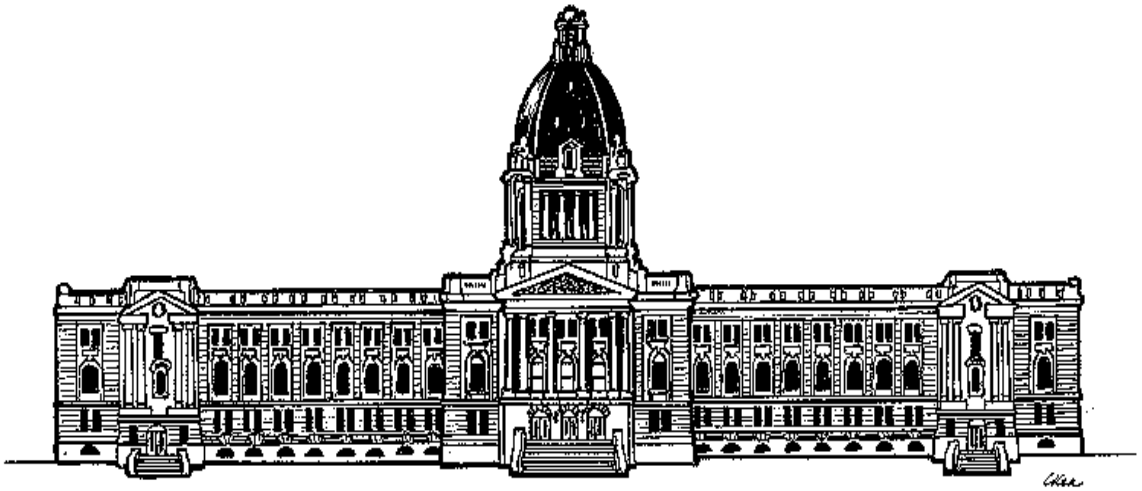
Special Committee on Tobacco Control

Hansard Verbatim Report

Yorkton – March 1, 2000



Legislative Assembly of Saskatchewan

Twenty-fourth Legislature

SPECIAL COMMITTEE ON TOBACCO CONTROL
2000

Myron Kowalsky, Chair
Prince Albert Carlton

Doreen Eagles, Vice-Chair
Estevan

Graham Addley
Saskatoon Sutherland

Brenda Bakken
Weyburn-Big Muddy

Bob Bjornerud
Saltcoats

Debbie Higgins
Moose Jaw Wakamow

Mark Wartman
Regina Qu'Appelle Valley

Published under the authority of The Honourable Ron Osika, Speaker

The committee met at 7:03 p.m.

The Chair: — Thanks for coming out to this, this public hearing of the Special Committee on Tobacco Control.

What I'm going to do today is take about 10 or 15 minutes — it ends up to be 15, I might as well admit it — to go through a little presentation. And then we have a . . . then we will be inviting those people who have registered to come one at a time and give us a presentation to the legislature. And all this material is recorded and it is used for . . . as a basis that will form part of the database that the committee will use to form its decision and report to the legislature.

I want to thank you for coming again. I want to especially thank the young people who are here today. The decisions that will be made as a result of our recommendations will affect our lifestyles in some way or another. And so young folks are the ones that will be affected more than anybody else, I suppose, so it's important that we do hear from our youth, and we do have representation from our youth here.

I'm pleased to be here at Yorkton, and we all know Yorkton to be — the rest of us in Saskatchewan — know Yorkton to be the place that holds the famous international film festival. And we congratulate you folks on that. Keep it up. It's something that puts you on the map. And of course some of us know it personally for our colleagues that have been elected from Yorkton . . . (inaudible) . . . at this particular time, Clay Serby.

And then we've got to check to see if our technology is going to work here. Oh, here we go. All right.

My name is Myron Kowalsky, I'm the member from Prince Albert Carlton. I'm Chair of this committee. Vice-Chair of the committee is Doreen Eagles; she's the member from Estevan, not with us this evening. But Bob Bjornerud is here. Bob is from your neighbouring constituency of Saltcoats. Bob is sitting here on the right.

Graham Addley, from Saskatoon Sutherland, not here today. Deb Higgins, from Moose Jaw Wakamow, is not here today. But Mark Wartman, sitting on my left, member from Regina Qu'Appelle Valley, and Brenda Bakken is here. Brenda is MLA (Member of the Legislative Assembly) from Weyburn-Big Muddy.

This is an all-party committee, so it's composed of four members from the government side and three members from the opposition side of the legislature.

We have with us some staff members: Donna Bryce, who is a committee Clerk, dressed in black. Behind me, dressed in white in the other corner, Tanya Hill, who is our research officer.

And we have people who are doing some work on the technology: Darlene Trenholm, sitting beside Ihor, and we'll get his name in here in a minute; and Alice is sitting at the door here and meeting you there. Then we have Ihor Sywanyk, who is broadcast technician. And if cable TV (television) comes into your homes here, from the legislature, Ihor is one of the people that's responsible for it.

The job of the committee has got sort of four main things that we're trying to do. First of all, we're supposed to assess the impact of tobacco use in Saskatchewan with particular emphasis on children and youth.

What provincial laws do we need to protect people, and again particularly as it affects children and youth.

And what should we do to protect the public from second-hand smoke? There's more and more evidence — medical evidence — coming in about the effects of second-hand smoke. Should we be doing something about designated smoke-free places? And who should do it — should it be in the hands of the province, municipalities, the owners themselves, or health boards?

What should we do to prevent and reduce tobacco use? Should we be changing our emphasis on enforcement or on pricing or on what's done in the schools or in public awareness in general.

So we're going through this public hearing process and we want to hear peoples' views. We're going to 17 communities. This is I believe our eighth community that we're in. We've done the southern part of the province and we're sort of moving north, and we've gone to 14 schools. Tomorrow we're going to be at Yorkton comprehensive high; this morning we were at Wynyard.

Here is a little bit of the statistics sort of that affect us, or that we look at, some trends that we're looking at, with respect to young people aged 15 to 19 and what per cent of our young folks smoke or report that they smoke. And across here, there you can see how much there is in BC (British Columbia), Manitoba, Ontario. Saskatchewan, you can see, has one of the tallest black bars here — 34 per cent of our young folks report that they smoke second only to the province of Quebec who have a greater number of smokers. That's for people aged 15 to 19.

People over 15, Saskatchewan is more or less in the middle of the pack here, roughly in the middle.

Another graph that I just want to bring to your attention and this is the amount that's been smoked, and it's recorded over time since '81 to '99. There are four lines here. The top line represents all males and you can see that the general trend from 1981 is downwards, downwards so that now at this time, the average male who smokes, smokes approximately 17 cigarettes, 17, 18 cigarettes daily.

Females, also a general downward trend except for the last few years here it sort of levelled off. Smoke a little bit less than the average male.

Young people, young males, sort of a slow general downward trend to about 12 cigarettes a day here right now, 12 or 13 cigarettes a day.

Young women in Canada, something like this. It jogs all over the place, but the most recent trend is kind of interesting here. Since about '96-97, the amount smoked by young people, young women in particular, has increased. So now we've got

equality between young men and young women at this number of about 11 or 12 cigarettes a day.

Here's a Saskatchewan-only statistic. This is given to us by the Institute on Prevention of Handicaps and their survey is taken . . . what they did is they split the province up into three parts — the northern part, which is north of Saskatoon; central part is from Saskatoon down to the No. 1 Highway; and the southern part is the No. 1 Highway and south, including Regina.

And they've done it, compared with females with males, and this is the percentage of youth that report that they are smoking. And you can see that the tallest bar is this one, which represents females in northern Saskatchewan — over 50 per cent of them report that they're smoking.

And the central region, which Yorkton is counted in, about roughly 39.7, about 40 per cent report that they're smoking. And in the southern part, fewer yet.

Same trend for young males, but just slightly lower numbers right across the board.

There is now legislation in Saskatchewan. There's a tobacco minors Act. This was legislation which was revised in 1978, and it prohibits the sale of tobacco to persons under the age of 16 and allows merchants to sell to minors providing there is a written permission from the parent. And people who sell to minors in Saskatchewan under the Saskatchewan law can be fined up to $10. Haven't heard of many people getting that fine lately.

There's also The Urban Municipality Act, 1984. It gives the urban authorities power to regulate smoking in public places. And there's The Occupational Health and Safety Act, 1993 which permits committees within a workplace to regulate smoking.

Now you can see that that legislation is not really up to date compared to what some other jurisdictions have and that is one of the reasons that this committee was formed, because we've been getting calls saying it's time that we did a little more about smoking.

There is, however, other legislation in place. That's the 1997 Act that is a federal Act. It's enforced in Saskatchewan and it prohibits the sale of tobacco to people under 18. And it allows for fines that are considerably stiffer — up to $3,000 for the first offence and up to $50,000 for the second offence. There is no minimum and there have been a couple of places that have been warned; I'm not sure if there's been any fines levied to date.

This legislation also prohibits the advertising of tobacco products via media in Canada. But as you know, there is media from the States that still gets here and there's very little restriction that I know of, of advertising of tobacco products in the States. And it does currently allow for sponsorship of adult-oriented events, namely sporting and cultural events.

It's the federal government who regulates the packaging of tobacco products. Of course we've heard a lot about that over the media over the last three weeks or a month. A little bit about the nature of tobacco.

For those of you that might not be able to see this from the back, this is: "These pictures of diseased lungs on my cigarette pack make me nervous." And she says: "Me too; so nervous that I need a smoke". It speaks a bit to the addictive nature of tobacco. And we are advised repeatedly in the committee so far that it's more addictive than alcohol or hard drugs, and harder to shake.

The cost of tobacco smoking to Saskatchewan. Statistics given to us from the Department of Health which uses the same methodology as other departments do across the nation, and it's based on studies that were conducted back in Eastern Canada, by people in the statistical and research fields. We are advised that the direct costs in Saskatchewan, due to hospitalization, doctors, cost of drugs, and fire loss is estimated at $87 million annually.

On top of that there's indirect cost to Saskatchewan. The estimates that Sask Health gives us is due to: mortality, that is wages lost because a person died prematurely due to a tobacco related disease; plus morbidity, that's wages lost due to days away from work because of illness or time off; low birth rates that result from prenatal effects of tobacco — all comes out to 179 million for a grand total of $266 million dollars to the provincial treasury. That's the cost side.

Now the province also gets money coming in from tobacco— at a charge $17.20 per carton of cigarettes plus the PST (Provincial Sales Tax), and that comes out to be about 125 million which is estimated for this current year. That's input of revenue; that's the expectation to the provincial treasury.

The federal government also taxes this — $10.85 per carton plus GST (Goods and Services Tax) for a total of 2.2 billion of which Saskatchewan smokers pay an estimated 67 million of that amount to the federal government in tobacco taxes.

So there's still not a net income to this, a net loss to the province . . . to the taxpayers of Saskatchewan.

Now the topics that we're interested in hearing about are the health effects, how it affects youth, about smoking in public places. We want to hear about your views about recovering health care costs and about accountability.

I want to bring this graph to your attention. This is given to us by Sask Health, and every time there's a death, of course there's a cause attributed to the death. We often hear about suicides. We hear about traffic accidents because they're rather spectacular and they happen instantaneously. The numbers here are under 200 — this is in 1993 — under 200. The numbers of deaths attributed to smoking-related diseases — over 1,100. Some sources have told us up to 1,600.

Just to review in graphical form, the provincial tax revenue from tobacco at this level, this little box, 125 million, health care costs, this box.

I kind of like this little thing here because it reminds me of my youth. Here is a little guy here who's just had an experience, one of the experiences of life, and mom says: "Are you okay?"

And she says, "You smoked some of that cigar, didn't you?" He says, "Yes, Mom, I think I caught the cancer." And dad says: "Well shouldn't we tell him it's just nausea?" And mom says: "Well all in good time."

This little cartoon sort of speaks maybe to the ideal situations, the balance between freedom to breathe clean air over here and have a nice little visit, and at the same time right beside him, he's free to enjoy all of his own smoke.

So now what I want to do is turn it over to people who have come here to make presentations. I want to bring to your attention a web site that the committee has. It's www.legassembly.sk.ca/tcc/ — Tobacco Control Committee. There's a online survey and some information there as well. And pass it on to the young folks and especially encourage young people to take five or ten minutes and take a look at it.

So thank you very much for your attention. And now what I'm going to do is take a look at the list and we'll get started. Now here's the way it's going to look for tonight. First we have Debora Grywacheski and Rod Holmgren . . . Debora Grywacheski and Rod Holmgren; then Dr. Datta; then Paul Van Loon and George Skwarchuk; then Judy Espeseth; then Curtis; and then Denis; and then the Yorkton branch of the diabetes association; then the Yorkton Body Image Interest Group — Heather Torrie.

We have allotted for up to 20 minutes for a presentation. If you want to provide room in that time for questioning or comments from the committee, then please do so. If you want to use the entire time to make a presentation, that's fine as well. If your presentation is only two or three minutes or five minutes long, that's fine as well; we'll just get this done sooner. But if everybody uses up their 20-minute allotment, right now we're going to be going about 10:20. And feel free to walk in and out; it's not . . . nobody's taking attendance here and there's no tests at the end.

