

SMOKE-FREE POLICIES DO NOT HARM YOUR BUSINESS - IN FACT...



- Smoke-Free policies help protect food and service workers as well as patrons from lung cancer, heart disease and other illnesses caused by secondhand smoke.¹
- Sound studies of smoke-free laws demonstrate sales tax revenues remain stable.²

BENEFITS OF A SMOKE-FREE WORKPLACE

- **DECREASED COSTS.** Economic studies estimate the annual cost to restaurants and bars per smoker ranges from \$624 to \$4,500.
- **DECREASED ABSENTEEISM.** National statistics indicate that smokers are absent 50 percent more often than nonsmokers, and that the mortality rate of smokers is three times that of nonsmokers. Nonsmokers also are made ill by environmental tobacco smoke exposure.
- **DECREASED VENTILATION COSTS.** Environmental tobacco smoke increases the load of ventilation systems. Air conditioning requirements are six times greater in areas where people smoke.
- **DECREASED HEALTH AND FIRE INSURANCE PREMIUMS.** Premiums can be 35 percent lower for smoke-free businesses.
- **DECREASED MAINTENANCE COSTS.** Interior cleaning and furniture replacement costs can be cut by 50 percent. Smoking bans in the workplace mean less clean-up of ashtrays and litter; no more filmy deposits on windows, walls, upholstery; no more cigarette burns in upholstery or carpeting; and no more damage to tile or wood floors from ground out butts.
- **FEWER CLAIMS UNDER WORKERS' COMPENSATION, LIFE AND DISABILITY INSURANCE.** The further away a smoker gets from their last cigarette, the more their health improves and the longer their life expectancy becomes. Removing dangerous side stream smoke from the nonsmoker's atmosphere is better for their health.
- **REDUCED RISK OF LAWSUITS.** There is an established legal precedent for a nonsmokers' right to a safe working environment.
- **REDUCED DISABILITY AND RETIREMENT.** Smokers tend to become disabled and retire early six times more than nonsmokers.
- **INCREASE SALES.** A majority of Arkansans do not smoke (75%). Freeing up the unused smoking section seating allows for more patrons to dine.



¹ National Cancer Institute, 1999

² Journal of Public Health Management and Practice, 1999

THE ECONOMIC IMPACT OF SMOKE FREE ORDINANCES



MASSACHUSETTS:

A systematic statewide comparison of 239 communities in Massachusetts revealed that local smoke free ordinances do not harm businesses. Taxable meals receipts data was collected for over 1,000 restaurants between 1992 and 1999.

Contrary to restaurateur predictions, researchers found that restaurant sales in towns with strong smoking restrictions experienced a slightly faster rate of growth than restaurant sales in towns without such restrictions. Included in the study was an analysis of the effect of comprehensive ordinances on communities bordering towns without similar smoking restrictions. The data revealed that this factor "failed to have a statistically significant effect on meals receipts."

(Bartosch, William, and Pope, Gregory, (2000), *The Economic Effect of Restaurant Smoking Restrictions on Restaurant Business in Massachusetts 1992-1998: Final Report*, Center for Health Economics Research, submitted to Massachusetts Department of Public Health, November 27, 2000.)

77% OF ARKANSANS SUPPORT A COMPLETE BAN ON SMOKING IN RESTAURANTS.

82.7% OF FAYETTEVILLE RESIDENTS SURVEYED SAID THEY WOULD BE MORE LIKELY TO GO TO A RESTAURANT IF THEY KNEW IT WAS SMOKE FREE.

TEXAS:

Clean indoor air ordinances were passed in Arlington, Austin, Plano, and Wichita Falls between July 1994 and March 1996. Researchers evaluated the effect of these ordinances on restaurant sales using restaurant and retail tax data. Information was collected from the first quarter of 1987 through the last quarter of 1999. Despite variations in the municipalities' geographic, demographic, and economic composition, no detrimental effect on restaurant sales was found to have resulted from the ordinances in any of the four cities studied.

(Hayslett, and Huang, "Impact of Clean Indoor Air Ordinances on Restaurant Revenues in Four Texas Cities" March 21, 2000)

CHAPEL HILL, NC:

Researchers at UNC-Chapel Hill examined restaurant sales data between 1990 and 1997 in ten counties; five with comprehensive smoking ordinances and five similarly situated counties with weak or no smoking ordinances. No differences were found in restaurant sales between the two groups.

(Goldstein and Sobel, "Environmental Tobacco Smoke Regulations Have Not Hurt Restaurant Sales in North Carolina," *North Carolina Medical Journal*, 59(5): 284-288, September/October 1998.)

CORVALLIS, OREGON:

A July 1998 smoking ban in Corvallis bars did not harm business, concluded a study conducted by the Pacific Research Institute in Eugene. Sales data was collected from September 1997 through September 1999 and compared to data collected in nearby communities where similar smoke free laws were not in place.

Researchers concluded that smokers did not abandon Corvallis bars and restaurants, and that revenues from the non-smoking majority replaced any loss of business from smokers. Furthermore, Corvallis showed no decline in malt beverage sales relative to surrounding communities.

(Dresser, Boles, Lichtenstein and Stricker, "Multiple Impacts of a Bar Smoking Prohibition Ordinance in Corvallis, Oregon." Pacific Research Institute, Eugene Oregon. n.d.)

TO DATE, THERE ARE 2,318 LOCAL SMOKE-FREE AND TOBACCO CONTROL POLICIES IN THE U.S. 1,531 ARE CLEAN INDOOR AIR ORDINANCES.

FLAGSTAFF, AZ:

A study conducted by researchers at Northern Arizona University found that Flagstaff's smoke free restaurant ordinance had no adverse effect on restaurant sales, as measured by tax data from January 1, 1990 (3.5 years before the enactment of the smoke free ordinance) to December 31, 1994 (1.5 years after enactment). Using four different methods of analysis, the study compared Flagstaff restaurant and retail sales with sales in two similar Arizona cities, three counties, and the entire state of Arizona.

(Sciacca and Ratliff, "Prohibiting Smoking in Restaurants: Effects on Restaurant Sales," *American Journal of Health Promotion*, 12(3): 176-184, January/February 1998.)