking policies, just as they may discipline them for violating any other legitimate workplace policy. Discipline is warranted when specific and direct safety issues are involved (e.g., an employee is smoking near flammable or hazardous materials). As is true for any disciplinary grievance, disciplinary measures taken by an employer to address an employee’s alleged violation of a smoking policy involve just cause analyses.

The application of the just cause standard to smoking policy disciplinary cases

Put simply, just cause means with good reason. The basic elements of the just cause standard have been reduced to seven tests that arbitrators apply routinely in disciplinary cases. An employer must satisfy all seven tests, but an arbitrator may give the tests varying weights when issuing a ruling. The seven tests are paraphrased below as they apply to disciplinary issues related to an employee’s alleged violation of a smoking policy.

1. **Notice.** Did the employer give the employee forewarning or foreknowledge of a change to the smoking policy? Should a reasonable employee have known that his or her behavior would constitute a violation of the policy? Did the employer warn the employee of the possible or probable consequences of his or her behavior?

2. **Reasonable Rule or Order.** Is the employer’s smoking policy reasonable? Is the policy reasonably related to the orderly, efficient and safe operation of the employer’s business or to performance that an employer properly expects of the employee? Does the smoking policy target specific employees arbitrarily? Was the application of the policy capricious or punitive in the case at hand?

3. **Investigation.** Did the employer make an effort to discover whether the employee did, in fact, violate or disobey the smoking policy before disciplining the employee?

4. **Fair Investigation.** Did the employer conduct a fair and objective investigation before issuing the discipline?

5. **Proof.** On what basis did the employer determine that the employee violated the smoking policy? Did the employer have substantial proof that the employee violated the policy?

6. **Equal Treatment.** Has the employer applied its smoking policy evenhandedly and without discrimination? Has the employer enforced the policy consistently?

7. **Penalty.** Was the disciplinary action appropriate in light of the alleged offense and the employee’s prior discipline record? Were there any mitigating circumstances that warrant a different outcome?
State Laws & Regulations

One of the most effective ways to eliminate people’s exposure to secondhand smoke and reduce the rate of smoking among youth and adults is by enacting clean indoor air laws and adopting policies that limit or prohibit smoking in indoor settings. To date, the federal government has played a lesser role than cities or states in regulating smoking. Most restrictions have been enacted by state and local government.

This section provides a brief overview of key provisions of Minnesota laws that regulate smoking in workplaces and the impact of smoking on employees. For more information, or to inquire about the applicability of laws to specific settings or circumstances, please contact WorkSHIFTS.

Minnesota Department of Health

The Minnesota Department of Health has primary responsibility for enforcement of the Minnesota Clean Indoor Air Act (MCIAA). In some instances, this authority is delegated to city or county health departments. Below is a summary of the applicability of the Clean Indoor Air Act to common types of workplaces, including restaurants, bars, hotels and other workplaces where the Act’s reach remains in flux.

Minnesota Clean Indoor Air Act (MCIAA)

Minnesota’s Clean Indoor Air Act, enacted in 1975, was the first in the nation. The Act has been amended several times since then, most recently in 2002. The latest amendments, which took effect in 2003, have strengthened existing requirements regulating ventilation in smoking-permitted areas of offices, factories, warehouses and similar workplaces, by prohibiting smoking in those locations except in specific, designated smoking areas that conform to MCIAA regulations. Bars, restaurants, portions of hotels, and certain other hospitality venues remain subject to less restrictive requirements.

[Please note that some, but not all, types of workplaces are referenced below. For specific inquiries, please contact WorkSHIFTS or the Minnesota Department of Health, Indoor Air Unit, 651–215–0909 or 800–798–9050.]