The committee would now like to hear from Debora and Rod. And when people come up here — you might want to bring another chair — please start by stating your names into the mikes and then proceeding.

Ms. Grywacheski: — Good evening, Mr. Chairman, and hon. members of the committee. Thank you for the opportunity to speak to the issues of tobacco use and control tonight. We are representatives of the Assiniboine Valley Health District, East Central Health District, and North Valley Health District.

My name is Debora Grywacheski and I'm a public health nurse working in the Assiniboine Valley Health District. My area of tobacco reduction work focuses on the prevention of cigarette smoking in young people. The number of young people who begin smoking is on the rise, and the age at which they begin is younger and younger.

With the assistance of teachers, public health nurses in the service area are involved in the peer assisted learning program or PALS program. This program is designed and delivered to grade 5 and 6 students, and provides them with the knowledge and the skills to resist the pressure to smoke. We know that if we can help them to avoid smoking until the age of 20, chances are they will remain non-smokers all of their lives. We know that once a person has started smoking, it's very hard to quit. So the key to fighting the health hazard of smoking is prevention.

The PALS program consists of six lessons on the health issues, addictions, social pressures, and how to resist them, and also the awareness of tobacco advertising strategies. When we do the pre-program survey, it is revealed to us that at 25 to 30 per cent of children in grade 5, 6 have already tried smoking. A colleague of mine has reported students as young as grade 5 requesting assistance on quitting smoking. These children are 10- and 11-years-old.

At the end of the program, the students are surveyed on the satisfaction of the classes. Ninety-five to 100 per cent of these grade 5 and 6 students have liked the program, felt it was something they wanted to spend more time on, and would not change anything by the six-week experience. Some of the comments received refer to the fact that they are actually taught ways to say no and that they have learnt a lot about general issues.

Due to the addictive nature of tobacco and its availability to children in this province, the hazards to youths are particularly great. Health Canada reports that eight out of 10 children who try smoking get hooked. Tobacco use prevention should be mandatory in every grade.

Another concern is that since asthma is the most common chronic disease of children, it is the most common cause of hospitalization of children under 10. And since cigarette smoke is a major trigger factor in asthma, smoke-free areas are essential to the health of children.

When children and their parents attended an asthma education day in our health district, the asthmatic children who are athletes expressed anxiety and discomfort with recreation areas that are still not smoke-free. The risk of triggering an attack while they are having to play or eat in the skating rinks, curling rinks, and other facilities that are not smoke free is a stressful situation for these children and their parents.

Though many facilities are now smoke free and more public events are smoke free, there needs to be legislation to ensure that all enclosed places that children and their families frequent are smoke-free areas. Currently, the public health inspectors in the service area are conducting a survey of public places to determine how many are smoke free. This information will be useful and will provide us some guidance in future tobacco reduction strategies.

Although there are few smoke-free restaurants or bars in Assiniboine Valley Health District, all health facilities and schools in the district are now smoke free.

For persons who are addicted to tobacco and wanting assistance to quit, there are smoking cessation services in the health district that are offered by local doctors, the alcohol and drug rehab workers, community groups, and services provided by the Sask Lung Association. But we encourage the committee to improve the availability of these options and to make them affordable to all Saskatchewan residents.

Members of the committee, as a health professional who works with people across the lifespan, I am concerned that the cost of smoking to our communities is undeniable. It is the leading preventive cause of death and disease in Canada. It is estimated that more than 1,600 adults die in Saskatchewan every year as a result of smoking. Thousands more develop heart/lung disease and cancer because of smoking. It also contributes to a higher infant mortality rate in our province.

The Government of Saskatchewan has a responsibility to prevent tobacco-related deaths and diseases.

Ms. Churko: — Good evening, hon. members of the committee. My name is Val Churko. I work as a health educator for the East Central Health District. My background is nursing and I have spent 22 years in the acute care sector.

In my personal life I have witnessed first-hand the powerful, addictive qualities of nicotine as I watched and supported my husband through withdrawal.

In my career, I have had the experience of looking after numerous patients dying from the effects of tobacco — the leading cause of preventable illness, disability, and premature death. As I say that statement, I believe many people are not aware of the impact tobacco use has on our society. As demonstrated in your slide, how many people in this room are aware that smoking kills more people than AIDS (acquired immune deficiency syndrome), suicide, and traffic accidents combined? How many people are aware that Health Canada estimates that second-hand smoke causes 300 deaths from lung cancer in non-smokers?

I work in the area of population health promotion. Population health promotion is about creating conditions which support the best possible health for all. Population health looks at the broad picture of what determines our health. Key strategies for promoting health including creative supportive environments.

As health professionals, we work on prevention of smoking. We also support those who are addicted to smoking by offering them services and support to stop. We do not blame the victim of addiction. We recognize the importance of good physical, social, and political environments which are needed to support health.

Strengthening community action — events such as this evening are very important to build capacity and to create an environment or a climate in the communities to come together to discuss issues such as the impact of smoking on our communities.

Building healthy public policies — it encourages all levels of policy-makers to consider the impact on health of the policies which they develop. In the issue of smoking, the availability of smoke-free public places can improve dramatically on the health of the community.

Developing personal skills — through awareness and education, people are given skills and abilities. When we offer the PALS program, we try to equip young people with the ability to adopt a healthy lifestyle and choose not to smoke.

Reorienting health services — we need to look upstream and prevent the tremendous burden on health care which is caused by tobacco use.

What are the issues which I feel are important relating to tobacco use? There is need for an increased awareness on the effects of tobacco. All sectors of the community need to be well-informed on the effects of tobacco in our lives and in our communities. Even health professionals need to increase their awareness on this important issue.

The economic costs of tobacco use are tremendous as demonstrated in your presentation, but what about the social and economic costs? How do you put a price tag on the loss of a family member?

Too many people view tobacco use as normal. In our area, a survey found many of our youth believe that up to 70 per cent of adults are smokers. In reality, only 25 per cent of our adults are smoking.

According to some surveys, many youth believe that they can smoke, then quit whenever they choose to. The reality is that many of these young people become addicted and are unable to quit smoking as easily as they had planned.

The tobacco industry has done a tremendous job of marketing their product. They target our youth and recognize how important it is to get our young people smoking. Cigarette ads that I have seen typically do not portray older people smoking; the ads show vibrant people using tobacco.

More smoke-free environments are needed. The risks associated with second-hand smoke are well documented. We need to advocate for those who do not have a voice, namely infants and children.

If these are the issues, what are some of the strategies to deal with these issues?

Our province needs a tobacco reduction strategy which includes legislative changes to reduce the risk of exposure to second-hand smoke. Canadians spend approximately 90 per cent of their time indoors, at work, at home, and in places such as recreation facilities. Indoor air quality is very important to health.

Legislation is often considered the most effective strategy to prevent youth from smoking. Saskatchewan falls behind other provinces with their legislation relating to tobacco use.

A province-wide education and awareness campaign with resources committed to reducing tobacco use in our communities — I think youth should be involved in developing and delivering the prevention messages and educating their peers on the importance of remaining smoke-free. Smoking cessation program supports need to be easily accessible and affordable to all.

An examination of issues relating to availability of tobacco and the tobacco industry — the young people in our area tell us they have easy access to tobacco. My children have told me it is not uncommon to see young entrepreneurs at the junior high school

These students sell cigarettes for up to $1 each to their addicted classmates.

Legislative changes must be accompanied by enforcement in order to be successful. The tobacco industry is currently being challenged in a number of provinces.

Through all of this we must remember nicotine is a highly addictive drug. It kills when used exactly as directed by the manufacturer.

Mr. Holmgren: — My name is Rod Holmgren and I'm the director of an addictions drug centre in the North Valley Health District. My graduate degree is in marriage and family counselling, and I have well over 20,000 hours of clinical counselling experience.

I've found that nicotine is not only the most common entry-level drug — meaning it's usually the first drug that people become addicted to — it's also the last and most difficult drug for many of my clients to stop using. I hear this from those addicted to heroin, cocaine, alcohol — it doesn't matter.

I give you the example of a man in his mid-'40s who came to see me with a stated desire to quit smoking. He explained that as a child he had been very close to his dad. He was enthralled with almost everything his dad did, including smoking. But with tears streaming down his face, he also described the agony he experienced as a teenager while watching his dad waste away and finally die from lung cancer. He talked about the anger that he presently feels toward the tobacco industry as he watches his older brother who is just in his 50s sit at home, unable to work, hooked up to an oxygen tank. This brother, who has severe emphysema and who unhooks the oxygen from time to time to have yet another cigarette, is not expected to see another Christmas.

Another man came to our office in a suicidal state of mind. He too is a smoker and is in his late 50s. He has recently been diagnosed with throat cancer. Even if this man lives — which his doctor says is very unlikely hence his suicidal ideation — his wife and children are so angry at him for continuing to smoke that during one counselling session, before he left for a treatment, she told him that she isn't sure she wants him back in the house again when he's finished treatment. It's too painful for her to sit there and just watch him smoke himself to death.

This family is going to have huge issues to deal with when this man dies from smoking. Not only will they be grieving the loss of a husband and a dad, but they'll have to work through the impotent rage they feel towards him, and also towards a society that supports and encourages the very addiction that is going to kill him.

Members of the committee, I'm guessing that you're going to hear over and over again from the restaurant and hotel industry that banning smoking in public places will take away business dollars. Well I'm telling you that making it convenient for people to smoke takes away the lives of moms and dads and grandparents.

It's statistically proven that smoking increases the rate of miscarriages as well as cases of sudden infant death syndrome. And this is true even for pregnant women who don't smoke but simply live with a smoker. Until you've seen it in a counselling session, I think it's difficult to comprehend the agony, the guilt, the pain that a woman experiences when it finally sinks in that she has contributed to the death of her own child.

This is not some economics class that we are dealing here, this is the real deal, folks. As stated there are those who say they are worried about the potential economic fallout of banning smoking in public places. I would say to those people that they should perhaps consider the moms and dads and grandparents who will die from their own smoking, and the infants and others who will die as a result of someone else's smoking.

These are people who will never, ever spend another cent in your restaurants, bars, or anyplace else; never mind the cost in lost productivity and disability payments, related medical costs.

And all our research — based on sales receipts and other hard evidence coming out of California, Colorado, and the BC Workers' Compensation Board — show that banning smoking in public does not reduce business income. Even if it did, I believe that sacrificing people's health for the sake of dollars is profoundly short-sighted, unbelievably irresponsible, and hideously selfish. Thank you.

The Chair: — Well thank you, Rod, Val, and Debora for your presentation. Committee members, does anybody wish to pose a comment or a question at this time? I just have one question I'd like to ask you. Do you have any recommendation with respect to cessation methods? Is there anything that works better than something else from your own experience?

Mr. Holmgren: — I think it needs to be a combination of . . . I mean we run a stop smoking program through the counselling centre. We've found that if that is used in concert with the medical profession — whether it's a patch or whatever — one of the drawbacks there is that a number of our clients just can't afford it. It needs to be under the drug plan or something for . . . so it's accessible to everyone.

My experience is that a combination of counselling plus something else is the most effective.

Ms. Churko: — I think what's important as well is to recognize the importance of the social supports around the people that is trying to quit smoking. They need the support from their family and being able to involve the family in smoking cessation programs as well. I see that as being important.

Mr. Wartman: — Val, one point. You said access to tobacco is too easy, and you had just previously said legislation is one of the best preventive measures. Access for youth is too easy. What do you see . . . What would be effective in dealing with that access?

Ms. Churko: — Well I think certainly the enforcement issue regarding who has access to tobacco is important. And I recognize that there are presently four tobacco enforcement officers in the province, and they — from what I understand — are doing a good job. But I think there is opportunity, strategies

that could be developed that maybe in . . . In some instances I've heard in other province they even use youth in order to enforce the enforcement of there not being access to young people being able to obtain cigarettes.

So as far as the legislation, I think it's something that has to be looked at in the communities and all policy makers are involved; that there's an awareness in the community of the need for the legislation as well.

Mr. Wartman: — Thank you.

The Chair: — Thank you. The committee would now like to hear from Dr. Datta.

Dr. Datta: — Ladies and gentlemen, it's a pleasure . . . (inaudible interjection) . . . okay. I apologize. I have a cold, you know, so I'll be . . . It's my pleasure to come and talk to you as a pediatrician, the effect of tobacco smoke on infants and children. I've made some slides.

Children are exposed to environmental tobacco smoke in two different ways. Number one — household exposure — what it means when mom is smoking in the house, father is smoking or somebody in the house, visitors or other house members smoking, the child or the infant is exposed to smoke and how can we detect it?

If you check the inner ear for . . . (inaudible) . . . levels, you find it is usually very high. That we can detect. The baby or the child has been exposed to household exposure. It again depends how close the mom is to the child when she smokes, how many cigarettes she smokes a day, whether one parent is smoking or both are smoking — so all those count.

The second way the children are affected by maternal smoking — during pregnancy, at any stage a mom smokes, it affects the fetus; it affects the newborn baby. In the next slide I'll show you how it affects . . .

