making QUIT happen

Canada's Challenges to Smoking Cessation

THE LUNG ASSOCIATION™

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Message from Chair, National Tobacco Task Force

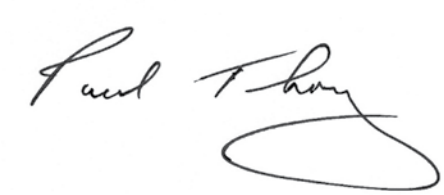
An estimated 37,000 Canadians will die this year from smoking-related diseases. Tobacco use is still the most significant risk factor in devastating diseases such as lung cancer and COPD. As a leader in lung health, The Lung Association is committed to helping smokers quit and using its voice to advocate for the system changes and tools needed to make it happen.

Why cessation and why now? Although smoking rates have declined over the past generation, the reality is that 19 per cent – or five million Canadians – continue to smoke. What's more, this report confirms that smokers want to quit. But they need our help. It is our vision that all smokers, regardless of where they live, have full access to the programs, supports and medications to help them quit permanently.

I would like to acknowledge the work of the task force who contributed their time and expertise to the development of this report. Thank you for your commitment and vision. I also want to thank the counselors, health professionals, families, youth advocates and partner organizations across this vast country who continue to work on a day-to-day basis to help smokers quit.

It is my sincere hope that with this report we have created a better understanding of the barriers to cessation services. It is our hope that the report will help promote changes that will better support the needs of all smokers and those committed to helping them quit, regardless of where they live and work in Canada.

Sincerely,



Paul Thomey

Chair, National Tobacco Working Group, The Lung Association

Introduction

Acknowledgements

Making Quit Happen: Canada's Challenges to Smoking Cessation was directed by a task force established by The Lung Association with medical expertise from the Canadian Thoracic Society (CTS) and the Canadian Respiratory Health Professionals (CRHP).

Task Force Members

Dr. Alan Kaplan	Family Physician and Chair, Family Physicians Airways Group of Canada
Dr. Christine D'Arsigny	Respirologist and Critical Care Specialist and Program Director for the Critical Care Fellowship Program at Queen's University
Ms. Deanne Kaar	Tobacco Cessation Services Coordinator, Saskatoon Health Region
Ms. Debbie Smith	Manager, Health Initiatives, Canadian Lung Association
Ms. Fay McLaughlin	Program Consultant, Tobacco Control Programme, Health Canada
Ms. Gredi Patrick	CHRP Member Representative; Research Associate Pulmonary Rehabilitation Program CDHA Department of Medicine CDHA Nova Scotia
Ms. Jo-Anne Douglas	Director, Tobacco Reduction Initiatives, Manitoba Lung Association
Ms. Mary-Pat Shaw	Vice President, National Programs and Operations, Canadian Lung Association
Ms. Niki Legge	Director, Cessation Initiatives and Tobacco Control, Newfoundland and Labrador Lung Association
Mr. Paul Thomey (Chair)	Executive Director, Newfoundland and Labrador Lung Association
Dr. Peter Selby	Clinical Director, Addictions Program and Head of the Nicotine Dependence Clinic at the Centre for Addiction and Mental Health. He is also an Associate Professor in the Departments of Family and Community Medicine, Psychiatry and Public Health Sciences at the University of Toronto.
Ms. Ratsamy Pathammavong	Tobacco Control Manager, Ontario Lung Association

Executive summary

This report is a comprehensive assessment of smoking cessation in Canada. It was developed by The Lung Association to identify key strengths, gaps, and issues. The goal of this report is to advocate for better access to programs and medications for all Canadians, better training of health care professionals and the addition of systemic cessation measures that highlight both the interim and the final successes. We know that most smokers want to quit and we have a responsibility to help them. The Lung Association hopes that this report will be a springboard for promoting the policy changes required to help all Canadians who want to quit smoking.

Scope and methodology

This report explores one aspect of tobacco control: smoking cessation. This is not peer reviewed research. The findings and calls to action published in this report were based on an environmental scan and analysis of the state of smoking cessation in Canada.

In addition, Leger Marketing was engaged to determine attitudes and experiences among health care professionals and the general population relative to cessation. Leger Marketing conducted a hybrid telephone and online survey between February 11th, 2008 and March 8th, 2008 among the following stakeholder groups (see Appendix: Survey Reliability Table):

- Family physicians;
- Other health care professionals (nurses, nurse practitioners, pharmacists, dental hygienists);
- Smokers;
- Ex-smokers; and
- Non-smokers exposed to second-hand smoke (those who live with smokers).

Key findings

The vast majority of smokers want to quit but there are barriers to their success. Some of the barriers are systemic while others reflect the realities of the quitting process itself. Smokers typically make several cessation attempts before they successfully quit smoking for good. In fact, the survey revealed only one-third of ex-smokers were able to quit permanently on their first attempt. Given this reality, smokers need access to a variety of supports to reflect the individual nature of the smoking cessation journey. A one-size-fits-all approach to cessation is not the answer.

Access to smoking cessation programs, medications, and support is not universal for all people living in Canada. People living in remote and rural areas, for example, do not have full access to online supports, help lines or counseling.

A variety of medications – both over-the-counter and prescription – also exist to help smokers quit. Yet access to the different medication options is disparate and depends on the smoker's province of residence. There is a perception among smokers surveyed that these medications are too expensive; and public and private insurance plans either do not cover them, or do not cover them sufficiently.

Physicians and other health care providers have a vital role to play in helping their patients to stop smoking. The interaction between patient and health care professional – in a variety of settings – offers an important window for supporting their patients' cessation efforts.

Health care providers need better access to training, tools and supports to support their patients in their desire to quit. Few health care professionals are trained in tobacco use intervention. Only 18 per cent of family physicians and 16 per cent of other health care professionals surveyed responded that they had received smoking cessation training.

Health effects of smoking

Smoking is linked to virtually all the major causes of death and disease in Canada. Almost 37,000 Canadians are expected to die in 2008 from tobacco related causes, including 1,000 from second-hand smoke.[1] Causal links have been established between tobacco use and many types of cancer, heart, cerebrovascular and lung diseases, and recently even to Type 2 diabetes.

Circulatory diseases are the leading cause of death in Canada.

