NATIONAL LUNG HEALTH FRAMEWORK

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PHASE I TECHNICAL REPORT
APRIL 2007

Tobacco Control Working Group

National Lung Health Framework Vision

"to advance respiratory health and health care of Canadians through public engagement in collaborative policy development, leadership, research, innovation and education".

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Public Health Agency of Canada Agence de santé publique du Canada

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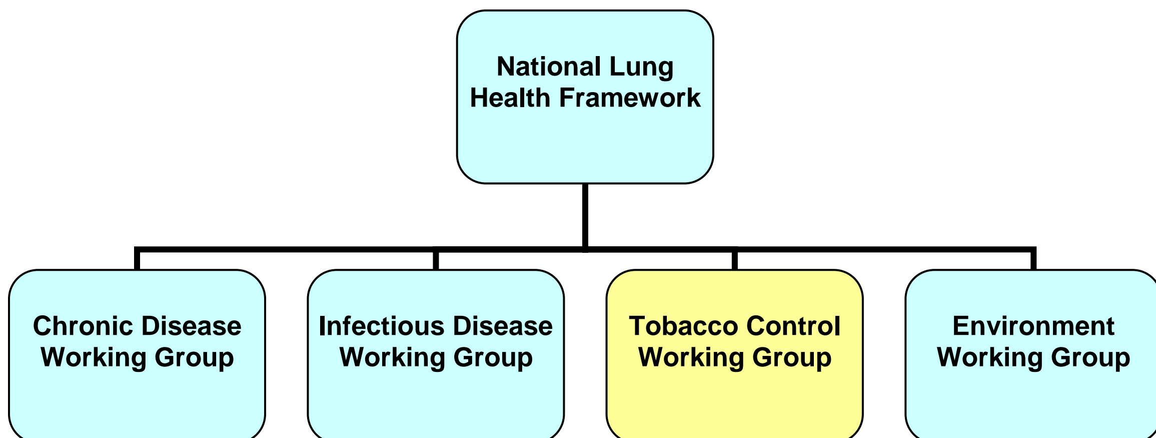
Background

The National Lung Health Framework is a "made in Canada" initiative spearheaded by The Lung Association in collaboration with the Public Health Agency of Canada (PHAC), which will provide a coordinated action plan for the prevention and management of respiratory diseases. The development of this plan is an inclusive process seeking to maximize opportunities for stakeholder collaboration, and is guided by the following vision statement:

"to advance respiratory health and health care of Canadians through public engagement in collaborative policy development, leadership, research, innovation and education".

The Tobacco Control Working Group is one of four multi-stakeholder working groups charged with providing input, recommendations and guidance towards the creation of this Framework. This Report is a summary of the initial discussions held by members of this working group.

This report provides direction for achieving important and measurable outcomes in the field of respiratory health in Canada. It reflects a range of emerging issues raised by working group members, and includes possible strategies and actions that should be considered when developing a National Lung Health Framework. This report is a launch pad for discussion, and will continue to be informed by additional research and stakeholder engagement in the months ahead.



Process/Methodology

The development of the National Lung Health Framework began in April, 2006, when The Lung Association, with support from Health Canada, the Public Health Agency of Canada, and industry partners, initiated the planning of a multi-stakeholder workshop to bring together parties interested in collaborating on the development of a National Lung Health Framework. During this two-day workshop, participants outlined a number of activities and research priorities that needed to be taken on in order to move forward, among which included:

- an asset map and gap analysis, to help create a clear picture of what is happening in respiratory health in Canada;
- a cost-benefit/risk analysis, to outline where financial investment will result in the most gains;
- the creation of a multi-stakeholder Steering Committee, chaired by the Lung Association; and
- the creation of four working groups to drive the content of the Framework, in the areas of Chronic Disease, Infectious Disease, Tobacco Control and Environment.

Since that workshop, steps have been taken to follow through on these action items, and Working Groups were formed. Each of the Working Groups began preparations for holding their own workshops, beginning with the design and distribution of a pre-workshop questionnaire to survey Working Group.

The Tobacco Control Working Group workshop was held in Ottawa on December 15, 2006 with the following objectives:

- to develop a shared understanding of the strategic issues, challenges and opportunities related to the Tobacco Control theme of the National Lung Health Framework;
- to articulate the desired outcomes to achieve related to the Tobacco Control theme; and, in light of the desired outcomes,
- to identify the key results that must be achieved and the activities to be pursued to deliver the outcomes

The Workshop followed a classic “strategic planning” approach beginning with an environmental scan to take stock of the issues, trends and factors influencing the tobacco related respiratory health environment and proceeding to identifying key priorities and ways to achieve them.

Subsequent to the workshop, key documents were consulted to support the environmental scanning process conducted during the workshop. Working Group members and key informant interviews by the consultant team were undertaken to further inform various aspects of the Report and to sharpen its focus. The Report is the result of an iterative, multi-stage process of engagement involving a wide range of stakeholders. The

following table summarizes the key stages in the process to date and the timeline at each stage.

Step	Process Activity	Timeline
1.	"Breathing Matters" Workshop	April, 2006
2.	Working Group Formation	November, 2006
3.	Pre-Workshop Survey	December, 2006
4.	Working Group Workshop	December, 2006
5.	Scan of key documents	Dec. 2006 – ongoing
6.	Review of Draft Report by Members	Jan. / Feb., 2007
7.	Key Informant Interviews (in conjunction with Asset Map and Gap Analysis research)	Jan. / Feb., 2007
8.	Discussion Draft, Draft and Final Report	Feb. / Mar., 2007

These steps are just the beginning. Highlights of this report and other key pieces of research will be compiled into a Framework Discussion Document, to be used to facilitate further discussion and stakeholder engagement over the coming months.

Objectives of the Working Group

The Working Group members were tasked to work together to provide recommendations and guidance for the content of the National Lung Health Framework. More specifically, the Working Group members were asked to:

- expand on the work completed by Working Groups at the "Breathing Matters" workshop, held in April, 2006;
- identify additional stakeholders to be involved in the development of the National Lung Health Framework;
- identify additional respiratory health issues to be included in the National Lung Health Framework;
- identify additional goals, objectives, and outcomes to be included in the National Lung Health Framework; and,
- identify potential activities that can achieve these goals, objectives and outcomes.

Members of the Tobacco Control Working Group share the common goal of lowering the mortality and morbidity rates associated with tobacco related respiratory disease. Given the still alarming rates of tobacco related respiratory disease in Canada and the toll on the health care system, this goal has taken on a greater urgency in recent years.