We found out about 38 per cent children are exposed to environmental tobacco smoke exposure and 23.8 per cent children are exposed in utero. It's quite a big number so we have to look into things how we can prevent those things.

We found out the effect of smoke is worse in children than in adults. The reason behind this, they have got smaller airways and the children breathe faster. The respiration rate is 25, 30, the adult rate is 15 to 18. So when they breathe fast, they inhale a proportional amount in proportion to their body weight. And not only that, the lungs and the respiratory system are growing, developing, so it directly affects the development of the respiratory system.

Now what of the health effects of environmental tobacco smoke in children? We can see very clearly, smoking by the mother during pregnancy increases the risk of miscarriages, stillbirth, premature birth, as well as death in the first weeks of life. We also found out that sudden infant death syndrome which is very, very frustrating, very, very upsetting to parents . . . 35 per cent of the sudden infant death syndrome — we call them SIDS (sudden infant death syndrome) — are due to maternal smoking.

We also found out that children of the smokers, of smoking parents, they have a high prevalence of respiratory irritations such as cough, wheezing, and production of phlegm. We also found out that this exposure . . . (inaudible) . . . to the risk of lower respiratory infection, such as bronchitis, pneumonias, bronchiolitis, etc.

And it's been found out in the States, there was 16 per cent of all lung infection of children are directly attributed to the smoking.

Children exposed to a house of smoking are at greater risk of surgery for recurrent ear infections from tonsillitis. It has been found out in the States, 86,000 children there go for ear insertion for the chronic . . . (inaudible) . . . and there were 18,000 children go every year for removing tonsils and the adenoids. So it costs a lot of money and those things can be easily avoided.

We also found out that smoking is definitely associated in promoting asthma attacks. In the United States, about 11 per cent of all asthma children, the cause is directly attributed to smoking. Even a little tobacco smoke exposure are also said to increase risk of developing chronic obstructive . . . (inaudible) . . . disease, and in adults too into cancer, lung cancer.

So what are the solutions and what are the recommendations as a pediatrician I can make? Number one, ensure that the home is completely smoke-free. And anybody wants to smoke, they should go out from the house. That is restricting smoking to the outdoors.

Avoid bringing children to public places, daycare centre, and private home where they would be exposed to smoking, particularly second-hand smoking. Avoid smoking in the presence of children and pregnant women. It's found out, not only smoking during pregnancy, if a pregnant lady exposed to other smoking people, that second-hand smoke also can affect the fetus — that newborn baby.

So they're to avoid smoking and . . . (inaudible) . . . tobacco smoke during pregnancy; ensure that smoking materials are kept out of the reach of children and adolescents. A lot of time they found out the match or the cigarette lighter, there's fire there. So we should support non-smoking bylaws in all workplaces, public places especially, where children are likely to be, such as familiar to student, malls, and child care centre.

So what will be my recommendations? It would be physician to take history from the parents and the guardians about their smoking habits. Number one. Number two: physician should inform the parents and the guardians about the hazards of basic smoking and what can happen to children if they continue smoking. Physicians should promote this more . . . (inaudible interjection) . . . using all facilities in which children visit the care.

I'd like to show some slides. The pictures that I'm showing there now the effect of smoking when mom is pregnant. The premature babies are quite often attributable to maternal smoking, and these babies are prone to respiratory distress syndrome, they can develop intra-ventrical hemorrhages, cerebral palsy, you can name them.

The other baby, premature baby, who's in respiratory distress, you can say . . . (inaudible interjection) . . . monitor there, the next one. It can affect both premature, and the other side we call them intra-uterine growth rate condition. They found out if the mother's smokes . . . like old people, their vessels become . . . (inaudible interjection) . . . So if mom smokes or she's a heavy smoker, the umbilical artery becomes . . . (inaudible interjection) . . . So they don't get nutrition, they cannot get enough oxygen. As a result babies are born with intra-uterine malnourished or call them intra-uterine growth condition.

There's another picture when a mom is a heavy smoker, look how the baby looks, like malnourished — the effect of maternal smoking, not enough nutrition, not enough oxygen — and these babies are very prone to complication, they develop hypoglycemia, they develop seizures, hypothermia, and sometimes they develop infections. When they get infection they cannot fight it, they're . . . (inaudible interjection) . . . they've no immune system. Next one please.

As you imagine previously, smoke also is a triggering factor for the asthma. And they found out that 11 per cent of asthmatics in the States are directly attributable to smoking. Here the typical picture of asthma, what has happened into the face — he's anxious looking, he's sour-mouthed in the lips because . . . (inaudible interjection) . . . it drops and he is in serious respiratory distress. This is the picture of asthma when the person was acute state, they call them . . . (inaudible). The next one please.

This is a real child, you can see the . . . (inaudible) . . . asthma. We call them barrel-shaped chest. Is chest like a barrel and I can . . . (inaudible) . . . is in drawn. His lungs are over inflated. I can see that in the video in particular, this you can see the picture. The next one please.

This is of a condition we call them allergic rhinitis, or hay fever. And that then can be also contributed to second-hand smoking. It is called grimacing face; his nose is itchy. And on the picture below, we call them allergic shiners with the dark circle on their eyes, they're always sneezing and sniffling, grimace in the face — all can be attributed to second-hand smoking.

This is called allergic salute again from the smoking. Nose become very, very itchy as though there were grease there and we call it allergic salute. Next one.

The next important is ear infections. In children we see so much ear infections coming back again, again, again, and again. They develop for fluids, they go for pus in the ear, and physician prescribing antibiotics, antibiotics; child is sick every two weeks, every two weeks. And cigarette smoke is directly rooted to the ear infections.

And so if you note picture there, these are diagrams of the ear, maybe I'll show what it means. Are they ready to go?

This is the pinna — I don't know if you can see it from there. This is the pinna . . .

The Chair: — Doctor, can you just hold it for a minute? One of our difficulties here is we have to get you to speak into the mike.

Dr. Datta: — Oh okay, sure.

The Chair: — I think this other mike is a little bit more . . . (inaudible) . . . I think I might give you my pointer. I think I'll give you my pointer . . .

Dr. Datta: — Okay, thank you. So this is the anatomy of the ear. This is called pinna, the outer ear, and this is called ear canal. We call them otitis externa. And this is the eardrum and this is the middle ear.

So when there is fluid in the ear, it remains — or smoke — it effects this part of the ear, the middle ear. That's why they have fluid. They can't hear properly. They get impairment of hearing. Sometimes severe earache from the pressure build up. And they come to us with a high fever and only thing for this is antibiotics. And we hate to give them antibiotics. When they come and see me, they have earache, can't sleep, crying, and this is very, very common. They go to different physician and antibiotics, antibiotics, antibiotics.

Go to ear specialist, they say, this child needs tubes in their ear. It is extremely common. They've found out smoking, particularly second-hand smoking, is one the commonest cause of giving rise to this common condition called . . . (inaudible) . . . of mid-ear.

I'll show some pictures of how they look like. So, the eardrums . . . I'll show the ear, how it look like — eardrum becomes so red, so bulging, with the fluid, this is how it looks like, and how it depends on the stage, acute stage, it becomes chronic, and then it goes on for months and months, it becomes like this.

So in that case, people needs . . . antibiotic never works, you have to put tubes in and sometimes the tube is not a cure. They fall out again and again, again and again. They put in two times, three times, with deep insertion, and the child is not treated properly in right time, right way, they'll land up with deafness.

So all those things, conditions can be easily preventable. At least most of them can be preventable if we avoid second-hand smoking for the children.

This is another condition. This is called tonsils, this is one tonsil, this is a tonsil. And in the back we can see this is called adenoids. You've heard about adenoids.

So they found out those children who are born to parents who are smokers, or children exposed to smoke again and again, again and again, they are very prone to develop tonsillitis and adenoid enlargement. And very often they're sick, goes to physician, cannot eat, cannot swallow, high fever, and ultimately what they need is a tonsillectomy. As shown in States, 86,000 children every year, they need tonsillectomy due to exposure to second-hand smoke.

So the incidence of tonsillectomy . . . (inaudible) . . . and it ignores also . . . The symptoms are the child is a mouth breather; he snores at night; he cannot sleep, restless sleeper — he's wakes up several times. In the morning he's sleepy. He's drowsy — he had no sleep, you know. And sometimes he even

stop breathing . . . (inaudible) . . . stop breathing . . . (inaudible) . . . So those can be preventable, at least three-quarter per cent of it if they can avoid second-hand smoke.

So I thought I'll show a few pictures because I can give some idea how the tonsils look like, what the nose look like, premature baby look like — a baby born to your mother, and babies malnourished, intrauterine . . . (inaudible) . . . So that will give you a good idea.

So as a physician, the paediatrician feel that it is absolutely needed that children should not be exposed to second-hand smoke. And particularly the mother who are pregnant, they should be taught, they should be counselled not to smoke, not to be exposed to second-hand smoke for the babies' sake, for the children's sake. Thank you.

The Chair: — Thank you very much, Dr. Datta, for taking the time to prepare for this, for your presentation. Our time is pretty well up with the 20 minutes. So with the permission of the . . . the concurrence of the committee, I'd like to go on to the next presenter.

Mr. Wartman: — Just one quick question.

The Chair: — One quick question.

Mr. Wartman: — I just wanted to ask if Dr. Datta was also handing that material in that was on the slides.

The Chair: — Just go ahead and ask.

Mr. Wartman: — Okay. Dr. Datta, I was just wondering if you had that material that you had slides in print if you would be handing it in as well?

Dr. Datta: — Sure.

Mr. Wartman: — Thank you very much.

The Chair: — Thank you very much, Doctor. If you can leave it here or if you can mail us copies of that, either one would be appreciated. And I should mention, any presenter, to all the presenters, if you have copies of material that you're dictating it would be . . . it's just good for a double-check for us to have a copy of your presentation as well.

Is Paul Van Loon here please?

Mr. Van Loon: — Good evening. I'd like to thank the committee for their perseverance in doing this day after day and night after night. As I'm speaking tonight, I'm going to make reference to some comments which have been made at earlier hearings. These are not meant to be taken in anyway personal. They are meant to be used as discussion points, and I hope that that is the context in fact in which they will be viewed.

I too would like to sort of jump in initially into the environmental tobacco smoke issue. Ultimately what we have before us is a decision which questions our own beliefs. Is environmental tobacco smoke a public health problem?

A British epidemiologist, in 1854, traced an outbreak of cholera to a particular pump in London. He asked simply that local authorities remove the handle from the pump to dispel the epidemic. A simple solution to a major health tragedy. This caused a tremendous reaction — not applause but outrage — and from whom? The for-profit water companies. This also happened 145 years ago but it certainly sounds not too dissimilar to what we are experiencing today. People who are making money but causing illness and death at the same time were willing to sacrifice people for the sake of profit. So the question, what do you believe? Is ETS (environmental tobacco smoke) harmful?

I bring you a statement made at one of these hearings. Because I know in my own personal experience I vote with my feet. If I go to a bar or a restaurant and there's absolutely no smoking, I don't go twice. So what does this remark confer to us? It suggests that the person feels it is acceptable to smoke in a public place and in this situation a workplace. It suggests that this person does not believe that ETS is harmful or it could suggest that this person just doesn't care. It suggests that this person does not feel that those patrons, who have chosen not to inhale tobacco fumes or employees, should have access to a clean air environment. It is your belief that would ultimately guide this decision. I know what I believe but I did not put myself in front of the public to get elected and thus I cannot make the actual decision.

A common response by those opposed to limiting tobacco smoke in public places goes something like this. For every one of those studies which show ETS is a problem, we can show you an opposite study. I invite you to ask these people for these studies. This argument has been presented frequently but yes, it is very uncommon to actually see these studies.

Most of the detractors base their case in the following ways: one, the EPA (Environmental Protection Agency) report, and their statement is that the EPA report is not valid. This report, published in January of '93, was not thrown out, as some claim. The chapters relating to lung cancer were rejected by the court. The EPA's findings re second-hand smoke, especially as it affects children, were left intact. Even the tobacco industry did not contest these aspects.

Not only was it endorsed by many organizations, including the US (United States) Surgeon General, I think you should realize that the judge who decided this case has no science background, was a former lobbyist for the tobacco industry, and did happen to reside in North Carolina.

But a part was thrown out and this we accept. Numerous studies since then have shown a correlation and are accepted without court challenge.

The Fraser Institute has since published a book, *The EPA's Betrayal of Science and Policy*, which the hotel association is known to favour — which is understandable. Once again I only ask you to understand the source — both authors have direct ties to the tobacco industry. One author is a scientist in the United States who has been paid by the tobacco industry to write articles downplaying the effect of ETS.

Second argument, the EPA study does not show statistical significance. Many studies cannot attain statistical significance

— not because a relationship does not exist but simply because of numbers.

If we examine persons who are present at one of your committee hearings, for example, on any one night we might find two people wearing blue jeans. We might thus conclude that 10 per cent of the audience are wearing jeans and we might feel fairly confident in suggesting that this is a normal average and likely to be the situation on any one night. But would it have the status of being significant? No. Simply because the numbers aren't there.

