Brussels, 14.3.2013
SWD(2013) 56 final/2

CORRIGENDUM:
Annule et remplace le document SWD(2013) 56 final du 22.02.2013
Concerne des changements mineurs suite aux commentaires venant des Etats membres et groupes d'intérêts

COMMISSION STAFF WORKING DOCUMENT

Report on the implementation of the Council Recommendation of 30 November 2009 on Smoke-free Environments (2009/C 296/02)

Report on the implementation of the Council Recommendation of 30 November 2009 on Smoke-free Environments (2009/C 296/02)

According to conservative estimates, over 79,000 adults, including 19,000 non-smokers, died in the EU-25 in 2002 due to the exposure to tobacco smoke at home (72,000) and at their workplace (7,300).[1] In this light, in November 2009 the Council adopted a Recommendation on Smoke-free Environments[2] (hereafter 'Recommendation'). The Recommendation calls on Member States to *"provide effective protection from exposure to tobacco smoke in indoor workplaces, indoor public places, public transport and, as appropriate, other public places"*. The Recommendation has taken inspiration from Article 8 of the WHO Framework Convention on Tobacco Control (FCTC)[3] and the corresponding guidelines on protection from exposure to tobacco smoke, as adopted by the Second Conference of the Parties to the FCTC[4] in 2007.

The Recommendation invites Member States to introduce smoke-free environments no later than November 2012 and invites the Commission to report on the implementation, functioning and impact of the measures. To prepare this report the Commission analysed responses to two questionnaires sent to Member States in 2012. Information was also received by Turkey, Serbia, Former Yugoslav Republic of Macedonia, Iceland, Croatia and Norway[5]. Information from the 2012 Eurobarometer Special Report[6] and relevant scientific studies were also used. The focal points appointed by the Member States were consulted on the draft report.

While the Recommendation is not legally binding, it reflects Member States political commitment to protect their citizens against second hand smoke and constitutes an important tool to benchmark Member States against best practices developed in the EU.

1. MAIN COMMITMENTS UNDER THE RECOMMENDATION

The Recommendation calls on Member States to introduce smoke-free environments by November 2012. Smoke-free environments should be created in particular for "indoor workplaces", "indoor public places", "public transport" and "other public places". Special emphasis is placed on measures to protect children and adolescents.

The Recommendation also calls for the adoption of complementary tobacco control policies, in particular in the areas of cessation and treatment of tobacco dependence, as well as for the adoption of comprehensive multi-sectorial strategies. To facilitate implementation and monitoring the Recommendation calls for the appointment of national focal points, which can also serve for the exchange of information and best practices.

The main objective of smoke-free environments is to protect EU citizens against the exposure to second hand tobacco smoke. Smoke-free environments might also have the potential to incentivise established smokers to quit smoking.

[1] Cf. recital 4 of Council Recommendation of 30 November 2009 on smoke-free enviroments (OJ C296, 5.12.2009, p. 4.).
[2] Council Recommendation of 30 November 2009 on smoke-free enviroments (OJ C296, 5.12.2009, p. 4.).
[3] http://whqlibdoc.who.int/publications/2003/9241591013.pdf
[4] http://www.who.int/fctc/cop/art%208%20guidelines_english.pdf
[5] The questionnaire was also sent to Montenegro who did not reply.
[6] Special Eurobarometer 385. Attitudes of Europeans towards tobacco. 2012 http://ec.europa.eu/health/tobacco/docs/eurobaro_attitudes_towards_tobacco_2012_en.pdf

2. RESULTS

Progress made by Member States to implement the Recommendation is summarised below under the headers (1) legislation on smoke-free environments, (2) enforcement of the legislation, (3) protection of children and adolescents including complementary measures, (4) measures for cessation, (5) multi-sectorial approach.

2.1. LEGISLATION ON SMOKE-FREE ENVIRONMENTS

All Member States have reported that they have legislation in place with the aim to protect their citizens from exposure to tobacco smoke at indoor workplaces, indoor public places, public transport and other public places[7]. However, the scope of this legislation varies considerably from one Member State to another. In certain Member States where the protection of public health falls into the competence of regional bodies there are even significant differences within one and the same Member State. Smoking bans are the most comprehensive in educational establishments, facilities providing services for children, public transport and in the healthcare sector. An overview of national legislation is contained in figure 1 below.

Educational establishments

With regard to educational establishments the vast majority of Member States have banned smoking altogether, even if a few accept some exceptions such as smoking rooms, e.g. for teaching personal. In some Member States smoking is completely banned in institutions of lower education, whereas smoking is allowed, or restricted to smoking rooms in the higher education system/institutions.

Public transport

Legislation against exposure to tobacco smoke in public transport is also well developed. A large majority of Member States report a total ban on smoking. The Member States that do not have a total ban, often have reported limited exemptions, such as Finland, Latvia and Denmark who allow smoking in areas or designated rooms on long distance passenger ships.

Health care facilities

In health care facilities, about half of the Member States have banned smoking completely. The others have introduced partial bans or restrictions that allow some exceptions or smoking rooms or designated smoking areas for either patients and/or employees.

Hotels

The large majority of Member States allow smoking in some hotel rooms or smoking is allowed in the rooms at the owners' discretion. Some Member States allow that a certain percentage of hotel rooms are reserved for smokers (e.g. Finland 10%). In other Member States smoking is not allowed in hotel bedrooms (Cyprus, Austria and Bulgaria).

[7] Some Member States (Belgium, Malta and Slovakia) do not only act against tobacco smoke, but extend their ban to the consumption of electronic cigarettes in enclosed public places, bars and restaurants and other workplaces. Finland reports that several owners/proprietors have banned the consumption of these products on their own accord.

Residential care facilities[8]

Regarding residential care units, some Member States (Greece, Hungary, Bulgaria and Malta) have reported that smoking is forbidden in these facilities. In Spain smoking is forbidden for staff and visitors in residential care, but allowed for residents under certain conditions.

Prisons

Smoking in prison cells is not allowed in Spain, Malta, Sweden, Bulgaria or Wales.

In most Member States that allow smoking in the "private" rooms (e.g. bedroom of a hotel), smoking in the communal areas/areas open to the public is restricted to designated smoking rooms, or banned altogether in line with the general smoke-free legislation concerning enclosed public places and workplaces.

Indoor workplaces, enclosed public places, including hospitality sector[9]

The scope of smoke-free legislation in indoor workplaces and public places, in particular in bars and restaurants varies widely between the Member States. The most far-reaching legislation is provided in Hungary, Bulgaria, Spain, Ireland, the United Kingdom, Malta, Greece, Former Yugoslav Republic of Macedonia and Turkey where smoking is completely banned in enclosed workplaces and public places, including bars and restaurants. There are some very limited exemptions in these Member States. 10 other Member States (Belgium, Cyprus, Finland, France, Italy, Latvia, Lithuania, Sweden, Poland, and Slovenia) and Norway and Iceland have a general ban on smoking in workplaces and enclosed public places, but allow separate, enclosed smoking rooms under specific conditions. Some of these countries have stricter legislation in the hospitality sector. In the remaining Member States (Denmark, the Netherlands, Luxembourg, Romania, Portugal, Austria, Germany[10], the Czech Republic, Estonia and Slovakia) and the Republic of Serbia and Croatia smoke-free laws give exemptions for certain public places such as bars and/or restaurants in general, or certain categories of bars and restaurants. In some Member States the legislation differs between the hospitality industry and other workplaces and enclosed public places. Legislation is often less strict in the hospitality sector.

---

[8] A generic term for a group home, specialized apartment complex or other institution that provides care services (medical, social or other) where individuals live.

[9] Hospitality sector: a broad category of fields within the service industry that includes restaurants, bars, clubs, cafes, brasseries etc. For the purpose of this report regulation concerning bedrooms and communal areas of hotels and accommodation are not included in the definition as they are dealt with separately in the report.

[10] Smokefree environments are regional competence. Legislation in Germany therefore varies on this point.