Working Group Participants share many other expectations from the process. Notably, the Working Group sees the Framework process as providing an opportunity to:

1. Discover what is happening in other provinces and jurisdictions
2. Develop a sense of where current mature strategies will fit into this Framework, to avoid duplication and identify what needs to done into the future
3. Maintain Canada's lead at the forefront of tobacco control policy
4. Bring advocacy to the discussion and explore how advocacy fits in the Framework
5. Better understand key stakeholders and what each can contribute
6. Obtain a clear endorsement from First Nations, Inuit and Métis leadership
7. Learn from each other and exchange contacts, ideas and inputs
8. Achieve outcomes that are coordinated and integrated

Working Group members also see an opportunity to make significant strides in the area of respiratory health and to learn lessons from other health related framework initiatives undertaken in Canada and internationally. Members recognize that an effective approach for combating tobacco-related respiratory disease involves an understanding of the scope of the problem including knowledge gaps. In keeping with the National Framework objectives, it also requires a pan-Canadian perspective – a true partnership, coordinated with, and supported by, provincial and territorial governments and other key stakeholders.

Multiple Perspectives

A multitude of perspectives are needed to fully inform the strategies employed to achieve expectations. The Working Group particularly wishes to acknowledge the importance of the patient voice/perspective in addressing respiratory disease.

The Working Group also recognizes the need for extensive coordination and linkage across many organizations to adequately respond to the wide range of tobacco-related respiratory conditions. Nor can tobacco-related respiratory disease be considered in isolation from other respiratory disease categories or disease in general. The acute care sector perspective, in particular, needs to be factored into the discussion as well as the broader public health perspective, with an increasing focus on prevention and advocacy.

The Working Group understands that the delivery of health care is constantly evolving. The perspectives of the primary care community, multi-disciplinary teams, community care practitioners and those involved in environmental health areas are all required to fully inform strategies to promote respiratory health.

The perspectives of many others who have a stake in tobacco control and respiratory health will also be necessary to inform and ultimately implement strategies. Cross-cutting issues among the Working Groups will need to be identified and responses to those issues coordinated. The views of at-risk populations such as Aboriginal Peoples (First Nations, Inuit and Métis) and new Canadians will be particularly important to achieving effective outcomes.[1] The coordination and cooperation of many varied and diverse stakeholder organizations and groups will be paramount to achieving results, including: Aboriginal organizations, multi-cultural communities, medical and dental associations, non-smoking rights and interest groups, tobacco control groups, building managers and management associations, health education and counseling groups and child welfare and social agencies, among others.

[1] Throughout this document, the term Aboriginal Peoples should be taken to mean First Nations, Inuit and Métis.

Logic Model

The following table illustrates the logic model that serves as the organizing framework for the Tobacco Control Working Group Report. The model contains seven (7) broad elements. Associated with each element are specific expectations, inputs, strategies, activities and outputs all of which lead to eight (8) key overarching outcomes. The model is shown to be informed and supported by the various steps in the development process. The logic model content will be further developed as the consultation process unfolds.

Vision	To advance respiratory health and health care of Canadians through public engagement in collaborative policy development, leadership, research, innovation and education						
Elements	**Policy & Legislation**	**Tobacco Industry Denormalization**	**Surveillance & Monitoring**	**Detection & Chronic Disease Management**	**Supportive Environment**	**Research and Knowledge Translation**	**Public Awareness, Health Promotion & Prevention**
Expectations	See Page 9	See Page 9	See Page 9	See Page 9	See Page 9	See Page 9	See Page 9
Inputs	Next steps	Next steps	Next steps	Next steps	Next steps	Next steps	Next steps
Strategies	Page 21	Page 21	Page 22	Page 22	Page 23	Page 24	Page 25
Activities	Page 21	Page 21	Page 22	Page 22	Page 23	Page 24	Page 25
Outputs	Next steps	Next steps	Next steps	Next steps	Next steps	Next steps	Next steps
Overall Outcomes	1. Health care costs decrease considerably (overarching expectation) 2. Canada has comprehensive legislation in all provinces/territories that make workplaces and public places 100% smoke-free with provisions that prohibit smoking in cars, on patios, in multi-unit dwellings and in homes where there are children 3. Smoking prevalence is reduced to less than 10% within the general Canadian population with significant reductions in at-risk groups from current (2006) levels 4. Development and implementation of a regulatory and legal environment in Canada not conducive to the viability of the tobacco industry as a profitable business 5. Monitoring of lung function (i.e. spirometry) is routinely conducted according to established guidelines leading to improved respiratory health (i.e. reduced mortality and morbidity) 6. Reduction in tobacco sales achieved due to the newly established measures where cigarettes in plain packaging are sold in special stores, prohibited from sale in pharmacies and substantially more difficult to access 7. Tobacco dependency is recognized as a public health priority (e.g. by media, government, health care providers) 8. Evidence-based best practices are identified or developed for tobacco dependence Rx by health care professionals. Such practices are framed, endorsed, disseminated and monitored as the standard of care for all						

Breathing Matters Workshop	Working Group Collaboration	Working Group Member Survey	Working Group Work-shop	Key Document Consultation	Key Informant Interviews	Working Group Review of Draft	Iterative Reports

Framework Elements

Seven (7) key elements constitute the organizing framework for the Tobacco Control Working Group strategy and logic model, and represent broad areas within which resources (inputs), key strategies, activities and outputs are to be aligned. The seven key elements are:

Logic Model Elements	Policy & Legislation	Tobacco Industry Denormalization	Surveillance & Monitoring	Detection & Chronic Disease Management	Supportive Environment	Research & Knowledge Translation	Public Awareness, Health promotion & Prevention

1. **Policy & Legislation** – Instituting policies and legislation at all levels that reflect the serious respiratory health risks and consequences of tobacco use will serve as an important deterrent as will appropriate compliance and enforcement mechanisms.

2. **Tobacco Industry Denormalization** – Educating and informing both smokers and non-smokers about the motives and tactics of the tobacco industry. Denormalization efforts/campaigns exposing the industry's practices are needed to counter ongoing claims by the industry that it operates like any other normal, legitimate business.

3. **Surveillance & Monitoring** – Understanding and tracking the trends, issues and impacts related to chronic respiratory disease through effective surveillance will ensure that the strategies and resources are in place for an optimal response.

4. **Detection and Chronic Disease Management** – Early detection and appropriate management can lead to significant improvement in quality of life for patients.

5. **Supportive Environment (Systems, Human and Community)** – Supportive environments are essential to an effective strategy. This includes information systems infrastructure within the health care system as well as supportive human and infrastructure environments in the community.[2]

6. **Research and Knowledge Translation** – Ethical and unbiased research reflecting the priorities of target populations is needed to address critical information gaps and support intelligent, evidence-based responses to respiratory disease challenges and it is vital that this research be translated into meaningful action and results.

7. **Public Awareness, Health Promotion and Prevention** – Respiratory disease suffers from comparatively low public awareness that results in adverse consequences such as unnecessary exposure to risk, under-diagnosis and treatment.