The WHO (World Health Organization) report. In 1988 two London newspapers reported the WHO had blocked publication of a research project on passive smoking. This was entirely a bogus media production. Many papers were quick to pick up the article; very slow to print the retraction. In fact, the study does show a correlation.

Neither the EPA or the WHO, however, has ever claimed that minimal exposure to ETS poses a huge individual cancer risk. Even though the lung cancer risk from second-hand smoke is relatively small compared to the risk from direct smoking, unlike a smoker who chooses to smoke, the non-smoker's risk is frequently involuntary.

Exposure rates also range dramatically, but for those who must work in an environment with smoke, the risk is certainly greater from those less exposed.

Interestingly, both of these studies refer to lung cancer. The hotel association was also a little confused on this issue. The paper they actually referred to suggested that exposure by young people to ETS in a restaurant, for example, is unlikely to result in lung cancer. This is a little like someone submitting a paper that quotes work done to show that January in Saskatchewan tends to be somewhat chilly.

Less than 1 per cent of lung cancer deaths occur in persons under the age of 20. This is general knowledge. It would include lung cancer deaths as the result of any reason and not just exposure to ETS.

The hospitality industry likes to use lung cancer as their marker. Why? Because it's a very poor marker of ETS effects. It is probably one of the worst markers, especially for children. Not only should you toss aside these statements, I ask you to exact from the presenter why they would use this as a marker when they know it's a poor marker. We've heard of parents from asthmatic children explain and we've just heard a presentation that I think showed much better some of the markers of ETS.

The hotel industry offers courtesy of choice. The choice in most of the hospitality industry in Saskatchewan is, would you like smoking or smoking. They offer to look at compromise. I cannot understand that making a hotel lobby and hallway smoke-free will cause a loss of business. People are going to sleep in their car just because they can't smoke in a lobby?

And yet in Saskatchewan, only in Saskatoon are the lobbies, generally speaking, smoke-free or can you go into a hallway without finding ashtrays. This was evident at the very first hearing in Moose Jaw. Why are they smoke-free in Saskatoon? Local legislation, not because of courtesy of choice.

The industry points out ventilation system technology. So where do they get their information? We don't know all the sources, but let's look at some. One US company was scheduled to give seminars in both United States and Canadian cities. I don't know if in fact they actually reached Canada.

This company was hired by the tobacco industry to do four things: (1) produce materials regarding ventilation alternatives to smoke-free bylaws; (2) provide no-cost technical assistance to hospitality owners; (3) provide testimony promoting the tobacco industry's position before government committees; and (4) to make presentations to trade associations. The tobacco industry frequently does not do this themselves but they hire people to do it for them.

This very same company presented a submission entitled "Comments on OSHA's (Occupational Safety and Health Administration) proposed IAQ rule", indoor air quality rule. Within this, they acknowledged the funding contribution to the tobacco industry to develop the document, and people have stated before you that they do not represent the tobacco industry. I believe that they truly don't think or always know to what extent this industry does get involved in the hospitality sector.

The latest ASHRAE (American Society of Heating, Refrigerating and Air-Conditioning Engineers Inc.) standards which have been mentioned: ventilation for acceptable indoor air quality, which is standard 62-1999 — it's a revision of the 1989 policy — contains the original '89 policy plus four new things. The one addition that we are interested in deletes from the '89 standard a footnote to the ventilation rate table that mentioned the standard accommodated a — and I quote — "moderate amount of smoking." So remember that is now deleted in the ASHRAE standard.

The new code which has been adopted already in parts of the United States will become official this month actually; official later this month, but it has been known for many months. However just before Christmas, the tobacco industry was sponsoring ventilation seminars in which the participants were instructed to base their ventilation work for hospitality owners on the '89 ASHRAE standard, even though this same group submitted a paper in appeal of the newer regulations before they ran the seminars. So they certainly knew.

As recently as three weeks ago, Philip Morris the maker of the world's most popular cigarette in fact, made formal representation at a hearing of the American National Standards Institute to appeal the new and stronger standard. So they're still trying to appeal it.

This is a standard that has nothing to do with the manufacture of tobacco products. But it does have to do with where the products should be used. Yet we will not be surprised if the appeal is unsuccessful, to learn that they have filed a lawsuit against ASHRAE because they have the time, they have the money, and they have the smarts.

Another example, a little closer to home, was in Montana. They held a "Let's Clear the Air" seminar, sponsored by the Montana

tavern association. The event was spearheaded by two recognized authorities — one an engineer, one a bar owner. I'm not opposed to having these seminars but did the attendees in fact understand that the bar owner is active in two other organizations that have connections to the tobacco industry and has worked hard to reduce effective smoke-free bylaws in other states previously? Then engineer works for a company with funding from the tobacco industry that is pushing for ventilation.

Organizations such as The National Smokers Alliance and others with more innocuous titles, such as: Californians for Fair Business Policy, Valley Business Owners and Concerned Citizens Inc., Michigan Restaurant Association, the Oregon Restaurant Association, and many others, stretched from the Atlantic to the Pacific, and they purport to represent the hospitality industry.

These were all — be they newly formed or already in existence — opposed to smoking control ordinances. They are all front groups for, and have received substantial funding from, the tobacco industry.

In our own country, we have The Lower Mainland Hospitality Group formed to oppose similar bylaws in British Columbia. We are told they receive large donations from the Canadian Tobacco Manufacturers' Council. Persons who are fighting the Lethbridge smoking bylaws admit to having connections to the tobacco industry. We know that people in this province are hired to represent the tobacco industry's interest. It is not just an American phenomena, connections are everywhere.

One final thing in regard to this, please note that Philip Morris concludes one of their seminar handouts with the following statement:

> The content presented in this workshop does not purport to address health effects attributed to smoking.

So if it doesn't address health effects, what does it address, and why are they doing it? I ask further that you be prepared for, but also to resist, any such overtures made to this committee. These are persons who are paid big dollars to deny us a healthier, cleaner community. They are people who have turned the art of selling a deadly product into a science. Do not confuse a ventilation system, that moves air, with clean air — they are not synonymous.

I'd like, secondly, to move onto education. I think education is a basic; it should be a given. But the question has to be asked: is it a key? I suggest that it is not, especially in the context of how it has been used so far. It is imperative, necessary, and an adjunct to other measures.

Perhaps it is not exactly bunk as we've heard, but is not the pivot around which everything else should revolve.

Education and awareness are very important, but they are not the key that will open the door to this public health issue. The concept that if we educate persons in elementary school it will stem the tide just does not work. None of us will suggest that we terminate attempts to educate. Unfortunately people who use this argument of education as a major initiative are either simply not aware of how education functions or do know and use this as a statement of motherhood and apple pie, because no one wants to be taken out of context and have it said that they do not support education.

Regrettably education does not equate to behaviour change. Its biggest role may in fact be to reinforce behaviour in those who are most likely to choose a healthier lifestyle rather than preventing other youth from starting.

We know that young smokers are more likely to miss school, have a greater tendency toward depression, social conformity, and rebelliousness. They are risk takers, have more experience with other unhealthy behaviours. Smoking may be just one more symptom. Treatment of the disease may be far more complex.

A statement was made at a hearing — I believe the main issue is to educate young people. The concept of basing the major plan of attack on tobacco-use reduction on education within a school system, especially at the elementary level, is flawed.

Young people do not learn the same way that older students learn. They do not conceptualize in the same manner. We don't teach the concept of density to young students — not because they lack science skills, but because they lack the ability to adjust from the concrete to the intangible, especially with abstract concepts.

We do the same thing. That's why we teach addition instead of subtraction. If you combine five tulips and five roses in a bunch and ask people how many tulips, up until a certain age the answer you will get is ten. At a certain point in our development we start to differentiate tulips from roses, and we will answer five. This process is an ongoing process, lasts throughout the whole educational process.

The reality of the curriculum was not — and this is a personal view — well explained by the ministry of Education. It's nice to discuss the decision-making model and the concept of wellness but what we have to know is, is tobacco use being discussed?

The reality is the only place within the curriculum that tobacco information has to be presented is grade 9, where there is a required unit on the tobacco industry. How extensively is it actually being taught? No one knows. Otherwise only in grade 4 is the word tobacco or smoking referred to.

There's discussion within some school boards as to how much of the grade 5, 1 to 5 curriculum is actually compulsory. The ministry explained that teachers are required to teach across strands. They didn't make it clear that not all items within the strands in fact don't have to be taught. This does not mean that tobacco is not being mentioned but it means we don't know; the ministry does not know.

In fact I found the ministry so obscure as to not explain when asked about the smoke-free grad of 2000 program, that it's not even a program of the ministry and never was. You may find it interesting to know that when this particular program was being developed for the graduating class of 2000 when they were in grade 1 in 1989, the government of the day — and they were

asked — declined to provide any funding.

So what can we do under the guise of education if you like? Well health warnings at point of sale. Let everybody know the health risks associated with tobacco use. The norm today is to see rows of tobacco products in countless outlets — wonderful advertising for the industry. They pay for the space; they demand the view.

Legislation. Legislation shakes public attitudes. One of the best ways to educate the public is to have legislation — perception of importance rises dramatically; people see a much stronger sense of urgency and belief. Encourage the federal government to proceed with the new health warnings. This is a form of education. People need to see new things periodically.

Will it convince mass numbers to quit? I doubt it. It's not intended to do that. So let's not pretend and let's not say that's what it's not going to do, because we know it's not going to do that. But it is part of the education process for smokers, both for those contemplating starting and for those contemplating stopping. Small children read the warnings as the package lies around the house.

Ban operation ID (identification) that presently exists in Regina. Educate the retailers. Don't wait for the tobacco industry to do it; don't allow them to do it. Assist with the enforcement officers. We already have. Provide them with provincially produced information.

Operation ID is designed as an educational program which is inherently designed for failure from a sale to minors or a health aspect, but it is well-designed to increase the tobacco industry's public relations efforts.

Prevent any school workplace programs to occur in a smoking environment. I found it interesting that we would encourage youths not to smoke, we teach them ETS is harmful, and then we put them into a school program which says in effect it's okay for you to work here as part of the school program; that stuff we taught you in school before doesn't really apply to the real world. The ministry allows this to happen. Here is an opportunity to educate by letting youth know that we won't accept unhealthy workplaces in school placement programs.

Put money into the system. We discussed tax dollars obtained from tobacco products. We know that less than half of 1 per cent of that money is used on reduction activities. No matter what education we do, it can't be done at zero cost. If we're not prepared to put money into the system, that's what we'll get out of the system — nothing. A foundation could be established; an additional levy of 10 cents a pack would raise millions of dollars in this province.

And finally, stop thinking we need to educate only the young. Educate the adults who have control over children's environment. In response to a grade nine's students attempt to have a healthier smoke-free environment in her local recreation complex, the following statement was made: I'm in sports facilities where there are a lot of kids. I mean, it isn't healthy for them to be in that smoke and I just wish you the best of luck.

Is it not ironic, or is it simply just sad, that we are asking adolescents to create a healthy environment which for the most part is being polluted unnecessarily by adults?

This is not a huge industrial process or some aspect of our industrial world which is essential to the running of a modern society. This is individual pollution. The moment people choose to light up in the presence of others, they effectively eliminate choice for everyone around them in order to satisfy a self-inflicted craving for a non-essential toxin. Do we as adults create a problem and then truly expect kids to solve it?

I'm asking you tonight as a government to take leadership on this issue. If you really mean — as was said in this statement — it isn't healthy for them, then please do something about it. You have the reason to do this. You have the authority to do this. And you have the support to do this.

Thank you.

The Chair: — Thank you very much, Mr. Van Loon. I ask the committee members to defer questions if you don't mind. One quick one?

Mr. Bjornerud: — One quick, short question. Did I understand you right when you said that you don't feel that teaching or educating or having part of the curriculum in the lower grades will do any good?

Mr. Van Loon: — That's not what I said. I said it's not the pivot around which we should revolve things. It is not the answer. It is one small part of the puzzle.

And yes, we should continue it. But not only should we continue it, we should make sure it's there perhaps. Because right now you can go through this entire system, except for grade nine, if it's done there, without any tobacco information. That's theoretically possible. And in grade nine, it's not even health related — i.e. it's the industry.

So I'm not saying that happens, but I'm saying it's possible that it can happen.

The Chair: — Thank you very much for your presentation. Oh, Mark?

Mr. Wartman: — I'll ask later.

The Chair: — You'll ask later. Okay. I don't want to run overtime and that's why I'm sorry panel members that we . . .

Next we're asking Judy Espeseth to come before the committee. Is Judy here? If Judy isn't here, well we'll just proceed to the next one.

Is Curtis Mullen here?

Mr. Mullen: — Hi. My name is Curtis Mullen. I am 16 and have been smoking for nine years.

When I first started smoking, I always thought I would be able to quit, but it kept on getting longer and longer. And I find now I cannot have the power to quit. I have tried to stop . . . quit

smoking with the patch, gum, and pills. I have not been successful yet to stop smoking.

