



## **European Heart Network's response to the European Commission's Green Paper on "*Towards a Europe free from tobacco smoke: policy options at EU level*" (COM(2007) 27 final)**

*May 2007*

### **Summary and Conclusions**

The European Heart Network (EHN) is a Brussels-based alliance of heart foundations and like-minded non-governmental organisations in 26 European countries.

EHN plays a leading role in the prevention and reduction of cardiovascular disease through advocacy, networking and education so that it is no longer a major cause of premature death and disability throughout Europe.

Every year over 1.9 million people die from cardiovascular diseases (CVD) in the European Union. Over 180 000 deaths from CVD are caused by smoking. Of the more than 79 000 deaths from secondhand smoke every year in the EU, almost 61 000 deaths are from coronary heart diseases and stroke.

EHN welcomes the Commission Green Paper as a timely addition to the EU and global debate on smokefree policies. We find the Green Paper a well-researched document based on strong scientific evidence which presents a range of policy options for smokefree policies.

EHN believes that the most desirable and appropriate policy option to promote smoke-free environments is:

- **introduction of comprehensive national legislation banning smoking in all public spaces and workplaces**

To help achieve this, EHN favours the following EU intervention:

- **adopt a Commission or Council Recommendation on smokefree public places and workplaces**

## Introduction

The European Heart Network (EHN) is a Brussels-based alliance of heart foundations and like-minded non-governmental organisations throughout Europe. EHN has member organisations in 26 European countries.

EHN plays a leading role in the prevention and reduction of cardiovascular disease through advocacy, networking and education so that it is no longer a major cause of premature death and disability throughout Europe.

Cardiovascular disease (CVD) - heart disease, stroke and other atherosclerotic vascular diseases - is the largest cause of death of men and women in the European Union (EU) and the second-heaviest disease burden expressed in DALYs (disability adjusted life years). Every year over 1.9 million people die from CVD in the EU(25). CVD causes nearly half of all deaths (42%) and 11 million DALYs are lost due to CVD every year. CVD has been estimated to cost the EU economies 169 billion euros every year. Of the total costs of CVD, just under €105 billion in 2003 are costs to the healthcare systems of the EU. Production losses due to mortality and morbidity associated with CVD cost the EU over €35 billion. Cost of informal care is another important non-healthcare cost. In 2003, the total cost of providing this care was over €29 billion.<sup>1</sup>

Tobacco use, a major modifiable risk factor involved in CVD, causes over 180 000 deaths from CVD every year. Based on a well-established epidemiological method, it has been estimated that 79 449 people die from secondhand smoke every year in the EU. Of these, almost 61 000 deaths are from coronary heart diseases and stroke.<sup>2</sup>

## Comments

EHN welcomes the Commission Green Paper as a timely addition to the EU and global debate on smokefree policies. We find the Green Paper a well-researched document based on strong scientific evidence.

The Green Paper presents five policy options available to achieve the smoke-free objectives for Europe:

1. No change from status quo
2. Voluntary measures
3. Open method of coordination
4. Commission or Council Recommendation
5. Binding legislation

In the Green Paper, the Commission calls on all the EU institutions, the Member States and all interested citizens to respond to the issues raised in the Green Paper and to respond specifically to four questions raised by the Commission.

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<sup>1</sup> European cardiovascular disease statistics 2005; European Heart Network and British Heart Foundation

<sup>2</sup> Lifting the Smoke Screen, 10 reasons for a smoke free Europe, 2006, available at [www.ehnheart.org](http://www.ehnheart.org)

EHN's response to the questions is given below.

- (1) Which of the two approaches suggested in Section IV would be more desirable in terms of its scope for smoke-free initiative: a total ban on smoking in all enclosed public spaces and workplaces or a ban with exemptions granted to selected categories of venues? Please indicate the reason(s) for your choice.**

EHN believes that a total ban on smoking in all enclosed public spaces and workplaces is the only approach that should be adopted.

The dangerous health effects of secondhand smoke have been documented in over 20 reports ranging from the International Agency for Research on Cancer (IARC) to the US Surgeon General. A cautious estimate is that exposure to secondhand smoke kills at least 79 000 people in the EU each year. This estimate includes deaths from coronary heart disease (CHD), stroke, lung cancer and chronic non-neoplastic respiratory disease. The estimate omits deaths in childhood caused by secondhand smoke, deaths in adults from other conditions known to be caused by active smoking and the significant, serious morbidity, both acute and chronic, caused by secondhand smoke. Therefore, the only legitimate response is a complete ban on smoking in all enclosed public places and workplaces.