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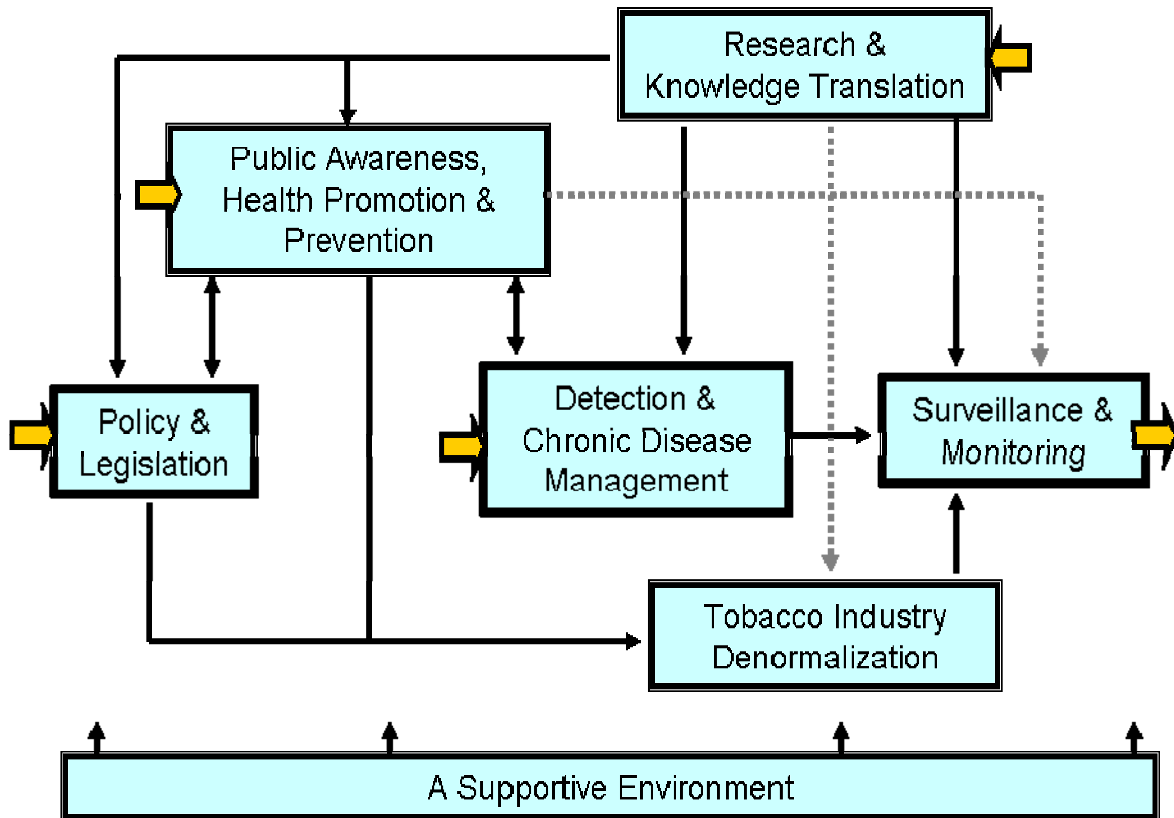
[2] For example, improvements in infrastructure and health human resources are particularly important for First Nations, Inuit and Métis communities.

Linkages

The Logic Model is a useful tool as an organizing framework. However, it is important to recognize that the elements of the model are not static but interdependent; each element influences the other and together form a complex system. This systemic aspect of the model is illustrated below.



Important linkages also exist among the various Working Group components that will comprise the Respiratory Health Framework. For example, many issues raised in the Tobacco Control Working Group were also raised or implied in other Working Groups such as Environment and Chronic Disease. These linkages, which will become evident as the process evolves, will highlight the dynamic and interdependent nature of the Framework components.

Stakeholder Interests, Expectations and Roles

All Canadians have a stake in addressing tobacco related respiratory disease. To be effective, however, it is important for strategies to focus on addressing the unique needs and interests of specific stakeholder groups. With respect to tobacco related respiratory disease, key stakeholders include:

- The federal government
- Regional health authorities
- Aboriginal Peoples (First Nations, Inuit and Métis)
- Patients and families
- Private Industry
- Non Governmental Organizations (NGOs)
- Research community
- Provincial / territorial governments
- Municipal governments
- Educators (health system and academic)
- Employers
- General public
- Private health care including pharmaceutical industry and insurers
- Practitioners, health care providers

Core Overarching Expectations

A number of core overarching expectations among these stakeholders were identified:

1. Lower health care costs
2. Clear roles and responsibilities (at legislative and program levels)
3. Access to services and information as and when needed e.g. nurses
4. Increased awareness/profile of respiratory illness
5. Identification of and endorsement of effective treatment modalities
6. Smoke free settings – home, school, work, and other public settings, especially health facilities
7. Identification of gaps – research to address the gaps and translation of research into new policy and programs
8. Training for health care providers; more training for GPs, include as part of regular check-up; ensuring that all health care providers have the help they need to quit smoking

Map of Core Expectations to Key Elements

Logic Model Elements	Policy & Legislation	Tobacco Industry Denormalization	Surveillance & Monitoring	Detection & Chronic Disease Management	Supportive Environment	Research and Knowledge Translation	Public Awareness, Health Promotion & Prevention
Core Expectations	2, 4, 6	4, 8	4, 5, 8	1, 3, 5	3, 4, 6, 8	4, 7, 8	4, 8

Analysis of Stakeholder Perspectives, Interests and Potential Roles

Individual stakeholders have differing perspectives, interests and roles with respect to tobacco related respiratory disease. An analysis of these differences is summarized in the following table:

Stakeholder	Key Perspective	Primary Interest/Expectation	Potential Role
Federal Government	National, pan-Canadian in scope	Access and Universality Canada Health Act Affordable and sustainable health care	• Supportive but not duplicating other strategies • Impact i.e. explaining why strategy relevant to reducing health care costs; patient wait times etc. • Coordination of programs across the country • Role in fully implementing FCTC
Provincial / Territorial Government	Provincial, regional and local in scope	System access and capacity; planning and management; Efficient/ affordable health care delivery; Quality care and metrics; e.g. reduction in wait times; health system infrastructure and human resources	• Explaining how impacts on long term provincial health care spending (e.g. costs of smoking related diseases) could bankrupt some P/Ts • Controlling health care costs related to respiratory diseases
Regional Health Authorities	Regional in scope	Coordination of regional resource Emergency preparedness Service delivery and capacity	• Serve on committees with public health officials at municipal level • Access/prevalence to resources/supports • Easier to make business case for own initiatives • Better/best practices that are easier to implement • More resources at community levels • Information readily accessible to help at community level
Municipal Government	Community-based care; local in scope; efficient and effective delivery	Capacity; quality service and access - responding to needs and demands of the community	• Expectations in BC, Alberta, Yukon where there is not yet province-wide smoke-free legislation • Municipal by-laws to provide/enforce smoke-free • Role/responsibility expectation between provinces and municipal government (i.e. smoke-free bylaws etc.) clarified