__Figure 1 - Overview of smoke-free legislation__[11]

Legend:

● - Total ban on indoor smoking

◍ - Ban on indoor smoking, while providing for separate enclosed smoking rooms / Obligation for employer to protect employees

○ - Partial ban on indoor smoking, e.g. smoking zones or exemptions for certain categories of venues

X - Recommendations, suggestions, or no ban

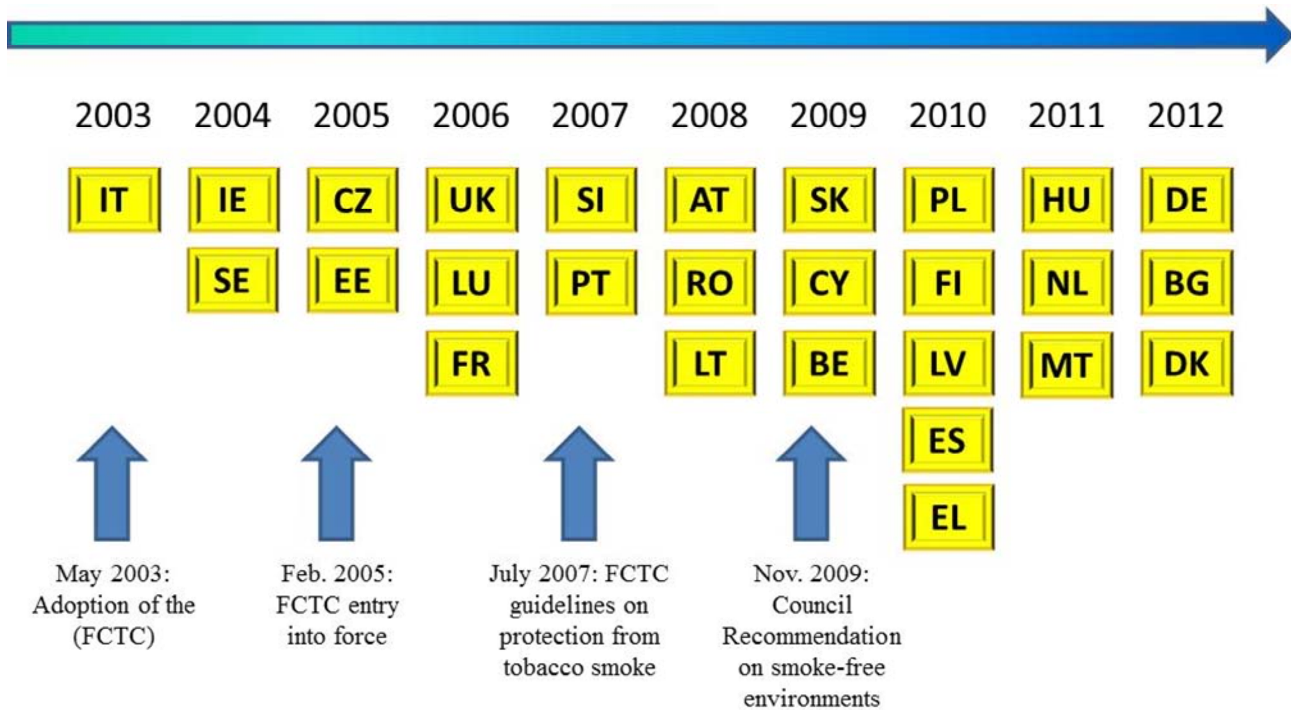
	General Workplace	**Enclosed Public Places**	**Restaurants**	**Bars**	**Health Care Facilities**	**Education Facilities**	**Public Transport**	**Hotels & Accommodation**	**Residential Care**	**Prisons**
Austria[i]	◍	◍	○	○	◍	◍	◍	◍	◍	◍
Belgium[ii]	◍	◍	◍	◍	◍	●	●	◍	◍	◍
Bulgaria[iii]	●	●	●	●	●	●	◍	●	●	●
Cyprus[iv]	◍	●	●	●	●	●	●	●	X	○
Czech Republic[v]	○	○	X	X	◍	●	◍	○	◍	○
Denmark[vi]	◍	◍	◍	○	◍	◍	◍	○	◍	◍
Estonia[vii]	○	○	◍	◍	○	○	○	○	○	○
Finland[viii]	◍	◍	◍	◍	◍	◍	◍	◍	◍	◍
France[ix]	◍	◍	◍	◍	●	●	●	◍	◍	◍
Germany[x]	◍	◍	○	○	◍	◍	◍	◍	◍	◍
Greece[xi]	●	●	●	○	●	●	●	●	●	●
Hungary[xii]	●	●	●	●	◍	●	●	◍	●	◍
Ireland[xiii]	●	●	●	●	●	●	●	◍	◍	◍
Italy[xiv]	◍	◍	◍	◍	◍	◍	◍	◍	◍	◍
Latvia[xv]	◍	◍	●	●	◍	●	◍	◍	◍	◍
Lithuania[xvi]	◍	●	●	●	●	●	●	○	◍	◍
Luxembourg[xvii]	◍	●	◍	○	◍	●	◍	◍	◍	◍
Malta[xviii]	●	●	●	●	●	●	●	◍	●	●
Netherlands[xix]	◍	◍	◍	○	◍	◍	◍	◍	◍	◍
Poland[xx]	◍	●	◍	◍	●	◍	◍	◍	◍	◍
Portugal[xxi]	○	○	○	○	○	◍	●	○	○	◍
Romania[xxii]	◍	◍	○	○	●	◍	●	○	◍	◍
Slovakia[xxiii]	◍	●	◍	X	●	●	◍	◍	◍	◍
Slovenia[xxiv]	◍	◍	◍	◍	●	●	◍	◍	○	◍
Spain[xxv]	●	●	●	●	●	●	●	◍	◍	◍
Sweden[xxvi]	◍	◍	◍	◍	◍	◍	◍	◍	◍	◍
Unit. Kingdom[xxvii]	●	●	●	●	●	●	●	◍	◍	◍
Turkey[xxviii]	●	●	●	●	●	●	●	◍	●	◍
Former Yugoslav Republic of Macedonia	●	●	●	●	●	●	●	●	●	●
Norway[xxix]	◍	◍	●	●	◍	●	◍	◍	◍	◍
Serbia[xxx]	●	●	○	○	●	●	●	◍	◍	◍
Iceland	◍	◍	●	●	◍	●	●	◍	◍	○
Croatia	◍	●	●	○	●	●	●	◍	●	◍

This overview is based on the analysis of the relevant legal provisions in each Member State as of January 2013, but does not take into account their enforcement nor does it reflect forthcoming legislative changes or plans in Bulgaria, the Czech Republic, Denmark, Estonia, Finland, Hungary, Latvia, Luxembourg, Portugal, Romania, Sweden and Norway.

[11] Information on private smoking clubs where no food or beverages are served is not included

In terms of timing many Member States started introducing comprehensive smoke-free legislation, including bans in the hospitality sector very early, with Ireland being the first European country to do so in a comprehensive manner in 2004. Other Member States for example, the United Kingdom, Slovakia, Greece, Hungary, the Czech Republic, Estonia and Poland followed in the years thereafter. However, many Member States did not adopt national legislation until after the adoption the FCTC guidelines (2007) and after the Council Recommendation (2009) as shown in figure 2. The Commission was in close contact with a number of Member States following the adoption of the Recommendation and assisted them in developing their legislation, e.g. by pointing to best practices (Poland (2010), Luxemburg (2011), Hungary (2011), Bulgaria (2012)).

Figure 2 - Adoption of most recent smoke – free legislation in the EU 2003-2012



2.2. ENFORCEMENT OF NATIONAL LEGISLATION

Legal framework for the enforcement

All Member States reported that measures are in place for effective enforcement of their policy. In most cases health authorities are responsible, but responsibilities are often shared with other bodies/agencies such as labour authorities, police, and food safety agencies.

All Member States have introduced sanctions for non-compliance, the most common being fines. In cases of repeated violations, the establishment may lose its license (Romania, Portugal, Ireland, Malta and Austria). Fines for individuals are generally at a lower level than those that can be imposed on enterprises. Typically the level depends on factors such as gravity of the offence, whether it is a repeated act, or the firm's turnover. The sanctions range from EUR 14 (individual) in Latvia to EUR 10,000 for repeated business violations in Austria and Greece.

All Member States have reported about actual enforcement activities and several cases have been decided in the courts. Lack of resources is most often reported to be the main difficulty in enforcement efforts. Several Member States have reported that enforcement in the hospitality sector is most challenging. A specific enforcement difficulty is measuring the size of venues in Member States where there are exemptions for certain venues and these exemptions are based on the size of the venue. Other difficulties are "covered outdoor areas" in colder months (e.g. covered terraces) or the designation of certain rooms as “private” in order to allow smoking indoors. It is reported that exemptions relating to outdoor areas in licensed premises is challenging and that there have been

several court cases concerning this issue. It is also reported that enforcement is difficult in prisons, psychiatric hospitals, nursing homes and outdoor areas of health and educational facilities.

A German survey[12] has concluded that the multitude and complexity of the exemptions in the individual German states have made it virtually impossible to monitor compliance with the ban on smoking in bars and restaurants, and legal violations are an everyday occurrence. This suggests that complicated legislation is more difficult to enforce and leads to lower compliance.

The information provided by Member States and studies show that complex legislation with many exemptions is more likely to lead to diverging interpretation, problems with enforcement and compliance and therefore appears to lead to inferior protection[13]. A study in Finland[14] showed that the exposure to tobacco smoke of employees in workplaces with designated smoking rooms is significantly higher than the exposure of employees who work in totally smoke-free workplaces. The report calls for legal amendments. A Spanish study[15] shows that best protection is achieved by a comprehensive ban.

Actual exposure to second hand tobacco smoke in the EU

The Eurobarometer survey of 2012[16] on exposure to tobacco smoke shows that - despite a significant reduction in EU citizens' exposure since the last survey in 2009[17] - a significant number are still exposed to second hand smoke. More specifically, the exposure was 28% of EU citizens who visited a **drinking establishment** in the preceding six months and 14% of citizens who visited eating places. [18] At work places the exposure rate to second hand smoke was still 6%. The subsequent figures (3a, 3b and 3c) provide an overview per sector and Member State.