1. Bars and Bar Areas of Restaurants

   Under the MCIAA, a bar is defined as any establishment or portion of an establishment where one can purchase and consume alcoholic beverages, where there are tables and seating facilities for fewer than fifty people at one time, and where licensed food service is limited. If a bar does not provide food service during hours of operation, it may allow smoking on its entire premises, provided this information is posted at the entrance of the bar. If the bar has a license for limited food service and seating facilities for fifty or fewer people, it may designate all seating as smoking-permitted. If the bar seats more than fifty or serves more than a very limited food service, it is considered to be a restaurant. Bar operators who witness violations must ask violators to refrain from smoking in designated nonsmoking areas. Violators are guilty of a petty misdemeanor. Bar owners who violate this provision may be fined or lose their licenses. The Minnesota Department of Health or local public health inspectors may order violators to correct violations, when necessary. The Department may impose fines up to $10,000 via administrative penalty orders.

2. Food Handling, Processing and Manufacturing Establishments

   Employees of food handling establishments (including grocery stores, restaurants, delicatessens, and other retail and wholesale food handlers; wholesale food processors or manufacturers; and food brokers) are prohibited from using tobacco in any form where exposed food, equipment, utensils, linens, unwrapped single-service or single-use articles or other items can be contaminated. Violators are guilty of a petty misdemeanor. Food handling establishments that violate this provision may be fined or lose their licenses. The Minnesota Department of Health may impose fines up to $10,000 by administrative penalty order.

3. Health Care Facilities

   Smoking is prohibited in any interior area of a hospital, health care clinic, doctor’s office, or other health care-related facility. No patient, staff, guest, or visitor on the grounds or in a state regional treatment center, the Minnesota security
hospital, the Minnesota sex offender program, or the Minnesota extended treatment options program may possess or use tobacco or a tobacco-related device. There are some notable exceptions: The prohibition does not apply to nursing homes, boarding care facilities or licensed residential facilities; and the provision applying to state treatment centers and security hospitals does not prohibit adult Indians from possessing or using tobacco or a tobacco-related device as part of a traditional Indian spiritual or cultural ceremony. Violations are misdemeanors. Fines up to $10,000 may be imposed by administrative order.

4. **Hotels and Motels**
   The MCIAA requires lodging establishments, such as hotels, motels and resorts, to comply as follows:

   **Lobbies and Common Areas:** Smoking in lobbies and other common areas is restricted to designated areas. A nonsmoking area must be at least 200 square feet, have appropriate signs, and be separated from the smoking-permitted area by a 4-foot wide unoccupied or occupied space, a physical barrier 56 inches or more in height, or outdoor air ventilation of not less than 15 cubic feet per minute per person. Smoking is prohibited in lobbies that are less than 200 square feet in size.

   **Registration Desks:** Neither guests nor employees may smoke at a registration desk.

   **Guest Rooms:** Lodging operators may leave the decision to smoke in rooms up to guests; designate nonsmoking and smoking-permitted rooms and assign guest rooms accordingly; or establish a smoke-free policy for an establishment.

   **Meeting Rooms:** Lodging operators may designate nonsmoking and smoking-permitted areas in meeting rooms or leave this to the discretion of the organization that has rented the meeting room.

   **Banquet Rooms:** Lodging operators or organizations renting the banquet room may designate nonsmoking and smoking-permitted areas within a banquet room. If the banquet room is rented for a private social function, smoking need not be restricted. A “private social function” means a specific social event, such as a wedding, for which an entire room or building has been reserved for entertainment or pleasure and not for the principal purpose of education, sales, or business; the function is limited in attendance to people who have been specifically designated and their guests; and seating arrangements for the function, if any, are under the control of the function’s sponsor and not the person otherwise responsible for the banquet room.

   **Employee Lunchroom/Lounge:** Employee lunchrooms or lounges must meet all requirements for lunchrooms and lounges described under "Offices, Factories and Warehouses" in this section, with the exception of ventilation and separation requirements.

   **Indoor Swimming Pool Areas:** Smoking is restricted to designated areas. Nonsmoking space and separation must be provided, along with the appropriate signs.

   **Nonsmoking Sleeping Rooms:** Smoking is prohibited in any hotel sleeping room designated as nonsmoking. Innkeepers must post signs conspicuously in all nonsmoking sleeping rooms stating that smoking is not permitted. Lodging management may adopt more restrictive nonsmoking policies. If management establishes a smoke-free policy for an entire building, it must post this policy at the main entrances.