Stakeholder	Key Perspective	Primary Interest/Expectation	Potential Role
Aboriginal Peoples (First Nations, Inuit and Métis)	National, provincial/territorial and regional and community based On-reserve and off-reserve	Improved Aboriginal health More and better resources targeted to needs	• Greater understanding of protocols/process of appropriate engagement/partnering • Less victim blaming as source of tobacco problem • Inclusive, holistic approach to Aboriginal issues/health • Greater focus on youth engagement
Practitioners & Health Care Providers	Community-based	Tools and resources along the continuum of care Patient care Inter-disciplinary care	• Endorsement of effective Rx and education • More training in smoking cessation • Clear understanding of their roles in cessation; standardized guidelines; training in universities and colleges • Smoking history/spirometry as part of vital signs measurement
Patients and Families	Perceptions of quality and responsiveness of health care system and providers; Was the treatment effective?	Improved access Improved and better health care outcomes Better quality of life	• 100% smoke free health care setting • Access to effective Rx (endorsement of) – esp. NRT • Parity of coverage for Rx (endorsement of) • Access to anti-smoking Rx (affordability) • Knowledge/acceptance of patients and family affected by respiratory illness • Less victim blaming of COPD patients • Access to cessation services • Access to information supports
Employers	Worker productivity; ability to attract and retain workers; competitiveness	Healthy workplace and workers; productivity and reduced absenteeism Education and awareness	• Health care costs • Safety in the workplace • Work absenteeism • SHS exposure prevention • Bill C45

Stakeholder	Key Perspective	Primary Interest/Expectation	Potential Role
Private Industry (Private HC, Pharma, insurers etc.)	Partners in the health care system; efficiency and effectiveness; innovation, research	Investment opportunity Avoid/minimize losses Shareholder value	• Workplace guidelines • Pharma endorsement of evidence-based Rx e.g. NRT; education re. emerging Rx options • Tobacco industry endorse freedom of choice, smokers rights • Industry would have to develop new strategies to target new smokers to maintain profitability; RHF would be something they could try to link with “health promotion” activities • Lower insurance premiums for non-smokers; insurer investment in tobacco stock • Pharma – potential to approval process for NRT
General Public	Affordability, fairness sustainability, quality, access	Access, quality health care and service, value for taxpayer dollars Self-management and prevention information Health care as opposed to sick care	• Smoke free environments • Consistent messaging • Awareness raising • Lung Associations will spend higher amounts on programming instead of just fund raising • Recipients of information/treatment /support from a variety of sources (e.g. website, practitioners, nurses, etc.)
Educators (Health System and Academia)	Systemic enablers and constraints; knowledge transfer and management Evidence-based research and knowledge translation	Education and research standards; best practice guidelines World-class education and certification/licensing of providers Oversight mechanisms	• Lung Associations will contribute ideas for research (esp. translational research) • Comprehensive programs for youth • 100% smoke-free campuses • More understandable information regarding asthma and lung diseases and how to support students affected • Greater focus on early anti-smoking education i.e. Grade 1
Research Community	Advancement of knowledge	Advancement of knowledge to obtain results along the continuum of care	• Increase in funding for research • Meaningful translation/transfer of research into program/planners/implementers • Research agenda focused on linkages of tobacco to respiratory diseases/factors (e.g. tobacco, marijuana, addictions/behavioural research etc.) • More activity and funding • Better surveillance • Contribute ideas on research

Stakeholder	Key Perspective	Primary Interest/Expectation	Potential Role
NGOs	Stakeholder specific; Issue specific	Advance agendas through research, advocacy etc. Respond to member needs and priorities	• Consensus on tobacco control – coordinated strategy/effort • Broader influence of tobacco control into disease related advocacy • Broader advocacy • More consistent participation at federal level in CCAT – Canadian Coalition for Action on Tobacco • Greater awareness/profile/knowledge of respiratory programs/services offered to parents/general public

Environmental Scan

There are a variety of key issues, trends and factors that are shaping the tobacco control environment which point to needs, challenges and opportunities for progress on the respiratory health front. The environmental scan summarizes relevant considerations of Working Group members, key informants and stakeholders.

Tobacco Control Respiratory Health – Issues, Needs and Challenges

Over 3 million Canadians are coping with serious respiratory disease.[3] Despite the fact that the overall trend in smoking in Canada is down – from 25% in 1999 to 18% in 2006 - tobacco use remains the most important preventable risk factor for respiratory disease.[4] According to the most recent data, just over 4.5 million Canadians aged 15 years and older, representing 18% of the population, are current smokers. Roughly, 20% of these are males and 15% are females.[5] Each year over 37,000 Canadians die due to smoking.[6,]

In addition to this staggering human toll, smoking is estimated to cost the economy $17B per year; and health care costs linked to tobacco use are over $4.4B per year. Exposure to tobacco smoke can either be direct as a result of cigarette smoking, or indirect as a result of maternal smoking in pregnancy or exposure to secondhand tobacco smoke. Thus, smoking affects people of all ages – children, teens, adults and seniors. The impacts are seen in alarming rates of respiratory disease including, lung cancer, COPD, asthma, bronchitis, bronchiolitis, macular degeneration, sudden infant death syndrome (SIDS) and infant respiratory distress syndrome.

Smoking rates among adolescents 15 to 19 (16%) and among young adults between the age of 20 and 24 (25%) are of particular concern given the potential long-term respiratory health implications.[7]

In addition to young adults (including an alarming number of young women), there are growing concerns about the prevalence of tobacco use among other high risk populations, such as Aboriginal Peoples or those with mental health issues. Research shows that these groups have much higher smoking rates than the general population; they are, therefore, at greater risk for developing respiratory disease. For example, recent data indicate that smoking prevalence among Aboriginal residents in the North West Territories is more than twice that of non-aboriginal residents – 60% compared to 25%.[8] Stakeholders point to the need for more research to fully understand the links between smoking and high risk population groups, including the link between smoking and socio-economic status.

Furthermore, many of the ill effects of exposure to tobacco smoke become more severe with age. Thus, as Canada's population ages, the toll will be greater and the burden on the health care system will be even more significant than it already is.

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[3] *Respiratory Disease in Canada*, 2004 The Canadian Lung Association
[4] Canadian Tobacco Use Monitoring Survey (CTUMS), Health Canada, 2006
[5] Ibid
[6] Healthy Living Factsheets, Health Canada, 2006
[7] CTUMS, 2006
[8] *Moving Forward, The National Strategy: The 2005 Progress Report on Tobacco Control*, Health Canada, 2005

Faced with a tobacco industry that continues to aggressively introduce new products, promotional strategies and tactics to lure smokers, the need for continued vigilance and more effective tobacco control efforts involving both government and outside partner organizations such as NGOs is seen to be substantial. For example, stakeholders see a pressing need for more targeted approaches such as stringent policies and legislation to regulate or control the use of tobacco in homes or vehicles where the health of children may be at risk, and in the workplace to protect employees.