- Smoking is responsible for almost 15% of all circulatory disease deaths.
- Almost 30% of all smoking-related deaths are manifested in the form of circulatory disease.[2]

Cancers are the second leading cause of death in Canada.

- Of all cancers, lung cancer continues to lead in rates of death.[3]
- Smoking is the single most preventable cause of lung cancer.[4]

Respiratory diseases are the third leading cause of death in Canada

- COPD (chronic obstructive pulmonary disease) is the fourth leading cause of death.[5]
- Smoking is the single most preventable cause of COPD.[6]

Smoking-related diseases

Smoking is also linked to poor asthma control, acute respiratory illness, and all major respiratory symptoms (coughing, phlegm, wheezing and shortness of breath). Passive or second-hand smoke is associated with a number of acute respiratory effects as well as eye and nasal irritations.[7]

Not only adults suffer. In children the effect of second-hand smoke is associated with bronchitis and pneumonia, asthma, chronic respiratory symptoms and middle ear infections.[8] It is also a major risk factor for SIDS – sudden infant death syndrome.[9]

In pregnancy, smoking affects both mother and baby. The mother is at greater risk of having a miscarriage or complications during the birth. Many of the 4,000 chemicals in cigarette smoke are passed to the unborn child. This can result in slower growth in the womb as well as a lower-than-average birth weight, or even pre-term birth. The baby of a non-smoking mother exposed to second-hand smoke while pregnant has a higher chance of having learning problems, more ear infections, more colds and breathing problems.[10, 11]

Canada's First Nations, Inuit and Métis experience higher rates of many smoking-related diseases than the rest of Canada. They are at greater risk for high blood pressure, heart disease and stroke than the general population.[12] Prevalence of Type 2 diabetes is 3 to 5 times higher than that of the general population.[13] Tuberculosis rates in Canada are highest among Aboriginal Peoples.[14] The incidence of cancer in First Nations people is increasing faster than in the general population.[15] Rates of asthma in First Nations adults,[16] COPD (in the form of chronic bronchitis) in First Nations youth,[17] bronchiolitis in Inuit infants,[18] and diabetes in Métis,[19] are all higher than the Canadian population.

What is the financial toll of smoking for Canada?

In addition to the devastating effects to Canadians' health, tobacco use costs Canada billions each year in health care. Health care costs related to tobacco have increased steadily since 1966.[20] In 2002 tobacco use accounted for $4.4B in direct health care costs and an additional $12.5B in indirect costs such as lost productivity, long-term disability and premature death.[21]

Barriers to cessation

Good news: Smokers want to quit

Of the smokers surveyed 91% indicate at least some desire to quit smoking. When asked to rate themselves on a scale where 10 means definitely wanting to be smoke-free and 0 means not wanting to be smoke-free at all, smokers scored an average of 7.2. Over half (52%) say they are seriously considering quitting within the next 6 months. More than three-quarters (79%) have already tried to quit. For those who have tried, an average of six quit attempts was reported.

When asked specifically why they would quit, future health concerns topped the list. Three out of four smokers say they are concerned about the impact of smoking on their health.

For those who quit the improvements in health are dramatic and immediate. Oxygen levels in the blood increase to normal within hours as carbon monoxide levels drop. Risk of stroke and other circulatory disease diminishes and the chance of smoking-related heart attack is cut in half within a year. Within a few years, compared to those who continue to smoke, the chance that an ex-smoker will get cancer is reduced by half. Within 15 years the risk of a fatal heart attack is almost the same as that of a person who has never smoked.[22]

Why are Canadians still smoking?

After years of public education campaigns, smoke-free legislation, tax increases, advertising restrictions, warnings on cigarette packages, restrictions on the sale of tobacco and where it can be used, 19 per cent of Canadians are still smoking.

All stakeholder groups surveyed identified habit and addiction as the two main barriers to quitting. At least 8 in 10 agree that nicotine addiction is why so many people keep smoking even when they want to quit.

Nicotine addiction: A key challenge to cessation

"NICOTINE ADDICTION IS WHY SO MANY PEOPLE KEEP SMOKING EVEN WHEN THEY WANT TO QUIT." [% AGREE]

Smokers	Ex-smokers	Non-smokers living with smokers	Family physicians	Other health care professionals
N=2002	**N=1296**	**N=898**	**N=200**	**N=397**
87%	86%	85%	93%	88%

The Definition of Success Varies

The subject of addictions and habit-breaking is a complex one. What works for one smoker will not necessarily work for another. As such, treatment programs must reflect the journey of cessation and consider relapse as a typical part of the process.

Seven out of every ten ex-smokers surveyed said that when they finally quit for good, the cessation method they used on their final quit attempt was the "cold turkey" method.

Smokers confirmed that all cessation methods worked to some extent before they relapsed.
Smokers identified several reasons why the cessation method they tried did not work:

- cravings and/or withdrawal symptoms were frequently reported across all cessation methods;
- lack of will power and not being ready;
- stress;
- cost of medications and dosing of medications;
- lack of support;
- worry about weight gain.

Success measures often overlook relapse

Clearly relapse happens. When it does, *staying quit* becomes the problem. For most smokers, quitting is a journey marked with several successes along the way. Formal smoking cessation programs measure success over a relatively short period of time; many measure success at six months; some one year.

The time in between successes is often overlooked in cessation programs. If a life-long quit is the ultimate goal, perhaps staying smoke-free longer 'this time' than 'last time' should also be measured as a success.

Behaviour change and cognitive learning models are particularly effective for dealing with life long journeys of staying quit. To assist smokers in this journey, health care systems should incorporate – and measure – the *continuum of quitting.* Tools are needed to assist smokers in planning for the whole cessation journey including how to avoid, and deal with, relapse.

The role of family physicians and other health care professionals

Most family physicians and other health care professionals surveyed feel they have a role to play in their patients' smoking cessation. The following table illustrates the differences in how health professionals see their role versus how smokers and ex-smokers perceive it.

