The Tobacco Control Environment: Ontario and Beyond

Ontario Tobacco Research Unit

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PREFACE

The Tobacco Control Environment: Ontario and Beyond is the first of three reports in this year's *Monitoring and Evaluation Series*. This first report describes tobacco control initiatives in Canadian provinces and territories, especially those that took effect or were updated during the time period 2005 to 2006. Selected international policies of current interest are also scanned. Every effort has been made to ensure accuracy, but we have not attempted a comprehensive review of all tobacco control policies in the jurisdictions under examination. Instead, we have reported significant policy initiatives, which, in our estimation, are instructive for the future of tobacco control.

The full *Monitoring and Evaluation Series* for 2005-2006 consists of:

Number 1: ***The Tobacco Control Environment: Ontario and Beyond***–an environmental scan of policy initiatives across Canadian jurisdictions, with some international examples, which provide a context for what is happening in Ontario;

Number 2: ***Indicators of OTS Progress***–a presentation of quantitative data from a variety of surveys and other sources measuring recent progress in tobacco control in Ontario; and

Number 3: ***OTS Progress and Implications***–a discussion of the implications of the findings in the previous two reports.

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The monitoring and evaluation activities of the Ontario Tobacco Research Unit (OTRU) are conducted under the guidance of John Garcia, Director of Evaluation, and Robert Schwartz, Associate Director of Evaluation.

The interpretation and opinions expressed in this report are the responsibility of OTRU's Director of Evaluation and participating staff:

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INTRODUCTION

The purpose of this report is to provide an environmental scan of tobacco control policy in Canada as a whole, including the provinces and territories, and Ontario in particular. To a lesser extent, recent highlights concerning tobacco control are reported for the United States and other selected international jurisdictions. Selection of places outside Canada is guided by reports of newsworthy developments in tobacco control, especially if those developments provide useful comparisons with the situation in Ontario. Although some historical information is given and some future projections are made, the focus is on the time period 2005-2006.[1] Data collection for this report ended September 30, 2006.

For each geographic area, the scan is organized along the lines of burden (costs associated with tobacco use) and recent developments in tobacco control (especially of a legislative nature), including litigation (emphasizing healthcare cost recovery). For the Canadian provinces and territories other than Ontario, the scan is less comprehensive, consisting of recent highlights in tobacco control initiatives. These include such major steps forward as smoke-free legislation, increases in taxation, restriction on promotion and marketing of tobacco products, and litigation against the tobacco industry. For the United States and other international jurisdictions, the discussion consists of a brief perspective with illustrative highlights.

More detail is provided about Ontario as the evaluation of the Smoke-Free Ontario Strategy is a primary mandate of the Ontario Tobacco Research Unit (OTRU) and is the focus of OTRU's annual Monitoring and Evaluation Series. Indeed, the scan of other jurisdictions is intended to serve as a context for what is happening in Ontario, making possible illuminating comparisons and contrasts. Attentiveness to Ontario is further warranted by the significant tobacco-related legislation passed and new program initiatives undertaken in this province during the time period in question.

By definition, a scan is broad and detailed rather than interpretive. It answers questions like, *What has been happening? Where did it happen? When did it happen?* The other reports in the 2005-2006 Monitoring and Evaluation Series examine quantitative data and provide a discussion of implications for the future. It is necessary to consult the full set of reports in the series in order to obtain a complete picture of tobacco control in Ontario during the notably active period from 2005 to 2006.

[1] For past Monitoring and Evaluation Reports, dating back to 1999, visit the website of the Ontario Tobacco Research Unit (OTRU) at http://www.otru.org.

A. CANADA: SCAN OF FEDERAL TOBACCO CONTROL

Burden

Healthcare, Lost Productivity, and Other Costs

Direct costs arising from tobacco use include the price of healthcare (treatment of illness resulting from smoking), prevention efforts and research. In cost studies, expenses for tobacco-related healthcare are typically broken down by acute care hospital days, ambulatory care, family physician visits, and prescription drugs. The most important indirect tobacco-related cost is lost productivity due to premature death (years of potential life lost).

In Canada, these and other tobacco-related costs were estimated at a total of almost $17 billion dollars for the year 2002, or $541 per capita[2] (Rehm et al. 2006[3]). A significant fraction of these national costs came from over two million acute care hospital days for tobacco-related health problems. The costs associated with lost productivity were even greater, comprising 73% of total measurable tobacco-related costs. National costs arising from tobacco use thus surpass those associated with alcohol ($14.6 billion) or illegal drugs ($8.2 billion).

In terms of fatalities, smoking is the single most serious public health problem in Canada, killing more Canadians than motor vehicle accidents, accidental falls, murders, suicides, and alcohol combined (Illing and Kaiserman 2004). In Canada, over 37,000 persons died from tobacco-related causes in 2002 (Rehm et al. 2006). Deaths associated with tobacco use often result from chronic illnesses like cancer, heart disease and lung disease, which tend to occur later in life (Rehm et al. 2003). Expressed as potential years of life lost from tobacco-related causes, the total for Canada in 2002 was 515,607 lost years.

The magnitude of these tobacco-related costs is all the more striking in view of the national rate of current smoking, which was estimated at 19% of the population aged 15 and older in 2005.[4] It is hard to imagine what the toll would be with an even higher national rate of smoking. Furthermore, estimates provided by cost studies actually tend to underestimate the real impact of tobacco use. For instance, they do not take into account private insurance-based healthcare costs (i.e., costs not tracked by national or provincial insurance schemes),[5] welfare benefits paid to persons disabled by tobacco use, or enforcement costs associated with tobacco-related crime.

Intangible costs like pain and suffering are experienced by direct and indirect victims of the unhealthy consequences of tobacco use. There is no way to measure such costs, and therefore no way to capture them in official estimates. Yet they represent a significant burden on Canadian individuals and families.

[2] Per capita cost means the cost for every resident of Canada regardless of age or smoking status.
[3] Most of the data reported in Rehm et al. (2006) from the Canadian Centre on Substance Abuse (CCSA) cost study are from the year 2002. Highlights can be seen online at the CCSA website (copied at the end of this footnote), using the link "CCSA Research Publications." To obtain a hard copy of the full report, contact the CCSA at: 75 Albert Street, Suite 300, Ottawa, Ontario K1P 5E7. It is also possible to request a CD containing about 250 tables used in the cost study. http://www.ccsa.ca/CCSA/EN/Research/Research_Activities/TheCostsofSubstanceAbuseinCanada.htm
[4] OTRU derived variable based on CTUMS 2005.
[5] The CCSA cost study (Rehm et al. 2006) derived data on healthcare costs from various reports of the Canadian Institute for Health Information (CIHI) (http://www.cihi.ca), in particular the National Health Expenditure Database 1975-2003. The data include public sector and private sector for prescribed and non-prescribed drugs. However, certain payments made directly by patients are omitted; for example, amounts extra-billed or balance-billed by physicians and the costs of plastic surgery for cosmetic purposes (CIHI: National Grouping System Categories Report, p. 15, 2004).

Fires

Fires result from careless smoking and discarding of lit tobacco products. In Canada, from 1995 to1999, more than 14,000 fires were started by cigarettes, cigars and pipes, killing 356 people.[6] In April 2004, Bill C-260 (*Cigarette Ignition Propensity Regulations*) was introduced in Parliament as an effort to reduce cigarette-initiated fires, which are the leading cause of fatalities due to fire in Canada. When the federal Cabinet approved this Bill in June 2005, Canada became the first country in the world to force tobacco companies to change their manufacturing practices to minimize the risk of cigarette-initiated fires.[7] The Bill requires that domestic and imported cigarettes meet ignition propensity regulations on or after October 1, 2005. The federal Bill was somewhat based upon previous legislation in the state of New York (effective June 28, 2004), which required all cigarettes sold in the state to self-extinguish when left burning.[8]

Using 2002 data (Rehm et al. 2006), the cost study conducted by the Canadian Centre on Substance Abuse (CCSA) takes into account tobacco-related costs from fires. In 2000, the total cost across Canada for property damage due to all fires was estimated at $1.19 billion; of these total fires, 7.3% were attributable to smoking materials (Council of Canadian Fire Marshals and Fire Commissioners, 2003). Based on the data supplied by the Council of Canadian Fire Marshals and Fire Commissioners (2003), Rehm et al. (2006, p. 60) estimate that tobacco-related property damage due to fire cost the country $86.5 million in the year 2000. Rehm et al. (2006, p. 52) estimate that in 2002, smoking caused 55 or 28% of total deaths (n = 198) due to fire across Canada.