   The Minnesota Department of Health is the lead enforcement agency and may delegate enforcement activities to city or county health departments. Lodging operators who observe violations are responsible for asking people to refrain from smoking in designated nonsmoking areas. Each violation is a petty misdemeanor. The Minnesota Department of Health may impose fines up to $10,000 by administrative penalty order. In addition, anyone convicted of violating the rule against smoking in a nonsmoking room may be required to reimburse the innkeeper for cleaning costs up to $100.

5. **Nursing Homes**
   Any nursing home, boarding care facility or other licensed residential facility that allows a smoking-permitted area must provide a comparable nonsmoking area. Smoking-permitted areas in nursing homes and boarding care facilities must comply with ventilation requirements. If smoking is permitted in the facility, prospective patients or residents must be assigned smoking-permitted or nonsmoking rooms depending on their preferences. Otherwise, smoking is prohibited in all rooms except those occupied exclusively by those who smoke or permit others to smoke. Visitors and staff cannot smoke in patient or resident rooms. Medical centers, nursing homes, or domiciliary care facilities operated by the U.S. Department of Veterans Affairs must allow a suitable indoor designated smoking area, which is ventilated as required by law or is in an area detached from the facility, is accessible to patients or residents, and has appropriate heating and air conditioning for
those persons receiving care or services who wish to smoke tobacco products. An exception applies to minors in licensed residential treatment centers, including rehabilitation and other care facilities. Minors are not permitted to possess or use tobacco products.

The Minnesota Department of Health may impose fines up to $10,000 by administrative penalty order. The Department has discretion to suspend or revoke nursing home and boarding care licenses.

6. **Offices, Factories, Warehouses & Similar Workplaces**

Smoking is prohibited in offices, factories, warehouses, or similar places of work, including elevators and restrooms. Exceptions:

- The smoking prohibition does not apply to a private, enclosed office (defined as a room occupied by one person with floor to ceiling walls and a closeable door) if the door is kept closed while smoking occurs and the office meets ventilation and separation requirements listed below.
- Smoking is not prohibited in a designated smoking-permitted area of a lunchroom or lounge that meets the ventilation and separation requirements listed below.
- If a designated smoking-permitted area of a lunchroom or lounge is not available in the office space, then one smoking-permitted area per 20,000 square feet may be designated, but it must meet the ventilation and separation requirements listed below.

Building management may adopt more restrictive policies. If management establishes a smoke-free policy for an entire building, signs must be posted at main entrances to identify the building as smoke-free.

**Ventilation and Separation Requirements.** All smoking-permitted areas must be at a negative pressure compared to nonsmoking areas, according to requirements verified and documented by a professional engineer licensed in the state or an individual certified by the National Environmental Balancing Bureau or the American Air Balance Council. Air from the smoking-permitted area must not be recirculated into nonsmoking areas and must be exhausted directly to the outdoors. The smoking-permitted area must have either walls with closeable door(s), except to permit necessary entry and exit, that separate the smoking-permitted area from areas where smoking is prohibited; or a ventilation system that ensures air flows only from the nonsmoking to the smoking-permitted area, and not vice versa.

**Smoking-Permitted Lunchroom or Lounge Requirements.** Lunchrooms or lounges must meet the above ventilation and separation requirements and comply as follows:

- The lunchroom or lounge must have a designated nonsmoking area that meets demand, which may be determined by a survey. Otherwise, at least 70 percent of the lunchroom or lounge must be designated as a nonsmoking area.
- The nonsmoking area must be at least 200 square feet in size.
- Amenities, such as refrigerators or microwaves, must be located in the nonsmoking area.
- If a business has two or more lunchrooms or lounges, one may be designated as smoking-permitted in its entirety as long as at least one other comparable lunchroom or lounge is designated as nonsmoking in its entirety.
- If there is only one lunchroom or lounge and it measures less than 200 square feet in size, it must be designated as smoking-permitted in its entirety.
- If a lunchroom or lounge is not available to designate as a smoking-permitted area, then one smoking-permitted area per 20,000 square feet may be designated, provided it complies with the above requirements.
- Signs must be posted on or immediately inside all entrances of facilities or designated areas advising people of the existence of acceptable nonsmoking and smoking-permitted areas.