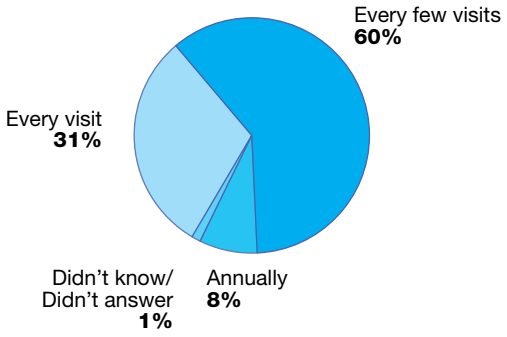
PERCEPTIONS OF THE ROLE OF HEALTH PROFESSIONALS IN SMOKING CESSATION

	%			
	Family physicians	Other health care professionals	Ex-smokers	Smokers
	(n=200)	(n=397)	(n=1296)	(n=2002)
Initiate the conversation	84	41	36	27
Help them to make a plan to quit	77	46	38	40
Suggest ways to quit	87	51	51	54
Suggest they see their family physician		42		
Suggest they see their family physician to obtain a prescription		41		
Suggest over-the-counter solutions such as nicotine gum		39		
Prescribe smoking cessation medications	90		35	42
Refer them to personal or group therapy	51	28	19	17
Provide smoking cessation counseling	76			
Schedule on-going consultations to follow their progress	62	24	24	28
Other		3	1	1
Should not play a role		4	17	13
Not sure/didn't answer		7	12	10

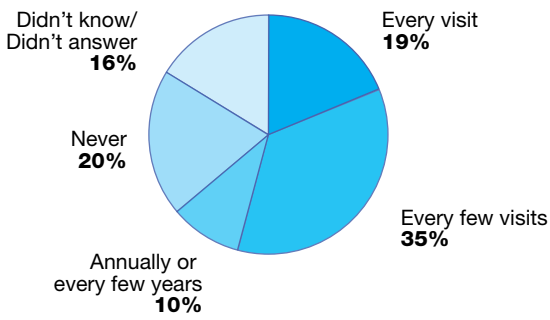
Family physicians consider themselves to be very involved with their patients' smoking cessation. The vast majority (92%) say they bring up the topic of quitting smoking with their patients and that they discuss it on a regular basis.

Other health care professionals report less involvement. Only about half (54%) of those surveyed say they discuss their patients' smoking habits with them on a regular basis.

FAMILY PHYSICIANS DISCUSS QUITTING WITH PATIENTS



OTHER HEALTH CARE PROFESSIONALS DISCUSS QUITTING WITH PATIENTS



Yet the majority of smokers, ex-smokers and non-smokers living with smokers indicate they don't discuss quitting with their family physician or other health care professional. Only 41% of smokers reported having discussed quitting with their family physician in the past 2 years. Only 15% of smokers had discussed quitting with a health care professional other than their family physician. Interestingly, of these smokers, 46% say they initiated the discussion; 46% say their health professional did.

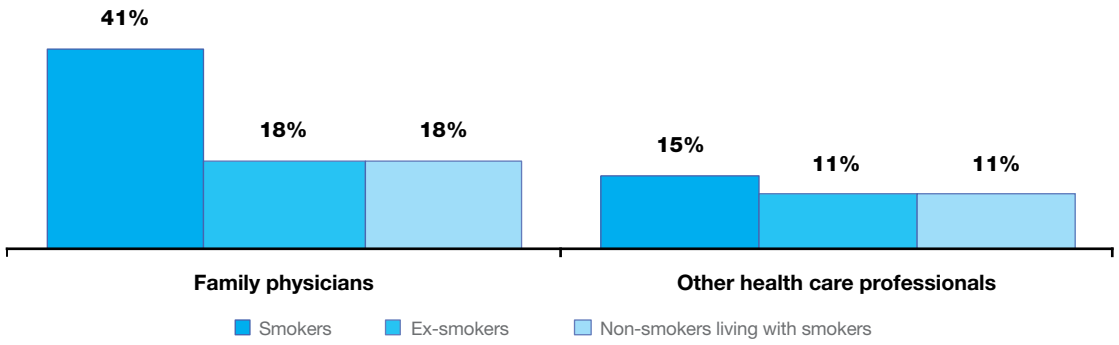
Among ex-smokers, only 21% report discussing quitting with their family physicians and 6% with another health care professional.

Non-smokers living with smokers are also concerned about their health. Most (69%) report discussing quitting with the smoker but only 18% report they have discussed the effects of living with second-hand smoke with a family physician in the past 2 years.

Nonetheless, there are clear benefits to having these discussions. Three out of four ex-smokers felt the advice their family physician or other health care professional provided helped them quit.

The following chart shows the proportion of smokers, ex-smokers and non-smokers living with smokers who report discussing quitting with a health professional.

DISCUSSING QUITTING WITH FAMILY PHYSICIANS AND OTHER HEALTH CARE PROFESSIONALS



The majority of pharmacists (73%) report that they are asked for their advice about quitting smoking at least once a day. Almost half (47%) are asked two or more times a day.

Gaps in continuity of health care

Not everyone sees one consistent family physician or general practitioner

Survey respondents report differences in the continuity of their health care. Respondents who report having a consistent family physician or general practitioner are most likely to be: women; those in Nova Scotia, BC, and Ontario; those with private or provincial health plans; those 40 years of age or older; those who have already discussed smoking cessation with their physician; and those who have attempted to quit in the past – particularly those who have attempted to do so five or more times. Quebeckers, on the other hand, are nearly twice as likely to indicate they have no consistent physician/general practitioner. Younger respondents (i.e. those under 30) are more likely to see multiple physicians or have none at all.

Among those who do see multiple physicians/general practitioners, most agree that having one consistent family physician or general practitioner would help them to quit smoking.

Gaps in training

Most health care professionals have not had any formal cessation training

Few family physicians (18%) and other health care professionals (16%) are trained in smoking cessation counseling but 57% of family physicians say they are reimbursed for it.