How I got started smoking was from mostly peer pressure and stress. The way I got my smokes when I was a kid was from stealing from my parents. When I got older, around 12, I was able to go to stores and buy my own smokes with my money from working or allowance.

And I say that smoking is highly addictive and there is a lot of consequences to it. I'm asthmatic, and I've been smoking for nine years, and it's been making me a little worse and worse every year. And right now, like, I'm in school, for Sacred Heart High School here in Yorkton. There is a policy of grade 9s are not supposed to be smoking near or around the school, but you were able to before; but they started on that now. But the teachers there have not been watching anybody and the grade 9s have been smoking there. And that has brought me onto smoking at schools now.

I do try to help others to not start smoking and/or try to quit. For awhile I went through all the stuff, the stress of even being on smokes, it got . . . everyday got stressful for me. I'm starting to wonder if I'm starting any diseases from it. I'm not sure yet and, like, how much I smoked was up to three packs a day when I started out. But I lowered that down and took it up even higher. But I'm actually lowering down, it's been helping a lot now.

The ideas I have for helping others not to start smoking — I think there needs to be more publicity on how addictive tobacco is. More people need to know how many people are dying from the use of tobacco, especially teenagers. Teenagers have a lot of smoking habits. Most everybody I've seen, even younger kids, are starting to get really into smoking. So far in Yorkton, I've noticed that almost every kid I've been running into has had an addiction problem.

And it is important for youth to talk to other youth. Because if adults try to talk to their youth, it might not help because they think they might be lying or something. I found out that it is easier for youth to talk to youth because they can help you understand a lot better and people who have been through it.

Like, what helped me to cut me down smoking was my girlfriend. I had a girlfriend that really helped me cut down and that's another good thing too. Like, your spouse and that can actually help you by giving you enough love to help you quit.

And I would like to see that there would be more public places having a smoke law of 18. There is not enough places lately that have the regulation of 18. And that's about it.

The Chair: — Curtis, thank you very much for your presentation. And I see you made some notes too. If that's something you'd like to leave with the committee, please do it. Does anybody have any questions?

Ms. Bakken: — Are you still smoking, Curtis, did you say, or have you quit?

Mr. Mullen: — I am still smoking. And I'm really trying to stop lately, but have not been successful.

Mr. Wartman: **—** Curtis, have you given any thought to other ways that might help young people not start smoking?

Mr. Mullen: — Right now I work for Boys and Girls Club for . . . (inaudible) . . . And what I might be planning to do . . . because there hasn't much been people going around and telling kids what it's about and how addictive it is and that, and I'm thinking of doing that for the Boys and Girls Club, all the girls . . . kids around here. And I think, like, publicity for the younger kids, more of it for people against smoking would be a lot better.

Mr. Wartman: — Any ways that you can see that we as government or legislators might help?

Mr. Mullen: — Well I'd say probably having most of the buildings smoke free now probably would really help. And one thing I know, it's hard to stop but . . . from youngsters buying smokes. There's a lot of people doing that now, from fake IDs, or even just go in there themselves.

Mr. Wartman: — Thank you very much.

The Chair: — Curtis, you mentioned how you thought that you could quit smoking at any time earlier, and you found out differently.

Mr. Mullen: — Yes, I did.

Mr. Wartman: — Do you think that's a prevalent attitude amongst youngsters?

Mr. Mullen: — Yes, it's really . . . Like I heard a lot of kids say that, oh I can stop smoking any time and they do try it, but they cannot, mostly because they don't have enough strength or courage to try and stop it. They think they can but they're not thinking hard enough. Because if you do think hard enough, you can quit.

And that's one thing I noticed about me . . . I've not been thinking hard enough about it. Because I have a lot of stress, like being in school and that. And now the place I live at. And that has not been helping either but . . .

The Chair: — Well good luck. You'll succeed. Thanks very much.

I just want to revert back now to Judy Espeseth, if she's here. Are you ready, Judy? Do you want to come in now? Sure. We're ready for you.

Ms. Espeseth: — Okay, I guess we . . . I'm a teacher. I teach at Esterhazy High School. Last year I was teaching in Stockholm. And as part of our grade 8 health curriculum, we had a campaign in which we tried to make the rink in our local town a non-smoking facility. The curriculum in grade 8 asks us to do community-oriented projects. So this project was a project that the students themselves devised. It was thrown completely open to them to see what sort of a project that they wanted to do. And this was what they had chosen.

They had known that there was non-smoking in other rinks in the area and they felt that this was really something that they

wanted to go after. So they sat down and devised a program in which they would campaign and talk to all the people in the community to see which people were in favour of it and which people were not. So they did a door-to-door campaign in which they got about 90 per cent people who were in favour of non-smoking. So they then compiled and tabulated these results and took it to the town council and the town approved the non-smoking.

Now the kids themselves, some of the kids at the grade 8 level were already smokers and yet they felt very strongly about this whole project. They were very proud of themselves to see the way it was handled and the way the people — even the smoking people — in the area were behind them trying to make it a non-smoking facility.

So I guess from the students' point of view that they feel quite strongly about not having to walk through a smoky area into a facility where they are going to perform some recreational activity and they were quite in favour of creating this non-smoking. That's my little story.

The Chair: — Well thank you for that. That's something we hadn't heard of before. It sounds like a positive thing. Do you have a comment, Mark?

Mr. Wartman: — Just a comment. One of the things that we have done from time to time, we also do hearings in schools. And we've tried to pass along information and stories from a variety of different places. And I'm sure this one will go into the works and be passed along to help other young people get a sense of what kind of power they may have in their communities. And empowerment is vital. Appreciate the work you've done there.

Ms. Espeseth: — Yes, and it did turn out so positively that the students really were on a high. Because I think they did feel that they had some power to control those kinds of activities and those kinds of situations. And so we were almost in favour of having them do another one in which they failed because they were really on a high.

A Member: — So did you implement this policy?

Ms. Espeseth: — Yes, actually they took it to the town council, and town council looked at the petition that they had taken up and the wording on the petition and at the favourable response that they got, and so they did then create a non-smoking facility. They passed a town bylaw. And the kids then developed posters that they put up in the lobby of the rink saying that it was non smoking and they posted the bylaw that was part of it.

There was some complaints and it wasn't a hundred per cent successful — there was some people who still smoked because it had been a smoking facility for a long time — by it. And they were very upset that then . . . when the kids were walking into the rink and they found people smoking. But at least it was a step.

Mr. Wartman: — One of the projects that we heard about the other day at a collegiate in Regina was around compliance in retailers; that they went to some of the retail outlets and underage tested to see if they could purchase. And it was quite informative for the children and people around them. There were some stores that were not complying with the laws, some that were, and they sent letters to the stores that were not complying letting them know that they were in violation. So there are many projects that kids can do that I think will help them learn and will help empower them.

Ms. Espeseth: — The kids have all the knowledge that they need. I think the schools do a fairly good job of presenting that information to them. And so from what I see, kids are at the point where they know that they shouldn't be smoking. Peer pressure is still there enough that they do start; but even the people who are smoking, the kids who are smoking, don't feel that it is a good thing for them so they kind of can get sucked into that way of thinking, really.

The Chair: — Thank you. You know, pass on our congratulations to your class.

Ms. Espeseth: — Okay, thanks.

The Chair: — Thank you. The committee would now call on Denis Maurice and Brenda Kowbel, and would you help me out please by stating your names first.

Mr. Maurice: — I'm Denis Maurice from Esterhazy. I'm from the Esterhazy Motor Hotel.

Ms. Kowbel: — And I'm Brenda Kowbel from the Waverley Hotel in Melville.

Mr. Maurice: — I'm here to present our concern about banning smoking from bars and restaurants. We feel that it's the quality of air in an establishment that's important. A total ban on smoking won't get to the core of the problem. Complete tobacco control is simply a knee-jerk reaction to a much deeper health-related issue, and it could leave an unnecessary trail of victims throughout Saskatchewan.

We feel that this would be really tough on all the hotels. We can't deny that smoking is a problem, particularly with youths. You may choose to emphasize a smoking ban in lounges. It is targeting the wrong age group. People are adults by law, and are there on their own free will. We have to stop young people from starting long before they are old enough to enter the bar.

Ultimately I want to convince the committee that a total ban on smoking is an overkill in aiming at the wrong target. Banning smoking in bars, lounges, clubs, restaurants, is completely unnecessary. People who choose to go to lounges are over 19 years of age and can make their own decisions. There's no possible way for children and youth to be affected in this situation. Including bars and lounges in a ban is completely unnecessary.

A smoking ban would be devastating particularly to rural hotels. Many hotels — particularly in the rural area — rely heavily on sales from food and drink to keep their business liable. A smoking ban would drive customers away in droves and have a resounding impact on the financial situation and the hotel. Fewer customers affect the bottom line, which would then force staff layoffs.

Second-hand smoke — we believe that patrons are entitled to a decent air quality whether it is through a non-smoking section or with adequate ventilation systems. It does not mean that smoking must be banned altogether. Environmental engineers say there is practical solutions to the proper design of a filtration system for air movement that meets the standard. This is the more moderate and reasonable solution to the problem of air quality.

In terms of lounges, people who patronize lounges are adults and can therefore make their own decisions. They do not need a law to protect them. Banning smoking in lounges does not help prevent youths from taking up smoking.

This has been tried in other jurisdictions — like in California in 1996 — and now they are looking at other alternate amendments that will allow smoking in establishments with proper ventilation. Also Victoria, BC has received hostile reception. In nine months they have spent over $3 million to enforce the law. In the first three months of the ban, revenues were down by $6 million in Victoria-area bars, restaurants, hotels, and cabarets. We feel that customers should have a choice on the matter whether they want to smoke or not.

Our industry is responsive to customer demands. Hotels, restaurants, and bars, and other hospitality establishments make their living by pleasing their customers. If there is a demand for certain things — no matter what they may be — business sense will prevail and owner-managers will meet the demand. If these establishments are receiving requests for larger non-smoking areas or a ban altogether, and it means that they will increase their customer base and financial profits, they will respond accordingly.

A great example of letting customer demand steer the issue is the number of non-smoking rooms in hotels. And there is absolutely no rules regarding non-smoking rooms yet many hotels have designated various numbers of rooms in response to customer demand. Some hotels have gone completely non-smoking if they feel this is what people want.

Having a government-imposed ban will exaggerate an issue that could be solved in more moderate, effective manners that will encompass the interests of everyone. We figure that zero tolerance is not the answer — air quality is. Thank you for listening to me tonight.

Ms. Kowbel: — Just to reiterate what he said — I'm just here behind him actually — I'm worried about my job, so I agree 100 per cent. I agree with all of the statistics that were thrown out earlier about the health and everything. I have three daughters at home — two of whom have bronchial asthma. But I like my job and I'd like to keep it.

The Chair: — Thank you very much for the presentation. Committee members. Mark.

Mr. Wartman: — We've had a variety of comments on ventilation and air quality. We've had testimony that talks about what is needed in order for the toxic elements of smoke to be taken out of a room. The testimony that we received said that at this point there is no proven method of cleaning out the air so that it is not a risk, so that environmental tobacco smoke is not a risk. If it still is a risk, are you willing to take that?

Mr. Maurice: — In our situation with — like I'm mentioning in our age group — that the customers that we serve, they have the right to choose whatever they like. They can . . . Why should I be able to go up to you and say you're not smoking? We're in a free country here, and if they . . . if it's their choice to smoke in our establishment, they should be allowed to smoke. And if the ones that don't want to smoke don't want to be around it, we can put them in a different section so that they're not . . . they don't have it completely around them all the time.

Mr. Wartman: — Well the matter of choice really is not a . . . I mean it doesn't hold much water because we do make choices. You make choices about what you will and will not allow within your establishments. And you may choose to say no, I don't allow this in my establishment, period. You may choose to do that. Just like you wouldn't allow spitting in your establishment.

And those are the kind of . . . I mean you have that right to allow or disallow.

Mr. Maurice: — That's correct.

Mr. Wartman: — And you could go up to somebody and say no, in this place we don't allow smoking. Why? Because environmental tobacco smoke causes these problems. There are clear correlations already. You could do that and it's not . . .

Mr. Maurice: — But it's like . . .

Mr. Wartman: — . . . a thing that you shouldn't expect to do.

Mr. Maurice: — People sitting around, having a drink, and socializing — I guess smoking goes hand in hand with that. Same as coffee. People go out for coffee; they have a coffee and a cigarette. It's the people's choice; that's what they like to do. If they can't do that any more, it's another good reason not to come to the hotel. We don't need empty chairs in there — more empty chairs than there is already. There's laws after laws trying to keep people away from these businesses, and we don't need another one.

Mr. Wartman: — That concern I understand. Thank you.

Mr. Maurice: — Do you want all our businesses to be closed?

Mr. Wartman: — Absolutely not. No question of that, but we also don't want all our people to be sick, hurting from all of the things that tobacco products . . .

Mr. Maurice: — We understand that fully too, yes.

Mr. Wartman: — I do want to ask you one other question, if I may? And this one you may or may not have the stats. But I really would like to know, do you have clear data that backs up the contention that there is a loss of some $6 million in trade?

