COMMISSION OF THE EUROPEAN COMMUNITIES

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Accompanying document to the proposal for a Council Recommendation on smoke-free environments

SUMMARY OF THE IMPACT ASSESSMENT

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1. INTRODUCTION

In its Environment and Health Action Plan (2004-2010), the Commission committed itself to improving indoor air quality, in particular by encouraging the restriction of smoking in all workplaces. The consultation launched by the Commission's Green Paper "Towards a Europe free from tobacco smoke: policy options at EU level" revealed significant support for comprehensive smoke-free policies and for further EU action to promote smoke-free environments. The Community strategy on health and safety at work (2007-2012) proposed greater efforts to improve health and safety protection for workers. At international level, the WHO Framework Convention on Tobacco Control (FCTC) commits its Parties to tackle exposure to tobacco smoke in indoor workplaces and public places.

2. CONTEXT AND PROBLEM DEFINITION

2.1. Context

2.1.1. Health burden of ETS exposure

Exposure to environmental tobacco smoke (ETS) – also referred to as second-hand smoke or passive smoke – is a source of widespread mortality, morbidity and disability in the EU. ETS is linked to lung cancer, coronary heart disease, stroke, asthma and chronic obstructive pulmonary disease in adults. It is also harmful to children, causing sudden infant death syndrome, acute respiratory infections, middle ear disease and more severe asthma.

According to earlier estimates, 7 300 adults, including 2 800 non-smokers, died as a result of ETS exposure at their workplace in the EU-25 in 2002. The deaths of a further 72 000 people, including 16 400 non-smokers, were linked to ETS exposure at home.[1] This Impact Assessment estimates the total number of deaths attributable to passive smoking in offices and bars/restaurants at 6 000 in the EU-27 in 2008, which includes 2 500 non-smoking staff. The exposure among non-staff members such as the customers of bars and restaurants could be expected to account for a substantial additional health burden.

[1] The Smoke Free Partnership (2006). Lifting the smokescreen: 10 reasons for a smoke-free Europe Brussels, Belgium, European Respiratory Society: 146.

Estimated EU-wide mortality due to ETS exposure among smoking and non-smoking staff in 2008

	Non-smokers			Smokers			Smokers and Non-Smokers
	Offices	**Bars and restaurants**	**Total**	**Offices**	**Bars and restaurants**	**Total**	**Total**
Lung cancer	387	156	542	600	161	761	**1303**
Stroke	378	160	538	601	197	798	**1336**
Heart disease	384	138	522	612	159	771	**1293**
Chronic lower respiratory disease	565	332	897	881	296	1,176	**2073**
Total	**1,714**	**786**	**2,500**	**2,694**	**813**	**3,507**	**6,007**

Comparison with fatalities from other health hazards - both specific to the workplace and occurring in the general population - shows the significant health burden of ETS exposure.

2.1.2. Economic burden of ETS exposure

Exposure to ETS poses a significant financial burden. The macroeconomic cost of workplace exposure to ETS across the EU-27 has been estimated at 2.46 billion euro per year. This consists of over 1.3 billion euro constituting medical expenditure on tobacco-related diseases (including €560 million accounted for by non-smoking staff) and over 1.1 billion euro constituting non-medical costs linked to productivity losses (including €480 million accounted for by non-smoking staff). The microeconomic burden of ETS exposure includes lower workers' productivity, fire damage caused by smoking materials as well as additional cleaning and redecoration costs related to smoking.

2.2. Problem definition

2.2.1. Incomplete compliance with international obligations resulting from FCTC

The WHO Framework Convention on Tobacco Control (FCTC) – ratified by the Community and 26 Member States – creates a legal obligation for its Parties to protect people from second-hand smoke in all indoor workplaces, public transport and indoor public places. The second Conference of the Parties to the Convention in July 2007 adopted guidelines setting a "gold standard" that every Party should aim to achieve.

However, as things stand, only slightly over a third of Member States have adopted policies to comply with their FCTC commitment. A number of countries have encountered serious difficulties in introducing and/or enforcing comprehensive smoke-free laws. Bars and restaurants have proved to be a particularly difficult area of regulation. At the moment, it seems unlikely that all Member States will be able to meet their FCTC obligation unless there is a political stimulus and a monitoring mechanism at EU level.

So far, only partial action to promote smoke-free environments has been taken by the Community. This issue has been addressed in non-binding resolutions and recommendations, but they do not provide detailed guidance on how to achieve fully smoke-free environments. In addition, a number of occupational health and safety directives address the issue, in some cases indirectly only while in others the level of protection is not comprehensive.