A review of various family physician, pharmacy, nursing and dental hygiene curricula across the country – with respect to tobacco use intervention training – revealed variances. Both training time and depth of content varied across and within disciplines. In family physician programs training times vary from less than one hour to several hours. Training addresses basic intervention models such as the 5 A's (Ask, Assess, Advise, Assist, Arrange), cessation pharmacology, and a population health approach to tobacco control. Within pharmacy, nursing, and dental hygiene programs the same variance was also identified. Here, the duration of training typically ranged from 2 to 12 hours, with some of the longer programs often including behavior change and motivational approaches such as the 5 R's (Relevance, Risks, Rewards, Roadblocks, and Repetition). Continuing medical and pharmacy education courses on tobacco use intervention are offered in some provinces from some educational institutions. Some national health professional associations such as the Canadian Pharmacists Association and the Canadian Dental Hygienists Association also teach tobacco use intervention through on-line continuing education courses. In addition, several health professional associations, including the Canadian Medical Association, the Canadian Pharmacists Association, the Canadian Nurses Association and the Canadian Dental Hygienists Association, have issued individual or joint position statements highlighting the role of health professionals in the control of tobacco use – a role which includes an intervention function.

Patients often see other health care professionals such as pharmacists, nurses and nurse practitioners, dentists and dental hygienists, respiratory therapists or physiotherapists more frequently than they see their family physician. These settings offer excellent opportunities for the health care professional to ask about smoking habits, to encourage quitters and to help them succeed in the current phase of their quit journey.

A model approach

Clinical tobacco intervention models can be applied beyond their clinical setting. At the Ottawa Heart Institute new medical residents and nurses receive one-on-one training in how to manage tobacco dependency. Patients are asked to confirm their smoking habits when they are admitted and smoking status is documented in their medical record. The attending physician or nurse advises all smokers to quit. Support is provided by a designated nurse counselor trained in all aspects of nicotine dependence and smoking cessation. Orders for stop-smoking aids can be provided by the attending physician. Recommendations to support smoking cessation are included in the patient's discharge letter and sent to the family physician.

Following discharge an automated voice messaging system is used to track patients' progress on days 3, 14 and 30. The system asks the patient a detailed series of questions. If any response suggests the patient is having trouble remaining smoke-free, or if the patient has started smoking again, a nurse counselor will call to review options and help get the patient back on track. This includes a referral to the Institute's outpatient smoking cessation clinic. Patients are assessed again six months after discharge.[23]

In addition to applying this model in other hospital settings, its principles can be applied outside the hospital setting. All public health systems should employ a similar approach:

- consistent screening;
- key personnel trained at various skill levels including in-depth behaviour modification and addiction treatment;
- primary care physicians trained with, at minimum, brief intervention techniques and smoking cessation planning strategies;
- designated physician specialists trained at the brief intervention skill level;
- designated health care professionals trained at appropriate levels of intervention techniques;
- all health care providers trained to ask about smoking habits and understand how to encourage smokers on their quit journey;
- all health care providers aware of the supports available to smokers and the appropriate referral routines;
- follow-up phone calls providing smokers with the encouragement and guidance required to help them stay quit;
- analysis and measurement that recognizes reduced length of relapse and renewed quit attempts as key indicators towards achieving and sustaining reduced rates of tobacco use.

Access to programs and medications

Programs

There are many types of smoking cessation programs. Most are provided free of charge. In addition, most are based on proven "best practice". They include common elements shown to be effective. Some programs are geared to specific target audiences. There are several other programs designed specifically for youth, including school-based programs and leadership programs. There are also several programs intended for pregnant and postpartum women. Some are designed to meet the needs of smokers who also have drug or alcohol addictions or mental health issues. Clinical tobacco intervention programs are also used in hospital settings.

Cessation programs have also been created specifically for a workplace setting. For employers it is worth the investment: an employee who smokes costs more than one who is smoke-free. In 1997, at the request of Health Canada, the Conference Board of Canada prepared a report detailing the costs to employers of workers who smoke.[24] In its August 2006 report *Smoking and the Bottom Line: Updating the Costs of Smoking in the Workplace* the Conference Board updated these costs. The four areas where smoking was determined to have a cost impact for an employer – absenteeism; productivity; insurance premiums; and designated smoking facilities – were reassessed. In 2006, an employee who smoked was determined to cost an employer $3,396 per year more than an employee who did not smoke.[25]

No matter the target audience or method of delivery, smoking cessation programs aim to provide smokers with incentive to quit, information to guide them through the process and tools and strategies help them along the way.

Self-help programs

The self-help approach involves the smoker using materials available from a variety of sources. Materials are typically available in a printed format and/or can be downloaded from the internet. Self-help programs are more than just a list of facts. They may be tailored for a specific target audience, for example programs for those who are ready to quit; or programs designed for youth. Materials typically take the smoker through a sequence of activities or steps along the road to quitting. There are also self-help programs that apply to people supporting a friend or loved one on their quit journey.

Helplines

Helplines, sometimes called quitlines, are toll-free phone-in lines staffed by trained smoking cessation personnel to provide support, counseling and referrals. These services are designed to encourage and support quitters. Some helplines also offer support for the "influencers" – those helping someone else quit. Almost all helplines provide mailed resources and many offer "proactive" calls for clients who meet predetermined criteria.[26] While helpline callers are often guided to this service by a health care professional, a referral is not a requirement.

Web-based programs

There are a variety of smoking cessation supports available "online" including counseling via email, find-a-buddy and chat groups. Most web-based programs allow users to establish a profile, view information and read success stories, complete workbooks and keep track of their progress. These programs are often geared to the younger smoker and most are free or provide at least a basic component free of charge.

Group counseling programs

Group counseling programs are also available in a limited number of communities and settings. Many group counseling programs are experiencing reduced rates of registration and organizers are seeing a shift in smoker preference from group to individual counseling. Some group counseling programs are short (for example only a few hours); some are compressed (such as a weekend "retreat"); and others are offered one or two nights a week for several weeks.

Individual counseling

Due to the highly individualized nature of the smoking cessation journey, demand for individual counseling is increasing. Counselors receive training specific to smoking cessation, including behaviour modification and cognitive therapies. They come from a variety of health care professions.

Smoking cessation counselors and teams

Several types of smoking cessation experts are trained to help smokers quit. The nursing profession is most often involved in cessation – nurses, nurse practitioners or public health or community health nurses. Social workers are also commonly involved in cessation. Addictions counselors, psychologists, pharmacists, dietitians, dental professionals, respiratory therapists and exercise therapists can also be involved. In some settings school or youth counselors assist. In First Nations, Inuit and Métis communities the community health representative (CHR) and sometimes a role model play a part. The idea of involving a supportive community in a smoker's cessation process is growing. In some settings that supportive community includes not only family or loved ones, but also other smokers, non-smokers and even those not yet ready to quit. Regardless of how many people are on a cessation team or what professions they represent, all need at least some education in smoking cessation and at least one of the resources should be skilled at in-depth quit counseling.