In 2005, 12% of current smokers in Canada aged 15 and older (about 580,000 current smokers) reported smoking in bed during the past week (CTUMS 2005[9]). Among current smokers who reported smoking in bed in the past year, 18% said they had done so every day. Almost one quarter (24%) of current smokers (about 116,000 respondents) said they had fallen asleep with a lit cigarette (in a bed, on a sofa, or on a chair) in the past year.

In addition to costs due to death, injury and property damage, tobacco-related fires cause escalation of insurance rates both at the individual and corporate level. This aspect is of particular concern to employers.

Tobacco Control, Including Litigation

National Strategies

In Canada, responsibility for restricting smoking falls under the jurisdiction of the federal, provincial, and municipal governments.[10] The following is a scan of some of the more important federal initiatives.

National Strategy to Reduce Tobacco Use in Canada

In 1999, the Steering Committee of the National Strategy to Reduce Tobacco Use in Canada in partnership with the Advisory Committee on Population Health produced a document entitled *New Directions for Tobacco Control in Canada: A National Strategy*. As stated in the 1999 National Strategy document (p. 4), the overall role of

[6] Health Canada, Ottawa: News release: "Reducing the fire-risk of cigarettes" available from: http://www.hc-sc.gc.ca/english/media/releases/2004/2004_19bk1.htm
[7] Health Canada, Ottawa: News release: "Minister Dosanjh announces Canada is the first country to have a national standard to reduce the fire risk of cigarettes" available from: http://www.hc-sc.gc.ca/english/media/releases/2005/2005_61.html
[8] For a summary and assessment of reduced ignition propensity legislation in New York State, see: http://www.hsph.harvard.edu/press/releases/cigarettes/cigarettes.pdf
[9] CTUMS defines current smoker as a person who smokes cigarettes daily or occasionally. The 2005 CTUMS data can be viewed at: http://www.hc-sc.gc.ca/hl-vs/tobac-tabac/research-recherche/stat/ctums-esutc/2005/index_e.html
[10] Physicians for a Smoke-Free Canada. *Background on protection from second-hand smoke in Canada.* Ottawa; Physicians for a Smoke-Free Canada; March 2005. Available from: http://www.smoke-free.ca/factsheets/pdf/Q&A-smokefreecommunities.pdf

the Steering Committee was to establish goals and strategic objectives for government and non-government organizations to collaborate on the national effort to reduce tobacco use. The role of the Advisory Committee was to advise the Conference of Deputy Ministers on national and interprovincial strategies designed to improve the health of the Canadian population.

The National Strategy to Reduce Tobacco Use in Canada was thus explicitly intended to have a positive impact on the health of all Canadians (a population health approach), though emphasizing groups with unique needs, such as First Nations peoples. The 1999 document recommends "a long term, sustained and comprehensive commitment to tobacco control" (p. 10) and makes a commitment to a "smoke-free society" (p. 19).

Under "Goals for a Renewed Tobacco Control Strategy" (p. 12), the 1999 National Strategy document includes definitions of four goals, as follows:

Prevention:	Preventing tobacco use among young people;
Cessation:	Persuading and helping smokers to stop using tobacco products;
Protection:	Protecting Canadians by eliminating exposure to secondhand smoke;
Denormalization:	Educating Canadians about the marketing strategies and tactics of the tobacco industry and the effects the industry's products have on the health of Canadians in order that social attitudes are consistent with the hazardous, addictive nature of tobacco and industry products.

A footnote to the 1999 National Strategy definition of denormalization quoted above states, "This includes a broad understanding of the health, social and economic burden resulting from the use of tobacco, and practices undertaken by the industry to promote its products and create social goodwill towards the industry."

In Appendix C (pp. 24-26), the 1999 National Strategy document further discusses the concept of denormalization. Here it is noted that the term can be used in a range of different ways. For example, it can be used with emphasis on social behaviour and attitudes (e.g., discouragement of smoking in public places); it can emphasize tobacco products and their effects (e.g., secondhand smoke); and it can be used to raise public concern about the tobacco industry itself (e.g., drawing attention to the size and impact of tobacco industry advertising budgets).

Progress reports on the National Strategy have been published, such as *The National Strategy: Moving Forward. The 2001 Federal Provincial Territorial Progress Report on Tobacco Control.*[11] In this 2001 National Strategy update, the following definition of denormalization is given (p. 22):

> The goal is to make tobacco use unacceptable. This is done through educating Canadians about the marketing strategies and tactics of the tobacco industry and the health effects of tobacco use so that they will realize the hazardous, addictive nature of tobacco and will consider its use socially unacceptable.

For comparison, here is the definition of tobacco industry denormalization posted on the website of the Canadian Council on Tobacco Control (CCTC)[12]:

> Denormalization of the tobacco industry is the process used to show that the tobacco industry operates outside the norms of legitimate business and that tobacco industry products are not normal, acceptable products in the marketplace (provided by Garfield Mahood, Non-Smokers' Rights Association).

[11] Available at:
http://www.hc-sc.gc.ca/ahc-asc/alt_formats/cmcd-dcmc/pdf/media/releases-communiques/2001/TobPReng.pdf
[12] http://www.cctc.ca: click Fundamentals—Denormalization—Basics & FAQs

The Canadian Coalition for Action on Tobacco[13] particularly espouses the goal of tobacco industry denormalization, and, in agreement with the 1999 National Strategy document (p. 10), advocates a large, sustained campaign of tobacco control at the federal and provincial levels. According to the Coalition, isolated and sporadic tobacco industry denormalization activities are not adequate in view of the larger goal of a smoke-free society.[14]

In summary, denormalization is a defining characteristic of comprehensive population-wide tobacco control, but different definitions of the term have different implications for smoking behaviour and for tobacco control policy (Hammond et al. 2006b; Leatherdale et al. 2006). It is important when using or encountering the term denormalization to understand whether the intended meaning is social denormalization, tobacco product denormalization, tobacco industry denormalization, or some combination of these.

Federal Tobacco Control Strategy[15]

On April 5, 2001, the federal government announced a 10-year Federal Tobacco Control Strategy with four main goals: protection, prevention, cessation, and harm reduction[16]. The Federal Tobacco Control Strategy targets all Canadians, but in its original configuration emphasized youth, young adults, and First Nations peoples. Within the context of this larger Federal Tobacco Control Strategy, Health Canada created the Federal Tobacco Control Program to fund mass media campaigns, education, cessation programs, research, enforcement, and other initiatives.

In fiscal year 2005-2006, funding for the mass media component of the Federal Tobacco Control Strategy fell from a planned $50 million[17] to $13 million. In April 2006, the Canadian Coalition for Action on Tobacco called for restoration of full funding of the Federal Tobacco Control Strategy, arguing that tobacco control efforts must be sustained if they are to be successful.[18]

On September 25, 2006, the federal government announced an overall $1 billion budget cut, including a $10.8 million cut causing the premature termination of the component of the Federal Tobacco Control Strategy devoted to First Nations and Inuit people[19]. As already mentioned, this component had been part of the original Federal Tobacco Control Strategy in 2001.

[13] Core members of the Canadian Coalition for Action on Tobacco are Canadian Cancer Society, Canadian Council for Tobacco Control, Canadian Dental Association, Canadian Lung Association, Heart and Stroke Foundation of Canada, Non-Smokers' Rights Association, and Physicians for a Smoke-Free Canada.

[14] "Government inaction on tobacco is costing lives," Jan. 19, 2004, refers to the 10-point action plan of the Canadian Coalition for Action on Tobacco, including tobacco industry denormalization, and can be viewed at: http://www.cancer.ca

[15] There is a difference between the Federal Tobacco Control Strategy and the Federal Tobacco Control Program. Health Canada has a program in the context of the broader strategy, which also includes Justice (RCMP) and Customs and Revenue. A 2005 progress report on the Federal Tobacco Control Strategy (at the mid-point of its planned 10-year duration) is posted at: http://hc-sc.gc.ca/hl-vs/pubs/tobac-tabac/foward-avant/index_e.html

[16] "The term harm reduction refers to a policy, strategy, or particular intervention that assumes continued use of an undesired behavior and aspires to lower the risk of adverse consequences associated with the continuation of this addictive behavior" (deRuiter and Faulkner 2006).