2.2.2. High and uneven ETS prevalence across the EU-27

In countries with no comprehensive smoke-free regulations, tobacco is present in the majority of public places, most of which are also somebody's workplace. Based on the Eurobarometer data from the end of 2006, it is estimated that 28% of EU employees are exposed to ETS on a daily basis in indoor workplaces and offices, and the corresponding figure for bars and restaurants is 39% as of end-2008. In addition, the customers of drinking and eating venues are at risk of particularly high levels of exposure to ETS and the related health hazards.

There are huge differences in the prevalence of ETS exposure between Member States, ranging from 3% in Ireland to 85% in Greece. The scope and strength of national smoke-free legislation is a crucial factor responsible for the differences in ETS exposure across the EU.

In addition, the risk of being exposed to ETS is significantly higher for the lower socio-economic groups, exacerbating the existing inequalities in health.

2.2.3. Inadequate protection of children and young people from tobacco smoke

Children's and adolescents' exposure to tobacco smoke is a particular health concern. Children have little or no control over their exposure to ETS from adult smokers. Children are also particularly vulnerable to the health effects of ETS. In addition to the health risks of ETS, exposure to tobacco smoke makes children more likely to perceive smoking as common adult behaviour and thus to take up smoking themselves in adolescence.

Most of children’s exposure to ETS comes from parents, and occurs in the home. In the last Eurobarometer, over a third of smokers said that they smoke inside their home in the company of children. The WHO Global Youth Tobacco Study found that 40-90% of teenagers were exposed to ETS in their homes across twelve EU Member States. In addition to homes, parental smoking in cars is a source of exposure to particularly high levels of ETS.

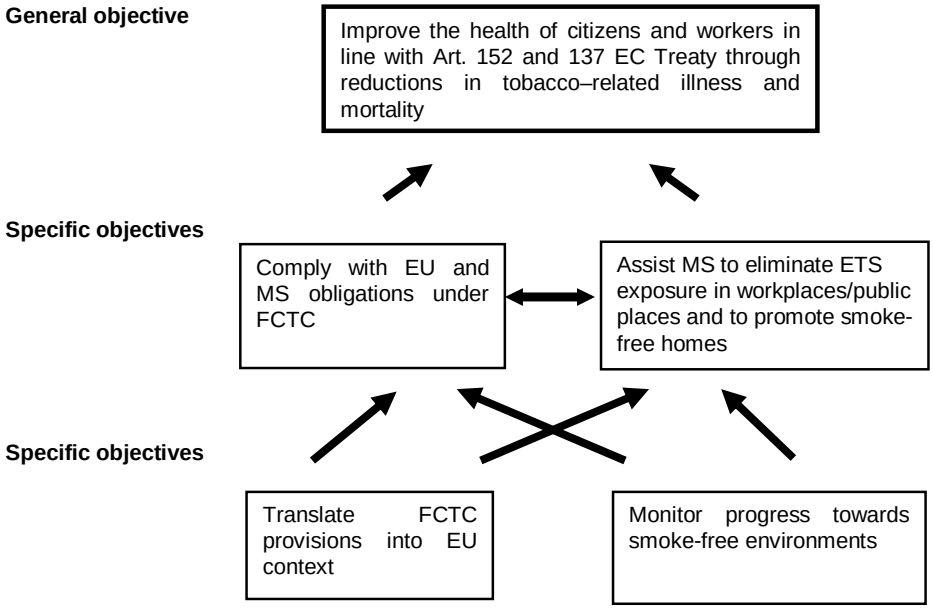
Children are also routinely exposed to adult role models smoking in outdoor places such as public playgrounds, outdoor areas of schools, hospitals and other institutions providing services to children as well as during outdoor sports or cultural events.

3. RATIONALE FOR EU ACTION

Articles 137 and 152 of the EC Treaty provide a clear legal basis for an EU measure in the area of protection from tobacco smoke. Such support at EU level would help the timely and coherent implementation of the FCTC provisions in line with the Member States' and the EU's international commitments. It would also contribute to reducing the differences in protection from ETS exposure both between and within Member States and the resulting health inequities and negative cross-border implications. Community action would bring clear added value to national efforts by setting out the evidence base, facilitating the exchange of experience and best practice among Member States, providing Member States that have not yet implemented comprehensive smoke-free legislation with guidance for doing so (possibly accompanied by minimum EU standards for worker protection), and monitoring progress throughout the EU.

4.