Governance of smoking cessation programming varies across Canada. In some health regions, responsibility for smoking cessation falls within the 'healthy living' department; in others it is the addictions department. Some programs are governed by advocacy organizations or charitable organizations like The Lung Association. These differences can impact the composition of the cessation team and the way success is defined. Also, the sources and availability of program funding vary widely.

With programs available via the telephone, the Internet and in every health region across the country it would appear that all Canadians have equal access to effective smoking cessation programs.

Access to cessation programs unequal

In reality, access to effective programming for each Canadian is not equal. Canada's First Nations, Inuit and Métis have notably higher rates of smoking than the rest of the country. Yet access to programming is not universally available. A toll-free smoking cessation helpline program is being tested in Yukon Territory, but no such service exists for the Northwest Territories or Nunavut. In addition, although many schools and businesses in Canada's far North are equipped with Internet access, many homes have only dial-up access or no internet access at all.

Language is also a barrier. Many First Nations, Inuit and Métis people do not speak English or French and lack access to quit smoking materials and programs in *their* language. Only a limited number of materials have been translated into some of the languages of Canada's First Peoples.

Along the smoking cessation journey, several programs, options and supports are required. Telephone helplines and web-based programs alone are not sufficient. Unfortunately, in more rural and remote areas where counseling professionals or cessation support teams must travel to smokers it becomes more difficult to "cost justify" programming. In addition, social structures and cultures differ. In some cultures there is a spiritual or sacred aspect to smoking tobacco. In these cultures it is the recreational use of commercial tobacco that is at issue. Cessation programs must be tailored to fit these social and cultural needs.

Medications

Smoking cessation medications fall under two main categories: nicotine replacement medications that can be purchased "over the counter"; and medications that are available only by prescription.

Over-the-counter nicotine replacement medications

In Canada over-the-counter medications include nicotine gums, patches, inhalers and lozenges. They are formulated to provide nicotine to the body in controlled doses, replacing the nicotine the body is no longer receiving from tobacco. Monitored dosing of these medications allows the quitter to gradually reduce the amount of nicotine in the body thus controlling withdrawal symptoms and cravings. This category of medication is sometimes referred to as OTC or NRT.

Prescription medications

Prescription-only medications for smoking cessation do their work in the brain. This category of medications includes bupropion hydrochloride and varenicline tartrate.

Bupropion hydrochloride comes in a pill format and has been used for some time to treat depression. While still available for that purpose, it was approved by Health Canada nine years ago for use as a smoking cessation aid. Bupropion appears to affect the balance of chemicals that occur naturally in the brain, reducing cravings and other withdrawal symptoms common when a smoker stops smoking. It does not provide nicotine to the body and can be used in combination with nicotine replacement therapy.

Varenicline tartrate is a new drug used in smoking cessation. It is available in pill format. Varenicline is known to affect the nicotine receptor in the brain that is thought to be most related to tobacco addiction. It does not contain nicotine, but reduces cravings and other withdrawal symptoms associated with quitting smoking. Varenicline cannot be used in combination with nicotine replacement therapy.

Access to medications

While smoking cessation medications are stocked in virtually every pharmacy across the country, not all Canadians have equal access to them. Because they are classified as "lifestyle" drugs they are excluded from most of the country's public health plans. "Lifestyle" drugs can be defined as those used to treat diseases that result from a person's social or lifestyle choices. Other "lifestyle" drugs are those used for hair growth, weight loss, fertility treatments, etc.

As a result of their "lifestyle" classification smoking cessation medications are also covered by only a minority of private employee health plans.

The following two charts outline what smoking cessation medications are covered under Canada's public health plans. The first illustrates coverage under federal health plans and the second illustrates coverage under provincial health plans.

FEDERAL HEALTH PLAN COVERAGE FOR SMOKING CESSATION MEDICATIONS

	Over-the-counter nicotine replacement therapies				Prescription-only medications	
Program	**Patch**	**Gum**	**Lozenge**	**Inhaler**	**Bupropion**	**Varenicline**
Correctional Services	**covered**, 1st course (12 weeks) free; pay for subsequent	**covered**, 1st course (12 weeks) free; pay for subsequent	n/a	**covered**, 1st course (12 weeks) free; pay for subsequent	**covered**, 1st course (12 weeks) free; pay for subsequent	not covered
Department of National Defense (DND)	reimbursed for 3 months if in approved program	reimbursed for 3 months if in approved program. No quantity limit	reimbursed for 3 months if in approved program. No quantity limit	reimbursed for 3 months if in approved program. No quantity limit	reimbursed for 3 months if in approved program. No quantity limit	not covered
First Nations	**covered**, up to maximum patches per year	**covered**, up to maximum pieces per year	not covered	not covered	**covered**, up to a maximum 180 tablets per year	**covered**, up to a maximum 165 tablets per year
Veterans Affairs	not covered	not covered	not covered	not covered	**covered**, requires special approval	not covered
RCMP	**covered**, for 12 weeks over 12 month period	**covered**, for 12 weeks over 12 month period	**covered**, for 12 weeks over 12 month period	**covered**, for 12 weeks over 12 month period	**covered**, for 12 weeks over 12 month period	**covered**, for 12 weeks over 12 month period
Interim Federal Health Program (humanitarian assistance for refugees)	not covered	not covered	not covered	not covered	not covered	not covered