According to the Eurobarometer results of 2009 and 2012, exposure in work places remained at the same level or dropped in all but four Member States (Cyprus, the Netherlands, Slovakia and Czech Republic). Over the same period, exposure in restaurants dropped in all but 4 Member States (Estonia, Ireland, Greece and Portugal). Results are less positive as regards bars, where exposure increased in this period in at least 7 Member States (Czech Republic, Denmark, Estonia, Ireland, Greece, Luxembourg and Portugal).

---

[12] Evaluations from Germany: http://www.dkfz.de/de/tabakkontrolle/download/Publikationen/AdWfP/AdWfP_Ineffectiveness_of_smoking_bans_in_Germany.pdf

[13] Evaluations from Germany: http://www.dkfz.de/de/tabakkontrolle/download/Publikationen/AdWfP/AdWfP_Ineffectiveness_of_smoking_bans_in_Germany.pdf

[14] Heloma A, Helakorpi S, Honkonen J, Danielsson P, Uutela A. Exposure to secondhand smoke in Finnish workplaces and compliance with national smoke-free workplace legislation. Scandinavian Journal of Public Health 2011; 39:723-9.

[15] Lopez MJ, Nebot M, Schiaffino A, Perez-Rios M, Fu M, Ariza C, Munoz G, Fernandez E. Two-year impact of the Spanish smoking law on exposure to secondhand smoke: evidence of the failure of the 'Spanish model.' Tob Control 2012; 21: 407-11.

[16] Special Eurobarometer 385. Attitudes of Europeans towards tobacco. 2012 http://ec.europa.eu/health/tobacco/docs/eurobaro_attitudes_towards_tobacco_2012_en.pdf

[17] Special Eurobarometer 332. Tobacco. 2010 http://ec.europa.eu/health/tobacco/docs/ebs332_en.pdf

[18] For the purpose of this report the data on exposure in figures 3a & b is calculated only for those persons who actually visited an eating or drinking establishment and provided information on exposure.

Figure 3a - Exposure to second hand tobacco smoke in EU-27 in 2009 and 2012

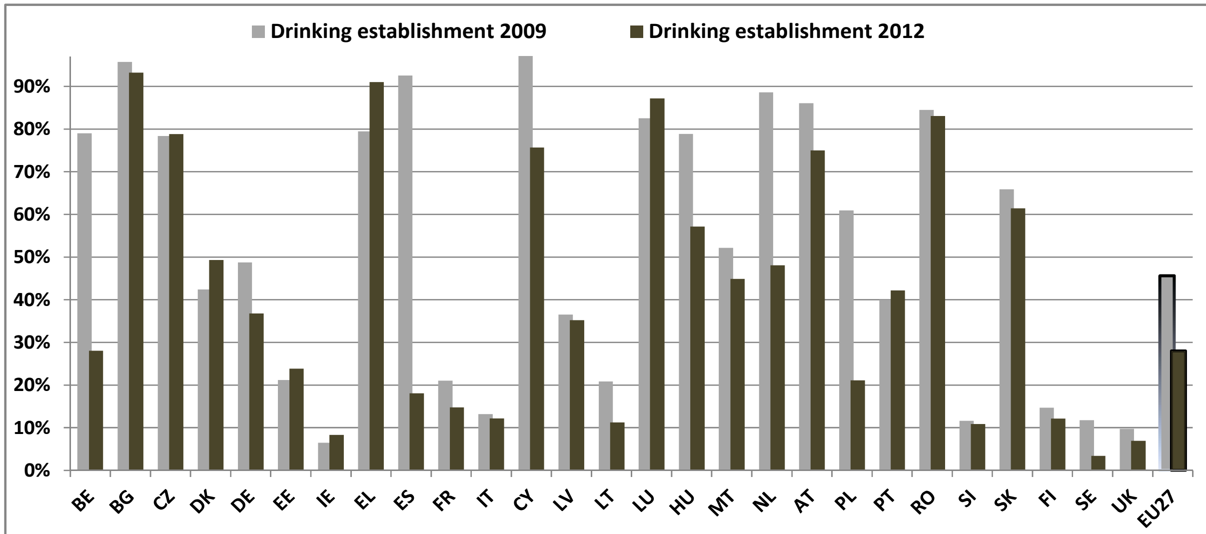


Figure 3b - Exposure to second hand tobacco smoke in EU-27 in 2009 and 2012

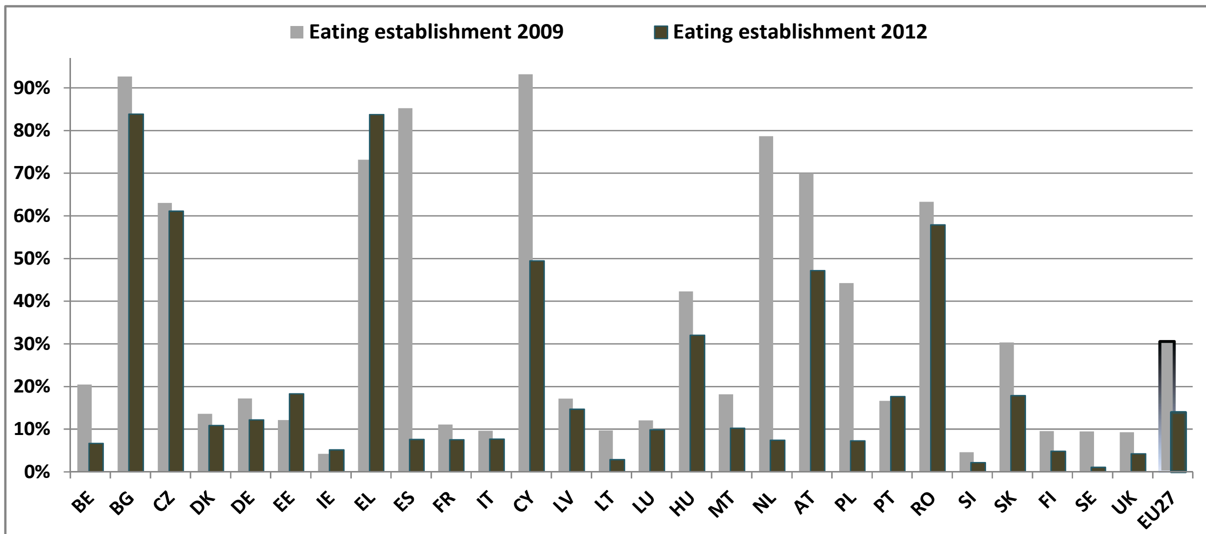
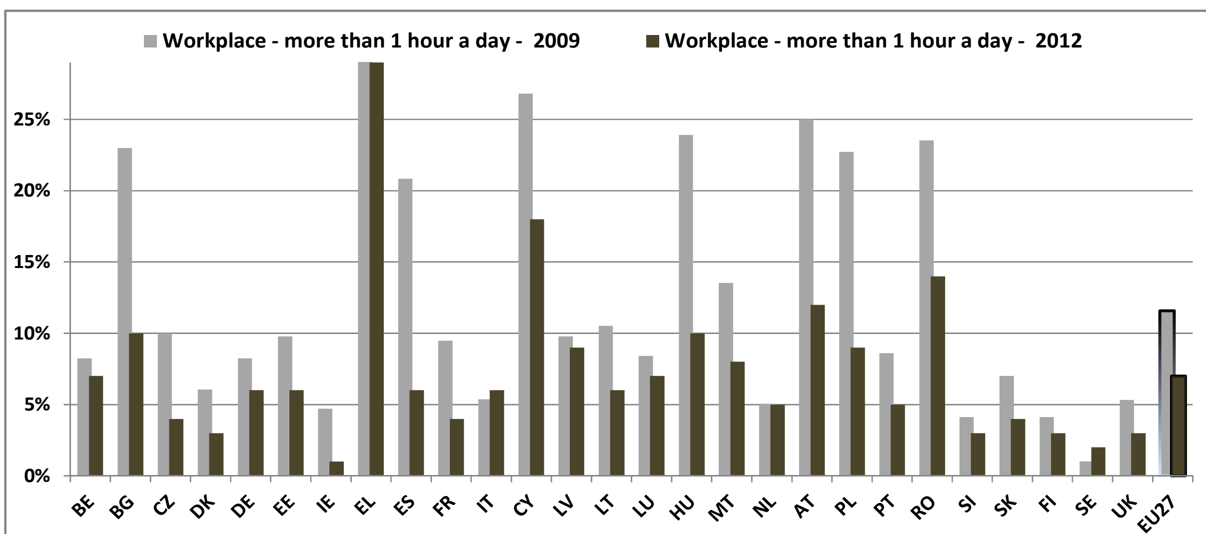


