Smoking duration varied between the three groups, $F(2,284) = 11.92, p < 0.0001$. As expected, the NSS had smoked the shortest period (1.0 years). Surprisingly, the LSS had smoked significantly longer (2.3 years) than the HSS (1.2 years). The proportion of former regular smokers was similar in the LSS (52%) and HSS (47%) groups. Perhaps averaging less than one cigarette a day enabled the LSS to remain longer as occasional smokers.

An evaluation of individual surveys identified two persons whose pattern of smoking matched Shiffman's description of chippers (smoking at least two years, never a regular smoker, and rating oneself non-addicted), suggesting that this is not a common pattern in young smokers.

These results seem consistent with the view that some-smoking (particularly HSS) is frequently a transitional state. Prospective studies would be helpful to document eventual smoking outcomes.

**Clean indoor air legislation in Australia**

To the Editor – Readers of Professor McAllister's article on Australian public opinion on restricting smoking in public places may be interested in an update on the legislation to which the author refers. The ACT Smoke-free Areas (Enclosed Public Places) Act was passed by the Legislative Assembly on 20 September 1994, with key provisions taking effect on 6 December 1994. It is the first (and to date, the only) Australian State or Territory law enacted expressly "to promote public health by reducing exposure to environmental tobacco smoke". The Act prohibits smoking in a wide range of enclosed public places, including restaurants, shops and shopping centres, educational institutions, business and trade premises, places of public meeting, buses and taxis, and sporting and recreational facilities. Proprietors are required to minimise smoke drift, to display no-smoking signs, and to ask a person to stop smoking in a smoke-prohibited area. It is also an offence for an individual to smoke in a no-smoking area.

The statement that "nothing in this Act shall be construed as creating or preserving the right of a person to smoke in an enclosed public place" is intended to give legal backing to proprietors wishing to extend non-smoking provision beyond the law's minimum requirements. The Act provides for breaches to be handled by prosecutions and the imposition of a fine, rather than through on-the-spot fines. Department of Health inspectors enforce the Act, largely by providing advice and assistance to proprietors.

The Act reflects a number of political compromises. For example, it was originally proposed that restaurants be included among the types of premises to which the Act would apply. This was rejected by a majority of the Assembly, which favoured a 12 month phase-in period, during which restaurants must provide a minimum of one non-smoking area in their dining area as non-smoking. The Act also sets a date for non-smoking in pubs, bars, and social clubs with liquor licenses, which is 30 months after the smoking prohibition applies to other premises.

Exemptions may be issued to restaurants (maximum of 25% smoking) and licensed premises (maximum of 50% smoking) that show that their air conditioning and ventilation equipment is effective in reducing smoke. Premises that meet the current Australian Standard with regard to fresh air flow (AS1668.2). Standards Australia and environmental and occupational health and safety authorities expressed concern about this use of the standard. A majority of the Assembly, however, felt that an exemption system based on this criterion was an appropriate "harmonisation" strategy.

Many members felt that the evidence concerning the health effects of short term exposure to environmental tobacco smoke was not strong enough to warrant total bans and that the use of ventilation to minimise smoke exposure was an acceptable, if imperfect, response. Businesses receiving exemptions will be advised that they still face legal liability for passive smoking related illness and conditions.

Public opinion of the type referred to by Professor McAllister was taken into account by the government in developing its proposals. An attitude survey of ACT residents also provided evidence of strong local support for smoking prohibitions.

Although the prevalence of smoking in the ACT is similar to that in Australia as a whole, the ACT may differ in several relevant respects: the population is highly educated, with a high average income; a large proportion of the workforce is employed by national or Territory government agencies, which have had a smoke-free workplace policy since the late 1980s; there is a relatively high incidence of asthma and respiratory ailments in the community; there is no local tobacco industry; and the previous leader of the Opposition (now the chief minister) is a pharmacist with a keen interest in health issues. While the tobacco industry actively opposed the legislation, organised objections to the legislation came primarily in the form of an expensive campaign by the
Adolescent use of cigarette vending machines

To the Editor—Public health officials have focused attention on the nature and extent of youth access to tobacco products in the United States.1 Studies have clearly shown that minors can purchase cigarettes unfettered.2 While model legislation calls for comprehensive measures to thwart youth access to tobacco,3 many communities have initially focused on regulating cigarette vending machines.