Mr. Maurice: — Not with me, I don't have. No. No.

Mr. Wartman: — If you have that, could you provide it to our

committee please? If you can find it.

Mr. Maurice: — Sure. I'd have to go . . . these are just some bulletins. We get bulletins around from hotels' associations is what we do, and I've read it.

Mr. Wartman: — Well, it's important that we get more than just a bulletin or anecdotal because what we need is evidence.

Mr. Maurice: — Okay.

Mr. Wartman: — Okay. Thank you.

Ms. Bakken: — I'd just like to comment on what you said, Mark, and I guess you're talking about the freedom to choose what happens in his establishment. And this is another choice.

And I think we have to think very, very carefully when we are dealing with individuals who have put money, time, investment into a business before we start telling them what they can do in that business. And they are the winners or the losers in the end. But at the same time, we have to consider the general public.

So it is a very . . . it's a very tough, touchy situation but I hear you. I have a business as well and I understand what you're saying, that as a business owner you do have rights and you should have rights of what you do in your establishment.

So thank you for your presentation.

Mr. Maurice: — And I just might add that we have 25 employees at our establishment, and they all signed a letter stating that they like, you know, they don't want no . . . the ban on bars and the restaurant part because they know it will affect their job and they're very concerned about it.

Ms. Bakken: — And jobs are hard to come by in Saskatchewan today.

Ms. Kowbel: — Some of these people are non-smokers also.

Mr. Maurice: — Yes. I'm also a non-smoker.

The Chair: — Before you go . . . Any more questions, Brenda? Good. I've two brief questions. What demand do you have now for a non-smoking area in your bar?

Ms. Kowbel: — I can . . . At the Waverley — very, very small. We have had a, I would say, like maybe 10 or 15 per cent of people who have asked to either sit where it's not as bad or . . . I think people just automatically know, they come in, it's a bar, that it's going to be that way.

And a big part of our clientele is supper people. We have a steak pit, and it doesn't stop them.

The Chair: — And my second question is, how practical in your case would a glassed-off area be? You know, splitting your premise. Is that a practical solution or is that just sort of a theoretical thing?

Mr. Maurice: — That's a tough thing to do. You know, people in smaller towns they've got their sort of table they want to go to all the time and they think they're like a coffee shop. You can tell everyday these people are going to be there at that spot and you're not going to move them. Some of them smoke but some of them don't, but they put up with each other because they're living in a small town.

And another thing about . . . we have 60 rooms in our hotel. And people have asked for non-smoking rooms. We're up to about 20 non-smoking rooms right now because people have requested it and we make sure that they keep smoke-free.

The Chair: — Thanks once again from all the committee.

Mr. Wartman: — Sorry, can I ask one more question?

The Chair: — One more question.

Mr. Wartman: — This was a question that Graham asked at Swift Current but it intrigues me. And that is, that right now we've got a ratio of somewhere around 70 per cent non-smokers, 30 per cent smokers. The question that he asked, and I'd like to pose to you is, in terms of pursuit of business, recognizing the majority are non-smokers, is there some point in terms of the ratio that you might say, it's good business to move the other direction?

Mr. Maurice: — Oh, definitely. Like I said earlier, anytime that the customers are requesting something we know we're going to make . . . will be a financial gain, then by all means we certainly will look at it.

Mr. Wartman: — In terms of the public ratio, does that have an effect or only those who currently come through your door?

Mr. Maurice: — Pardon me?

Mr. Wartman: — In terms of the public ratio, 70/30 right now. If it moves to 80/20 would you say I'm going to go non-smoking?

Mr. Maurice: — We would certainly have to look at it.

Mr. Wartman: — So you're watching those ratios.

Mr. Maurice: — Certainly.

Mr. Wartman: — Okay. Just curious because when you're doing your assessment, it seems already the majority of the population is non-smoking and I wonder about trying to attract them, draw them in.

Mr. Maurice: — I understand what you're saying.

Mr. Wartman: — Okay, thank you.

Ms. Bakken: — Just a follow-up on that. Okay, we're talking about ratios. Do you have any idea in your bar how many people, you know, would be smoking and non-smoking that actually come to your . . .

Mr. Maurice: — The ones that are coming now?

Ms. Bakken: — Yes. You know, on an average, would you say

how many smokers . . .

Mr. Maurice: — I would say it would be close to 50 per cent non-smokers.

Ms. Bakken: — So half and half.

Mr. Maurice: — Yes.

Ms. Bakken: — Okay, I'll let you go. Thank you.

The Chair: — Okay, you're free now I guess. The committee would now like to call on George Skwarchuk.

Mr. Skwarchuk: — Where do we give from?

The Chair: — Any one of those is fine, George. Sit in the middle, you'll feel like a king.

Mr. Skwarchuk: — It might be a good idea. I've been singing for an hour and a half so I don't know how good my throat is but . . .

Mr. Chairman, Mr. Kowalsky, the members of the hearing committee, and ladies and gentlemen. I don't know whether — I wasn't here long enough, I just got in — whether this is formal or informal. But what I have done, I have prepared a paper and if you don't mind I will read most of it and then if there's any questions, if I can answer them I will be happy; if I can't, I'll tell you I can't.

The Chair: — George what we've done is allotted about 20 minutes per presenter. So however you want to divide that up.

Mr. Skwarchuk: — I don't want to have more than 20 minutes.

The Chair: — Okay.

Mr. Skwarchuk: — I will be out of breath by then. Ladies and gentlemen my presentation tonight to all the party . . . all-party hearing committee is to emphasize my views and observations and the factual findings on the necessity to control tobacco usage, and its hazards in human consumption.

As caring and responsible citizens of Saskatchewan and Canada we must zero in on providing an awareness and seek legislation to act and protect a healthy living of all citizens from infancy to the aged. The heavy concentration from environmental tobacco smoke, ETS, is a great hazard to healthful living and especially to those who may experience respiratory diseases and allergies.

As responsible citizens let us rally and sensibly react against the tobacco smoke. The faculty of making wise judgments come from all we have learned and all we have experienced. Your disappointments and victories, your worries and tranquilities, your burnt fingers, and your escapes of your fears and hopes, this infers that if we do not follow our best judgment we have to face the consequences with severe penalty.

Let us practise good quality of life and rule down all vices that tobacco smoking is bound to bring. Let us be responsible and compassionable citizens of Saskatchewan. Tobacco smoking is a huge problem and a legislation to control it must be put in place.

Let us use all strategies to prevent or reduce tobacco use, particularly related to children and youth. This requires legislation that includes smoke-free enclosed public places such as child care facilities; workplaces; services; and entertainment facilities; recreational sporting facilities; and educational institutions, including school grounds of elementary and secondary schools; health care facilities; transportation services; and parkades.

Children are basically the only new source of tobacco industry customers since very few people begin smoking after age 18; hundreds of children in the province where an average age of 12 to 13 begin smoking each year. Research indicates half of the children who begin smoking will die prematurely due to tobacco. Each year over 1,600 Saskatchewan residents die from tobacco-related causes. Smoking is responsible for almost one-third of cancer deaths in Saskatchewan. Lung cancer is now the leading cause of cancer deaths in men and women.

The cost of tobacco use is very, very expensive both with respect to health and economics. In 1992, the total impact of tobacco use in this province was estimated at $281.842 million. This includes direct costs such as hospitalization, physicians, service, drug cost, fire loss.

In 1997, the province collected 116.869 million from tobacco tax and another 23.8 million in sales tax. Here we must conclude that the revenue generated by tobacco are lower than the economic burden to the province. It is noteworthy to know that an estimated amount of $5.6 million was collected in Saskatchewan from illegal sale of tobacco to minors.

There is a great need of awareness and legislation to cover the prevention of tobacco use by youth and children.

The legislation should deal with: prohibit giving or selling tobacco products to anyone under aged 19; denormalize tobacco behaviours including banning candy cigarettes; prohibit selling of flavoured tobacco products such as chewing tobacco; permit the sales of tobacco only in designated places; maintaining or increase retail price on tobacco; tobacco prevention education to be mandatory in every grade; encourage the public to support tobacco cessation; a co-operative effort with the medical staff to have them proactively involved in the intervention with their patients; include nicotine replacement therapies under provincial drug plans and promote research to develop a range of cessation strategies that respect the unique experience of youth, women, Aboriginal people, who are addicted to tobacco — research and monitoring must continue to grow; a recommendation that the government establish a surveillance system through a medical billing system to track effects of tobacco reduction efforts; and that the government track effects of smoke-free places legislation on business.

Because children are susceptible to tobacco, its addictive nature, and its availability to as low as 8- and 9-years-old, Health Canada reports that 8 out of 10 children who try smoking get hooked. Saskatchewan must enforce a minor tobacco Act to restrict the sales of tobacco to minors.

In 1992, the US Environmental Protection Agency classified second-hand smoke as class A carcinogen. Provincial legislation bylaws should ban smoke in public places and workplaces. The human and economic burdens of tobacco to Saskatchewan is devastating and very taxing. Tobacco effects on health are frightful and of much concern. Tobacco kills more people than AIDS, motor vehicles, accidents, drugs, suicide, and homicide combined, approximately about 1,600 each year.

Smoking is the major risk factor for 29 per cent of the heart attacks; 40 per cent of the strokes; it is a risk factor for hardening and the blocking of the arteries of the legs. Smoking is responsible for 70 per cent of the deaths . . . of disabilities due to chronic obstruction of lung disease.

Smoking during pregnancy has a direct, harmful effect on the developing fetus and results in the low-birth-weight babies. Smoking in the home of . . . after birth and during pregnancy is implicated in many as 50 per cent of the cases of Sudden Infant Death Syndrome.

Children exposed to environmental tobacco smoke experience a greater risk of middle ear infections, pneumonia, sinuses, and asthma. Smoking is responsible for 660 cancer deaths annually in Saskatchewan — including lungs, pharynx, mouth, esophagus, stomach, pancreas, kidneys, urinary bladder, and cervix. Chewing tobacco can lead to cancers of oral cavity and other serious problems with mouth, and teeth, gums.

Economic cost of tobacco consumption in 1998 in Saskatchewan indicate that its residents consumed about 1,244,062,000 cigarettes, 4 million cigars, and 746,000 grams of cut tobacco. Cigarettes consumption accounts for 82 per cent of the tobacco consumed.

Direct cost of tobacco consumption includes costs of hospitalization, physician's service, drug cost, fire loss, estimated at $75.97 million in 1997. Indirect cost which included the loss of earning due to premature death, productive days lost due to morbidity, and other illnesses was $264.84 million in '97.

In conclusion, it is obvious that a concerted effort must be made by instituting rational and religious legislation by the Government of Saskatchewan for the citizens of Saskatchewan and show love and care and humanity and the economics of the province for a better Saskatchewan. Thank you very much.

The Chair: — We're quite all right for time, so we've got time for a couple of comments or questions. Do you want to start, Brenda? No questions. Mark, do you have any?

Mr. Wartman: — Thanks for doing the work and giving your presentation, George.

Mr. Skwarchuk: — Thank you.

The Chair: — Something came to my mind, George, when you were talking about the children there. Eight out of ten children, you said, who try smoking get hooked.

Mr. Skwarchuk: — That's right.

The Chair: — You got that from . . .

Mr. Skwarchuk: — This is, yes, from the . . .

The Chair: — From where?

Mr. Skwarchuk: — From the statistics.

The Chair: — Health Canada statistics?

Mr. Skwarchuk: — Yes. Health Canada statistics, yes.

The Chair: — Did you notice anything in there about, you know, how long it takes them to get hooked on the average? Do they say anything about that, or . . . because I haven't come across that yet.

Mr. Skwarchuk: — Till what age?

The Chair: — Well, young people. Do they have to smoke just two or three cigarettes, or do they have to smoke for a month, or for a year, or do we know?

Mr. Skwarchuk: — Well I don't think it says that. But we know that one leads to two. And two leads to three. And three leads to seven. And at this age, you know, they don't realize it. They think it's big and they want to feel just, you know, grown up.

The Chair: — Yes.

Mr. Skwarchuk: — I've had children and grandchildren and I know what they want to do. They want to feel big and a cigarette in their mouth . . . Even with little kids that we have at Christmastime I notice that in many cases, buying cigarette candies. You know, they look like a cigarette with a red end and what not. And that is, that's a beginning. We don't realize that. We feel it's, you know, it's nice; a kid up there is having one of these in his mouth it's all right, it won't do him any good. But it may not in everyone.

And as a result, as I say again, it does not say as to when. But after 18, if they do not smoke, the statistics say that after 18, if they don't smoke till 18, the percentage is very, very small after that they'd get started.

The Chair: — OK. Well thank you very much and if you have a copy of your presentation, the committee would be pleased to receive it.

Mr. Skwarchuk: — Yes. Well, do you want more than one, or do you want one or . . .

The Chair: — One is good.

A Member: — He has lots.

The Chair: — Oh, if you have several there, then it's even better.

Mr. Skwarchuk: — I have three or four that I can give.