Figure 3c - Exposure to second hand tobacco smoke in EU-27 in 2009 & 2012

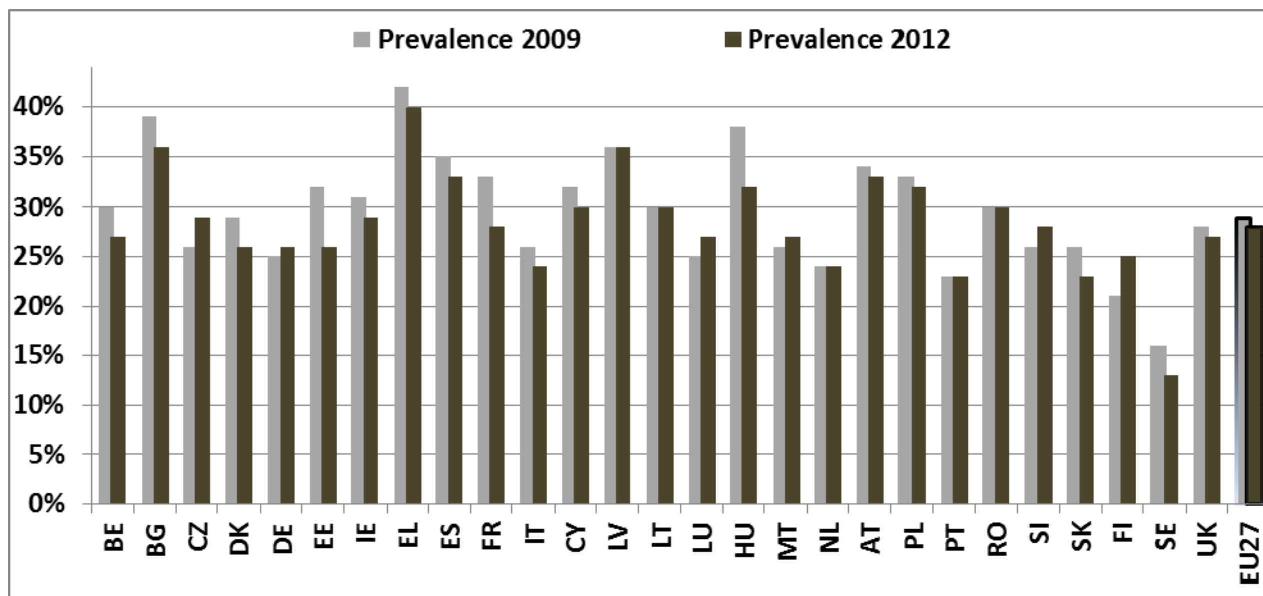


Some Member States[19] reported national exposure and smoking prevalence data. In a number of cases the information deviates from the Eurobarometer data. Different sample sizes and other methodological issues may account for these differences.

Respondents in Greece (71%), Bulgaria (69%)[20] and Luxembourg (68%) are the most likely to say that - when they visited a drinking establishment within the last 6 months – they were exposed to tobacco smoke. In contrast, very few respondents in Sweden (3%), the United Kingdom (6%), Lithuania (8%), Ireland (8%) and Finland (9%) have recently been to a drinking establishment where people smoked inside. The largest decrease is observed in Spain (-70 points). Large drops are also observed in Belgium, the Netherlands and Poland. It is apparent that the drops in Spain, Belgium and Poland followed the entry into force of amendments to their smoke-free legislation underlying the impact of such measures.

When comparing the actual level of exposure with the legislation on smoke-free environments formally in place, it is clear that some Member States do quite well in terms of enforcement. This is for example the case in Sweden and the United Kingdom. In Sweden very few eating and drinking establishments have enclosed smoking rooms, despite the fact that the legislation allows it. In other Member States the high exposure rates are either the result of a lack of enforcement or of a lack of ambition in terms of legislation or both. In some cases stricter legislation only came into effect after the Eurobarometer survey (e.g Bulgaria). The national prevalence level for smoking can also play an important role when it comes to enforcement (see figure 4). In Member States with high prevalence levels effective enforcement might be more challenging taking into account that smoking is perceived as more acceptable. However even Member States with a prevalence level exceeding 30% have managed to reduce exposure to second hand smoke very significantly (e.g. Spain, Poland).

Figure 4 – Prevalence in EU 27 2009 -2012



[19] National data: Denmark reported that 41% were exposed to tobacco smoke in bars in 2012, 15% in restaurants and 16% in other workplaces. Hungary reported that 47% were exposed to tobacco smoke in bars, 19% in restaurants and 33% in other workplaces. Latvia contests Eurobarometer data, but does not have national data on exposure. Romania reported that 94% were exposed to tobacco smoke in bars, 86% in restaurants and 34% in workplaces. France reported that 5% were exposed in bars, 3% in restaurants and 21% in workplaces. Italy reported that 12% were exposed in restaurants and 10% in workplaces in 2011. Slovenia reported that 9% were exposed in bars, 9% in restaurants and 14% in workplaces. Estonia reported that 22% were exposed in the workplace. Furthermore, Greece reported a smoking prevalence of 36.7% for 2012.

[20] In Bulgaria the total smoking ban did not enter into force until 1 June 2012. Before this time smoking was allowed in bars and restaurants under 50 m^2, in all-night premises in designated smoking rooms during the day, and everywhere after 22.00 in night bars. This may account for the high exposure reported in this country.

2.3 EXPOSURE TO TOBACCO SMOKE IN PRIVATE PLACES

While the exposure to tobacco smoke in private places (homes, cars) is not covered by the Recommendation, a number of Member States have nonetheless provided information. The underlying reason is that the Recommendation invites Member States to pay particular attention to the protection of children and adolescents. In Member States with comprehensive smoke-free legislation in public places and high enforcement levels, smoking in private places is the most likely risk for children and adolescents to be exposed to second hand smoking.

Most Member States have not introduced legislative measures to protect children against tobacco smoke in homes and cars. Cyprus has banned smoking in cars if children under 16 are present. Similar legislation has been proposed by the Irish Ministry of Health. The National Public Health Institute in Sweden has been tasked to prepare a report on exposure to tobacco smoke as a basis for potential new legislation, which would include regulation of smoking in outdoor areas, particularly those that are frequented by children and adolescents. In Norway the government has proposed a ban on exposing children to tobacco smoke. Icelandic legislation imposes a duty of care to protect children from tobacco smoke in all areas.

Figure 5 summarises the information concerning exposure in private settings. Results are not directly comparable as they are from different years, use different samples and age groups.

Figure 5 – Exposure to tobacco smoke in homes and cars

Country	Exposure to tobacco smoke in homes and cars
Denmark	69% never exposed in homes, 15% are exposed daily or weekly
Estonia	23.5% are exposed in homes
Finland	16% are exposed in homes
Hungary	44% are exposed in homes
Ireland	14.9% of children are exposed in cars
Italy	14.4% exposed in cars
Latvia	44.6% are exposed in homes
Poland	44.2% are exposed in homes
Portugal	33% are exposed in homes
Romania	35.4% are exposed in homes
Slovenia	19% are exposed in homes, 6.6% are exposed in cars
Sweden	6% are exposed in homes
Serbia	45% are exposed everywhere, 37% are exposed in some areas at home
Norway	88% are never or almost never exposed in homes
Former Yugoslav Rep. of Macedonia	67.5% are exposed in homes

2.4. Protection of children and adolescents

The Recommendation places a special emphasis on the need to develop or strengthen measures to reduce exposure to tobacco smoke for children and adolescents and to adopt complementary/supporting measures. Almost all Member States reported that strategies to protect children and adolescents were introduced. They also reported about complementary measures, most of which are contained in the recent Commission proposal for the revision of the Tobacco Products Directive.

In Denmark, the Czech Republic, Germany, Portugal, Hungary, Italy, Romania, Luxembourg, the United Kingdom, Sweden, Portugal, Poland and Croatia there are specific programs and/or projects to raise awareness in schools - sometimes involving parents. Mass media campaigns are also in place in some Member States to raise awareness. In Belgium, Denmark, Czech Republic, Estonia, Hungary, Latvia, Portugal, Spain, Bulgaria, France, Slovenia, Malta, Poland, Cyprus, Finland, Lithuania, the Netherlands, and Greece, various smoking bans are in place in establishments used by children and adolescents such as indoor and outdoor school premises, playgrounds, and childcare institutions.

In the majority of Member States, a number of complementary measures are taken to protect young people against the risks associated with tobacco consumption. Most of them aim at reducing the initiation of tobacco use. All Member States have advertising bans or limitations in place (in line with the Advertising Directive 2003/33/EC), but significant differences prevail for advertising and promotion activities, in particular at points of sale. Currently, three Member States (Finland, Ireland and the UK) and two EEA countries (Iceland and Norway) have laws to prohibit the visible display of tobacco products at the point of sale. Fourteen Member States (Austria, Denmark, France, Greece, Hungary, Latvia, Lithuania, Luxembourg, Malta, the Netherlands, Poland, Portugal, Sweden, and Spain) have put in place restrictions or bans on promotion at point of sale.

As of 2009, about half the Member States ban sales of sweets and toys which resemble tobacco products. In some Member States the prohibition is based on the fact that these products constitute indirect tobacco advertising.

All EU Member States have age limits in place as regards purchasing of tobacco. The legal buying age is 18 years in 22 Member States and 16 years in the remaining five.