[17] The mass media component of the Federal Tobacco Control Strategy was originally to have been $110 million a year at maturity, with about 40% into mass media. Canadian Cancer Society, "Cuts to the Federal Tobacco Control Strategy," 2006. A breakdown of federal tobacco control mass media expenditures from 2001 to 2006 is contained in an undated document released under the *Access to Information Act*, with the heading "Health Canada/PCO tobacco expenditures." See also: Health Canada, Backgrounder, "Health Canada's Tobacco Control Program," April 2001.

[18] "Canadian Coalition 10-Point Federal Action Plan," e-mail from Rob Cunningham, Senior Policy Analyst, Canadian Cancer Society, July 7, 2006.

[19] For *Toronto Star* coverage of the Sept. 2006 federal budget cuts, including the cut to First Nations and Inuit smoking cessation programs, see:
http://www.thestar.com/NASApp/cs/ContentServer?pagename=thestar/Layout/Article_Type1&c=Article&cid=1159221039296&call_pageid=968332188492&col=968793972154&t=TS_Home

Non-Smokers' Health Act

Since 1988, the federal *Non-Smokers' Health Act* has restricted or banned smoking from areas under federal regulation, which include interprovincial transportation (ground, water, and air travel), telecommunications, banks, and crown corporations.[20] According to the Canadian Coalition for Action on Tobacco (2006),[21] the *Non-Smokers' Health Act* is "seriously outdated." It permits designated smoking areas and designated smoking rooms, which should be eliminated in order to protect federally regulated employees from secondhand smoke.

The Federal *Tobacco Act*

The Federal *Tobacco Act* was passed in 1997. Provinces and territories must uphold the provisions of the federal *Tobacco Act* as a minimum requirement. Several provincial and municipal jurisdictions have passed more restrictive policies in certain areas.[22]

Vending Machines

Regulations regarding the sale of tobacco from vending machines fall under the *Tobacco Act*, which states:

> No person shall furnish[23] or permit the furnishing of a tobacco product by means of a device that dispenses tobacco products except where the device is in (a) a place to which the public does not have reasonable access; or (b) a bar, tavern or beverage room and has a prescribed security mechanism.[24]

The federal *Tobacco Act* does not have regulations restricting the sale of tobacco in designated places. Nevertheless, in several provincial jurisdictions, places such as healthcare facilities, pharmacies, residential care facilities, schools, and childcare facilities have taken the initiative to adopt such restrictions.

Protecting Youth

Some of the provisions in the federal *Tobacco Act* regarding the sale and supply of tobacco products in Canada are intended to protect youth.[25] For example, the federal government legislated a minimum selling age prohibiting tobacco sales to persons under 18 years. The sale and supply of tobacco to youth is further restricted in the federal *Tobacco Act* by the provision, "No person shall furnish a tobacco product to a young person in a public place or in a place to which the public reasonably has access."[26] Notwithstanding the federal requirement, several provinces, including Ontario, have raised the age of minority for the sale of tobacco to 19.

[20] Collishaw N, Meldrum H. *Legislative basis for effective protection from tobacco smoke in workplaces in federal and provincial jurisdictions*. Ottawa: Physicians for a Smoke-Free Canada; 2003. Available from: http://www.smoke-free.ca/Second-Hand-Smoke/2002-03%20Workshop%20CDROM/2003Collishaw-Meldrum.pdf

[21] Available at: http://www.cancer.ca

[22] In Canada, the federal power over tobacco control is permissive rather than preemptive: provinces are free to enact legislation that is more stringent than federal regulations. By way of contrast, in the United States, some federal legislation on tobacco is preemptive, meaning individual states cannot enact provisions that are stronger than those existing at the federal level (Studlar 1999).

[23] "Furnish" means to sell, lend, assign, give or send, with or without consideration, or to barter or deposit with another person for the performance of a service.

[24] Government of Canada. Ottawa: Canadian Council for Tobacco Control; c2005. Tobacco Act: Chapter T-11.5 (1997, c.13), available from: http://www.ncth.ca/CCTCLAWweb.nsf/MAINframeset?OpenFrameSet&Frame=BodyFrame&Src=http://www.ncth.ca/CCTCLAWweb.nsf/16a7a46a13d27dd4852569ac007ec6f9/9a3174bc95ca6fe2c22569f80036e725?OpenDocument.

[25] The importance of preventing young persons from initiating smoking behaviour has been highlighted by recent findings suggesting that nicotine dependence can occur soon after the first puff of a cigarette, preceding monthly, weekly and daily smoking (Gervais et al. 2006).

[26] Government of Canada. Ottawa: Canadian Council for Tobacco Control; c2000. Tobacco Act: Chapter T-11.5 (1997, c.13), available from: http://www.ncth.ca/CCTCLAWweb.nsf/MAINframeset?OpenFrameSet&Frame=BodyFrame&Src=http://www.ncth.ca/CCTCLAWweb.nsf/16a7a46a13d27dd4852569ac007ec6f9/9a3174bc95ca6fe2c22569f80036e725?OpenDocument.

Toxic Emissions

In June 2000, the Tobacco Products Information Regulations increased requirements under the federal *Tobacco Act* regarding information to be provided on chemical emissions resulting from the burning of tobacco products. Tobacco manufacturers were required to provide information on the levels of over 40 chemical emissions found in mainstream and sidestream smoke. Guided by public opinion research as well as known toxicity, Health Canada made six of these emissions—tar, benzene, formaldehyde, nicotine, carbon monoxide, and hydrogen cyanide—mandatory on tobacco packaging. Tobacco manufacturers had previously listed only three of these emissions (tar, nicotine, carbon monoxide).

Tar is a sticky, black residue containing hundreds of chemicals (e.g., polyaromatic hydrocarbons, aromatic amines, inorganic compounds), many of which are carcinogenic or classified as hazardous waste. Benzene, a Group 1 carcinogen, is described under the *Canadian Environmental Protection Act* as toxic for smokers and nonsmokers alike and harmful at any level of exposure. Formaldehyde is classified by the United States Environmental Protection Agency as a probable human carcinogen, and is registered in Canada as a pesticide. It produces drastic eye, nose and throat irritations as well as breathing problems in smokers and nonsmokers exposed to burning tobacco products.

Nicotine occurs naturally in tobacco plants and causes addiction to tobacco products, harming the human cardiovascular and endocrine systems. Carbon monoxide occurs as a result of burning tobacco, and seriously harms the heart, brain, and skeletal muscles by reducing the ability of red blood cells to deliver oxygen to tissues. (Also found in automobile exhaust, this colourless odourless gas can be fatal when inhaled.) Hydrogen cyanide is one of the most toxic agents found in tobacco smoke, causing weakness, headache, nausea, vomiting, rapid breathing and eye and skin irritations upon frequent exposure to low concentrations.[27]

Retail Displays

The federal *Tobacco Act* states that "any person may display, at retail, a tobacco product or an accessory that displays a tobacco product-related brand element".[28] Additionally, "a retailer of tobacco products may post, in accordance with the regulations, signs at retail that indicate the availability of tobacco products and their price." However, several provinces/territories have their own legislation banning or restricting the display of tobacco products.[29] Self-service displays are banned in Canada.

Plain Packaging

Section 15(1) of the *Tobacco Act* can be interpreted as making it possible for the federal government to strip cigarette packages altogether of promotional elements. Such plain packaging would be achieved by requiring health warnings that would occupy a larger package surface than that now allowed for tobacco promotion.[30] Also, the remaining face of the package would become standard colours (black and white). Plain packaging is associated with reduced curiosity about smoking in young persons and has been acknowledged by the tobacco

[27] For more information on toxic emissions from tobacco products, see: http://hc-sc.gc.ca/hl-vs/tobac-tabac/legislation/label-etiquette/tox/index_e.html

[28] Government of Canada, Ottawa: Canadian Council for Tobacco Control; c2005. Tobacco Act: Chapter T-11.5 (1997, c.13), available from: http://www.ncth.ca/CCTCLAWweb.nsf/MAINframeset?OpenFrameSet&Frame=BodyFrame&Src=http://www.ncth.ca/CCTCLAWweb.nsf/16a7a46a13d27dd4852569ac007ec6f9/9a3174bc95ca6fe2c22569f80036e725?OpenDocument

[29] The following Canadian provinces and territories have adopted laws to prohibit the visible display of tobacco products at point of sale: Saskatchewan (Mar. 22, 2002—applies to premises accessible to minors under 18); Manitoba (Jan. 1, 2004—premises accessible to minors under 18); Nunavut (Feb. 1, 2004); Prince Edward Island (June 1, 2006); Ontario (projected for May 31, 2008); Québec (projected for May 31, 2008); Northwest Territories (Sept. 2006—premises accessible to minors under 18); *source*: http://www.cctc.ca and provincial government websites.