Extending protection from secondhand smoke to citizens and workers in certain categories of venues but excluding them from such protection in other categories of venues cannot be justified. The drop in secondhand smoke exposure has been particularly spectacular in hospitality and leisure venues leading to a considerable reduction in the incidence of and mortality from heart attacks within months of policy implementation.<sup>3</sup>

Partial bans, particularly in the hospitality sector, do not work and lead to confusion and non-compliance. They are economically unfair because they lead to an uneven playing field created under the imposition of arbitrary limits. If given the choice, employers tend to choose the status quo and to continue to allow smoking. This has been the experience in all countries which have permitted the establishment of smoking zones in workplaces. For example, in the UK, the hospitality trade made an agreement with the Government in 2000 to increase smokefree provision and set a number of targets. However, the agreement failed to meet even its own minimal standards. Pubs and restaurants were encouraged to provide separate smoking and non-smoking areas and to put up signage indicating the nature of their smoking policy. Three years after the launch of the campaign, only 43% of licensed premises were compliant with these requirements while 47% of premises allowed smoking throughout and only a handful of pubs were totally smokefree.<sup>4</sup> In Spain, where bars and restaurant under 100 metres sq have the right to remain smoking or to become non-smoking, less than 10% of establishments elected to become non-smoking after the imposition of the Spanish smokefree law on 1 January 2006.<sup>5</sup>

Finally, comprehensive legislation has a significant potential to 'de-normalise' smoking in society creating environments that encourages smokers to give up smoking and discouraging young people from taking up smoking.

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<sup>3</sup> European Heart Journal, 2006 October; 27(20):2468-72

<sup>4</sup> Smoking policy research in pubs and bars. England and Wales. Curren Goodden Associates Ltd, May 2003.

<sup>5</sup> Press release from the Ministry of Health, Madrid 2 February 2006

**(2) Which of the policy options described in Section V would be the most desirable and appropriate for promoting smoke-free environments? What form of EU intervention do you consider necessary to achieve the smoke-free objectives?**

**1. *No change from status quo***

Given the risks to health from secondhand smoke, EHN considers that no change is not an option.

**2. *Voluntary measures***

Evidence shows that voluntary measures do not protect workers and members of the public from exposure to secondhand smoke.

As stated above, voluntary agreements in the UK resulted in little improvement in exposure levels. Also, when some bar and restaurant owners were given the opportunity to go smokefree or maintain smoking establishments in Spain, 90% chose to continue to expose their staff, customers and themselves to secondhand smoke. In Germany, the voluntary agreement between the hospitality associations (DEHOGA) and the Federal Ministry of Health to provide smokefree areas which came into effect on 1 March 2005 has failed. Only 10% of establishments comply with the full terms of the voluntary agreement in terms of offering smokefree areas with good signage to customers. The actual target was 60%. Over two thirds of hospitality outlets have no smoking restrictions at all. The remaining third offer minimal levels of protection to staff and customers. The failure of the voluntary agreement has led the German Drugs Commissioner to call for the agreement to be abandoned and binding legislation to be adopted.<sup>6</sup>

**3. *Open Method of Coordination***

Whilst EHN appreciates the benefits that the Open Method of Coordination may be capable of bringing to this issue, we remain convinced that a voluntary approach is unlikely to introduce completely smokefree enclosed public spaces and workplaces. EHN encourages Member States, which have already gone smokefree, to share their experiences with their colleagues still contemplating this step but do not believe that this in itself would be sufficient to protect Europe's citizens and workers against secondhand smoke.