Thirteen Member States have banned the sale of tobacco from tobacco vending machines completely and Finland will introduce it as of 2015. In the Member States that allow vending machines provisions are in place to limit uncontrolled access to tobacco products. Restrictions range from ID control systems to the need of adequate supervision. Some Member States also regulate where the machines can be installed (e.g. Portugal and Spain). Ireland permits the use of vending machines only in licensed premises or retail stores.

Member States have different rules in place as regards the minimum number of cigarettes per package (to limit the use of "kiddy packs"). 14 Member States (Austria, Czech Republic, Estonia, Finland, France, Greece, Ireland, Luxembourg, Lithuania, Poland, Portugal, Denmark, Romania and Spain) specify a minimum pack size of 20 cigarettes. In four Member States (Hungary, Germany, the Netherlands and Sweden) the minimum pack size is 19 cigarettes. Italy specifies that cigarettes must be sold in either packets of 10 or 20. In the UK the minimum pack size is 10 cigarettes. Furthermore, Slovenia and Latvia ban the sale of single cigarettes.

14 Member States regulate ingredients. Poland bans the use of ingredients, which enhance the addictive properties of tobacco. Three Member States (Belgium, Romania, UK) have introduced different varieties of positive lists of ingredients allowed to be used in tobacco products. Lithuania has introduced a negative list which restricts specific additives (e.g. vanilla root and clove) from being included in tobacco products and the Czech Republic, Germany, Hungary, Bulgaria and Slovakia have a combination of positive and negative lists. In 2009, France adopted a legislation

focusing on the attractiveness of certain tobacco products. The French law allows setting up maximum levels for ingredients that impart a sweet or fruity/acid taste to cigarettes. In Sweden, there is no positive or negative list, but it is possible to regulate ingredients on an ad-hoc basis.

10 Member States have adopted legislation on combined health warnings as defined by Article 2(4) of Commission Decision 2003/641/EC: Belgium, Denmark, Hungary (in force from 1st January 2013), Latvia, Romania, Spain, the United Kingdom, France, Malta and Ireland (in force from February 2013). Seven of these countries include information on services supporting cessation on the packaging. In Bulgaria, the process of adoption is underway. Outside the EU, Norway, Iceland and the Former Yugoslav Republic of Macedonia and Turkey have introduced picture warnings.

2.5. CESSATION MEASURES

The Recommendation calls on Member States to introduce tobacco cessation policies. This is in line with Art. 14 FCTC and the implementation guidelines adopted in 2010[21]. All Member States have reported about cessation measures. The large majority of Member States have developed comprehensive cessation guidelines based on scientific evidence and best practice, media campaigns to promote cessation, cessation programs for certain target groups, telephone quitlines and local events (e.g No Tobacco Day). Almost all Member States report about cessation programs in educational institutions, health care facilities or workplaces. Diagnosis and treatment of tobacco dependence and counselling services for cessation are in place in the large majority of Member States. 21 Member States have specialized centres for cessation and treatment of tobacco dependence, and 12 have these programs in rehabilitation centres. Seven Member States have low cost dispense of NRT or reimbursement schemes for NRT (Nicotine Replacement Therapy). Figure 6 summarises the main measures taken by Member States.

Figure 6 – Tobacco cessation and tobacco dependence treatment measures

	Cessation Guidelines	Media campaigns	Targeted cessation programs	Quitlines	Specialized centres for cessation services	Low cost dispense of NRT
Austria	x	x	x	x	x	
Belgium		x	x	x	x	
Bulgaria	x	x	x	x		x
Cyprus		x	x		x	
Czech Republic	x	x	x	x	x	
Denmark	x	x	x	x	x	
Estonia	x		x	x	x	
Finland	x	x	x	x		
France	x	x	x	x	x	
Germany	x	x	x	x	x	
Greece	x	x	x	x	x	
Hungary	x	x	x	x		
Ireland	x	x	x	x		x
Italy	x	x		x	x	
Latvia	x			x	x	
Lithuania	x	x		x	x	
Luxembourg	x	x	x	x	x	x
Malta	x	x	x	x		
Netherlands	x			x	x	x
Poland	x	x	x	x	x	
Portugal	x		x	x	x	
Romania	x		x	x	x	x

	Cessation Guidelines	Media campaigns	Targeted cessation programs	Quitlines	Specialized centres for cessation services	Low cost dispense of NRT
Slovakia	x	x	x	x	x	x
Slovenia	x	x	x	x		
Spain	x	x	x	x	x	
Sweden	x		x	x	x	
United Kingdom	x	x	x	x	x	x
Turkey	x	x	x	x	x	x
Former Yugoslav Republic of Macedonia		x	x		x	
Norway	x	x		x		
Serbia	x	x	x			
Iceland		x		x		
Croatia		x	x			

2.6 MULTI-SECTORIAL TOBACCO CONTROL STRATEGY

Traditionally the health sector is in the lead when it comes to developing tobacco control policy. The Recommendation invites Member States, however, to extend tobacco control beyond the health sector and to develop a comprehensive multi-sectoral approach. In practice this means that other governmental sectors and ministries should support the development of comprehensive tobacco control measures (e.g. through taxation).

A majority of Member States reported that they have a multi-sectorial tobacco control strategy. Most Member States referred to national tobacco control and public health strategies that are either adopted, in the process of adoption or under revision. Most Member States did however not report specifically on the multi-sectorial aspect of tobacco control. The Netherlands commented that although they do not have a multi sectorial strategy as such, the tobacco control strategy is a part of the national prevention policy, for which the engagement of other sectors such as the business sector, civil society, health organisations and care providers is encouraged. Portugal and Cyprus reported that their tobacco control strategies are based on the WHO MPOWER strategy[22] which, inter alia, promotes multi-sectorial collaboration. Lithuania has an inter-sectorial Action Plan for alcohol and tobacco for the period 2012-2014.

The Recommendation also calls for the appointment of focal points with a view to exchange information and best practices between Member States and with the Commission. Focal points have been appointed by all Member States and a meeting is scheduled for February 2013.

[22] http://www.who.int/tobacco/mpower/en/

3. IMPACTS

Many Member States aim to measure the success of their tobacco control policies including smoke-free environments. Health and economic impacts are measured in particular. Often the attitude of citizens to the smoke-free policy (acceptance) is also measured.

Only a few Member States have carried out an impact assessment prior to the adoption of the smoke-free measures. However many Member States have carried out evaluations concerning the effectiveness of national smoke-free legislation.

For the purpose of this report all studies submitted by Member States were considered. Some of them predate the adoption of the Recommendation taking into account that Member States started introducing smoke-free legislation prior to the adoption of the Recommendation. This does not undermine the relevance of these studies when assessing the impacts of smoke-free policies, as the impacts of smoke-free legislation show only/continue years after implementation. Studies from countries outside the EU where smoke-free legislation has been in place for several years is also useful, in particular for Member States that are still considering to adopt additional measures on smoke-free environments.

3.1. INDICATORS

The Recommendation calls for Member States to cooperate closely on a coherent framework of definitions, benchmarks and indicators for the implementation of the Recommendation. Member States were asked to report on the indicators used for this purpose.

A majority of Member States are monitoring smoke-free and other measures using one or more indicators with an aim to evaluate implementation, functioning and effect of the measures presented in the Recommendation. About one third of Member States have evaluated their smoke-free legislation more comprehensively and another third have evaluated their smoking cessation and tobacco prevention programs.

Smoke-free environments

Belgium, Cyprus, Lithuania, the United Kingdom, Luxembourg, and Ireland report that they use, for example, compliance data for monitoring and evaluation. The Czech Republic, Denmark, Latvia, Portugal, Romania, Spain, and Slovenia include data on exposure to tobacco smoke in their monitoring scheme. Finland, Greece, the Netherlands, and France conduct national surveys. Hungary conducts national surveys measuring, for example, smoking habits and attitudes as well as measuring indoor air quality. Several Member States use a combination of the abovementioned indicators.

Tobacco cessation and treatment for tobacco dependence

Most Member States use annual prevalence data, or more specified quit rate data from cessation services. Some also use data on NRT consumption and the number of prescriptions of Vareniclin and Bupropion, (two specific pharmaceuticals used for tobacco dependence treatment). Evaluations of treatment and cessation facilities/programs are on-going in a number of Member States.

Comprehensive tobacco control strategy

In most Member States tobacco control strategies are monitored by population surveys on smoking prevalence. Some also include data on population support, and reviews and studies on compliance with tobacco control legislation and implementation of other tobacco control measures.

3.2. HEALTH AND SOCIAL IMPACT

3.2.1. Health and environmental impact

Studies from EU Member States clearly indicate the health benefits of smoke-free legislation. Examples include substantial reductions in the incidence of heart attacks in the general population (e.g. in Italy)[23], and in hospital admission for myocardial infarction and other acute coronary events (e.g. Germany, Italy, UK, US)[24]. In England[25] the legislation resulted in a statistically significant reduction (2.4%) in the number of hospital admissions for myocardial infarction (MI). This amounted to a reduction of 1,200 emergency admissions for MI in the year following the introduction of smoke-free legislation. Denmark, Italy and Malta also have data on reduction in morbidity among the general public.