Tobacco control advocates, as well as the tobacco industry and retailers, recognize that a small percentage of youth tobacco sales is through vending machines. However, vending machines should be cause for concern because of their ubiquitous nature.

A highly publicized mail intercept survey commissioned by the National Automatic Merchandising Association (NAMA) found that teenagers (13–17 years old) generally used over-the-counter sources for purchasing cigarettes, in smaller numbers than from over-the-counter sales, the younger, experimental smoker is at greater risk of purchasing from a cigarette vending machine. Tobacco control groups should be aware of this risk to such a vulnerable target audience and should adjust their educational programmes and policies accordingly.

STEPHEN F GAMBESCIA
American Heart Association
Southeastern Pennsylvania Affiliate
Conshohocken, PA 19428-1190, USA


Son of Premier

To the Editor—In 1988, the RJ Reynolds Tobacco Company (RJR) introduced a unique cigarette product called Premier.1 This product was unique because, unlike conventional cigarettes, Premier heated rather than burned tobacco, thereby significantly reducing the harmful components in tobacco smoke.

American cities (Phoenix, Arizona, and St Louis, Missouri). However, it did not sell well in these cities and was removed from the market in February 1988.

The concept of a smokeless tobacco product, however, did not die with Premier. On 27 November 1994, a New York Times article revealed that RJR was testing a second version of "smokeless tobacco called Eclipse."2 Like Premier, Eclipse heats rather than burns tobacco, but is designed somewhat differently.3 RJR has been conducting consumer tests of Eclipse in eight different American cities, including Buffalo, New York.4

One week after the New York Times story on Eclipse, we undertook an informal mail intercept survey to determine consumer awareness of and interest in trying the "smokeless cigarette". We were curious to see how smokers perceived this product, and were interested to see if non-smokers might be induced to try smoking Eclipse. Respondents were recruited by asking individuals at three shopping malls in Buffalo to participate in a 5 minute interview on cigarette smoking. Overall, interviews were completed with 94 persons, including 26 smokers, 28 former smokers, and 40 individuals who had never smoked. Only two individuals who were approached were interviewed refused participation in the study. None were aware of what product was being tested. We are not sure to what extent persons would know about the Eclipse cigarette, interviewers were given a diagram of Eclipse to show respondents. To help respondents understand the differences between Eclipse and a conventional cigarette, the diagram also listed several claims made about the product in the New York Times article (that is, reduce tar levels by 90%, eliminate 95% of secondhand smoke, produce less smoke and tar, and contain much nicotine as a regular cigarette).3

Sixty percent of respondents stated that they had heard about the Eclipse cigarette. However, the respondents who described potential problems associated with the Eclipse cigarette. The most frequently mentioned benefits were less side-stream smoke and tar. All respondents were asked to describe potential problems associated with the Eclipse cigarette. Most of those who did not describe the benefits they believed to be associated with the product. The most frequently mentioned benefits were less side-stream smoke and tar. All respondents were asked to describe potential problems associated with the Eclipse cigarette. The most frequently mentioned problems were addiction and disposal of the device.

The vast majority of respondents answered affirmatively to a question asking whether Eclipse should be subjected to government testing for safety. However, when asked whether Eclipse should be sold alongside regular cigarettes only 70% said the product should be available like cigarettes. Anecdotal comments received from respondents to our survey give us the impression that both smokers and non-smokers are sceptical about claims being made about the safety of Eclipse in relation to conventional cigarettes.

A recent study showed that about 70% of adult smokers in the United States want to stop smoking, but 93% of those who do stop smoking do so out of concern for their health.