**4. *Commission or Council Recommendation***

A Council Resolution on banning smoking in places open to the public was adopted in 1989.<sup>7</sup>

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<sup>6</sup> Press statement from Sabine Bätzing and the German Federal Health Ministry, 27 February 2007  
[http://www.bmg.bund.de/cln\\_041/nn\\_599776/sid\\_E43613307D01DCF27522B70894D6D1E7/DE/Presse/Pressemitteilungen/Presse-Drogenbeauftragte/pm-26-2-07,param=.html\\_\\_nnn=true](http://www.bmg.bund.de/cln_041/nn_599776/sid_E43613307D01DCF27522B70894D6D1E7/DE/Presse/Pressemitteilungen/Presse-Drogenbeauftragte/pm-26-2-07,param=.html__nnn=true)

<sup>7</sup> OJ C 189 26.7.1989 (89/C 189/01)

A Council Recommendation on the prevention of smoking and initiative to improve tobacco control including a recommendation to Member States to provide protection from exposure to secondhand smoke in indoor workplaces, enclosed public places and public transport, was adopted in 2003.<sup>8</sup>

The evidence shows that following the adoption of the 1989 Resolution, Member States did introduce legislation which led to some sectors of the workforce and the public becoming smokefree.<sup>9</sup>

EHN believes that a further Commission or Council Recommendation could enjoy similar success provided that it is adapted to recent legislative and evidential developments in the Member States and beyond. Such a Recommendation would, inter alia, need to:

- urge Member States to adopt comprehensive legislation such as that passed in Ireland as best practice;
- refer to the need for mass media education campaigns to raise awareness about secondhand smoke and increase support for smokefree laws;
- stress the importance and relevance of Article 8 of the Framework Convention on Tobacco Control (FCTC) and the Conference of the Parties (COP) guidelines, currently under development;
- recommend the collection of data on smoking prevalence and attitudes towards smokefree provisions;
- extend the scope of the Carcinogens and Mutagens Directive 2004/37 to cover secondhand smoke; and
- strengthen the requirements for the protection of workers from tobacco smoke in Directive 89/654/EEC on minimum health and safety requirements.

## **5. *Binding legislation***

The Limassol Recommendations on smokefree policies developed by consensus by the European tobacco control community in April 2005 recognised the uniquely cultural elements of introducing smoking bans and identified 12 factors which need to be present for the successful implementation of smokefree legislation (see appendix 1).

Based on these, EHN believes that the best way to introduce effective legislation that would be supported and complied with is at the national level. For the time being, EHN would therefore not recommend a separate EU directive on workplace smoking. Moreover, EHN is concerned that the expression of intent to introduce EU legislation could slow down the momentum towards smokefree laws. Given the time involved in adopting a European Commission legislative proposal, the fact that the European Parliament elections will take place in 2009 and a transition period before the legislation enters into force, EU legislation could effectively mean that Member States, which might otherwise enact legislation in the next couple of years, would delay it. EHN is also not encouraged by the recent almost unanimous decision of the Bureau of the European Parliament to overturn the Parliament's own smoking ban after only 6 weeks. We fear that this lack of awareness amongst some

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<sup>8</sup> OJ L 22 25.1.2003 (2003/54/EC)

<sup>9</sup> [http://ec.europa.eu/health/ph\\_determinants/life\\_style/Tobacco/smoke\\_free\\_en.htm](http://ec.europa.eu/health/ph_determinants/life_style/Tobacco/smoke_free_en.htm)

MEPs, including those from countries in which successful smokefree legislation has already been implemented, could result in ineffective legislation.

## **Conclusions**

In Conclusion, EHN believes that of the five policy options described in Section IV of the Commission Green Paper, the most desirable and appropriate to promote smoke-free environments would be:

- **Comprehensive national legislation banning smoking in all public spaces and workplaces**

To help achieve this, EHN favours the following EU intervention:

- **adopt a Commission or Council Recommendation on smokefree public places and workplaces**

## Appendix 1

### The Limassol recommendations to obtain comprehensive smoke free legislation

#### Introduction

These are key recommendations which are mainly based on research findings and the experience of successful countries like Ireland, Norway and Italy. These recommendations should be relevant to most circumstances. However, going smoke free is affected by local political, social and economic circumstances, which might need an adaptation at the local or national level.

#### **1 The main scientific argument is the proven danger of passive smoking**

Smoke free legislation is health and safety legislation. The scientific evidence establishes that tobacco smoke causes disease, disability, and death to those exposed - both smokers and non smokers. The World Health Organisation "*International Agency for Research on Cancer*" identifies passive smoking as a cause of lung cancer, and classifies second-hand smoke as a human carcinogen. Article 8 of the WHO Framework Convention on Tobacco Control (FCTC), which was adopted unanimously by 192 countries in May 2003, recognises that scientific evidence has unequivocally established that exposure to tobacco smoke causes death, disease and disability. The guiding principle is the right of every one to work in a healthy work environment. Support of the public health community is vital and the backing of the workers unions in the hospitality industry can also be crucial. An awareness campaign on the danger of passive smoking is recommended. Ventilation can not be considered as an option to resolve the health problems caused by second hand smoke.