The United Kingdom and Ireland have also collected data on reduction in morbidity among workers due to second hand smoke.[26] The Irish study showed a rapid improvement in respiratory health. A study of bar workers in England[27] showed that their exposure to second hand smoke reduced on average between 73% and 91% (from 2007 to 2008) and as a result their respiratory health improved significantly after the introduction of the legislation. In Sweden[28] a study found that smoke-free legislation was associated with a substantial reduction in respiratory and sensory symptoms, as well as reduced exposure to environmental tobacco smoke at work, particularly among workers in game centres.

No Member State reported data on the reduction in annual mortality among *workers* due to reduced second hand smoke, but Malta[29] reported data on the reduction in annual mortality in the *general public.*

Improved health also leads to reductions in medical costs as shown by studies in Finland, Spain, Greece and the United Kingdom.[30] A Finnish study[31] has calculated that 85% of life long health care costs could be saved, if every smoker stopped smoking. Cessation at a younger age provides

---

[23] Cesaroni G, Forastiere F, Agabiti N, Valente P, Zuccaro P, et al. Effect of the Italian Smoking Ban on Population Rates of Acute Coronary Events. Circulation 2008; 117:1183-8.

[24] Bartecchi C, Alsever RN, Nevin-Woods C, Thomas WM, Estacio RO, Bartelson BB, et al. Reduction in the incidence of acute myocardial infarction associated with a citywide smoking ordinance. Circulation 2006; 114: 1490–6;
Sargent RP, Shepard RM, Glantz SA. Reduced incidence of admissions for myocardial infarction associated with public smoking ban: before and after study. BMJ 2004; 328: 977–80; Francesco Barone-Adesi F, Vizzini L, Merletti F, Richiardi L. Short-term effects of Italian smoking regulation on rates of hospital admission for acute myocardial infarction. European Heart Journal 2006; 27:2468-72; Richiardi L, Vizzini L, Merletti F, Barone-Adesi F. Cardiovascular benefits of smoking regulations: The effect of decreased exposure to passive smoking. Preventive Medicine 2009 48(2):167-72; Juster HR, Loomis BR, Hinman TM, Farrelly MC, Hyland A, Bauer UE, et al. Declines in Hospital Admissions for Acute Myocardial Infarction in New York State After Implementation of a Comprehensive Smoking Ban. Am J Pub Health 2007; 97: 2035-9; Pell JP, Haw S, Cobbe S, Newby DE, Pell AC, Fischbacher C et al. Smoke-free Legislation and Hospitalizations for Acute Coronary Syndrome. N Engl J Med 2008; 359:482-91; Sargent JD, Demidenko E., Malenka DJ, Li Z, Gohlke H, Hanewinkel R. Smoking restrictions and hospitalization for acute coronary events in Germany. Clinical Research in Cardiology 2012; 101: 227-35; Sims M, Maxwell R, Bauld L, Gilmore A. Short term impact of smoke-free legislation in England: retrospective analysis of hospital admissions for myocardial infarction. BMJ 2010; 340:c2161; Trachsela LD et al. Reduced incidence of acute myocardial infarction in the first year after implementation of a public smoking van in Graubuenden, Switzerland. Swiss Medical Weekly 2010; 140: 133-138.

[25] As quoted in: Bauld L. Impact of smokefree legislation: evidence review. Report for UK Department of Health.Bath: University of Bath; 2011

[26] Allwright S, Paul G, Greiner B, Mullally BJ, Pursell L, Kelly A, Bonner B, D'Eath M, McConnell B, McLaughlin JP, O'Donovan D, O'kane E, Perry IJ. Legislation for smoke-free workplaces and health of bar workers in Ireland: before and after study. BMJ. 2005 Nov 12;331:1117.

[27] As quoted in: Bauld L. Impact of smokefree legislation: evidence review. Report for UK Department of Health.Bath: University of Bath; 2011

[28] Larsson M, Boëthius G, Axelsson S, Montgomery SM.. Exposure to environmental tobacco smoke and health effects among hospitality workers in Sweden—before and after the implementation of a smoke-free law. Scand J Work Environ Health. 2008; 34:267-77.

[29] http://spo.escardio.org/Abstract.aspx?abstractBookId=98326

[30] As quoted in: Bauld L. Impact of smokefree legislation: evidence review. Report for UK Department of Health. Bath: University of Bath; 2011

[31] Vitikainen K., Pekurinen M., Kiiskinen U., Mikkola H. (2006). Kannattaako tupakoinnin lopettaminen? Helsinki: Stakesin raportteja 1/2006. [Viitattu: 29.8.2008]. Saatavissa: http://www.stakes.fi/verkkojulkaisut/raportit/Ra1-2006.pdf

for the greatest savings. An improvement in health also leads to reduction in non-medical costs due to reduced second hand tobacco smoke exposure among staff (e.g. increased productivity through reduced sick leaves etc.).

Concerning environmental impacts, seven Member States have studies on the reduction of indoor air pollution. In Spain, England, Scotland, Wales and Ireland concentration of $PM_{2.5}$ (a general measure of air pollutants) decreased by between 84 and 93% following the introduction of smoke-free legislation.[32] Significant decreases have also been measured in Hungary, the Netherlands and Portugal.[33]

3.2.2. Social impact

Reports from Member States and European survey data show that support for the legislation often increases after the introduction of smoke-free environments. As indicated in a Eurobarometer report from 2009, a majority of EU citizens support smoke-free public places, such as offices, restaurants and bars[34], particularly in those Member States where smoke-free laws are already quite comprehensive. Support for smoking restrictions at workplaces was slightly higher than support for such restrictions in restaurants (84% vs. 79%). Still two-thirds of the participants supported smoke-free bars, pubs and clubs.

Fifteen Member States have reported an **increased support for smoke-free policies**. In Italy support for smoke-free policies increased progressively from 83% before the ban was introduced in 2001 to 93% in 2006 after the introduction of the ban.[35][36] The same is true for Ireland[37] and Scotland[38]. In Ireland support for total bans among Irish smokers increased in all venues from 2003 to 2005, including workplaces (43% to 67%), restaurants (45% to 77%), and bars/pubs (13% to 46%). Overall, 83% of Irish smokers reported that the smoke-free law was a "good" or "very good" thing. In Scotland 69% of pub goers supported the legislation, up from 56% in May 2005. A study looking at public support in France, the Netherlands and Germany[39] found that comprehensive smoke-free policies attracted more support than partial policies. The study concludes that smoke-free policies seem to have the potential to receive more support once the policy is in place. Public approval of a smoke-free hospitality industry continues to grow in Germany. According to a recent

---

[32] Semple S, van Tongeren M, Galea KS, MacCalman L, Gee I, Parry O, Naji A, Ayres JG. UK Smoke-Free Legislation: Changes in $PM_{2.5}$ Concentrations in Bars in Scotland, England, and Wales. Ann Occup Hyg 2010; 54(3):272-80
McCaffrey M, Goodman PG, Clancy L. Particulate pollution levels in Dublin pubs pre and post the introduction of the workplace smokingban. Dublin: Scientific symposium "The Health Impacts of Smoke-free Workplaces in Ireland", March 2005

[33] Pacheco SA, Aguiar F, Ruivo P, Proença MC, Sekera M, Penque D, Simões T. Occupational Exposure to Environmental Tobacco Smoke: A Study in Lisbon Restaurants. J Toxicol Environ Health A. 2012; 75:857-66; Opperhuizen A, Sleijffers A, Cremers H, Jacobs P, Knoll B, Borsboom W. Zwerfrook en alternatieven voor rookruimten, http://www.rivm.nl/bibliotheek/rapporten/340004001.html

[34] Flash Eurobarometer 253: Survey on Tobacco – Analytical support, 2009. http://ec.europa.eu/health/ph_determinants/life_style/Tobacco/Documents/eb_253_en.pdf

[35] Gallus S, Zuccaro P, Colombo P et al. Smoking in Italy 2005–2006: Effects of a comprehensive national tobacco regulation. Prev Med 2007;45: 198–201.

[36] http://www.epicentro.iss.it/passi/pdf2012/Scheda%20F_R%20Nazionale%20fumo_2011.pdf

[37] Fong GT, Hyland A, Borland R et al. Reductions in tobacco smoke pollution and increases in support for smoke-free public places following the implementation of comprehensive smoke-free workplace legislation in the Republic of Ireland: findings from the ITC Ireland/UK Survey. Tobacco Control 2006 Suppl 3:iii51-8.