[30] It is believed the provinces of Québec, Ontario, Manitoba and British Columbia also probably have the statutory authority to approve plain packaging regulations, according to: Section 28 of Québec's *Tobacco Act*, Section 5(1) of Ontario's *Tobacco Control Act*, Section 9(e) of Manitoba's *Non-Smokers Health Protection Act* and Section 11(2)(a) of British Columbia's *Tobacco Sales Act*. See: http://www.cctc.ca/cctc/EN/lawandtobacco/analysis/index_html#packaging

industry as an impediment to the promotion of its products (Northrup et al. 1995; D'Avernas et al. 1997). It may also serve to make health warnings more prominent.

In April 2006, as part of its 10-point action plan,[31] the Canadian Coalition for Action on Tobacco called on the government to address three main recommendations regarding the *Tobacco Act*:

1. The *Act* should be updated to prohibit advertising and promotion in magazines and other publications, in adult-only venues such as bars, in stores at point of purchase, and on lighters and matchboxes or match covers.
2. Promotion regulations should be adopted, especially to ban "power walls" and other visible displays in retail outlets.
3. The *Act* should be enforced more vigorously, particularly in the matter of illegal sponsorship advertising.

Youth Possession

Banning youth possession of tobacco is a controversial issue. Critics see it as deflecting attention away from the culpability of the tobacco industry and assigning inordinate responsibility to individual young persons. It is opposed by such tobacco control groups as the Expert Panel on the Renewal of the Ontario Tobacco Strategy and the Canadian Cancer Society. The latter argues, for example, that "there is insufficient evidence showing that laws prohibiting the purchase, possession or use of tobacco by young people are effective. As a result, it would be premature to recommend the implementation of such laws at this time."[32] Nevertheless, the provinces of Alberta and Nova Scotia[33] have made it illegal for youth to possess tobacco.

Cessation

Across Canada, the variety of cessation programs and resources has expanded considerably over the past several years.[34] Federally, pharmacological aids are covered by the Non-Insured Health Benefits (NIHB) program available only to registered Indians and recognized Inuit and Innu living in Canada not covered by another insurance plan.[35]

Tobacco Product Displays at Point of Sale

In Canada, there are an estimated 65,000 retailers selling tobacco products.[36] Retail displays play an important role in the tobacco industry's marketing strategy because of restrictions on traditional forms of tobacco advertisement and promotion.[37] Retail displays range from a simple display of packages on a counter

[31] Available at: http://www.cancer.ca
[32] Canadian Cancer Society. Toronto, c2002-2004: "Youth tobacco possession laws," available from: http://www.cancer.ca/ccs/internet/standard/0,3182,3543_334407_371580_langId-en,00.html
[33] An evaluation of the Nova Scotia youth tobacco possession law found it to be ineffective. ("Is it making a difference? An evaluation of Nova Scotia's Youth Tobacco Possession Law," prepared for Smoke-Free Kings by Pyra Management Consulting Services Incorporated & Research Power Incorporated, June 2005.)
[34] Health Canada. *Tobacco use cessation programs: an inventory of Canadian tobacco cessation programs and resources*. Ottawa: Health Canada, 2000; available from: http://www.hc-sc.gc.ca/hecs-sesc/tobacco/pdf/inventory_e.pdf
[35] Health Canada, Ottawa: "Non-insured health benefits," available from: http://www.hc-sc.gc.ca/fnihb/nihb/aboutnihb.htm
[36] The projected number of retail outlets for Canada is based on provincial estimates, as reported informally by the Reports Control Division, Office of Regulations and Compliance, Tobacco Control Programme, July 2006.
[37] Canadian Cancer Society. Toronto: c2002-2004: "The case for banning tobacco product displays," available from: http://www.cancer.ca/ccs/internet/standard/0,3182,3702_76524294_77059551_langId-en,00.html

to a "power wall" of cigarette packages behind the counter.[38]

In 2003, it was reported that the tobacco industry paid $88 million to retailers in Canada to place tobacco products on display.[39] In 2005, this amount increased to $100 million.[40] Studies by promotion advertising researchers have shown that tobacco product advertisements and displays in retail stores increase average tobacco sales by anywhere from 12%[41] to 28%.[42]

Tobacco companies concentrate their marketing dollars at the point of sale, which is their primary communication channel with customers. Yet this major advertising channel was left untouched by the federal *Tobacco Act*. In light of the tobacco industry's use of point of sale as a way of attracting customers, Feighery et al. (2003) recommend closer scrutiny of retail stores on the part of researchers and tobacco control advocates. Henriksen et al. (2004) see youth as being especially vulnerable to tobacco-related promotional materials in stores. These findings are bolstered by DiFranza et al. (2006) who report that exposure to tobacco promotion causes children to initiate tobacco use. DiFranza (2005) and Levy et al. (2000) also highlight the importance of enforcement of tobacco control regulations at the point of sale in order to achieve retailer compliance and reduced sales to minors.

Litigation in Canada

In view of the enormous ongoing costs associated with the use of tobacco, combined with a perceived failure on the part of the tobacco industry to disclose the risks associated with its products[43] (Bero 2003; Muggli et al. 2004; LeGresley et al. 2005), an increasing number of tobacco control researchers (e.g., Carter and Chapman 2003; Crow 2005; Daynard 2003; Proctor 2004; Sweda 2004) see litigation against the tobacco industry as a necessary component of a comprehensive strategy to recover costs, reduce consumption, and prevent initiation of smoking behaviour (Sandford 2003).

At the federal level, JTI-Macdonald and related companies, including a number of executives, are currently defendants in a $1.5 billion federal lawsuit related to contraband (Spurgeon 2003). They are charged with fraud and conspiracy based on claims that the company was aware that cigarettes were being smuggled across the Canada-U.S. border to avoid taxes. The government claims that between 1991 and 1996, JTI-Macdonald exported tax-free cigarettes to the United States, which were later smuggled back into Canada through Indian reservations straddling the border of New York State and Ontario.

The case was announced by the RCMP in February 2003, filed in Ontario Superior Court in August 2003, and continues at the time of writing in a Toronto courtroom. In late 2005, a judge refused to excuse the governor of the Bank of Canada and 12 other former government officials from testifying in the case.[44]

In its 10-point action plan to curb the tobacco epidemic, the Canadian Coalition for Action on Tobacco urges

[38] Canadian Cancer Society. Toronto: c2002-2004. "What are tobacco product displays?", available from: http://www.cancer.ca/ccs/internet/standard/0,3182,3702_76524294_76890538_langId-en,00.html
[39] Canadian Cancer Society. Toronto: c2002-2004. "The case for banning tobacco product displays," available from: http://www.cancer.ca/ccs/internet/standard/0,3182,3702_76524294_77059551_langId-en,00.html
[40] E-mail from Rob Cunningham, Senior Policy Analyst, Canadian Cancer Society, Apr. 25, 2006; data source cited: Health Canada
[41] PROMO Magazine. The 1999 annual report of the promotion industry, a PROMO magazine special report. Overland Park, Kansas: Intertec Publishing, 1999.
[42] Point of Purchase Advertising Institute. The point of purchase advertising industry fact book. Englewood, New Jersey, 1992.
[43] Some researchers believe the tobacco industry is also not accurate in its interpretation of the root causes of smuggling (e.g., Joossens and Raw 2003).
[44] "Judge rules Dodge can't dodge testifying in tobacco fraud case," *National Post*, Dec. 8, 2005.

the federal government to adopt legislation and file a lawsuit to recover federally incurred health costs from the tobacco industry. The Coalition also recommends the initiation of civil and criminal proceedings against all tobacco companies legally responsible for the contraband of the early 1990s.[45]

Canada as a Player on the Global Stage

Canada is internationally recognized as a lead player in tobacco control initiatives, and has to its credit the passage and successful implementation of smoke-free and other tobacco-related legislation at all three levels of government.[46] This legislation along with tobacco control policies and strategies is continually being refined and expanded. As a significant token of its earnestness in the realm of tobacco control, Canada was among the original 40 countries to ratify the Framework Convention on Tobacco Control[47] (in force February 27, 2005), the first global public health treaty.[48]

[45] http://www.cancer.ca
[46] The reputation of Canada as a leader in tobacco control on the international scene is described by Health Canada at: http://hc-sc.gc.ca/hl-vs/pubs/tobac-tabac/forward-avant/part5_e.html#11
[47] Framework Convention Alliance. Framework Convention Alliance for Tobacco Control; c2005. "Current signatories to the FCTC," available from: http://fctc.org/treaty/currentsigs.php
[48] The Framework Convention on Tobacco Control is discussed further in this report under International Jurisdictions.