The Chair: — Thank you. Well, here's the way it's working

out. We have left to hear the Yorkton branch of the Canadian Diabetes Association, and then we've got Heather Torrie at Body Image, and then Jim Atkinson, and then Marcel Shevalier. So we're moving along quite well and we'll ask Laurie Miller to come forward.

Ms. Miller: — Thank you. I'm Laurie Miller and I'm the local president . . . I'm the president of the local branch of the diabetes association. I'm also the east-central rep for the division.

The Canadian Diabetes Association is dedicated to helping Canadians work toward a reduction in consumption of tobacco products.

While smoking is a dangerous and avoidable risk factor for people with diabetes, the effects of second-hand smoke in some Yorkton public places is currently unavoidable.

I will focus specifically on the effects experienced by people with diabetes. In Canada, it is estimated that at least $6 billion is spent annually on treating people with diabetes and its complications. Studies have shown that cigarette smoking increases the risk of developing these complications of diabetes.

Persons with diabetes have a risk of heart disease and stroke which is two or three . . . two to four times greater than persons who do not have the disease. Mounting evidence shows that exposure to second-hand smoke also further increases this risk to the person with diabetes.

Due to excess glucose and lipids in the blood, people with diabetes experience damage to both the large and small blood vessels in the body. Often the smallest blood vessels are damaged first — those in the eyes and the kidneys. Exposure to tobacco smoke constricts the blood vessels and therefore increases one's already high risk of diabetes complications like blindness and kidney disease.

When blood vessel damage in people with diabetes involves the feet, foot ulcers can worsen and infections develop. Gangrene and amputations may result. One US study reported that persons with diabetes who have developed gangrene were smokers in nearly all of the cases. In addition to these persons with diabetes who need amputations, 95 per cent are smokers.

Another established paper which studied women with diabetes showed that non-smoking women with diabetes who were exposed to second-hand smoke throughout their lives, died almost four years earlier than those people with diabetes who were not exposed to second-hand smoke. In addition, people with diabetes who actively smoked died five years earlier than those smokers who did not have diabetes.

Finally, there is some early evidence that smoking may be a risk factor for the development of non-insulin dependent diabetes. Data suggests that current smokers have an increased risk of developing the disease.

All of these issues are of great concern to the Canadian Diabetes Association because our vision for 2005 states that the diabetes association will be pivotal in preventing the onset and reducing the burden of diabetes in Canada.

It is difficult for people with diabetes to quit smoking when they are faced with the issues of daily living and the challenges of diabetes management. Smoking is reinforced by the activities of everyday life and dependence becomes stronger as smoking is integrated into the pattern of regular behaviour. High risk situations such as smoky surroundings provoke relapses while a smoker tries to quit. However the individual with diabetes has even more to gain from avoiding exposure to tobacco smoke than those without diabetes.

In conclusion, the diabetes association strongly supports proposed changes to the laws regarding tobacco. It is our hope that these changes will play a significant role in decreasing the number of new smokers and provide a smoke-free environment for those who do not smoke.

As we strive to attain an optimal quality of life for all persons affected by diabetes, the Canadian Diabetes Association is proud to contribute to the community effort aimed at decreasing the health burdens posed by smoking.

Thank you.

The Chair: — And thank you for your presentation. This is the first one we've had directly on . . . from somebody who's working in the field of diabetics. So now we'll go to our committee members.

Ms. Bakken: — You mentioned that many diabetics smoke. My question is, how is legislation going to stop those people from smoking? These are adults.

Ms. Miller: — Oh, exactly, and I'm not saying it is going to stop them but, if we can get smoke-free places and children aren't starting to smoke — I mean for prevention of diabetes — one of the big places to work is with young people.

Ms. Bakken: — So you're talking more about prevention as opposed to . . .

Ms. Miller: — Well, yes, at this point I am.

Ms. Bakken: — . . . or stopping them from starting. Okay.

Ms. Miller: — Yes.

Mr. Wartman: — Did you also indicate — and I thought I heard this — but did you indicate that adults are at greater risk of developing diabetes if they smoke? There's facts showing that?

Ms. Miller: — Yes. That has been proven now.

Mr. Wartman: — Okay. And you also said something in terms of environmental tobacco smoke or adults who are trying to quit find it more difficult to quit if they are exposed to environmental tobacco smoke.

Ms. Miller: — Yes, and I can speak as an ex-smoker. I quit smoking 11 years ago before I was diagnosed with diabetes. And yes, I mean the more people that smoke around you, the more tempting it is in the beginning. It certainly isn't any more, but in the beginning it is.

Mr. Wartman: — Thank you.

The Chair: — Well, thank you very much for coming before the committee.

The committee would now like to hear from Heather Torrie.

Ms. Torrie: — Good evening. My name is Heather Torrie. I am a public health nutritionist and member of the Yorkton Body Image Interest Group. And it is through my work with the Body Image Interest Group that I am presenting tonight.

A society that values the worth and health of young people will reflect that value and policy. I say healthy public policy is a key strategy to prevent or reduce tobacco use. The prevalence of smoking among 15- to 19-year-old females is particularly striking because it occurs in the face of an outpouring of hard scientific evidence that smoking is harmful, although sociological pressure and stress are also significant.

Research indicates that negative body image is a major factor in women smoking. In western culture the reigning model for women is ultra-thin. Television, movies, magazines, and music videos project this model constantly in advertising, in commercials, as well as in articles and programs. And perhaps you're familiar with the ads from Kellogg's that are telling us now that this is not a healthy body image, counteracting the message that's in the media.

Society's obsession with fitness parallels the rise in smoking among 15-to 19-year-old females. Smokers believe that smoking controls body weight, and there is widespread belief that if you stop smoking you'd gain weight. Research does support this but it also shows that the effects are limited. One study has reported the average weight gain was about 5 pounds, which is almost insignificant.

Smoking emerges as a disastrously unhealthy and dangerous method of weight control. Adolescent females who are addicted to tobacco do not only jeopardize their own health, because of their addiction they can jeopardize the health of children they may have. A study recently undertaken by two professors at the University of Saskatchewan College of Medicine found that 30 per cent of women smoke during early pregnancy. The use of tobacco during pregnancy is linked to miscarriage, premature birth, and low birth weight. Surely these are reasons to develop policies that support tobacco-free environments and send a very clear message that tobacco use is not acceptable.

Our body image interest group received provincial funding to develop a reach and teach kit that is used in schools throughout Saskatchewan to promote healthy body image and prevent eating disorders. The resources that we've compiled consist of videos, activities, and school projects that help promote positive self-esteem, healthy eating, and enjoyable physical activity. But it's becoming increasingly apparent that dieting is no longer being used as the main route to achieve the ultra-thin size that is being promoted through the media and that young girls are wanting to attain.

The ability to self-control ends when hunger takes over. And in order to help achieve that body younger females are going to cigarette smoking and I think that that's a tragedy. We've got the message across that dieting is not acceptable; they're now turning to cigarettes. And I would encourage you to consider healthy public policy in which there is no tobacco use in public places because it does send that message that tobacco use is not acceptable.

Thank you very much.

The Chair: — Thank you Heather for your presentation. I'll go first to Brenda.

Ms. Bakken: — This is something new to me, this group that you're involved with. Is this something you've started? Is this an independent group or is it through the Health department or . . .

Ms. Torrie: — It's a group of health professionals and community people who were . . . It started in about 1990 when we began to realize there was more adolescents developing eating disorders. So that was the initial thrust of it. We have now gone into the prevention of eating disorders and the promotion of a healthy body image.

Ms. Bakken: — Is this something just in Yorkton or is this something province-wide or . . .

Ms. Torrie: — Our group is in Yorkton but there are groups pretty well across the province that have formed to work at the prevention of eating disorders.

Ms. Bakken: — And so is it through the Department of Health? Is that who . . .

Ms. Torrie: — Not necessarily. There may be people, school teachers who are on it, mental health workers, nutritionists, community leaders, for example CGIT (Canadian Girls in Training) leaders, 4-H group leaders. It's not specifically to health.

The Chair: — This ad that you were referring to here, Heather — what is the point of the ad? What is the point that Kellogg's are trying to make here?

Ms. Torrie: — That this beauty is somewhere . . . this says if this is beauty, there's something wrong in the eye of the beholder, trying to point out that this thinness is not a healthy body to counteract the message that we see in the media. This is another one that's put out actually by SaskTel: "not an image to die for". It's related to the fact that dieting is not a healthy choice, but as I said, people, young women now are using cigarettes to attain that and the consequences are devastating.

Ms. Bakken: — Have you seen positive results from your program in the schools?

Ms. Torrie: — We've certainly seen that there hasn't been resources in the schools to support that part of the curriculum and that's what our kit is designed to do, to provide teachers with resources that they can use in the classroom setting.

Ms. Bakken: — Okay, so it's a kit that you give them; you don't go into the school yourself and actually teach.

Ms. Torrie: — No, I'm one that covers three Health districts so I can't go into all the schools, but the way we can reach it wider is to provide teachers with resources. There's one resource kit for grades 4 to 6 and another one for grades 7 to 10 promoting positive self-esteem and healthy body image.

Mr. Wartman: — Heather, would these fit into the curriculum . . . We had a presentation on curriculum the other day and it sounded like there was a fair bit of flexibility on the part of the teachers and that self-esteem were a couple of the units. I think 4 to 6 was a primary part of that. Have you designed your program so that it would fit with the provincial curriculum?

Ms. Torrie: — Yes it has. The provincial curriculum is resource-based and these are resources that support the curriculum. And our group has been involved in working with the Department of Education to preview and evaluate some of the resources that they use . . . recommend for teachers.

Mr. Wartman: — And I also wanted to say that I appreciate the work that you're doing in that regard. I have a daughter who is in grade 12 and just recently some of her friends were over at the house — most of whom smoke — and we were talking about the work I'm doing on this committee. And they indicated that, oh, they could never quit smoking because they'd gain weight.

So there's a lot of that out there, and body image is a vitally important thing to many of them.

Ms. Torrie: — And we need to be able to provide supportive environments that when they want to quit smoking, they can engage in physical activity and have healthy eating choices so that they . . . the weight gain is minimal.

Ms. Bakken: — In your kit, do you actually talk about smoking directly and the harm, or is it . . .

Ms. Torrie: — No, we don't have much on smoking. There's very little to show the effects of smoking. It's become more apparent to us from comments back from teachers that this is becoming . . . that this is the issue. It's not so much dieting any more; it's the smoking that they're using to control weight.

Ms. Bakken: — So the program is just developed around self-esteem in general and . . . Okay.

Ms. Torrie: — Yes.

Ms. Bakken: — So that it could . . . it would be possible to go into more of that though if . . .

Ms. Torrie: — I think we'd have to go into more of that, yes.

Ms. Bakken: — Okay. Okay.

The Chair: — This effect on, or is known as their concern with body image. I'm assuming here that it's more prevalent among young women than it is young men.

Ms. Torrie: — It's becoming more prevalent among young men, but it's not the same that it is for women. Women's desire is to be thinner. Men's desire is to be bigger and to bulk up. And so you get into a whole different area where you use protein supplements and some of the artificial or so-called steroid analogues to build up that muscle.

Eating disorders and slimness in men is not as prevalent as in women.

The Chair: — So this tendency could be part of the explanation for how come there's an uptake in young women in the statistics showing that young women are taking up smoking more.

Ms. Torrie: — I think there's a strong correlation, yes.

The Chair: — Well it's been very enlightening. Thank you very much, Heather.

Ms. Torrie: — Thank you.

The Chair: — Okay. Marcel Shevalier, a long wait but it's your turn. And if there's anybody else that wishes to make a presentation or make a comment, please, if you want to stick around, we'll stick around. Go ahead.

Mr. Shevalier: — Good afternoon . . . or good evening, everyone. My name is Marcel Shevalier. I'm with the Pipestone Health District. I must apologize to Donna about myself. I'm very apprehensive about doing this whole thing. And I had backed out once, and I decided, oh I should do a talk.

What I do with the Pipestone Health District is I'm an addiction counsellor, and I've worked in addictions for seven years now. The majority of my experience comes from in-patient treatment. And in that in-patient treatment, when I was dealing with the clients, when I would ask the clients to do a life history, the first thing I wanted to find out is when the person started using — not drugs, not alcohol, but nicotine.

And the reason I was looking for that is because nicotine, or tobacco, is a very strong drug. Nicotine tobacco is the most addictive substance in our society today. It is stronger than cocaine, it is stronger than heroin.

And I've heard all the people that spoke before me give out statistics, give out data and figures, but the strongest evidence I can give towards nicotine being the strongest drug out there was by the young man Curtis who was here, who he himself, a 16-year-old young man, talked about smoking up to three packs a day, if I heard him correctly.

As an adult, if I go out and start using alcohol, if I go out and start using hard drugs, it'll take me upwards of three years to become addicted to that substance. Kids on the other hand are very much different than us. They are just developing and it can take them as short a time as three months to become addicted. This is why the tobacco companies really like to target their products towards kids.

I have worked, as I've said for . . . in addictions since 1993, and I have helped people with addiction problems to cocaine, to heroin, to alcohol. All these substances are substances which can greatly affect a person. But also nicotine can.