[38] Office of Tobacco Control. Press release. Ireland: OTC; 2005. http://www.otc.ie/article.asp?article=267 (accessed 6 Dec 2012); NHS. Smokefree England factsheet – Smokefree is wanted. Sevenoaks: District Council; 2006. http://www.sevenoaks.gov.uk/documents/smokefree_is_wanted_factsheet_final_30.11.pdf (accessed 17 Sept 2012); Hilton S, Semple S, Miller BG, MacCalman L, Petticrew M, Dempsey S, et al. Expectations and changing attitudes of bar workers before and after the implementation of smoke-free legislation in Scotland. BMC Public Health 2007; 7:206; ASH Scotland. Smoke-free success. ASH Scotland presents the Scottish experience. Edinburgh: ASH Scotland; 2007 http://www.ashscotland.org.uk/media/2825/Smokefreesuccess07.pdf (accessed 17 Sept 2012); Norwegian Directorate of Health. National representative opinion polls in the period 2004 -2011: http://www.helsedirektoratet.no/folkehelse/tobakk/tall-og-undersokelser/holdninger/Sider/default.aspx (accessed 06 Dec 2012);

[39] Mons U, Nagelhout GE, Guignard R et al. Comprehensive smoke-free policies attract more support from smokers in Europe than partial policies. Eur J Public Health 2012;22 Suppl 1:10-6

survey[40], more than three quarters of Germans (77.5 percent) are in favour of a smoking ban in restaurants and bars. In Portugal public support is very high at 96.3% of the population and has increased for pubs, bars, discos commercial centres and malls, schools, public transport and airports. In the Czech Republic support for the smoking ban in restaurants increased from 65.4% in 2010 to 68.4% in 2011. In Finland,[41] support for smoke-free restaurants rose from 34% in 2004 to 61% in 2005. Surveys from Slovenia show that support for smoke-free legislation increased from 73% in 2007 to 84% in 2011. Research from Norway[42] also shows that public support for smoke-free legislation has increased significantly after the introduction of smoke-free legislation in bars and restaurants; from 54% in 2004 to 90% in 2011.

3.3. Economic impact

Several studies from the EU indicate that the **economic impact of smoking bans** on the restaurant/hospitality sector is limited (neutral or even positive). This is also confirmed by international studies covering also countries outside the EU**.** Two recent systematic reviews show that smoke-free laws do impact businesses in the hospitality industry in a number of ways, many of them positive, e.g. improved health of employees.[43] As outlined in the International Agency for Research on Cancer (IARC) Handbook concerning the evaluation of smoke free policies, insurance, cleaning, maintenance and potential litigation costs can all be reduced when smoke-free workplaces are introduced. While some studies indicate that there are short-term costs associated with the legislation for all businesses (e.g. new signage and training for employees), evidence from developed countries suggests that smoke-free laws have a net positive effect on businesses.

Studies using a high quality methodology consistently find that smoke-free policies have no negative economic impact on restaurants, bars, and other segments of the hospitality sector, with the possible exception of gaming establishments. Indeed, many studies provide evidence of a small positive effect of smoke-free policies on business activity. The Cochrane review identified three studies that examined the economic impact of smoke-free legislation on the hospitality industry in the US, Italy and New Zealand. All three found no significant decrease in bar patronage pre and post-legislation, and two of these reported no significant decrease in restaurant attendance, with one study finding a significant increase in the number of non-smokers who attended restaurants.[44]

Another review analysed a significant number of studies on the economic effects of smoke-free policies on the hospitality industry.[45] It was established that 47 of the 49 studies that are best designed, report no negative economic impact on measures such as taxable sales. According to a WHO Report, smokefree environments result in either a neutral or positive impact on businesses,

---

[40] http://www.dkfz.de/en/presse/pressemitteilungen/2012/dkfz-pm-12-36-Smoke-free-restaurants-and-bars-in-Germany-2012.php (accessed 6 Dec 2012)

[41] Health Behaviour and Health among the Finnish Adult Population – Survey http://www.julkari.fi/bitstream/handle/10024/90868/URN_ISBN_978-952-245-640-3.pdf?sequence=1

[42] Norwegian Directorate of Health. National representative opinion polls in the period 2004 -2011: http://www.helsedirektoratet.no/folkehelse/tobakk/tall-og-undersokelser/holdninger/Sider/default.aspx (accessed 06 Dec 2012);

[43] As quoted in Bauld L. Impact of smokefree legislation: evidence review. Report for UK Department of Health.Bath: University of Bath; 2011: IARC (International Agency for Research on Cancer). *IARC Handbook of Cancer Prevention Vol. 13: Evaluating the effectiveness of smokefree policies*. Lyon: IARC; 2009; Callinan JE, Clarke A, Doherty K and Kelleher C. Legislative smoking bans for reducing secondhand smoke exposure, smoking prevalence and tobacco consumption. Cochrane Db Syst Rev 2010; 4. Art. No. CD005992.

[44] Biener L, Garrett CA, Skeer M, Siegel M and Connolly G. The effects on smokers of Boston's smoke-free bar ordinance: a longitudinal analysis of changes in compliance, patronage, policy support, and smoking at home. J Publ Health Manag Pract 2007; 13:630–6; Gallus S, Zuccaro P, Colombo P et al. Smoking in Italy 2005–2006: Effects of a comprehensive national tobacco regulation. Prev Med 2007;45: 198–201; Waa A, McGough S. Reducing exposure to second hand smoke: changes associated with the implementation of the amended New Zealand Smoke-free Environments Act 1990: 2003–2006,Wellington: HSC Research and Evaluation Unit; 2006. http://archive.hsc.org.nz/sites/default/files/publications/SFEWorkplace_Final.pdf (accessed 17 Dec 2012)

[45] Scollo M and Lal A. Summary of Studies Assessing the Economic Impact of Smoke-Free Policies in the Hospitality Industry. Melbourne: VicHealth Centre for Tobacco Control; 2008. http://www.vctc.org.au/tc-res/Hospitalitysummary.pdf (accessed 17 Sept 2012).

including the hospitality sector.[46] These findings were similar in all places studied, including in Australia, Canada, the United Kingdom and the United States, Norway and New Zealand. This finding is also confirmed in a recent US Centre for Disease Control factsheet.[47] Moreover, the US Surgeon General's report[48] concluded that "evidence from peer-reviewed studies shows that smoke-free policies and regulations do not have an adverse economic impact on the hospitality industry". These findings are supported by more recent studies in different countries (e.g. Norway, Mexico, Italy).[49]

Very few Member States reported data on the economic impact of smoke-free legislation on hospitality revenues. In Spain and Finland studies are underway. Some of the reported studies show a decline in revenues in the short term, whereas others show there is no significant long – term effect. Ireland reported a study showing a decline in bars sales of 4.6% following the ban.[50] Data from Norway[51] indicate that revenues in restaurants and pubs show that the law did not have a statistically significant long-term effect on revenue in restaurants. Similar analysis for pubs in Norway shows that there was no significant long-term effect on pub revenues.

The introduction of smoke-free policies can also have other economic effects such as private and governmental costs, changes in tax revenue and revenue in the tobacco industry. Comprehensive smoke-free legislation incurs less private costs than partial legislation as shown by a study from Scotland[52] that describes that building designated smoking areas incurs extra costs for employers. The study from Scotland[53] also shows that smoke-free workplace arrangements without designated smoking areas reduce employer costs and increase productivity. Another study[54] found that exposure to second hand smoke caused additional absenteeism among non-smokers.

Governments also incur costs in enforcing smoke-free legislation. The Netherlands reported an estimated cost for this to be around 4-5 mEUR annually.

Seven countries reported on results of revenues from tobacco taxes after the introduction of smoke-free legislation. In Finland, revenues are not reduced, even though prevalence has declined. In Italy revenues from tobacco taxes increased by 25% in the period 2004–2011 even though sales decreased. France has also had increased revenues over the last few years. In Latvia the revenues from tobacco taxes were reduced by 8% from 2009 to 2011 and in Spain by 2% from 2010 to 2011.

Finland is preparing new studies concerning annual lost revenues in the tobacco industry and working productivity related to smoking breaks.

---

[46] WHO. WHO Report on the Global Tobacco Epidemic, 2009 - Implementing smoke-free environments. Geneva: WHO; 2009. http://whqlibdoc.who.int/publications/2009/9789241563918_eng_full.pdf (accessed 17 Dec 2012).

[47] CDC. Smoke-Free Policies Do Not Hurt the Hospitality Industry. Atlanta, GA: CDC; 2012. http://www.cdc.gov/tobacco/data_statistics/fact_sheets/secondhand_smoke/protection/hospitality/index.htm (accessed 17 Dec 2012)

[48] U.S. Department of Health and Human Services (HHS). The Health Consequences of Involuntary Exposure to Tobacco Smoke: A Report of the Surgeon General. Atlanta, GA: HHS, Centers for Disease Control and Prevention, Coordinating Center for Health Promotion, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health; 2006.

[49] Melberg HO, Lund KE. Do smoke-free laws affect revenues in pubs and restaurants? Eur J Health Econ 2012; 13(1): 93–9. Guerrero López CM, Jiménez Ruiz JA, Reynales Shigematsu LM, Waters HR. The economic impact of Mexico City's smoke-free law. Tob Control 2011; 20(4):273-8; Gallus S, Zuccaro P, Colombo P et al. Smoking in Italy 2005–2006: Effects of a comprehensive national tobacco regulation. Prev Med 2007;45: 198–201.

[50] This followed a similar decline of 4.2% in bar sales in 2003. However, in 2005, sales increased by 0.1%. Employment in the hospitality sector as a whole and in bars specifically increased during 2005. Visitor numbers to Ireland increased by 5.0% in 2003, 3.2% in 2004 and 6.1% in 2005. Ireland Central Statistics Office.