On the compliance and enforcement side, the problem of underground tobacco continues to be particularly acute. Contraband and counterfeit traffic present certain segments of the population with a low cost supply of cigarettes. Failure to prevent the flow of contraband and counterfeit goods is seen to pose a serious impediment to effective tobacco control. Stakeholders feel more work needs to be done both in regards to tax policy and in support of policing agencies such as the RCMP in their enforcement efforts, to stem the flow of these illicit goods. This view is supported by recent analysis showing that cigarette smuggling is a growing threat to the health of Canadians.[9]

The tobacco industry continues to explore innovative ways to market its products. Working Group members see a need for denormalization campaigns to combat industry marketing tactics and to promote greater public awareness regarding the links between exposure to tobacco smoke and respiratory health. Denormalization is seen to be fundamental to a shift in societal values leading to behavioural change. Tobacco industry denormalization campaigns can reduce the social acceptability of smoking by highlighting the tobacco industry's overt attempts to make smoking more palatable.[10]

Some Working Group members express concern that the overall reduction in smoking rates in recent years is leading to complacency; they point out that more, not less, effort is needed, especially with respect to difficult to reach or marginalized populations. Some also wonder whether anti-smoking efforts are actually preventing people from taking up smoking or just delaying the habit. Others worry about a possible resurgence of industry promotional activity, lamenting for example, that many research organizations and universities still accept funding from tobacco companies.

Informants also point out that widely held perceptions that tobacco advertising has been banned are inaccurate. They note that court challenges to tobacco legislation are likely to continue unabated and adverse outcomes could spark a new wave of tobacco advertising. More than a decade after attempts to implement a complete ban on tobacco advertising were dismissed by the Supreme Court of Canada, stakeholders note that tobacco advertising in Canada continues to be legal in many forms.[11] Working Group members point out that the need for a comprehensive ban on tobacco advertising has been recognized in other countries and codified in the Framework Convention on Tobacco Control (FCTC).

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[9] *Doctors Propose Methods to Reduce Tobacco Smuggling*, Physicians for a Smoke Free Canada, News Release, Dec. 18, 2006
[10] Lavack, Anne, *Designing a "Made for Canada" Approach to Federal Tobacco Control Mass Media*, Health Canada, July, 2001
[11] *Health Groups Urge Feds to Ban Tobacco Advertising*, Physicians for a Smoke Free Canada, News Release, Dec., 2005

Working Group members point to other problems. They note, for example, suspected links between the use of "spit" tobacco and rising rates of mouth cancer, and between alcohol, tobacco and drug use. While non-cigarette tobacco products such as pipe tobacco, cigars, cigarillos and smokeless tobacco account for a marginal portion of tobacco sales, there appears to be a slight increase in their use.[12]

Although attitudes towards smoking have changed dramatically, the prevailing view among stakeholders and key informants is that much more needs to be done, especially among targeted segments and even within the health care community itself. For example, it is noted that among health care workers, smoker facilitation still exists and many can expect to encounter barriers when providing smoking cessation services.[13] Stakeholders find it surprising that cigarettes can still be purchased in pharmacies in four provinces.

At the local level, the view is that health practitioners need to be able to learn new skills and enjoy sustained funding through public health to implement effective tobacco control programs in all aspects of prevention, protection and cessation. It is felt that this could be done, for example, through the creation and maintenance of strong, systematic provincial government infrastructures that nurture partnerships among groups with a mandate to support all aspects of tobacco use reduction.

Key informants agree that more research is needed on all aspects of respiratory disease, including data on incidence, health outcomes, risk, prevention and treatment factors.

One area that is seen as controversial and where informants feel more research could prove beneficial is that of harm reduction and the efficacy of harm-reduced products. Nicotine replacement therapy (NRT) is also seen as an area offering significant potential as a cessation approach although more research is said to be needed regarding its effectiveness.

An area of growing concern is that of toxicity related to tobacco smoke. Regulations under the federal Tobacco Act require tobacco manufacturers to report on levels of more than 40 different chemical compounds found in mainstream and side stream tobacco smoke. Six of these chemicals must be reported on tobacco packaging.[14]

Tobacco Control Respiratory Health – Progress and Opportunity

Despite the many problems and challenges that still exist, informants see progress and opportunity on many fronts. They note, for example, that legislation in many provinces has now surpassed that at the federal level. New bodies are getting involved in regulation, enforcement, advocacy and education. Investments and increased collaboration in tobacco control are also seen to be paying off. Non-smokers rights, healthy workplace and greater acknowledgement of employer obligations are seen to be gaining momentum. Smoking cessation and control programs such as *Leave the Pack*

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[12] *Moving Forward, The National Strategy: The 2005 Progress Report on Tobacco Control*, Health Canada, 2005

[13] *Tobacco: the Role of Health Professionals*, Joint Statement, January 17, 2001
[14] Ibid

Behind are also said to be gaining ground. The goal of this innovative program is to deliver appealing, effective smoking cessation and prevention support to young adults on post-secondary school campuses.

Some stakeholders believe that an important potential opportunity may lie in the area of legislated treatment. They see the potential to make treatment for tobacco addiction a legalized standard of care. Failure to meet those standards could potentially result in claims of negligence. Many see merit in a “carrot and stick” approach based on both incentives and disincentives. Many also see the need for stronger measures to drive home the risks of smoking. It has been suggested, for example, that listing tobacco as a cause of death on death certificates could do a lot to heighten awareness.

Informants note that activism continues to occur on many fronts, from smoking in the home (i.e. multi-unit dwellings), at work, in vehicles and around children. Although there is agreement that more needs to be done to bolster awareness of the links between tobacco use and respiratory disease, empirical evidence suggests that attitudes regarding the effects of smoking have improved and that there is growing public support for more control. As a result, many see an increasing scope of opportunity for governments to take decisive action.

Control strategies are also working. Smoking prevalence is said to be decreasing due mainly to government population level interventions such as higher tobacco taxes, smoke free laws and controls on tobacco advertising - what one informant describes as “the whole comprehensive approach” – an approach that notably was built on political will, bureaucratic support and an active and committed voluntary sector doing advocacy.

Now that the Provinces and Territories are seen to be moving more into the tobacco control field, informants perceive a move towards redefining roles - “who delivers what to whom” – among stakeholders. In the current environment, many see a potential opportunity for more synergies between private and public sectors to work on cross-cutting issues. This could include, for example, tobacco control as an ‘upstream’ intervention that links to healthy living, chronic disease prevention, heart health, cancer, respiratory health, addiction research, and mental health on the public health side, and to harm reduction, compliance, enforcement, and industry monitoring on the regulatory side. Marijuana smoking (possibly or not combined with tobacco smoking) is also seen to impact respiratory health. More research is needed to explore the potential links between marijuana use and respiratory disease, including cancer.

Some stakeholders believe that the growing focus on environmental issues, including outdoor and indoor air quality, may allow for synergies to advance both environmental messages and secondhand smoke messages (e.g. danger of radon and smoking in the house).