And in every centre that I've worked at or I've gone and visited, the one substance that the centres allow them to use, continue to use, is nicotine. And I've asked about that because I'm a non-smoker myself. I've never smoked although my parents smoked like chimneys. I tried it. After I finished throwing up, I never touched it again. And I have found that trying to help someone with nicotine addiction is very difficult.

The centres allow them to continue to use nicotine because they say one addiction at a time. Let's focus on the alcohol, let's focus on the drugs, because those can do a lot of harm. But the nicotine can as well. Nicotine, as with your own cartoon that you had up earlier where, oh this is somebody's lungs, oh I need a smoke.

Stress — people use nicotine to decrease their stress level. It's a very strong suppressant of emotions. My main focus when I have people in the treatment centres was for them to deal with their emotions and by doing that, they get over the need, or my hope is they can overcome the need for addictive substances.

I feel that nicotine, alcohol, gambling, these are all accepted things within society. They all can become addictive. They all can do you great harm. I have known alcoholics that have died because of their drinking. I have known people that have lost everything because of their gambling. And I know from personal experience, from my own aunt, she died because she would not give up her nicotine habit. Her doctor, two months before she died says, either give up smoking or go home and die. She would not. The doctor put it in as plain language as he could; my aunt could not give up smoking because it was such a strong addiction.

Addiction is a very serious problem within our society. And unfortunately what I see law makers doing, is making it easier for addictions to happen with the gambling, with the alcohol, with the tobacco. I find it also strange that, you know, they're starting to look at well, maybe marijuana. How many steps do you need to provide in society to have people addicted.

I only found out about this meeting at about 3 o'clock today so everything I have talked about is off the top of my head. And I realize that it's very jumbled too, and I apologize for that. That's about the end of it. Thank you.

The Chair: — Marcel, you too, I want to thank you for coming even though as you say it's straight out of your heart, but maybe that's even a better way. Mark or Brenda, do you have something you want to . . .

Ms. Bakken: — What would you recommend if you could give the solution for the problem we're faced with as what do we do? What would you do if you had the opportunity?

Mr. Shevalier: — As a legislator?

Ms. Bakken: — Yes.

Mr. Shevalier: — Currently there are laws as — is it Myron? — pointed out. You know some agency or federal law states that there are fines — $3,000 for the first offence, up to $50,000 for second offence — and that's up to. Although they are never enforced. We have the laws. We need to enforce them.

If somebody wants to sell tobacco, they need to be held accountable for who they sell the tobacco to. And I feel it should be mandatory that, if a person sells an addictive substance to a minor, they should be held accountable for that behaviour. Twenty-five thousand dollar fine minimum — first time out. And then a person would really think about it.

And also, remove it from the stores. I can walk into any 7 Eleven, any Mac's, any IGA (International Groceries Association), any store in Saskatchewan and purchase cigarettes. I can't go into any store in Saskatchewan to purchase liquor. They should be licensed, regulated establishments.

I find it very damaging that, you know, kids can buy, get these things. I can remember with the old law where a kid could be able to purchase at 16 with a note from their parents. I can remember when I was in school, in grade 4, grade 5, grade 6, kids going up with a note to the store: oh yeah, I'm picking up smokes for my mom. You know, things have changed, but I feel that they should be regulated just as much as we regulate alcohol. Alcohol is nowhere near as addictive as nicotine is.

So I feel that they should have it almost the same as they do with the liquor. If you sell liquor to a minor, you can lose your licence. And for the people that own a business where they sell liquor — a hotel, a bar — they check regularly. Okay, do you have proper ID? That doesn't happen with nicotine.

Ms. Bakken: — So do you think, on the same token then, that those that are purchasing it and are underage should be charged as well?

Mr. Shevalier: — The people who are underage are acting upon their addiction. They need that cigarette. And they do not look beyond the . . . they do not look to the consequences of their action, they look to their need.

Ms. Bakken: — So you don't think that would have any bearing on their use?

Mr. Shevalier: — Oh no. Oh no. Not at all.

Ms. Bakken: — If they knew that they might be charged?

Mr. Shevalier: — I've dealt with people who are heroine addicts, cocaine addicts. All they're focused on is that fix. They'll go in, they'll break into houses, they'll break into drug stores, they will rob people to get the money they need for that fix. All the addict looks towards is that fix, they do not look beyond that.

Ms. Bakken: — That's good to know.

The Chair: — You're talking here about people that are already addicted. What about a deterrent?

Mr. Shevalier: — Deterrents for?

The Chair: — Would making it illegal for a youth to purchase cigarettes serve as a deterrent to them starting smoking?

Mr. Shevalier: — Could you rephrase that? I didn't quite hear it all.

The Chair: — When you were talking . . . what you addressed in your comments just now, I believe, had to do with youth that are already addicted. And I know that's your expertise is working in the field of addiction. Do you have any opinions about whether making it illegal for youth to purchase cigarettes, actually putting some onus on them, whether it would have any deterrent effect from them smoking — from starting smoking?

Mr. Shevalier: — I don't think it would because right now it is already illegal to sell. And I find it ironic it's illegal to sell to a minor but it's not illegal for the minor to possess. It's for me like a Catch-22 situation. If it's illegal to sell would it not also follow that it's illegal to have?

The Chair: — Well, that's what I'm getting at.

Mr. Shevalier: — Yes. I don't think it would be a deterrent at all because for the person that wants to smoke they will do it. Just as, you know, there are laws out there saying it is illegal to have heroin, it is illegal to have cocaine on your person . . .

The Chair: — Right.

Mr. Shevalier: — . . . but people still use it. It would be the same thing for nicotine because nicotine is actually more addictive than the heroin or cocaine. When people want it they'll get it.

Education I feel is very, very important. If you can educate someone about the dangers of something, then they have the ability to make an informed choice.

The Chair: — And you also mention in your comments that kids become addicted as early as three months. What is your source for that? Is that your experience or is there some kind of other experimental database or something like that that we could refer to on that?

Mr. Shevalier: — This was some facts that were given to me through my university education. I could probably find the source of that in some of my lecture notes that I still have, but I don't have that . . .

Mr. Wartman: — I think we do have some information already, Myron, on age of addiction and, I think — I can't put my finger on it either — but I think we have data that would indicate that addiction happens much faster for those under 18 and the younger children even more quickly. Over 18 it could be a year or two years before addiction.

The Chair: — Okay. Well apparently we know where to find it, so thank you very much.

Mr. Wartman: — Thank you.

Ms. Bakken: — Just one more question. What, through your work with young people, what age have you found most common when they start to smoke? Or when they first . . .

Mr. Shevalier: — Most of the people that I've dealt with, their onset of smoking was at age 6, 7, and 8.

Ms. Bakken: — So if we're going to do education — make it pay — it's going to have to be in grade 1 or whatever or . . .

Mr. Shevalier: — It will have to be something that is a comprehensive-education program. I heard from some of the people that spoke before me of, you know, specific modules in grade 6 or grade 8 or grade 9. It needs to be . . .

Ms. Bakken: — It's not too late?

Mr. Shevalier: — Pardon?

Ms. Bakken: — It's too late, right?

Mr. Shevalier: — By grade 8, grade 9, it is already too late because there's a big chance that they will have already started. The one experience that I've had in seeing youth and their smoking was when I was in Quebec. And I can remember being at a high school in Quebec a year and a half ago, and when that bell went for a break between classes the whole outside foyer right in front of the school was full of smokers, and they were as young as 12 and upwards to 18. And this was in Quebec a year and a half ago. You need to start right in grade 1, kindergarten.

Ms. Bakken: — Quebec and Saskatchewan have the highest ratio . . . or percentage. Do you have any idea why that is?

Mr. Shevalier: — I have feelings about it and that has to do with the stress levels that are currently happening in Saskatchewan. You look into any rural town in Saskatchewan, what's the biggest worry? Will dad be able to put in a crop? There's a lot of stress in the house. When there is stress there is need to reduce that stress, and people choose whatever method they can — acting out, addiction, perfectionism, whatever they can find to reduce their stress, they will use.

Ms. Bakken: — Okay.

The Chair: — I think that's it. Thank you. Now is there anybody else that would like at this time to make a comment or ask a question? Yes come forward to the mike . . . but if you want to do it please come to the mike and start with stating your name and . . .

Mr. Laughton: — David Laughton. I'm a pastor actually but I have conducted a lot of stop-smoking programs at church, structured them about 40-some-odd years ago.

I would just like to ask you, committee members, are you aware of any areas in North America where there have been any innovative techniques where the smoking rate amongst the young people has went down considerably in two, three, four years? Because it seems to me that it's the youths. Fifteen years ago we'd have a stop smoking program, maybe get 40, 50 people in attendance. Today you get five, six, maybe eight. Okay, so the adult population of today, you know, they've either stopped, given up, or don't want to stop.

But we are going to be having the younger people which are becoming addicted today in another decade probably wanting to get off it. But are there any areas where they've had good success at lowering the starting ratio of the younger people?

The Chair: — We haven't had anybody make any kind of a presentation to us on that yet. But I don't know, there may have been some research that individual committee members may have conducted themselves and found some information on. I'm not sure, Tanya, if you've run across anything yet.

Ms. Hill: — I don't have any statistics, but just some things I've read, include that, like youth are the hardest sector to impact, to make a difference in whether smoking rates go down; like they're the last group to see a decrease when it comes to an initiative because they're harder to impact. But I don't have any statistics.

Mr. Wartman: — Anecdotely, what we get from the kids is that peer group support is probably one of the most effective things right now in terms of helping them stop smoking. One of the other programs that Balfour Collegiate in Regina is using, is a partnering program where the kids are helping each other not to smoke. A couple of them have also referred to the older children talking to the younger children about not smoking.

So those are few of the things that we've heard, but as far as clear evidence, we will have to check further. I don't think we have anything clear in terms of a particular type of program that is more effective.

The Chair: — The best model that we have sort of to work from, is the model that had been used in youth by organizations called SADD, Students Against Drinking and Driving; and the SWAT groups that are forming around the province, Students Working Against Tobacco, are modelling their organization a bit after that. And they use techniques which are informative and publicity and image and they're sort of developed . . . It's young people developing methods to influence their peers.

Mr. Laughton: — Okay. Okay, that's all I wanted to know. Thank you.

Ms. Zeeben: — Annette Zeeben. I have just a couple of quick questions.

The Chair: — I'm sorry, we missed your name.

Ms. Zeeben: — Annette Zeeben — z-e-e-b-e-n.

The Chair: — Thank you, Annette.

Ms. Zeeben: — I'm a retired person, grandma, concerned about these issues. I just wondered if you had any incidents . . . or you had any statistics on whether smoking and children involved in sports . . . whether children that were involved in sports had a lower incidence of smoking? And if so, you know like how could that impact on children, you know, on youth?

The Chair: — Yes. You're saying, is there . . .

Ms. Zeeben: — Well, if they're involved in sports actively, do most of them not smoke? I don't know if you've had any discussion on that or if anybody's brought that up.

Mr. Wartman: — We've had some discussion. Some of the children who spoke to us talked about that. They did smoke; they were into sports but they were finding that they were starting to move away from it because they were short of breath, and you know, having more difficulty.

The other thing that one young fellow came up to us after the presentation in Weyburn and said, well it's not that so many kids in sports are smoking, but there are sure a lot that are chewing, particularly the boys. And that's a real problem for mouth and throat cancers in particular, stomach cancers.

And so I don't know that . . . all I can say is that there's no . . . I don't have and I don't think we've heard any kind of direct correlation between smoking and sports.

Ms. Zeeben: — I just wondered if sports was a deterrent to smoking. Not the opposite. You know, like I meant, does smoking . . . if kids are in sports, do they smoke, are less likely to smoke?

Mr. Wartman: — Don't know.

Ms. Zeeben: — Don't know. Okay.

The Chair: — I think it's something that we could look up. I'm sure that there's been some grad student that's picked up on and looked at that somewhere to see if they draw a correlation. And then maybe they may have explanations as to . . . You know, I'd suspect, I would guess that if you're spending a lot of time in sports, you've got less time to fiddle around with smoking.

Ms. Zeeben: — And my only other comment is that government ads themselves should reflect realistic body images. For example, governments that are doing public relations ads, brochures, and so on should have realistic public, should have realistic body image as well — in your own government advertising. That's all I have to say.

A Member: — What do you mean by that?

Ms. Zeeben: — Well, when you do your own government ads and brochures and so on, the people that you use in these ads should have realistic body images. Like you shouldn't have the very thin model in your own government advertising. You should be promoting realistic body images yourselves.

Mr. Wartman: — A variety of shapes and sizes?

Ms. Zeeben: — Right. Thank you.

The Chair: — If there's nobody else, then I want to take a moment and thank every one of you that's made a presentation, for coming here tonight. And those of you that came just to listen, thank you as well from all of the committee members. Does anybody have any comments at this time that they might want to add?

If not, good night. Drive home safely.

I should mention if there's anybody that has a written submission over and above what they've contributed here today, please mail them in.

The committee adjourned at 9:44 p.m.