OBJECTIVES



5. POLICY OPTIONS

1) No change from status quo

This option would mean no new activity on the part of the EU, while continuing the current work on ETS under the different Community programmes, information and education campaigns and networking initiatives.

2) Open method of coordination (OMC)

Under this option Member States would be encouraged to cooperate on smoke-free environments with a view to exchanging information, agreeing common targets and indicators and periodic review. A coordinating body bringing together Member States and the European Commission would need to be set up. The content of this option would depend on agreements between Member States but theoretically could be comprehensive in scope and could go beyond the FCTC guidelines (focused on protection from ETS in indoor public places and workplaces).

3) / 4) Commission or Council Recommendation

A Recommendation from the Commission or the Council based on Art. 152would encourage and assist Member States in introducing comprehensive smoke-free policies in line with their FCTC requirement by introducing a uniform EU deadline for implementation and a clear reporting and monitoring mechanism. On top of the provisions of the FCTC guidelines, such Recommendation should include measures to tackle ETS exposure among children and adolescents as well as flanking measures such as awareness raising and smoking cessation support.

3+ / 4+ Combination of Commission or Council Recommendation and Open Method of Coordination

A Commission or Council Recommendation could be an incentive for strengthened cooperation between Member States. In this scenario, the text of the Recommendation would serve as a basis and point of reference while Member States would exchange information and best practice on its implementation, adopt common targets and benchmarks for reaching and possibly going beyond its requirements, and develop common indicators to monitor progress.

5) Binding legislation

The adoption of binding legislative measures could consist in revision of the existing health and safety directives (in particular Directive 89/654/EEC on minimum health and safety requirements for workplaces and/or the Carcinogens and Mutagens Directive 2004/37) or enactment of a separate directive on workplace smoking based on Art. 137. This option would be restricted in scope to the workplace environment and would not cover either public places that are not workplaces or self-employed workers.

6. ASSESSING THE OPTIONS

The identified policy options have been analysed across five main parameters: the added value of EU involvement, the expected speediness of adoption of the given policy instrument, the likely content of the policy option, the level of political or legal obligation to comply on the part of the Member States and possible unintended consequences. Based on this qualitative analysis and the forecasted developments in the Member States, the following assumptions have been made about the relative effectiveness of each of the policy options in reducing ETS prevalence by 2013 (i.e. the last year of the current Health Strategy):

Policy 1 (status quo) would bring the least reduction in ETS prevalence ratios that would be largely consistent with a situation in which countries with advanced or fairly advanced smoke-free legislation proposals have implemented their proposed policies by 2013. The existing trend towards smoke-free could be expected to continue, but at a slower pace.

The effects of the five non-regulatory options are likely to be somehow similar in the sense that they would offer support for policy development but could not oblige Member States to adopt and enforce smoke-free laws. They are expected to have the potential to bring about a two- to fourfold reduction in ETS prevalence ratios as compared to the status quo. Policy 2 (OMC) and Policy 3 (Commission Recommendation) are likely to be the least effective out of the non-regulatory options. The implementation of OMC would be relatively lengthy and it does not seem well suited to tackling a "mature" problem like ETS. The impact of a Commission Recommendation, on the other hand, would be limited by the fact that it would not create a sense of commitment among Member States. Policy 4 (Council Recommendation) is potentially more effective, primarily due to the ownership effect. Similar effects could be assumed for Policy 3+ (Commission Recommendation with OMC). Policy 4+ (Council Recommendation with OMC) is expected to be most effective out of the non-regulatory options. It would give the strongest sense of ownership to Member States, who would be involved both in adopting the text of the Recommendation and in developing benchmarks and indicators for its implementation.

Policy 5 (binding legislation) is likely to bring the greatest reductions in ETS prevalence. In the best-case scenario, it could be expected to virtually eliminate ETS exposure in workplaces throughout the EU. However, it would be narrower in scope than the non-regulatory options since self-employed workers as well as flanking measures would not be covered by the legislation. In addition, the time frame for realising the benefits stemming from a new legal instrument is likely to be relatively lengthy.

6.1. Comparing the options

The expected social, economic and environmental impacts under each of the policy options are based on the assumptions about their potential to reduce the prevalence of ETS exposure. Policy option 5 (binding legislation) is therefore expected to have the strongest effect, followed by option 4+ (Council Recommendation + OMC), 4/3+ (Council Recommendation / Commission Recommendation + OMC) + and 2/3 (OMC / Commission Recommendation), while the status quo would bring the least change.