Seen as a potential benchmark, Ontario is currently undergoing its first year after the Smoke-Free Ontario Act went into effect on May 31, 2006. The Act prohibits smoking in all enclosed workplaces and enclosed public places in Ontario. The legislation will also strengthen measures to ensure only those 19 years of age and older can buy cigarettes and will phase out the display of tobacco products, with a complete ban

beginning May 31, 2008.[15] The Program Training and Consultation Centre, is playing a key role in supporting its implementation through facilitating systematic program planning and capacity building for all Ontario tobacco control practitioners. The overall net impact on quit attempts, smoking cessation, and reduced exposure to secondhand smoke -- and ultimately, improved respiratory health is yet to be measured but the results should prove interesting.

Many stakeholders see key opportunities to build on the substantial progress and successes already being made. For example, pending hard data, they speculate that there are likely to be fewer secondhand tobacco smoke risks in communities over time due to the increasing number of restrictive by-laws and legislation. They note, for example, that smoking counselors have been trained and made available locally in a number of Inuit communities, and ample, culturally appropriate resource materials have already been developed. It has been noted that among these same communities, many health worker-led awareness activities are being conducted annually and youth/elder community development programs focusing on tobacco reduction now exist.

Continued funding is seen as essential for sustaining momentum and making progress. This includes continued funding of Health Canada's Tobacco Control Program (TCP). The elimination of funding for the First Nations and Inuit Tobacco Control Strategy is seen as an unacceptable setback and means a major cut for implementation of any activities until a "replacement" program is put in place. It is feared that a great deal of momentum in tobacco reduction initiatives among these groups will be lost unless regions can find alternate sources of funding.

Stakeholders see continued interest in the possible introduction of mandatory plain packaging (generic packaging) for tobacco products. As well, more health authorities are said to be interested in looking at ways to help smokers suffering from mental health illness and addictions. Research has shown that smoking is much more prevalent among people with psychiatric illnesses than among the general population.[16] There is said to be growing interest in providing a continuum of care within the health care system with more jurisdictions implementing smoke-free policies in public places and some looking at smoke-free homes and cars. There is also said to be a growing interest in drifting smoke problems in multi-unit dwellings. These settings include commercially owned apartments, condominiums and public housing facilities. Secondhand smoke from one unit in a multiunit housing complex can seep into an adjoining unit through shared air spaces and ventilation systems.[17] Stakeholders believe that, collectively, all of this focus, combined with targeted measures, will help to reduce exposure, ultimately leading to improved health outcomes.

In summary, stakeholders see progress as well as new opportunities forming across a broad spectrum of possibilities. That continuum calls for an activist agenda to reach hard core smokers and vulnerable populations. That agenda potentially includes, but is in no way limited to: legalized standards of care, guidelines, smoking cessation, compliance

[15] The Smoke Free Ontario Act, Ministry of Health and Long Term Care http://www.health.gov.on.ca/english/public/updates/archives/hu_04/hu_tobacco_leg.html Jan. 2007
[16] *Smoking Cessation Approaches for Persons with Mental Illness or Addictive Disorders*, Psychiatric Services, American Psychiatric Association, September, 2002
[17] *The Health Consequences of Involuntary Exposure to Tobacco Smoke*, Surgeon General's Report

(esp. contraband and counterfeit tobacco), industry denormalization, targeted research and programs, surveillance, supportive environments, and education and awareness. They see these as being among the key tobacco control "survival issues". The prevailing view is that while much progress has been made, much more is yet to be done; many feel the time is right for coordinated and decisive action by all stakeholders. By building on the success and momentum already achieved, stakeholders are cautiously optimistic of achieving even better health outcomes at lower overall cost to the health care system.

Overall Outcomes

Key outcomes represent the desired "future state" for tobacco controlled respiratory health in Canada as articulated by Working Group members and stakeholders as leading experts, practitioners and key informants in the field. The outcome statements reflect the world as stakeholders would like it to be with the Tobacco Control component fully implemented - that is, over the longer term. The key longer-term outcomes defined by the Working Group are as follows:

1. Health care costs decrease considerably (overarching expectation)
2. Canada has comprehensive legislation in all provinces/territories that make workplaces and public places 100% smoke-free with provisions that prohibit smoking in cars, on patios, in multi-unit dwellings and in homes where there are children
3. Smoking prevalence is reduced to less than 10% within the general Canadian population with significant reductions in at-risk groups from current (2006) levels
4. Development and implementation of a regulatory and legal environment in Canada not conducive to the viability of the tobacco industry as a profitable business
5. Monitoring of lung function (i.e. spirometry) is routinely conducted according to established guidelines leading to improved respiratory health (i.e. reduced mortality and morbidity)
6. Reduction in tobacco sales achieved due to the newly established measures where cigarettes in plain packaging are sold in special stores, prohibited from sale in pharmacies and substantially more difficult to access
7. Tobacco dependency is recognized as a public health priority (e.g. by media, government, health care providers)
8. Evidence-based best practices are identified or developed for tobacco dependence Rx by health care professionals. Such practices are framed, endorsed, disseminated and monitored as the standard of care for all

Map of Outcomes to Key Elements

Logic Model Elements	Policy & Legislation	Tobacco Industry Denormalization	Surveillance & Monitoring	Detection & Chronic Disease Management	Supportive Environment	Research and Knowledge Translation	Public Awareness, Health Promotion & Prevention
Overarching Outcomes	2, 3, 4, 6	4, 6	3, 5, 7, 8	1, 5, 7, 8	2, 4, 6, 7, 8	7, 8	3, 7

Key Strategies/Activities

Following are the key recommended strategies and activities that are expected to lead to the achievement of the overall outcomes that were identified.

A. Policy and Legislation

S.1 Tighten tobacco control legislation and regulation

- Ensure all provinces and territories have policies that ban smoking in all public places and workplaces including restaurants, bars, pubs, and casinos
- Curtail smoking in homes, vehicles and multi-unit dwellings
- Legislate national Quit Line telephone numbers to be prominently displayed on highly visible consumer products (e.g. breakfast cereals, milk and juice cartons and cigarette packaging)
- Legislate plain packaging
- Establish laws to restrict smoking around buildings and building entrances
- Regulate and control cigarettes with respect to emissions, ingredients, burning rates etc.