PROVINCIAL HEALTH PLAN COVERAGE FOR SMOKING CESSATION MEDICATIONS

	Over-the-counter nicotine replacement therapies				Prescription-only medications	
	Patch	**Gum**	**Lozenge**	**Inhaler**	**Bupropion**	**Varenicline**
BC	not covered	not covered	n/a	n/a	not covered	under review
AB	not covered	not covered	n/a	n/a	**covered** for specified groups; ("those who are on social assistance", "through a special arrangement with the GoA")	not covered
SK	not covered	not covered	n/a	n/a	not covered	not covered
MB	not covered; no PST as of April 2008	not covered; no PST as of April 2008	n/a	n/a	not covered	under review
ON	not covered; temporary retail sales tax exemption: August 12, 2007-August 13, 2008	not covered; temporary retail sales tax exemption: August 12, 2007-August 13, 2008	not covered; temporary retail sales tax exemption: August 12, 2007-August 13, 2008	not covered; temporary retail sales tax exemption: August 12, 2007-August 13, 2008	not covered for smoking cessation; covered for depression	under review
QC	**covered;** max 12 consecutive weeks per 12 month period	**covered;** max 12 consecutive weeks per 12 month period	**covered;** max 12 consecutive weeks per 12 month period	not covered	**covered;** max 12 consecutive weeks per 12 month period	**covered;** max 12 consecutive weeks per 12 month period
NB	not covered	not covered	n/a	n/a	not covered	not covered
NS	not covered; provided in conjunction with counseling through Addiction Services	not covered; provided in conjunction with counseling through Addiction Services	n/a	n/a	not covered	under review; **covered** in some districts (South Shore #1, Southwest Nova #2, Annapolis Valley #3)
PE	**special coverage only;** covered for program participants in group or individual counseling programs; max $75 per year	**special coverage only;** covered for program participants in group or individual counseling programs; max $75 per year	n/a	n/a	**special coverage only;** covered for program participants in group or individual counseling programs; max $75 per year	under review
NL	not covered	not covered	n/a	n/a	not covered	not covered
NU	n/a	n/a	n/a	n/a	n/a	n/a
NT	n/a	n/a	n/a	n/a	n/a	n/a
YT	n/a	n/a	n/a	n/a	n/a	n/a

There is a need for affordable medications

There is a perception among all stakeholder groups surveyed that smoking cessation medications are too expensive – for some a barrier to quitting. When family physicians were asked what they thought could be done to achieve the reduction in smoking rates targeted by the federal government the suggestion chosen most frequently was affordable cessation programs and medications.

What encourages smokers to quit?

When asked what factors encouraged them/would encourage them to quit smoking, an interesting difference surfaced between ex-smokers and the other two groups surveyed – smokers, and non-smokers living with smokers. Approximately 70% of all three groups agreed that the increasing cost of cigarettes encourages quitting. However, they did not all agree regarding the impact of being diagnosed with a health problem. Only 42% of ex-smokers feel this provided their greatest motivation for quitting. For them the cost of cigarettes increasing ranked highest (74%) followed by pressure from family, friends or loved ones (64%), and fewer public places allowing smoking (53%). Sadly, smokers and non-smokers living with smokers indicated that the greatest motivation for quitting would come from being diagnosed with a health problem (71% of smokers and 81% of non-smokers living with smokers). Clearly, work is required to encourage today's smokers to quit before they receive a significant diagnosis.

Recommendations

In August 2007, the federal government announced a new goal for the renewed Federal Tobacco Control Strategy: to reduce the rate of smoking to 12% by 2011. In addition to reducing the overall rate, the Federal Tobacco Control Strategy also aims by 2011 to:

- reduce the prevalence of smoking among 15 to 17 year olds from 15% to 9%;
- increase the number of adults who quit smoking by 1.5 million;
- reduce the prevalence of Canadians exposed daily to second-hand smoke from 28% to 20%.[27]

To achieve any meaningful reduction in rates The Lung Association advocates for the following recommendations. (These recommendations are based on an environmental scan of the current availability of programs, supports, medications, and best practices, and the key findings of the market research contained in this report.)

Improve and expand surveillance

Expand the measurement and tracking of success to reflect the reality of the quitting process – a highly individualized journey that typically involves several quit attempts – by reporting the rate of former smokers who remain smoke-free each year, and for those continuing to smoke, the number of quit attempts, the length of relapse and the length of time between relapses.

Access to programs and trained counselors

Provide better access to cessation programs and supports to all people living in Canada by ensuring trained smoking cessation counselors are available to everyone who wants to quit.

Training for family physicians and other health care professionals

Provide tools and training to family physicians and other health care professionals by including standard intervention strategies in the curriculum for all health professionals and more extensive intervention training where required or requested.

Access to medications

Improve access to affordable medications for all people living in Canada by including all medications on provincial formularies and drug coverage plans.

Culturally relevant cessation support for Aboriginal Peoples

Provide smoking cessation programs and supports to First Nations, Inuit and Métis peoples that recognize the realities of their cultures, traditions, and languages as well as their remote and/or dispersed locations.

Investment in tobacco control: Setting benchmarks

To date, no Canadian benchmarks have been developed to suggest appropriate levels of investment in tobacco control. Such benchmarks could help facilitate the achievement of goals set out in all smoking cessation strategies – those set out at the provincial level as well as the federal targets.

The Centers for Disease Control and Prevention (CDC) is one of the major operating components of the United States Department of Health and Human Services. In 1999 the CDC issued a Best Practices document outlining the cost components of tobacco control. Based on these costs, it suggested appropriate levels of investment for effective tobacco control in each state. The CDC's Best Practices for Comprehensive Tobacco Control Programs – 2007 recommends an annual investment in the United States of $12.34 per capita (per person 18 years of age or older). The following chart shows the breakdown of this recommended investment by component of tobacco control.

US CENTERS FOR DISEASE CONTROL AND PREVENTION
2007 RECOMMENDED PER CAPITA INVESTMENT IN TOBACCO CONTROL (USA)

Total	State & community interventions	Health communication interventions	Cessation interventions	Surveillance & evaluation	Evaluation & management
12.34	4.88	2.36	3.49	1.07	0.54

[28]

Tobacco sales generate significant tax dollars each year in Canada. These funds could be directed towards Federal and Provincial tobacco control initiatives – including smoking cessation initiatives. The following chart outlines the various taxes charged across the country on a typical carton of (200) cigarettes. Based on the current average of 15.5 cigarettes smoked per day, Canada's 5 million smokers generate a total tax revenue exceeding 2.5 billion dollars a year.