6.1.1. Social impacts

By reducing the prevalence of ETS exposure, an EU initiative is expected to reduce illness and mortality from major ETS-associated diseases (lung cancer, stroke, heart disease and chronic lower respiratory diseases). It is also expected to have an indirect effect on morbidity and mortality associated with active smoking by reducing tobacco consumption and encouraging quit attempts among smokers. An EU initiative would likely bring particular benefits to the most deprived groups in society. It could also help increase support for smoke-free policies, including at home. A possible unintended consequence for smokers could be a sense of stigma and alienation.

	Baseline	**Policy 1**	**Policy 2/ Policy 3**	**Policy 3+ /Policy 4**	**Policy 4+**	**Policy 5**
Social impacts						
Reduction in annual mortality due to ETS exposure among staff	6,007	-386	-774	-774 to -1,550	-1,550	-4,884
Reduction in morbidity due to ETS exposure		+	++	+++	++++	+++++
Reduction in mortality from reduced active smoking		+	++	+++	++++	+++++
Reduction in morbidity from reduced active smoking		+	++	+++	++++	+++++
Reduction of ETS at home		+	++	++	++	+++
Reduction in socio-economic inequalities		+	++	++	++	++++
Increased support for smoke-free policies		+	++	++	++	++++

6.1.2. Economic impacts

At macro-level, the health improvement resulting from an EU initiative is expected to substantially reduce medical and non-medical costs connected with major ETS-associated diseases. The anticipated reduction in the levels of active smoking is unlikely to have a significant impact on the Member States' revenues from tobacco taxation. The economic impacts at the micro-level include reduced cleaning, maintenance and redecorating costs and reduced costs related to fire damage.

The main sectors concerned are the hospitality and the tobacco industries. Based on the evidence reported in the literature, the impact on employment and revenue in the hospitality sector could range from reductions to increases. Overall, no major economic impact is expected. There may be a loss of profit to the tobacco industry and, consequently, reductions in tobacco-related employment.

	Baseline	**Policy 1**	**Policy 2/ Policy 3**	**Policy 3+ /Policy 4**	**Policy 4+**	**Policy 5**

Economic impacts						
Reduction in annual medical costs due to reduced ETS exposure among staff	€1336 mn	-€ 85 mn	-€172 mn	-€172 mn to -€344 mn	-€344 mn	-€1073 mn
Reduction in annual non-medical costs due to reduced ETS exposure among staff	€1124 mn	-73 mn	-144 mn	-144 mn to -290 mn	-290 mn	-893 mn
Reduced revenues from tobacco taxes		-	--	---	----	-----
Workers' productivity related to smoking breaks		+/-	++/--	+++/---	++++/----	++++/-----
Reduced costs of fires, cleaning and redecoration		+	++	+++	++++	+++++ €965 mn
Annual change in revenues in hospitality sector	€114 bn	+/-	++/--	+++/---	++++/----	+++++/------ -€11bn to +€10 bn
Change in employment in hospitality sector	6,887,912	+/-	++/--	+++/---	++++/----	+++++/------ -265,000 to +271,000
Annual lost revenues in tobacco industry	€67 bn	-	--	---	----	----- -€3.3 bn
Lost jobs in tobacco industry	53,521	-	--	---	----	----- -2,609
Implementation and enforcement costs		-	--- --	--- --	---	---

6.1.3. Environmental impacts

The main environmental impact would be a significant improvement in indoor air quality. The potential negative impacts include an increase in the use of patio heaters and increased litter from cigarette butts in the streets. However, these impacts are likely to be relatively small.

	Baseline	**Policy 1**	**Policy 2/ Policy 3**	**Policy 3+ /Policy 4**	**Policy 4+**	**Policy 5**
Environmental impacts						
Reduction in indoor air pollution		+	++	++	+++	++++
Increased street litter and use of air heaters		-	-	-	--	---

6.2. The preferred option

While binding legislation would bring the biggest reductions in ETS prevalence and the related health and economic benefits, its implementation would take longer and the scope would be narrower than would be the case with a Recommendation. A Council Recommendation with elements of OMC has been identified as the preferred option in the short term because it appears to be the fastest and most comprehensive means of helping Member States to implement strict smoke-free laws in line with their FCTC commitment while providing a proportionate approach to the problem.

7. MONITORING AND EVALUATION

The indicators used to monitor the effects of the chosen policy option need to include the prevalence and quality of national policies, exposure to tobacco smoke in different settings, tobacco use, knowledge and attitudes related to tobacco (smoke) as well as the incidence of and mortality from tobacco-related diseases. It is envisaged to evaluate the overall impact of the initiative in a Communication on tobacco control strategy, planned for 2010 or 2011.