S.2 Strengthen enforcement and compliance

- Stop smuggling of illegally manufactured cigarettes
- Greatly reduce number of places where tobacco products are sold (i.e. limit distribution to liquor stores, beer stores)

S.3 Support control oriented programs

- Continue funding of Health Canada's Tobacco Control Program (TCP)
- Continue cessation and harm reduction programming
- Enhance collaboration with provincial and territorial tobacco control programs to build synergy and avoid duplication
- Address program needs of First Nations, Inuit and Métis populations including support/advocacy for First Nations and Inuit Tobacco Control Program

B. Tobacco Industry Denormalization

S.1 Educate public regarding tobacco industry tactics

- Publish cases where Canadian provinces have successfully sued the tobacco industry to recover costs associated with treating tobacco related illnesses
- Use funding recovered from industry to support sustained, comprehensive, systematic tobacco control efforts – managed through an independent, arm's length to government organization
- Heighten awareness of tobacco industry marketing practices with special focus on high risk groups such as youth and pregnant women

C. Surveillance & Monitoring

S.1 Measurable smoking cessation targets

- Build on C. Everett Koop, (former US Surgeon General) who indicated that the largest gains in tobacco control are to come from cessation strategies
- Reduce smoking prevalence to specified targets (i.e. <1 M Cdns or < 7%)

S.2 Understand scope of the problem

- Better tracking, analysis and monitoring - develop a system of tracking through administrative services and a system to obtain data on use of health services, prevalence and health outcomes
- Obtain better epidemiological information from practitioners (e.g. hospitals, doctors) on number of patients smoking (occasional and regular smokers)
- Obtain comparable data collection processes and data sets between regions and population segments (e.g. Aboriginal Groups)
- Maintain funding for the Canadian Tobacco Use Monitoring Survey (CTUMS)
- Conduct an environmental scan of public expectations
- Promote regular, speedy, relevant data collection and its dissemination

D. Detection and Chronic Disease Management

S.1 Focus on smoking cessation and harm reduction initiatives

- Maintain smoking cessation and harm reduction programming[18]
- Continue to develop, maintain and collaborate on initiatives that reduce disparities relating to the socio-economic determinants of tobacco related health issues

S.2 Combat secondhand tobacco smoke

- Continue to support any initiatives that decrease exposure to secondhand tobacco smoke

S.3 Coordinate efforts with other disease strategies

- Establish links to cancer, cardiovascular, diabetes and other disease management strategies and initiatives

[18] The term "harm reduction" has different connotations among stakeholders. One of these is "ensuring that tobacco is available in its least toxic form". *A Reflection on Alternative Nicotine Delivery Systems*, Physicians for a Smoke Free Canada, 1997.

E. Supportive Environment (Systems, Human, Community)

S.1 Exposure reduction

- Reduce/eliminate exposure to secondhand smoke in specified workplace settings e.g. foster care, health professionals who provide services in homes and facilities for the aging
- Support readily available cessation programs including quit lines, free NRT programs and other formats with active follow up

S.2 Supportive community environments and programs

- Use community development/participatory/culturally relevant approaches
- Support existing initiatives that decrease SHS or partner to develop new ones
- Develop partnerships with at risk groups such as Inuit organizations
- Work on health, education, environment and other related sectors to develop population-specific frameworks, resources, training and programs and to share knowledge
- Train health professionals to provide cessation information and conduct systematic interventions with all smoking clients
- Provide health care professionals and community workers with the resources, support and tools they need
- Encourage health professional partnering with their community health representatives
- On-going transferred funding to support part-time community-based tobacco control advocates and smoking counselors

S.3 Integrated processes and systems

- Adopt early screening, of hospital based-systematic practices to a) diagnose smoking related illness and initiate treatments, and b) to establish patient and staff smoking and quit patterns so that appropriate interventions can be routinely applied (e.g. Ottawa Health Institute model)
- Provide communities with resources, both financial and personnel, to deliver education and cessation to those who need it e.g. via public health nurses, community centers, health centers, etc.

F. Research and Knowledge Translation

S.1 Targeted medical research

- Greater understanding from medical/physiological points of view of impacts of smoking with other issues (e.g. radon, other air-environmental issues)
- Research on needs and management among those with respiratory disease

S.2 Targeted socio-economic research

- Develop/collaborate on initiatives to reduce disparities relating to the socio-economic determinants of health
- Conduct cost benefit study on what gains could be made in the future by acting on respiratory health issues today (i.e. projection analysis)
- Evaluation and intervention research conducted to determine effective cessation tools and cessation programs for different social/cultural groups (e.g. immigrants, First Nations, Inuit, Métis youth, pregnant women, etc.)
- Ethical and unbiased research respecting the priorities of targeted at-risk groups concerning respiratory health as part of holistic health and well-being
- Further research impact of health warning messages and plain packaging
- Evidence to better understand the reality of how programs and interventions are actually used in different communities – and the impact of various interventions
- clinicians (doctors, nurses, dentists etc) supported with cessation and prevention guidelines/counseling techniques to assist patients in stopping smoking

S.3 Translate research into knowledge

- Create annual opportunities and on-going mechanisms to share learnings from effective initiatives and interventions.
- Keep NGOs working together in advocacy
- Implement a system for researchers and practitioners to share research, program and surveillance information on an ongoing basis
- Improve networking between organizations and all levels of government with clear roles and responsibilities
- Encourage/support tobacco control organizations to work in partnership with universities so that evidence-based programming can be implemented in all communities. One example of a web-based program is PTCC's Better Practices Toolkit http://www.ptcc-cfc.on.ca/bpt/bpt.cfm
- Obtain and make use of information on effective interventions (e.g. what works)

G. Public Awareness, Health Promotion and Prevention

S.1 Increase awareness

- Conduct mass media campaigns to promote increased awareness of the safety and benefits of NRT over continued smoking, and to draw people to web-based and telephone cessation supports
- Conduct mass media campaigns to increase awareness of the merits of not smoking, smoke-free legislation, and where to go for cessation support
- Conduct mass media campaigns about tobacco industry denormalization and increase funding for mass media counter-advertising
- Train educators about the health effects of smoking and exposure to secondhand smoke
- Conduct targeted community or regionally based social marketing to focus on at risk groups

S.2 Targeted outreach, incentives and linkages

- Develop partnerships with organizations (e.g. Aboriginal) that work on health, education, environment and other related sectors to develop population-specific frameworks, resources, training and programs where there are any existing gaps and to share knowledge
- Launch awareness campaigns to change attitudes of youth and adults who give children access to cigarettes
- Implement campaigns aimed at parents with children age 12 and under, to promote smoke free homes and cars, and partner with pre-natal and early childhood care providers to augment campaign message
- Provide incentives for workplaces that provide cessation programs and education activities; expand involvement of unions and obtain their buy-in
- Create linkages with other areas of health, such as nutrition and exercise, post-secondary institutions, youth organizations;
- Explore cultural approaches to cessation to determine need

S.3 Targeted effective messaging

- New health warning messages on packs
- Public education activities that drive home simple messages (e.g. anything that it is combustible and breathed into the lungs is bad)

Conclusions and Next Steps

The Tobacco Control Working Group Report is the result of an intensive research and engagement process involving many stakeholders, however, it also marks the beginning the launch of a collective process to develop the National Lung Health Framework. This Report, along with those from the other Working Groups and other pieces of researcher, will inform the Framework outline being prepared for the "Lung Health Framework: Plan for Action" Working Meeting scheduled for April, 2007.