B. Ontario: Scan Of Provincial Tobacco Control

Burden

In Ontario, a 2002 estimate of the annual direct and indirect costs of tobacco-related problems to the province was $6.1 billion dollars or 42% of the total cost of substance abuse (including alcohol, illegal drugs and prescription drugs but not over-the-counter pharmaceuticals) (Rehm et al. 2006). Based on the 2002 total Ontario population of 12,068,301 persons, this estimate translates into a cost of about $502 per person or 1.4% of the Gross Domestic Product (Rehm et al. 2006).[49] In 2002, a conservative estimate of the number of tobacco-related deaths in Ontario was more than 13,000[50] (Rehm et al. 2006, Table 1-S-6[51]).

Total tobacco-related costs are related primarily to healthcare and loss of productivity, including sick time and premature death (years of potential life lost) (Table 1.1). In Ontario, tobacco-related deaths resulted in 184,304 potential years of life lost in 2002; tobacco-related illness accounted for 782,520 days of acute hospital care. Over 36,000 of these days in hospital were for infants under the age of one year who died or were hospitalized as a result of tobacco-related problems, such as low birth weight, short gestation, and sudden infant death syndrome.

Table 1.1: Economic Costs of Tobacco Use in Millions of Dollars, and Percentage of Total Tobacco Costs, Ontario and Canada, 2002

	Ontario (CDN$)	Canada (CDN$)
Direct healthcare costs	$1,553.1 (25.6%)	$4,360.2 (25.7%)
Direct cost for prevention and research	$30.0 (0.5%)	$78.1 (0.5%)
Other direct costs	$33.4 (0.6%)	$87.0 (0.5%)
Indirect costs: productivity losses	$4,440.6 (73.3%)	$12,470.9 (73.4%)
Total	**$6,057.2 (100%)**	**$16,996.2 (100%)**

Note: Cost components may not add to totals because of rounding. This table appears in "The Burden of Tobacco Use in Ontario," OTRU Research Update, June 2006.

Source: Canadian Centre on Substance Abuse (Rehm et al. 2006); summary available at http://www.ccsa.ca/CCSA/EN/Research/Research_Activities/TheCostsofSubstanceAbuseinCanada.htm

Not reflected in the CCSA estimates are private costs, such as the amount of money individuals spend on tobacco products, and intangible costs, such as the physical pain and emotional suffering associated with illnesses like lung cancer, heart disease, and respiratory disease, whether experienced directly as a victim or indirectly as a caring witness. Nor does the CCSA study (Rehm et al. 2006) include costs associated with the illegal import and export of tobacco products and enforcement of tobacco-related bylaws.

[49] Cost estimates for the Canadian provinces/territories are copied from The Costs of Substance Abuse in Canada 2002, Highlights, Table 3, pp. 10-11. See:
http://www.ccsa.ca/CCSA/EN/Research/Research_Activities/TheCostsofSubstanceAbuseinCanada.htm
[50] Speaking of national tobacco-related mortality estimates, which may to some extent be extrapolated to the provincial level, Rehm et al. (2006, Highlights, p. 11) state: "Although still substantial, the burden of tobacco-attributed disease in Canada has eased somewhat and constitutes at least one bright spot in developments over the past 10 years. The reduction in smoking-attributable death and illness may be the result of improved tobacco control measures in the 1980s and '90s." The CCSA Cost Study Highlights can be viewed at:
http://www.ccsa.ca/CCSA/EN/Research/Research_Activities/TheCostsofSubstanceAbuseinCanada.htm
[51] According to the CCSA estimate, the exact number of tobacco-related deaths in Ontario in 2002 was 13,244 (cited in OTRU Research Update "The Burden of Tobacco Use in Ontario," June 2006). The original estimate appears in Rehm et al. (2006), Supplementary Table 1-S-6, available in CD format from the CCSA: 75 Albert Street, Suite 300, Ottawa, Ontario K1P 5E7.

In 2005, 16% of the Ontario population aged 15 and older were current smokers (i.e., smoked daily or occasionally in the past month and had smoked at least 100 cigarettes in lifetime).[52]

Tobacco Control, Including Litigation

Smoke-Free Ontario Act: Overview of Legislation[53]

In Ontario, a substantial development for 2005-2006 was the *Smoke-Free Ontario Act*. This legislation was achieved by means of Bill 164, which amended, renamed, and replaced the 1994 *Tobacco Control Act*[54] with the *Smoke-Free Ontario Act*. After three readings, Bill 164 received Royal Assent on June 13, 2005, came into force on May 31, 2006, and promised further provisions to follow as of May 31, 2008. Bill 164 repealed the former *Smoking in the Workplace Act* and made complementary amendments to the Human Rights Code and the *Provincial Offences Act* (Table 1.2).

Table 1.2: Chronology of Major Ontario Legislation Directly Relevant to the *Smoke-Free Ontario Act*, 1990- 2006

Year	Legislative Step
1990	*Smoking in the Workplace Act*
1994	*Tobacco Control Act*
1994-2004	Proliferation of municipal smoke-free bylaws
2005	Royal Assent to Bill 164 amending and renaming the *Tobacco Control Act*
2006	*Smoke-Free Ontario Act* in effect May 31
2006	Ontario Regulation 48/06 in effect May 31
2008	Total ban on display of tobacco products in effect May 31

Associated with the *Smoke-Free Ontario Act* was Ontario Regulation 48/06 (revoking Ontario Regulation 613/94), made and filed on March 1, 2006, printed in *The Ontario Gazette* on March 18, 2006, and scheduled to take effect at the same time as the *Smoke-Free Ontario Act* on May 31, 2006[55]. Regulation 48/06 provides clarification, amplification and practical instructions regarding the meaning and implementation of points covered by the *Smoke-Free Ontario Act*. These points include signage, acceptable age identification, display exemptions (for tobacconists, duty-free retailers, and manufacturers), promotion of tobacco products, prohibition of sale in designated places, packaging requirements, health warnings, patios, smoking shelters, employer and proprietor obligations, psychiatric and veteran facilities, home healthcare workers, and traditional use of tobacco. Appended to Regulation 48/06 (as Schedule 1 of the Regulation) are detailed requirements for the maintenance, structure, furnishings and ventilation of controlled smoking areas. From the point of view of public health, particularly promising highlights of the *Smoke-Free Ontario Act* include

[52] OTRU derived variable based on CTUMS 2005

[53] To view the actual text of the new regulations, visit:
English: http://www.e-laws.gov.on.ca/DBLaws/Source/Regs/English/2006/R06048_e.htm
French: http://www.e-laws.gov.on.ca/DBLaws/Source/Regs/French/2006/R06048_f.htm
To view the *Smoke-Free Ontario Act*, including amendments still to come into force, visit:
English: http://www.e-laws.gov.on.ca/DBLaws/Statutes/English/94t10_e.htm
French: http://www.e-laws.gov.on.ca/DBLaws/Statutes/French/94t10_f.htm
To view explanatory information from the Ministry of Health Promotion, visit:
English: http://www.mhp.gov.on.ca/english/health/smoke_free/legislation.asp
French: http://www.mhp.gov.on.ca/french/health/smoke_free/legislation.asp

[54] The *Tobacco Control Act* itself amended the former *Ontario Municipal Act*, which had enabled municipalities to pass bylaws controlling smoking. To view the 1994 *Tobacco Control Act*, see the Canadian Council for Tobacco Control (CCTC) website: http://www.cctc.ca/cctc/folder.2005-07-28.9601546915/folder.2005-07-28.5386873816/folder.2006-03-15.1494244380/on%20legislation/document.2006-03-29.3912696110/view

[55] Full text of Ontario Regulation 48/06 available at:
http://www.e-laws.gov.on.ca/DBLaws/Source/Regs/English/2006/R06048_e.htm

prohibitions on smoking in enclosed workplaces and enclosed public places, restrictions on tobacco promotions in places of entertainment, enhanced restrictions on selling tobacco to young persons, and restrictions on sale of tobacco by means of countertop displays. The latter restrictions (countertop displays) are slated for upgrading at the end of May 2008 at which time a total ban will be enforced on displaying tobacco products for sale where customers can see them.