Violations are misdemeanors. The Minnesota Department of Health may impose fines up to $10,000 by administrative penalty order.

7. **Restaurants**

Restaurants must designate at least 30% of their total seating capacity as nonsmoking. Nonsmoking and smoking-permitted seating must be separated in at least one of three ways: by a 4-foot wide space; a physical barrier 56 inches or higher; or outdoor (fresh) air ventilation with a documented rate of at least 15 cubic feet per minute per person.

Entrances must have signs stating that smoking is prohibited except in a designated area. Waiting areas measuring less than 200 square feet in size must be designated and posted as nonsmoking. Waiting areas measuring more than 200 square feet in size may be divided into nonsmoking and smoking-permitted areas, provided that at least 200 square feet are
nonsmoking. All smoking and nonsmoking areas must be posted and separated as described above. If there is a private office in the restaurant, it must meet State ventilation and separation requirements to allow smoking. A restaurant may adopt more restrictive nonsmoking policies. A growing number of Minnesota’s restaurants are choosing to go smoke-free. Many of Minnesota’s smoke-free restaurants are listed at www.ansrmn.org/SFRests.htm.

If the entire restaurant is entirely smoke-free, this policy must be posted at the main entrances. Areas where food is handled and prepared must comply with requirements described under “Food Handling, Processing and Manufacturing Establishments.” Lunchrooms or lounges provided for employee breaks must meet all but the ventilation requirements described for lunchrooms and lounges under “Offices, Factories, Warehouses and Similar Workplaces.” An exception applies where seating is controlled by a host or hostess. In those settings, nonsmoking and smoking-permitted areas do not have to be posted with signs. Where patrons seat themselves, the areas must be posted appropriately.

Inspectors may issue orders to correct violations, when necessary. Restaurant and bar operators who observe violations are responsible for asking people to refrain from smoking in designated nonsmoking areas. Smoking in a designated nonsmoking area is a petty misdemeanor. The Minnesota Department of Health may fine restaurants up to $10,000 by administrative penalty order and revoke or suspend their licenses.

8. Stores

Smoking is prohibited in all customer-accessible areas of retail stores, except for designated smoking-permitted areas. If a smoking area is created in an area used by customers, the same goods and services must be available in a separate nonsmoking area of the store. The main entrances of a smoking-permitted area must be posted with signs stating: “Smoking is prohibited except in designated areas” or a similar statement. If no smoking is allowed in the building, the main entrances must be posted with signs stating, “No smoking in this entire facility” or a similar statement. If management establishes a smoke-free policy for the entire building, it must post no-smoking signs at main entrances. Lunchrooms or lounges provided for employee breaks must meet all but the ventilation requirements described for lunchrooms and lounges under “Offices, Factories, Warehouses and Similar Workplaces.” Restaurants located within a retail store must comply with state requirements described under “Restaurants.” Retail operators who observe violations are responsible for asking people to refrain from smoking in designated nonsmoking areas. Smoking in a designated nonsmoking area is a petty misdemeanor. The Minnesota Department of Health may impose penalties up to $10,000 by administrative penalty order and revoke or suspend licenses.

Minnesota Department of Labor and Industry

Workers’ Compensation Act

Minnesota’s Workers’ Compensation Act provides benefits to injured employees when an injury is related to work activity, regardless of fault or negligence. All Minnesota employers, with very limited exceptions, are subject to the Act. Injured employees must demonstrate that the risk of harm was increased by being at work or by performing job functions, and that the injury took place during the course of employment. Worker’s compensation claims can be exceedingly complex and usually require the assistance of legal counsel. A growing body of case law supports the receipt of workers’ compensation claims for workers who become ill as the result of exposure to secondhand smoke at the workplace. The merits of each claim must be determined on a case-by-case basis. In general, an injured employee must establish a causal relationship between the workplace exposure to secondhand smoke and the injury, must have notified the employer of the harmful effect from tobacco smoke and requested that this concern be addressed, and, after being notified about the employee’s concern, the employer must fail to make a reasonable accommodation to eliminate the source of the injury, such as exposure to secondhand smoke.