The Meeting represents a key milestone in the collaborative effort to address the challenge posed by respiratory disease in Canada. There will be many more opportunities to build on the efforts of the Working Group, and further stakeholder engagement lay ahead. Members of the Working Group look forward to continued engagement in that process.

Appendices

A. Working Group Members
B. Working Group Roles
C. Workshop Agenda
D. Pre-Workshop Questionnaire

Appendix A: Working Group Members

TOBACCO CONTROL WORKING GROUP – PHASE I

Name	Organization
Paul Thomey - CHAIR	The Lung Association - Newfoundland
Catherine Carry	National Aboriginal Health Organization
Neil Collishaw	Physicians for a Smoke Free Canada
Dr. Charl Els	Consulting Agent
Dr. Alan Kaplan	Family Physician Airways Group of Canada
Ken Kyle	Canadian Cancer Society
Dr. Oxana Latycheva	Asthma Society
Karen McLean	Program Training and Consultation Centre
Brenda Paine	Health Canada
Ratsamy Pathammavong	The Lung Association – Ontario
Veda Peters	The Lung Association – British Columbia
Shirley Thompson	Health Canada

Appendix B: Working Group Roles

Working Group Objectives

Each Working Group is to work together to provide recommendations and guidance for the content of the Respiratory Health Framework. The Working Group members will:

- expand on the work completed by working groups at the Pre-Summit, held in April, 2006;
- identify additional stakeholders to be involved in the development of the Respiratory Health Framework;
- identify additional respiratory health issues to be included in the Respiratory Health Framework;
- identify additional goals, objectives, and outcomes to be included in the Respiratory Health Framework; and
- identify potential activities that can achieve these goals, objectives and outcomes.

The primary deliverable of each Working Group is a report reflecting this discussion, to be researched and completed by a researcher assigned to this task. This report will be submitted to the Respiratory Health Framework Steering Committee for consideration.

Chair

The role of the Chair is to work with the Senior Researcher and the Facilitator to ensure that the vision of the Respiratory Health Framework is reflected in the activities and outcomes of the Working Group.
Specific responsibilities include:

- review the members list;
- participate in a teleconference with the Senior Researcher and Facilitator to review the process and meeting agenda;
- review and comment on the goals and objectives of the meeting;
- review (and comment if necessary) on the background materials that will be provided to the members prior to the meeting;
- provide a welcome and introduction at the meeting;
- provide concluding comments at the end of the meeting; and
- if requested by the Steering Committee, to speak briefly at the outset of the Summit about the Working Group activities.

Senior Researcher

The role of the Senior Researcher is to work closely with the Chair and the Facilitator to ensure that the structure and resources are in place for the Working Group to achieve its goals.
Specific responsibilities include:

- identify potential participants for each working group;

- identify the background documents that are required for members;
- develop the goals and objectives of each working group; and
- work with the Facilitator and Chair to identify the strategy that will be used to meet the goals and objectives.

Meeting Facilitator

The role of the Facilitator is to provide the meeting coordination and to ensure that the meeting progresses towards its goal and objectives.
Specific responsibilities include:

- coordinate the Working Group meeting,
- ensure full and meaningful participation of all working group members;
- ensure that the discussion adheres to the identified schedule and meeting structure; and
- identify and review key messages, themes, recommendations, activities, goals, objectives and activities communicated throughout the meeting.

Working Group Researcher

The role of the Researcher is to participate in the meeting as an observer and to ensure that the discussions are reflected in a Working Group report.
Specific responsibilities include:

- participate as an observer in the Working Group meetings and
- produce a report that accurately reflects all discussion points.

Working Group Members

The role of Working Group Members is to identify and discuss issues in respiratory health in Canada, and to make recommendations for issues to be included in the Respiratory Health Framework. Specific responsibilities include:

- become familiar with the past work of the “Breathing Matters” Pre-Summit and other relevant documents;
- Provide feedback through the Pre-Meeting Questionnaire
- participate in a face to face meeting to discuss respiratory health issues in Canada (if scheduling permits);
- review and provide comments on the draft research report; and
- participate in a teleconference call to discuss the draft research report.

Steering Committee

The role of the Steering Committee is to use the Working Group report as a recommendation to identify the issues to be included in the Respiratory Health Framework.

Appendix C: Workshop Agenda

TOBACCO CONTROL WORKING GROUP MEETING - AGENDA

December 15th, 2006
Meeting Location: Novotel Hotel, Whitton Meeting Room, Ottawa, Ontario

Objectives of the meeting:

- *To develop a shared understanding of the strategic issues, challenges and opportunities related to the Tobacco Control theme of the Respiratory Health Framework;*
- *To articulate the outcomes that we wish to achieve related to the Tobacco Control theme; and*
- *In light of the desired outcomes, to identify the key results that must be achieved and the activities to be pursued to deliver the outcomes*

08h30 Coffee

09h00 Welcome, objectives of the meeting

- Overview of the agenda and approach for the day
- Participant expectations

09h15 Setting the Stage

- Update on the Respiratory Health Framework
- Mandate & objectives of the Working Group
- Identification of additional stakeholders who's perspectives are necessary
  - Individuals
  - Organizations
  - Sectors
- Researcher's role
- Proposed logic model and framework elements

10h30 Health Break

10h45 Identification of Strategic Issues/Challenges/Opportunities

- Important issues/trends/factors
- Stakeholder expectations
- Strategic implications and assumptions

12h00 Lunch

13h00 Development of the Short, Medium and Long Term Desired Outcomes

- In light of the strategic issues/challenges and opportunities, what outcomes do we wish to achieve short, medium and long term

14h30 Health Break

14h45 Framework Element Key Results

- Working with the proposed framework elements, what key results must we achieve over the next 3 years in order to move the yardstick forward?

15h30 Next Steps

Evaluation

16h00 Adjourn

Appendix D: Pre-Workshop Questionnaire

TOBACCO CONTROL WORKING GROUP PRE-MEETING QUESTIONNAIRE

Please complete and return by **Thursday December 7th** to:

E-mail address: achapman@lung.ca
Fax: 613 569 8860
Attention: Ainsley Chapman, Senior Researcher

Your Strategic Outlook for the Next 3 Years -

1. In order to begin to shape the desired outcomes for the future of Tobacco Control related respiratory health in Canada is important to understand our current and future contexts.

a) With regard to our current environment, what are your key working assumptions (information/knowledge, important issues/ trends, Canadian population expectations, etc.)?

b) With regard to the future, what is going on in your world that is either shifting or changing that will have a real impact on respiratory health?

2. Strategies work best when people at all levels share a basic common vision in relation to the directions that we are pursuing and outcomes that we are trying to achieve.

In your mind, what Tobacco Control related outcomes should we be trying to achieve short, medium and long term?

3. In light of all of your answers above, what key results must be achieved in the following areas?

a) Applied research
b) Surveillance and Monitoring
c) Detection, clinical practice and treatment
d) Community care and support
e) Knowledge transfer
f) Public awareness and prevention

From:...

Phone / fax: ....

e-mail:...