Amendments that Shape the New Legislation: Definitions

A perusal of the new definitions provided in the *Smoke-Free Ontario Act* serves as a guidepost for major areas of impact. For example, the terms "employee," "employer," "enclosed public place" and "enclosed workplace" are defined. The definitions of enclosed public place and enclosed workplace both make reference to vehicles and conveyances as well as places, buildings, and structures. The definition of enclosed workplace includes not only places where employees work but also places they frequent during the course of their employment whether or not they are acting in the course of their employment at the time. In other words, the definition of enclosed workplace—and therefore the health protection intended for working persons—is broad in scope.

"Place of entertainment" is defined in such a way as to encompass locations where the public goes for eating, drinking, or amusement, whether or not a fee is paid. "Proprietor," "home healthcare worker," and "record" (i.e., something that can be demanded by an inspector) are also defined.

Youth

Under the former *Tobacco Control Act*, it was forbidden to sell or supply tobacco to a person who appeared to be under 19 years of age, regardless of that person's actual age (Table 1.3). The *Tobacco Control Act* allowed a defense to a violation on the grounds that the proprietor had reason to believe the young person to whom tobacco had been sold was past the age of majority.

Table 1.3: Comparison of 1994 *Tobacco Control Act* with 2005 *Smoke-Free Ontario Act*: Highlights

Feature of Legislation	Tobacco Control Act 1994	Smoke-Free Ontario Act 2005
100% smoke-free public places province-wide, including casinos, bingo halls, bowling and billiard establishments, restaurants and bars	No	Yes
Designated smoking rooms	Allowed	Not allowed
Controlled smoking areas at residential care facilities that protect residents and healthcare workers	No	Yes
Smoking on patios	Allowed	Restricted
Protection for home health workers	No	Yes
Smoking at exits to healthcare facilities	Yes	No
Retail cigarette promotion allowed	Yes	No
Ban on any tobacco displays	No	Yes — immediate restrictions leading up to a total ban in 2008
Minimum age to purchase tobacco	19	19
Apparent age to which identification to be provided	19	25

Source: http://www.mhp.gov.on.ca/english/health/smoke_free/chart.asp

The new legislation requires that no person shall sell or supply tobacco to anyone who appears to be under 25 years old unless he or she has required the person to provide identification and is satisfied that the person is at least 19 years old. The defense of simply believing the person was past the age of majority has been removed. Thus, retailers and proprietors of establishments where tobacco products are sold are encouraged to err on the side of caution. They are no longer permitted to hazard a guess about the age of a young person within a precariously narrow range. When in doubt, they must ask for identification.

The owner of a business where tobacco is sold is considered liable for any contravention of the apparent age provision, unless the owner has exercised due diligence. For example, if the owner or salesperson requests and is shown appropriate age identification, which appears to be authentic, demonstrating that the purchaser is at least 19 years old, this is a defense against liability. This defense is acceptable even if it is proven later that the identification was false. It is an offense for the purchaser to present false proof of age.

Tobacco Displays

In contrast to the 1994 *Tobacco Control Act*, which did not ban tobacco displays, the 2005 *Smoke-Free Ontario Act* provides immediate restrictions on the display of tobacco products, leading up to a total ban in 2008. The immediate restrictions consist of forbidding countertop displays and other types of display which would allow the purchaser to handle the tobacco product before purchase. Only individual cigarette packages (not cartons) are allowed to be displayed. As of May 31, 2008, these restrictions will be tightened in such a way as to prohibit any display at all of tobacco products, i.e., the purchaser must not be able to see the tobacco product per se before purchase.

Promotion

Subsection 3 of the *Smoke-Free Ontario Act* prohibits promotion of tobacco products, including packaging, in any place where tobacco products are sold or offered for sale and in places of entertainment. Types of promotion specifically forbidden include product association, product enhancement, and "any type of promotional material." Examples of the latter category are decorative panels and backdrops associated with brands, promotional lighting, and three-dimensional exhibits.

Ontario Regulation 48/06 further clarifies the meaning of promotional material, stating that it includes signage about tobacco products or tobacco accessories other than signage required by law. (Signage required by law means health warnings and statements about the legal age for purchase of tobacco.) Also stipulated by the Regulation is that permissible tobacco product-related signs (notifying customers of price) must not be visible from outside the place where tobacco is sold, must not exceed a certain size, and must not contain background in a colour other than white or text in a colour other than black, or show any kind of brand-related graphic. Thus, the emphasis is on dissociation of tobacco products with glamour and brand specificity.

The requirements for signs about age restrictions and health warnings are more or less the opposite of the requirements for promotional signage. For example, the age and health-related signs are to be clearly visible at the place of sale and of a certain size, have a red background with black and white text, and bear the words:

> Tobacco products are addictive and kill 1 out of every 2 long-term smokers. It is illegal to sell or supply them to anyone under 19 years of age.
>
> Government I.D. with a photo and birth date must be shown when requested. You must be 19 or older to purchase tobacco products.

Designated Places and Employer Obligations

Under the *Smoke-Free Ontario Act*, it is forbidden to sell tobacco in private and public hospitals, psychiatric facilities, nursing homes, homes for the aged, pharmacies or any establishment that contains a pharmacy. It is

forbidden to smoke tobacco or hold lighted tobacco in any enclosed public place or workplace,[56] with specific mention of schools, common areas[57] of condominiums, apartment buildings, university or college residences, day nurseries, daycare centres, and the reserved seating area of a sports arena or entertainment venue (whether inside or out).

Exceptions are made for residents of nursing homes, psychiatric facilities, and veterans' residences as well as hotel/motel guests, provided that controlled smoking areas are made available according to prescribed requirements. An exception is also made for research facilities when smoking occurs as part of the research being conducted.

The onus is on employers and proprietors who control the space in question to ensure compliance with these prohibitions. For example, an employer is responsible for notifying employees that smoking is prohibited in the workplace, posting relevant signage, removing ashtrays, and ensuring that persons who refuse to comply do not remain in the workplace area. The legislation contains provisions for the protection of employees who act in accordance with or seek enforcement of the *Smoke-Free Ontario Act*. Employers are not allowed to dismiss, threaten, discipline, suspend, punish, intimidate, or coerce such employees.

Packaging, Health Warnings and Signs

The sale of tobacco products is illegal unless these products are packaged according to regulations, with at least 20 cigarettes per package. The packages must bear health warnings. It is illegal to sell tobacco unless the required signage about age restrictions is posted at the place of sale.

Vending Machines

The sale or dispensing of tobacco by vending machines is forbidden. This prohibition was already included in the 1994 legislation.

Home Healthcare Workers

Home healthcare workers have the right to request no smoking in the home while they are providing healthcare. If the request is refused, the home healthcare worker has the right to leave as long as no immediate serious danger is thereby presented to the person receiving care. Ontario Regulation 48/06 stipulates that the home healthcare worker who decides to leave must telephone his or her employer within 30 minutes of leaving, explain the situation, and follow the employer's guidelines about how to ensure the safety of the person to whom healthcare services were being provided.[58]

Traditional Use of Tobacco by Aboriginal Persons

Under the *Smoke-Free Ontario Act*, traditional use of tobacco by Aboriginal persons for spiritual or cultural purposes is permitted. A gift of tobacco for spiritual or cultural purposes may be made to an Aboriginal person even if that Aboriginal person is less than 19 years of age. If requested to do so, operators of hospitals, psychiatric facilities, nursing homes, homes for special care and homes for the aged must set aside an indoor area, separate from any area where smoking is otherwise permitted, for the use of tobacco for traditional Aboriginal cultural or spiritual purposes.