#### **2 The most convincing argument in the political debate is the overwhelming success of the implementation of comprehensive smoke free legislation in Ireland, Norway and Italy**

In all three countries support for the law has increased after its introduction. Research in Ireland has indicated that 93% of people think the introduction of the law was a good idea, including 80% of smokers and 98% of people feel that workplaces are healthier since the introduction of the law including 94% of smokers. A smoke free environment is a joy for ever.

#### **3 Opt for clear legislation**

Unclear legislation will not be respected. Clear legislation means a legal text without ambiguity, a clear date of enforcement, clear visible signs, clear fines and clear responsibility for enforcement. An awareness campaign on the provisions of the law is crucial: it is a relatively cheap way of reducing the costs of enforcement, as the legislation will rely to great extent on self policing to be enforced effectively.

#### **4 A total ban without exemptions is the best option**

There is evidence that a total ban is easier to enforce than smoking restrictions. Restriction means that smoking is allowed in some areas and banned in other areas. This leads to confusion and disputes between smokers and nonsmokers. Compliance with the legislation in Ireland and Norway improved when a total ban was introduced in 2004.

#### **5 Comprehensive smoke free legislation is our objective**

Comprehensive smoke free legislation includes a total ban of smoking at the work place, bars and restaurants, public places (including health and educational facilities) and public transport. A society will not become smoke free overnight. Smoke free legislation at the work place is the most important provision. It is easiest to introduce smoke free legislation for short distance public transport such as buses and subways. Smoke free legislation in bars is the toughest to obtain. If there is not enough support for comprehensive smoke free legislation at once, a step by step approach can be considered.

#### **6 Avoid legislation with smoking areas or zones**

A smoking area is an unclear concept which is difficult to enforce. In addition it provides no health protection as the smoke in the smoking and non smoking area will mix. A total ban is the best option. If a total ban is not feasible, an alternative for smoking areas is a closed smoking room. Characteristics of the closed smoking room should be defined in such a way that the choice for this option is rather exceptional. At a minimum, where smoking is allowed in separately smoking rooms, it is important that these rooms should be limited in space, totally separated from non smoking rooms, have walls from floor to ceiling and ventilated under strict conditions directly to the outside. Additionally, workers and members of the public should not be required to enter these rooms to do their job or to pass through them. Legislation in Italy, Malta and Sweden is mainly based on these principles.

#### **7 Avoid the introduction of legislation which is likely not to be enforced**

Compliance with smoke free legislation has to start at the first day of the entrance into force. If the legislation is not been enforced during the first week, it is likely that non compliance problems will remain. It is easier to maintain high compliance when the law has been respected from the start.

#### **8 Provide an effective enforcement system**

Enforcement depends on several factors such as information on the date of enforcement (is the population aware that the law enters into force), the visibility of the non smoking signs, the clarity of the law (is the law easy to understand and easy to enforce), the level of fines, information on the level of the fines, information on the complaint mechanisms (such as a phone number), the number of controls and the probability to be caught.



**9 A total ban in the work place, including bars and restaurants is only possible after a proper preparation and consultation process**

A key factor for successful legislation is the attitude of the population towards smoke free legislation. The implementation of such a law requires the endorsement of the population. Opinion polls on smoke free policies are recommended. A proper preparation and consultation process is needed which can take the form of a public and parliamentary debate.

**10 A pro-active and reactive media strategy**

In order to have the population on side, a permanent media strategy has to be developed, which includes continuously providing new research and information in relation to smoke free legislation and a media response team capable of reacting rapidly.

**11 Be prepared for strong opposition when introducing a comprehensive smoke free law**

The hospitality and tobacco industry has always claimed smoking ban laws in restaurants and bars have a negative impact on business and lead to less sales and to less employment. There is no evidence for these claims, but it may have an impact on public opinion. Research in Norway has indicated that more people believed that the law creates more problems before the introduction than the law actually did after the enforcement.

**12 The introduction of a smoke free legislation requires a united public health community**

The public health community has to form a broad coalition of organisations in support of smoke free legislation. This coalition must develop a strategic plan with a clear message and speak with one voice.