[51] Melberg HO, Lund KE. Do smoke-free laws affect revenues in pubs and restaurants? Eur J Health Econ 2012; 13(1): 93–9.

[52] As quoted in : Heloma A, Helakorpi S, Honkonen J, Danielsson P, Uutela A. Exposure to secondhand smoke in Finnish workplaces and compliance with national smoke-free workplace legislation. Scandinavian Journal of Public Health 2011; 39:723-9. (Parrot S. Costs of employee smoking in the workplace in Scotland. Tob Control 2009;9)

[53] As quoted in: Heloma A, Helakorpi S, Honkonen J, Danielsson P, Uutela A. Exposure to secondhand smoke in Finnish workplaces and compliance with national smoke-free workplace legislation. Scandinavian Journal of Public Health 2011; 39:723-9.

[54] Heloma A, Helakorpi S, Honkonen J, Danielsson P, Uutela A. Exposure to secondhand smoke in Finnish workplaces and compliance with national smoke-free workplace legislation. Scandinavian Journal of Public Health 2011; 39:723-9. (Tsai SP et al. Workplace smoking related absenteeism and productivity costs in Taiwan. Tob Control 2005;14

4. CONCLUSIONS

Overall, there has been good progress in transposing the Recommendation on smoke-free environments into national law. All Member States report that they have adopted measures to protect citizens from exposure to tobacco smoke, partially even before the Recommendation. However national measures differ considerably in extent and scope, which may reflect diverging national circumstances (e.g. climate in winter), national preferences or different levels of ambition.

The most comprehensive measures typically relate to educational establishments, health care facilities and public transport. Exemptions are more common in the hospitality sector. A number of Member States have also reported about enforcement problems, caused in particular by a lack of resources. The complexity of legislation was also mentioned as an important reason why enforcement might be challenging.

The progress to protect citizens against second hand smoke in public places is reflected in EU citizens' actual exposure rates, which dropped from 2009 to 2012. There are however very significant differences in citizens' overall exposure to second hand smoke between Member States, ranging from 3% in Sweden to 71% in Greece. The examples of Belgium, Spain and Poland show that the adoption of comprehensive legislation can lead to very significant drops in exposure rates within a short period of time.

A limited number of Member States are in the process of taking action against smoking in private places. Cyprus is the only Member State at this stage which has prohibited smoking in cars in the presence of children under 16. In Ireland, which was the first Member State to introduce a comprehensive ban on smoking in public places, the Ministry of Health has proposed similar legislation.

Reports from Member States confirm that citizens' support for the legislation often increases after the introduction of the smoke-free policies. Overall the support is very high for such policies.

Studies on the health effects of smoke-free legislation indicate that positive impacts appear very quickly after starting to implement smoke free legislation. They include reduction in the incidence of heart attacks in the general population and improvements in respiratory health. The economic impact of smoking bans on the restaurant/hospitality sector is limited (neutral or even positive). Positive impacts include the improved health of employees for example in terms of improved respiratory health.

Monitoring and evaluation is on-going in many Member States. Regular exchange of information between Member States and the Commission is therefore considered useful and continued monitoring and efforts are needed.

Endnotes referring to figure 1

[i] Federal legislation allows smoking in bars and restaurants smaller than 50 m^2.In venues larger than 50 m^2 enclosed smoking rooms are allowed. In enclosed public places and other workplaces enclosed smoking rooms are allowed. Smoking is also allowed if smokers have their own offices and there is no contact with clients. Regional authorities can adopt stricter legislation.

[ii] General ban with an exemption for clearly designated, enclosed smoking rooms with appropriate ventilation. In the hospitality sector all service is forbidden in smoking rooms.

[iii] Comprehensive ban with a limited exemption for designated, ventilated smoking rooms in airports and minors are not allowed to enter.

[iv] In restaurants, bars and enclosed public places, smoking is only allowed in open outdoor places. In other workplaces enclosed smoking rooms are allowed.

[v] The operator may allow smoking, or provide structurally separated areas for smokers and non-smokers and there must be sufficient ventilation. In other workplaces there is an obligation for the employee not to smoke where non-smokers can be exposed.

[vi] Smoking is allowed in bars smaller than 40 m^2. In enclosed public places, restaurants and other workplaces smoking is allowed in enclosed smoking rooms.

[vii] Smoking allowed in smoking rooms or smoking areas in workplaces and enclosed public places, whereas smoking is only allowed in enclosed smoking rooms in the bars and restaurants.

[viii] In the hospitality sector smoking is allowed in enclosed, ventilated smoking rooms where no food or drink can be served or consumed. In other workplaces smoking is allowed in enclosed, ventilated smoking rooms.

[ix] In the hospitality sector smoking is allowed in enclosed, ventilated smoking rooms where no food or drink can be served. In other workplaces smoking is allowed in enclosed, ventilated smoking rooms.

[x] Smoke-free legislation is regulated at regional level. In most states in Germany, separate, enclosed smoking rooms are allowed, and smaller establishments that do not serve food are exempted from the smoking ban altogether. Total smoking bans for the hospitality sector are in place in Saarland, Bavaria and North Rhine-Westphalia.

[xi] Comprehensive smoking bans in workplaces and enclosed public places, and smaller venues in the hospitality sector. However, smoking is allowed in entertainment centres larger than 300 m^2 with live music and casinos.

[xii] Comprehensive ban, the only exemptions are cigar rooms in hotels, prisons, police detention cells, psychiatric institutions and certain types of workplaces with increased risk of fire and/or explosion. In these workplaces smoking rooms are allowed under certain conditions.

[xiii] Comprehensive ban, smoking is only allowed in dwellings, prisons, hotel bedrooms, nursing homes, hospice settings and psychiatric hospitals

[xiv] In the hospitality sector smoking is allowed in enclosed, ventilated smoking rooms which cover less than half of the serving area. In other workplaces smoking is allowed in enclosed, ventilated smoking rooms.

[xv] Total smoking ban in the hospitality sector and in enclosed public places with few exceptions for casinos and gambling halls where it is allowed to smoke in premises seperated for smoking or premises specially designated for smoking. In other workplaces smoking allowed in enclosed smoking rooms. Smoking is allowed in long distance trains and at international airports in specially designated areas.

[xvi] Total smoking ban in enclosed public places and the hospitality sector. In other workplaces smoking allowed in enclosed, ventilated smoking rooms.

[xvii] There is a smoking ban in brassiere's during dining hours (12.00-14.00 and 19.00-21.00). Smoking is allowed in enclosed smoking rooms in restaurants and tea rooms, and other workplaces .Total ban in enclosed public places.

[xviii] Comprehensive ban, smoking only allowed in hotel bedrooms

[xix] Smoking is allowed in bars that are smaller than 70 m^2 and that have no serving staff. In enclosed public places, restaurants and other workplaces smoking is allowed in enclosed smoking rooms.

[xx] Total ban in enclosed public places. Enclosed, ventilated smoking rooms allowed in the hospitality sector and other workplaces. Smoking is banned public transport; special isolated rooms for smoking are allowed only in airports and in waiting halls in bus/train stations

[xxi] Smoking allowed in enclosed smoking rooms in hospitality venues smaller than 100 m^2. In venues larger than 100 m^2, owners may designate up to 30% of the total area as a smoking area, or 40% if it is an enclosed smoking room, as long as the area does not include areas destined exclusively for workers, or where workers have to be permanently. In enclosed public places and other workplaces smoking rooms or smoking areas are allowed.

[xxii] In restaurant and bar venues smaller than 100 m^2, smoking may be allowed. In larger hospitality venues, other workplaces and enclosed public places enclosed, ventilated smoking rooms are allowed.

[xxiii] Smoking is allowed in enclosed smoking rooms in restaurants, whereas in bars the owners can decide whether to allow smoking or not, given that food is not served on the premises. In other workplaces smoking is banned where non-smokers work. In enclosed public places there is a total ban.

[xxiv] In the hospitality sector smoking is allowed in enclosed, ventilated smoking rooms where no food or drink can be consumed. In other workplaces smoking is allowed in enclosed, ventilated smoking rooms.

[xxv] There are no exemptions to the ban on smoking in the workplace as such, but private smoking clubs established under certain, strict conditions are allowed. Minors are not allowed in the private smoking clubs

[xxvi] In the hospitality sector smoking is allowed in enclosed, ventilated smoking rooms where no food or drink can be consumed. In other workplaces smoking is allowed in enclosed, ventilated smoking rooms.

[xxvii] Comprehensive ban, smoking is only allowed in designated hotel rooms, care home and hospice rooms and prison cells, as well as offshore installations, research and testing facilities, in specialist tobacconists and on stage if needed for artistic integrity

[xxviii] Comprehensive ban, smoking only allowed in hotel bedrooms and prisons

[xxix] Total smoking ban in the hospitality sector. In other workplaces and enclosed public places, smoking is allowed in enclosed smoking rooms.

[xxx] Smoking is banned completely in workplaces and enclosed public places. However smoking is permitted in 50% of bars and restaurants smaller than 80 m^2. Larger businesses can allow smoking and non-smoking areas, provided they have ventilation.