Employee Right to Know Act

This act requires employers to evaluate their workplaces for the presence of hazardous substances and harmful physical agents and to provide training to alert them about their potential exposure to any such substances or agents. Tobacco products and other products intended for personal consumption by employees in the workplace are specifically exempted from these provisions. Penalties can range from $1 to $70,000.
Prohibited Employer Conduct
Employers may not refuse to hire a job applicant or discipline or discharge an employee because the applicant or employee engages in, or has engaged in, the use or enjoyment of a lawful consumable product, such as tobacco, if the use or enjoyment takes place off-premises during nonworking hours; however, an employer may restrict employees’ use of tobacco products during nonworking hours if the restriction relates to a bona fide occupational requirement and is reasonably related to employment activities or responsibilities of a particular employee or group of employees, or is necessary to avoid a conflict of interest or the appearance of a conflict of interest with any responsibilities owed by an employee to the employer. Violators may be subject to a civil action for damages, limited to wages and benefits lost because of a violation. The court may award the prevailing party court costs and reasonable attorney fees.

Whistleblower Act
An employer may not discharge, discipline, threaten, otherwise discriminate against, or penalize an employee regarding the employee’s compensation, terms, condition, location or privileges of employment because the employee or a person acting on behalf of an employee, in good faith, reports a violation or suspected violation of any federal or state law or rule adopted pursuant to law (such as a company smoking violation) to an employer or to any governmental body or law enforcement official. Civil penalties may include all damages recoverable at law, costs and disbursements, reasonable attorney’s fees, and any injunctive or equitable relief determined by the court.

Minnesota Department of Human Rights

Human Rights Act
The Minnesota Human Rights Act, like the federal Americans for Disabilities Act, may afford legal protections to employees affected by smoke in the workplace, including places of public accommodation, such as restaurants and bars. A disabled person is defined as one who (1) has a physical, sensory, or mental impairment that materially limits one or more of the person’s major life activities; (2) has a record of such an impairment; or (3) is regarded as having such an impairment. The Human Rights Act protects qualified disabled persons or those who, with reasonable accommodation, can perform essential functions required of all employees performing the job in question. Disabled persons who wish to be protected from secondhand smoke in the workplace may file a complaint with the Department of Human Rights or bring a lawsuit under the Minnesota Human Rights Act. Any person who commits a prohibited discriminatory act, or aids, abets, incites, compels, or coerces another to do so, is guilty of a misdemeanor. Damages may include back pay, compensation for lost benefits or mental pain and suffering, reinstatement, punitive damages up to $8,500, and a civil penalty.

Minnesota Department of Economic Security

Unemployment Insurance Law
Under both federal and Minnesota law, employers who employ individuals within the state must contribute unemployment taxes to the federal and state reemployment insurance fund. The purpose of the fund is to provide weekly payments to employees who have lost their jobs through no fault of their own and who, although physically able, have not found suitable reemployment. Employees who are discharged for reasons other than misconduct and employees who quit their employment due to a serious illness or injury or for a good reason caused by the employer may qualify for the receipt of unemployment benefits. Nonsmoking employees who leave employment because they are unable to continue working due to the effects of workplace secondhand smoke have been found to be eligible for benefits.
Related Federal Laws & Regulations

**Environmental Protection Agency (EPA)**

Although the EPA has classified tobacco smoke as a Group A carcinogen for which there is no known safe level of exposure, it does not regulate secondhand smoke in the workplace and has no indoor air quality standards for tobacco smoke. The EPA maintains that secondhand smoke is a carcinogen that "causes cancer and other significant health threats to children and adults," and recommends that employers protect nonsmokers from exposure by allowing smoking only in outdoor spaces or in isolated indoor spaces that are separately ventilated to the outdoors and sponsoring employer-paid cessation programs.3

**National Institute for Occupational Safety and Health (NIOSH)**

Like the EPA, NIOSH has not established indoor air quality standards for secondhand smoke. NIOSH recommends that employers "reduce environmental tobacco smoke to the lowest feasible concentration."