[56] The definitions of enclosed public place and enclosed workplace include vehicles under certain conditions. For example, an enclosed public place could be a vehicle if the public is ordinarily invited or permitted access to the vehicle. An enclosed workplace could be a vehicle if employees work in or frequent the vehicle in the course of their employment, whether or not they are acting in the course of their employment at the time.
[57] Common areas of condominiums include elevators, hallways, parking garages, party rooms, laundry facilities, lobbies and exercise areas.
[58] The home healthcare provisions do not apply to other ministries. For example, public health nurses carrying out duties under non-health funded programs are not covered.

Inspection, Offences, Fines, Automatic Prohibition, Miscellaneous Provisions

The rest of the *Smoke-Free Ontario Act* concerns powers and duties of inspectors employed for the purpose of determining whether the *Act* is being complied with, the nature of offences possible under the *Act* and determination of fines in cases of conviction. Depending on type and number of contraventions, individual fines range from $1000 to $100,000 and corporate fines range from $5000 to $300,000[59]. Also discussed are the sales offences which will result in automatic prohibition and what that automatic prohibition entails. Miscellaneous provisions outline the types of regulations that may be made by the Lieutenant Governor in Council with reference to the *Act*.

Strengths of the *Smoke-Free Ontario Act*

This forward-thinking legislation promotes the goals of prevention, cessation, and protection. In many ways protection is emphasized. For example, the elimination of designated smoking rooms, bans on smoking in daycare settings, and protection for home healthcare workers serve to protect nonsmoking bystanders and employees from secondhand smoke.

According to Health Canada,[60] the U.S. Surgeon General,[61] and the California Environmental Tobacco Smoke (ETS) Report,[62] secondhand smoke is much more than an annoyance. It is a serious health hazard, leading to heart disease, cancer and premature death in nonsmoking adults. Secondhand smoke is a known cause of sudden infant death syndrome as well as respiratory problems, ear infections, and asthma attacks in infants and children. Evidence of a causal association between secondhand smoke and breast cancer is growing. For example, in the chapter entitled "Carcinogenic Effects" (Chapter 7, p. 7-1) of the California Environmental Tobacco Smoke (ETS) Report, the authors write, "Epidemiologic studies, supported by animal data on carcinogenicity of ETS components, provide evidence consistent with a causal association between ETS exposure and breast cancer in younger primarily pre-menopausal women."[63]

There is no risk-free level of exposure to secondhand smoke. In order to avoid the health risk, people have to avoid the smoke. Elimination of smoking in indoor spaces provides protection, but mere separation of smokers from nonsmokers, cleaning the air, and ventilation of buildings do not provide protection from secondhand smoke. Thus, the *Smoke-Free Ontario Act* has strong scientific support for its emphasis on the harm caused to nonsmokers by secondhand smoke and the importance of implementing legal measures to reduce this harm.

In the *Smoke-Free Ontario Act*, prevention is directly addressed by the higher apparent age (25 years) required of a purchaser of tobacco if no identification is to be requested. Prevention is also addressed by the list of designated places where tobacco sales are forbidden, including hospitals, nursing homes, and pharmacies. Indirectly, prevention is addressed by the general thrust of the provisions.

A social climate of increased discouragement of public smoking throughout the province, especially in workplaces, is expected to motivate smokers to try to quit (e.g., Farkas et al. 1999; Brownson et al. 2002). Research has shown a positive impact of smoke-free workplaces and smoke-free public places on smoking cessation (quitting) and reduction (cutting down) (Fichtenberg and Glantz 2002) as well as benefits for population-level cardiovascular health (Ong and Glantz 2004; Sargent et al. 2004). For example, in their systematic review of 26 studies on smoke-free workplaces, Fichtenberg and Glantz (2002) conclude that

[59] For more detail about fines for contraventions of the *Smoke-Free Ontario Act*, see: http://www.mhp.gov.on.ca/english/health/smoke_free/chart.asp
[60] "Make your home and car smoke-free: a guide to protecting your family from second-hand smoke," published by authority of the Minister of Health, Health Canada, 2006; to view document or order a copy, see: http://www.hc-sc.gc.ca/hl-vs/pubs/tobac-tabac/second-guide/index_e.html
[61] For links to the full report, the remarks of the Surgeon General, and a series of fact sheets, see: http://www.surgeongeneral.gov/library/secondhandsmoke/
[62] http://www.arb.ca.gov/toxics/ets/finalreport/finalreport.htm
[63] http://www.arb.ca.gov/toxics/ets/finalreport/finalreport.htm

smoke-free workplaces not only protect nonsmokers from the dangers of passive smoking but also encourage smokers to quit or to reduce consumption. Decreasing the smoker's opportunities to light up may serve as a policy lever in the overall repertoire of tobacco control strategies (Aquilino and Lowe 2004).

In a larger sense, the *Smoke-Free Ontario Act* has the strength of introducing greater consistency into the province's tobacco-related legislation. As one journalist put it (Campbell 2006), "It's intended to put an end to the patch work of rules that vary from region to region." This standardization of regulations is likely to lead to long-term benefits in terms of compliance and enforcement. Enforcement will become the responsibility of local health agencies[64] rather than municipalities and cities (Terfloth 2006).

Limitations of the *Smoke-Free Ontario Act*

No matter how praiseworthy, no single piece of legislation can encompass every initiative which research has shown to be effective in reducing the morbidity and mortality associated with tobacco use. The *Smoke-Free Ontario Act* reduces retail access by minors but does not directly reduce the overall availability of tobacco products. There are still issues to be dealt with regarding exposure to secondhand smoke in automobiles, multi-unit dwellings, and private residences, in particular when children are present.

There is confusion about the precise meaning of a "roof" when it comes to patios (e.g., Ferguson 2006). In addition to the provinces of Newfoundland and Nova Scotia, a number of Ontario municipalities, such as Brighton, Kingston, and Thunder Bay, have enacted total bans on smoking on patios, regardless of roof structure. Therefore, some tobacco control advocates think a total ban on patio smoking across the province would have been feasible and better from a public health point of view.

Further issues remaining to be addressed through legislative and other means – in some cases, more at the federal than provincial level – include but are not restricted to:

- cigarette engineering, e.g., increased or decreased nicotine content (Dunsby and Bero 2005; Hammond et al. 2006a)
- tax loopholes for roll-your-own tobacco
- nationalization of tobacco markets (Callard et al. 2005)
- tobacco industry liability, and
- health cost recovery litigation

Summary of Public Health-Related Strengths and Limitations of the *Smoke-Free Ontario Act*

Strengths: Foundation to Build On

- expanded health protection for nonsmokers
- elimination of designated smoking rooms
- more places where people are not allowed to smoke
- more places where tobacco is not allowed to be sold
- restrictions on patio smoking
- restrictions on tobacco displays and marketing

[64] In Ontario, local boards of health are the legal entities, public health units are the geographic areas, and local health agencies are the administrative and professional public health organizations that deliver services and administer public health laws. In the past, some Ontario municipalities had enforcement responsibility under smoke-free bylaws whereas in other cases staff of local boards of health had enforcement responsibilities.

- setting the stage for total display ban in 2008
- encouragement for quitting smoking
- regulatory consistency across province

Limitations: Opportunities for Future Initiatives

- tobacco products still sold in universities, colleges, restaurants, bars, and athletic/cultural centres
- confusion about what constitutes a patio roof
- no restrictions on smoking in multi-unit dwellings, private residences and cars when children are present

In summary, the *Smoke-Free Ontario Act* is a major historical step towards improved tobacco control in the province of Ontario The commitment to tobacco control in Ontario is equally reflected in the provincial tobacco control funding for fiscal 2005-2006: $50 million or $4.01 per capita, putting Ontario first among the Canadian provinces and territories for overall expenditure and third for per capita expenditure.