TAXES PER CARTON OF 200 CIGARETTES – 2008

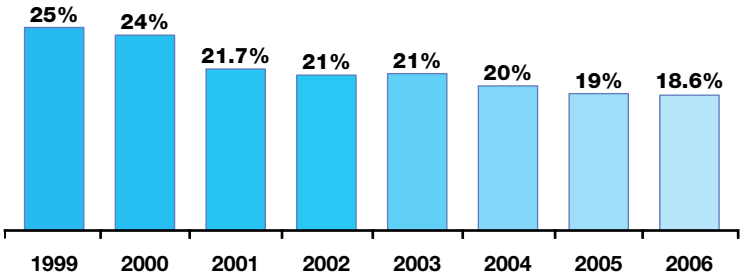
	$						Federal tax		Provincial tax	
	Product		Provincial tobacco tax	GST	PST/ HST	TOTAL price	as a % of total taxes	as a % of total price	as a % of total taxes	as a % of total price
Prov./ Terr.	Base Price	Federal Excise Duty*								
BC	20.00	17.00	35.80	3.64	0	76.44	36.6%	27.0%	63.4%	46.8%
AB	20.00	17.00	37.00	3.70	0	77.70	35.9%	26.6%	64.1%	47.6%
SK	20.00	17.00	36.60	3.68	4.24	81.52	33.6%	25.4%	66.4%	50.1%
MB	20.00	17.00	35.00	3.60	4.87	80.47	34.1%	25.6%	65.9%	49.5%
ON	20.00	17.00	24.70	3.09	0	64.79	44.8%	31.0%	55.2%	38.1%
QC	20.00	17.00	20.60	2.88	0	60.48	49.1%	32.9%	50.9%	34.1%
NB	20.00	17.00	23.50	3.03	4.97	68.49	41.3%	29.2%	58.7%	41.6%
NS	20.00	17.00	33.04	3.50	5.17	78.71	34.9%	26.0%	65.1%	48.5%
PE	20.00	17.00	34.90	3.60	0	75.50	37.1%	27.3%	62.9%	46.2%
NL	20.00	17.00	36.00	3.65	5.49	82.14	33.2%	25.1%	66.8%	50.5%
NU	20.00	17.00	42.00	3.95	0	82.95	33.3%	25.3%	66.7%	50.6%
NT	20.00	17.00	42.00	3.95	0	82.95	33.3%	25.3%	66.7%	50.6%
YT	20.00	17.00	26.40	3.17	0	66.57	43.3%	30.3%	56.7%	39.7%

* Excise duties are charged on spirits, beer, and tobacco products. When these goods are manufactured in Canada, duty is charged on goods at the point of manufacture rather than sale. When they are imported into Canada, duty is payable by the importer at the time the goods are imported.[39]

Rates of smoking

Tobacco use remains an urgent public health issue. Smoking rates have declined since their peak in the 1960s when the health risks associated with tobacco began to be broadly publicized. The rate of smoking has declined from almost 50% in 1965 to 19% in 2006. Nevertheless, five million Canadians still smoke. At-risk populations include youth, pregnant women and Aboriginal Peoples.

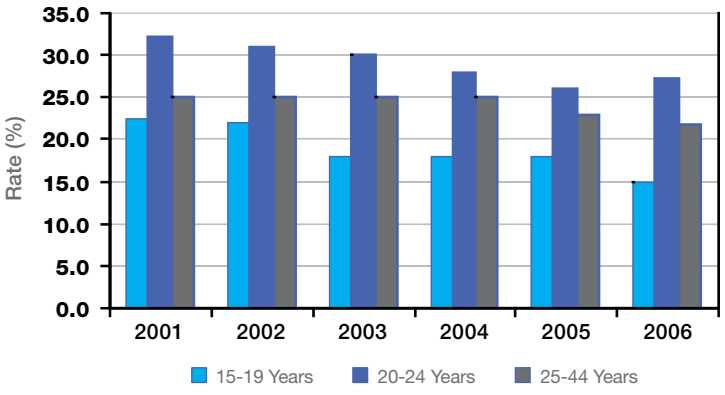
SMOKING RATES IN CANADA[30]



Youth

Tobacco use among younger segments of the population remains a difficult challenge. The rate of smoking among youth is not declining as quickly as it is in other age sectors. In fact, among 20 to 24 year olds, the rate of smoking actually increased between 2005 and 2006.

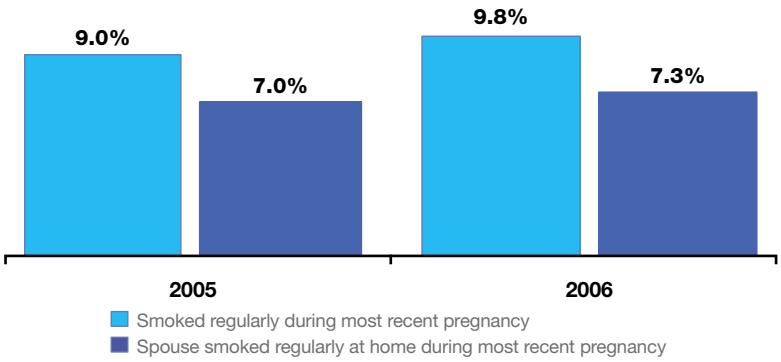
SMOKING AMONG CANADA'S YOUTH[31]



Pregnant women

Pregnant women who smoke are another segment of the population of particular concern. Smoking rates have dropped for pregnant women aged 15 to 24 , but have increased for pregnant women aged 20 and 44. In 2006 the rate among 20 to 24 year olds was particularly high at 22% with 17.5% exposed to smoke on a regular basis.

RATES OF SMOKING AND EXPOSURE TO SMOKE AMONG PREGNANT WOMEN BETWEEN 20 AND 44 YEARS OF AGE[32]



First Nations, Inuit and Métis

Unfortunately, data on smoking amongst Canada's Aboriginal Peoples is often out of date or unavailable. What is known points to a significantly higher prevalence of smoking in First Nations, Inuit and Métis than for other people living in Canada.