**Occupational Safety and Health Administration (OSHA)**

In Minnesota, the Occupational Safety and Health Division of the State’s Department of Labor and Industry adopts and enforces federal OSHA standards, as well as local standards. Even though secondhand smoke has been classified as a Group A carcinogen, known to cause cancer in humans, it is the only Group A carcinogen that is not specifically regulated by OSHA. In 1994, OSHA proposed restrictions under its Indoor Air Quality Rules. Under pressure from the tobacco industry, no final regulations were issued. Today, OSHA regulates secondhand smoke in very limited circumstances, such as when manufacturing process contaminants combine with smoke to create a dangerous air supply that fails OSHA standards.

Minnesota Statute §182.653, Subdivision 2, requires each employer to furnish "conditions of employment and a place of employment free from recognized hazards that are causing or are likely to cause death or serious injury or harm to its employees." Minn. Stat. §182.657 requires the Department of Labor and Industry to "promulgate...such rules as may be deemed necessary to carry out the responsibilities of this chapter."

**Americans with Disabilities Act (ADA)**

The ADA prohibits discrimination against an employee with disabilities and requires an employer to provide reasonable accommodation to a qualified disabled employee, as long as the accommodation does not cause the employer an undue hardship. The law applies to employers with at least fifteen employees, including those who operate places where the public is invited, such as restaurants, hotels, and theaters, and those who receive government services. The ADA defines disability as (1) a physical or mental impairment that substantially limits one or more major life activities; (2) a record of such impairment; or (3) being regarded as having such impairment. If an employee specifically requests reasonable accommodation or notifies the employer of the seriousness of the problem, the employer is obligated to accommodate the employee.

A person with respiratory problems may succeed in proving that a sensitivity to smoke is disabling, in that it impairs the ability to perform a major life activity (breathing freely), and that a reasonable accommodation would be a smoke-free workplace policy or an appropriate ventilation system. An employer may argue that a proposed accommodation will create an undue hardship, imposing an extraordinary financial or other burden on an employer or interfering substantially with the ability to run an enterprise. Although an effective, reasonable accommodation must be made, the ADA does not require an employer to make the accommodation preferred by the disabled employee or recommended by experts. The Equal Employment Opportunity Commission (EEOC) must investigate all properly filed complaints. If the EEOC does not pursue an action, an individual may file a private lawsuit. ADA penalties include monetary damages, court orders to stop the violation in question, and attorneys’ fees.
Sources

The information within these pages is provided for educational purposes only and is not to be construed as legal advice or as a substitute for obtaining legal advice from an attorney. Laws and rules cited are current as of the digest’s publication date. WorkSHIFTS provides legal information and education about tobacco and health, but does not provide legal representation. Readers with questions about the application of the law to specific facts are encouraged to consult legal counsel familiar with the laws of their jurisdictions.

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WorkSHIFTS is a collaborative labor outreach initiative of the Tobacco Law Center at William Mitchell College of Law, partnering with Minnesota’s labor community.

WorkSHIFTS’ goal is to provide practical tools and resources that support labor’s efforts to address tobacco-related workplace concerns through education, collective bargaining, policy initiatives and the assertion of workers’ rights to health and safety.

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sweisman@wmitchell.edu
www.workshifts.org

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I smoked 55 packs this year without ever taking a puff.

Young children are most vulnerable to secondhand smoke because their lungs are still developing.

A nonsmoker who is exposed to a pack-a-day smoker inhales the equivalent of 3 cigarettes a day—nearly 55 packs a year.

Children who breathe secondhand smoke have substantially increased risks for sudden infant death syndrome (SIDS), asthma, bronchitis, middle ear infections, and pneumonia.

Breathing even small amounts of secondhand smoke can damage health.

Smokers who live in smoke-free homes are more likely than other smokers to try to quit and to quit for good.