First Nations

According to the First Nations and Inuit Regional Health Surveys of 1997, the smoking rate in First Nations adults was at 62%, double the Canadian average. Rates were even higher at younger ages with almost three-quarters of people in their early 20s smoking. These rates remained unchanged since 1991. Most adults began smoking around age 16, some as early as 11, and a few as young as eight.[33]

Statistics from 2002/03 show that the rate of smoking among First Nations people in Canada was 59%. Although this represents a decline from 1997 rates, the rate of reduction was greater for the rest of Canada and by 2003 smoking among First Nations was three times the rate for the general Canadian population.[34] Based on a 2004 Baseline Study by Environics Research Group 52% of on-reserve First Nations people were smokers. For those between the ages of 19 and 34 the rate was 60%.[35, 36]

A recent report from the Assembly of First Nations suggests that First Nations girls between 15 and 17 years old have a smoking rate of 61% – four times the national smoking rate of girls of the same age. First Nations boys between ages 15 and 17 years old have a smoking rate of 47%, compared with the national rate of 13% for boys of the same age.[37]

Inuit

A1999 study showed that smoking rates among Inuit (72%) were the highest in Canada.[38] More recent data suggests that for Inuit living in Nunavut, rates have decreased from 64.9 % in 2003 to 53.1 % in 2005.[39] Approximately half of Inuit people live in Nunavut. The most recent youth statistics show that 70% of Inuit between the ages of 18 and 45 smoke.[40]

Métis

Few statistics are available on smoking among Métis peoples. In 1991, the percentage of Métis who smoked was quite high, 54% (SC 1996). Forty-seven percent (47%) of Métis smoked on a daily basis, while the remaining 7% smoked only occasionally (SC 1996). The prevalence of smoking is highest among the 25-44 age group, and is considerably lower among seniors (SC 1996). In 1991, the rates were 54% for Métis aged 15-24, 59% for Métis aged 25-44, 49% for Métis aged 45-64 and 37% for Métis aged 65 and over (SC 1996).[41]

Off-reserve smoking rates also high

In 1997, smoking among off-reserve Aboriginal Peoples (51.4%) was almost double that of the general Canadian population. In addition, the smoking rates of off-reserve Aboriginal Peoples were significantly higher than those of the non-Aboriginal population in both urban and rural areas.[42]

Challenges for Aboriginal Peoples

In addition to facing higher rates of smoking, Aboriginal Peoples face other challenges relative to smoking cessation. Other addictions such as alcohol and drug addictions present an additional barrier to cessation. Tobacco has a ceremonial and spiritual role in Aboriginal Peoples' culture. Many First Nations Elders believe that the recreational use of tobacco is disrespectful of the spiritual, medicinal, and traditional uses. Traditional healing forms a wide belief among all Aboriginal Peoples. They look to the principles and approaches of traditional healing to support smoking cessation efforts. Another challenge for smoking cessation approaches is the variances in culture and language that exist in First Nations, Inuit, and Métis peoples. Smoking cessation approaches for Canada's First Nations, Inuit and Métis must take into account all of these realities to be successful. Few interventions in these populations have been studied, or studied sufficiently to prove effectiveness.

Tobacco strategies and legislation in Canada

		Smoking in publc places			
		Public places indoor (enclosed)	Public places outdoor	School grounds	Work place
BC	Targeting our Efforts Aboriginal Tobacco Strategy	•	• ■ Mar. 31/08 3m from air intake; Vancouver 6m.	•	• incl. work vehicles
AB	Reducing tobacco use in Alberta: a comprehensive strategy Aboriginal Tobacco Strategy	•	•		• incl. work vehicles
SK		•	◆	◆	◆
MB	The Manitoba provincial tobacco control strategy: a co-ordinated, comprehensive approach to reduce smoking-related disease, disability and death in Manitoba ("Cutting Through the Smoke")	•		◆	• indoor workplaces & work vehicles
ON	Smoke-Free Ontario Strategy	•		•	• enclosed; exempt specific residences
QC	Le Québec respire mieux : plan québécois de lutte contre le tabagisme 2006-2010	•	•	•	• incl. work vehicles
NB	There's a change in the air: New Brunswick anti-tobacco strategy	•		•	• incl. work vehicles
NS	A comprehensive tobacco strategy for Nova Scotia	•	•	•	• incl. work vehicles
PE	Tobacco is part of: Prince Edward Island strategy for healthy living: the journey to health and wellness	•		•	• designated smoke areas OK
NL	Provincial tobacco reduction strategy 2005-2008: a partnership plan to reduce tobacco use	•		•	• designated smoke areas OK
NU		•	•	•	•
NT	Action on tobacco				
YT	Yukon tobacco reduction strategy	• May.15/08	• May.15/08	• May.15/08	• May.15/08 incl. work vehicles
Federal Tobacco Control Strategy		• if under Federal jurisdiction			• if under Federal jurisdiction

*** In SK tobacco, once purchased by somone 18 or over, can be given to someone under 18 for the purpose of cultural use.**

• = province-wide ◆ = some municipalities ■ = enacted, but not yet in force

Smoking in vehicles			Minors		Sales/Advertising/Display limits		
Public vehicles (Buses, taxis, etc,)	Cars	Cars when children present	Minor - possession	Sales/provision to those under 18*	limits places sales permitted	limits on displays	limits on advertising
•		introduced		• under 19	•	•	•
•			• under 18		■ Jan.1/09	■ Jul.1/08	■ Jul.1/08
• when vehicle available for hire				•	•	• except where minors not permitted/not visible to minors	
•				• except cultural use		•	•
•		introduced		• under 19; except cultural use	•	■ May.31/08	•
•				•	•	■ May.31/08	• incl. sponsorship
•							
•		• under 19	• under 19	• under 19	•	•	•
•				• except cultural use	• designated places		
				• except correctional facility	• pharmacies only		
•				• under 19	•		
	• May.15/08	• May.15/08 under 18				• May.15/08	• May.15/08
• if under Federal regulation				•		• regulates signage	• nature of advertising

Summary

We know that most smokers want to quit and we have a responsibility to help them. With improved access to programs and supports, better training of health care professionals and the addition of systemic cessation measures that highlight both the interim and the final successes, we can make meaningful progress in further reducing smoking rates in Canada.

Appendix

Survey Reliability Table

The following table outlines the reliability for each stakeholder group surveyed by Leger marketing:

	Total Sample size	Margin of error at the 95% confidence level
Smokers	2002	±2.2%
Ex-smokers	1296	±2.7%
Non-smoker exposed to second-hand smoke	898	±3.3%
Family physicians	200	±6.9%
Other health care professionals	397	±4.9%

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