SMOKE-FREE HOMES WORK!

www.workshifts.org • 651.290.7506
It used to be fun. But now, man, it’s something controlling me and I can’t control it...I’ve figured out a lot of things, but this one I can’t figure out, and it makes me angry.

Your family and friends want you to quit. You want to quit. But how?

Quitting comes in stages, with strong support at work, at home and at play.
Your health plan may provide quitting assistance. Information on quitting is also available from the QUITPLAN℠ Helpline, a stop-smoking, personalized phone counseling service for Minnesota residents who do not have insurance coverage. English: 1-888-354-PLAN (7526); Spanish: 1-877-266-3863; Hearing impaired TTY line: 1-877-777-6534

Benefits of Quitting

<table>
<thead>
<tr>
<th>Improved Health</th>
<th>Cost Savings</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>After</strong></td>
<td><strong>You’ve saved</strong></td>
</tr>
<tr>
<td>1 year</td>
<td><strong>1 year</strong></td>
</tr>
<tr>
<td>Physical benefits</td>
<td>1 year</td>
</tr>
<tr>
<td>Your risk of heart disease drops to half of that of a smoker</td>
<td>$1,095</td>
</tr>
<tr>
<td>5 years</td>
<td>5 years</td>
</tr>
<tr>
<td>Your risk of stroke is the same as that of a nonsmoker 5-15 years after quitting</td>
<td>$5,475</td>
</tr>
<tr>
<td>10 years</td>
<td>10 years</td>
</tr>
<tr>
<td>Your risk of lung cancer is half that of a smoker</td>
<td>$10,950</td>
</tr>
<tr>
<td>15 years</td>
<td>20 years</td>
</tr>
<tr>
<td>Your risk of heart disease is similar to that of someone who never smoked</td>
<td>$21,900</td>
</tr>
</tbody>
</table>

DON’T QUIT ALONE!

www.workshifts.org • 651.290.7506
Before, I worked at a tool factory and we could smoke because the pollution was so bad in there it didn’t make any difference...It was the cool thing to do. Now, we have respect...It has to do with education. In the last ten years, with asthma...and secondhand smoke and whatnot, I think we realized we’ve got to do something.

People at risk for heart disease should avoid all buildings that allow indoor smoking. —Centers for Disease Control and Prevention (CDC), 2004

Secondhand Smoke...

- contains more than 4,000 chemicals, including at least 50 that cause cancer.
- when combined with exposure to other hazardous substances, greatly increases workers’ health risks.

Smoke-Free Workplace Policies...

- help smokers to cut back or quit for good.
- protect all workers’ health.
- reduce absenteeism and increase productivity.
- lower healthcare, maintenance and insurance costs.

Workers face hazards every day—but secondhand smoke shouldn’t be one of them. This is one hazard we can prevent.

HEALTHY WORKPLACES WORK!

www.workshifts.org • 651.290.7506
Three waitresses have died from lung cancer since I started, and another one who used to work here died around the same time. They were all smokers, and that scares the heck out of me, and I tried to cut down. I can cut down to almost nothing, but then I turn around and I’m just like a chimney again.

Restaurants & Bar Workers...

• are more likely than other workers to work in smoky establishments.

• smoke at rates that are almost double the smoking rate for all U.S. adults. About 45% of U.S. waitpersons smoke, compared to 23% of all U.S. adults.

• have a lung cancer risk that is 50% higher than the lung cancer risk for any other occupation, including firefighters and miners.

• breathe 4-8 times more secondhand smoke than someone living with a smoker.

• nearly double their risk for a heart attack if they face prolonged exposure to secondhand smoke at work or at home.

The Centers for Disease Control (CDC) warns that people at risk for heart disease should avoid all buildings that allow indoor smoking.

Smoke-Free Workplace Policies...

• help smokers to cut back or quit for good.

• protect everyone’s health and safety.

• reduce absenteeism and increase productivity.

• lower healthcare, maintenance and insurance costs.

SMOKE-FREE WORKPLACES WORK!

www.workshifts.org • 651.290.7506