Media Coverage and Public Reaction to the *Smoke-Free Ontario Act*

Judging by media coverage, the public was given sufficient opportunity to learn about the *Smoke-Free Ontario Act* and its implications. For example, during the few weeks before and after May 31, 2006, the Media Network[65] reported such a high number of newspaper, television and radio mentions and commentaries ("impressions") about the legislation that it could not cope with the volume. Media coverage peaked on June 1st, 2006, with a total of 310 tobacco-related media items on a single day (Media Network Bulletin Board, June 1, 2006).

A preliminary media analysis[66] dated June 16, 2006, indicated:

- there were over 50 million media impressions about the *Smoke-Free Ontario Act* from May 1, 2006 to June 13, 2006
- the share of coverage was print 85%, radio 9%, and television 6%
- during the week of May 31, 2006, there were a million media impressions
- the tone of 89% of these media impressions was neutral or positive
- 20% of total coverage was about designated smoking rooms, retail outlets and patios

According to provincial sources like Media Network and international sources like Globalink,[67] reactions to the *Smoke-Free Ontario Act* are generally positive from the public health side and negative from a small but vocal sector of the business side. Public health and tobacco control advocates praise the legislation for moving forward on such key matters as expanded protection from secondhand smoke (not only for workers but for all citizens), restrictions on tobacco product displays, and prohibition of sales in designated places. Reservations expressed by public health and tobacco control advocates include the failure to make patios 100% smoke-free regardless of roof structure and the continuing sale of tobacco products in places like universities and colleges. Some small business owners, especially those who operate convenience stores, and members of the hospitality industry complain that the legislation is confusing (e.g., definition of patio roof), economically harmful

[65] The Media Network for a Smoke-Free Ontario is a media advocacy program with a mandate to act as a knowledge broker for media communications within the tobacco control community and to build capacity as required through media and public relations training, skill development and customized consultation. Funded by the Government of Ontario and administered by Cancer Care Ontario, the Media Network has about 600 members, within Ontario and from other parts of Canada, who work or volunteer in tobacco control. To view the Media Network website, visit: http://www.media-network.org
[66] E-mail from Ministry of Health Promotion, June 16, 2006; data source: Cormex Research.
[67] http://member.globalink.org (password required, members only)

(anticipated loss of business,[68] including tourism), conducive to smuggling,[69] and intrusive into civic freedom. Groups who have voiced such concerns include the Canadian Restaurant and Food Services Association, the Pub and Bar Coalition of Ontario, the Fair Air Association of Canada, and the Ontario Restaurant Hotel and Motel Association. Members of the Ontario Korean Businessmen's Association have expressed fear of loss of revenue and increased thefts in convenience stores, although these fears are sometimes associated with increased tobacco taxes rather than smoke-free legislation. These types of criticisms received media attention in a number of sources, beginning months before the legislation was enacted (e.g., Ferguson 2006; Rogers 2006).

Monitoring and Evaluation of the *Smoke-Free Ontario Act*

The OTRU evaluation team plans to evaluate the impact of the *Smoke-Free Ontario Act* through a combination of macro-monitoring and compliance studies. Survey data will be used to measure rates of current smoking, exposure to secondhand smoke, and public opinion on a variety of policy topics. The results will be published in future reports in the Monitoring and Evaluation Series. In many cases, it will be possible to use the same survey items before and after enactment of the legislation, thus allowing for pre- and post analysis. Although OTRU will make use of a number of surveys for this purpose, the most important are the Canadian Tobacco Use Monitoring Survey (CTUMS), the Canadian Community Health Survey (CCHS), the Centre for Addiction and Mental Health Monitor (CAMH Monitor), and the Ontario Student Drug Use Survey (OSDUS).[70]

Litigation in Ontario

Healthcare Cost Recovery Legislation

The Ontario healthcare cost recovery legislation[71] is less detailed than the British Columbia model upon which it is based.

In June 2006, the CBC released a news item saying more than 100 prominent health officials had signed a letter urging the Ontario government to sue cigarette companies to recover healthcare costs for tobacco-related illnesses. Addressed to Premier Dalton McGuinty, the letter was dated April 11, 2006, and made public on June 19, 2006. In addition to financial restitution, the letter described litigation as a means of achieving justice, promoting public health, and protecting children.[72]

Tobacco Farmers in Ontario

Historically, about 90% of tobacco agriculture in Canada has been concentrated in the province of Ontario, with small amounts in Québec, New Brunswick and Nova Scotia and one known grower in Prince Edward Island.[73] Ontario ranks as the fourth largest tobacco producer in comparison with all the U.S. states and

[68] Note, however, the findings of Luk et al. (2006) showing no significant adverse impact of smoke-free legislation on restaurant and bar sales in Ottawa, Canada.
[69] Note, however, the opinion of Joossens and Raw (2003) that smuggling is largely due to the exporting practices of the tobacco industry.
[70] For a complete description of these surveys, see Monitoring and Evaluation Series Vol. 11, No. 2, under Methods, posted on the OTRU website: http://www.otru.org
[71] Ontario: Ministry of Health and Long-Term Care Statute Law Amendment Act, 1999, S.O. 1999, c.10. Loi de 1999 modifiant des lois en ce qui concerne le ministère de la Santé et des Soins de longue durée. Enacts s.36.0.1 and s.45(1)(x.1) of the Health Insurance Act and s.59.1 and s.68(1)(43.1) of the Long-Term Care Act. Assent Dec. 14, 1999. Sections 1-4 proclaimed into force on Jan. 5, 2000, by virtue of O.C. 2427/99 dated Dec. 22, 1999.
[72] http://www.cbc.ca/toronto/story/to-tobacco20060619.html
[73] http://www.ontarioflue-cured.com; http://www.citt.gc.ca

Canadian provinces (Studlar 1999).

In the fall of 2005, Imperial Tobacco announced the closure of its two Ontario processing plants in Guelph and Aylmer. Estimates suggest the number of tobacco farmers in Ontario dropped from about 4,500 in the 1960s to about 600 in 2006. These changes reflect decreasing demand for tobacco products as well as the fact that the tobacco market is international, tobacco is a legally traded commodity, and the international market is increasingly competitive.[74]

In response to reduced demand for their product, an organization called Tobacco Farmers in Crisis is seeking an exit plan from the business of growing tobacco in Ontario. At a July 6, 2006, meeting of the Ontario Flue-Cured Tobacco Growers Marketing Board, more than 350 members of Tobacco Farmers in Crisis asked for a timetable for a full exit from the industry. The Board's plan is a payment of $3.30 per pound for a grower's basic production quota, which translates into a funding requirement of $897 million over a negotiated time period. To fund the buyout, the Board is hoping for financing based on the sale of tobacco products across Canada. The Board also wants $150 million for a redevelopment strategy for communities affected by the loss of tobacco production. According to the Board chair, both provincial and federal governments have made a commitment to participate in the exit process (Hartlen 2006).

The federal government is working with officials at Agriculture Canada to determine the best way to bring relief to tobacco farmers. Proposals being considered include the requested financial bail-out of almost $1 billion and the use of tobacco plants for the nutraceutical[75] industry. At the time of writing, the federal government has not reached a decision about how to respond to the problem (Puxley 2006).

[74] http://www.ontarioflue-cured.com
[75] Nutraceuticals are nutritional supplements usually sold in health and natural food stores.

C. Canadian Provinces And Territories Other Than Ontario: Scan Of Tobacco Control

Overall Provincial/Territorial Burden

In terms of tobacco-related costs, the picture for the Canadian provinces and territories roughly mirrors that for Canada as a whole, i.e., the use of tobacco products is associated with higher estimated costs than the use of alcohol or illegal drugs. Overall, the toll of substance abuse, including tobacco, presents a uniform pattern across Canada, except in the territories where social costs are higher. Note that territorial residents tend to receive specialized medical treatment in nearby provinces. Therefore, the costs associated with their treatment end up being recorded as part of the costs for other provinces (Rehm et al. 2006).[76]

Overall Provincial/Territorial Tobacco Controls, Including Litigation

Developments in provincial and territorial laws in favour of tobacco control can be interpreted at different levels. On their own, they show what is happening in individual jurisdictions. Seen in the context of Canada as a whole, they suggest trends in the national scene.

It is also useful to compare developments outside of Ontario with what is happening in Ontario in order to highlight impressive areas of progress and thus encourage emulation of best practices across the country. For example, an increasing number of provinces/territories have banned designated smoking rooms, but often exceptions are allowed and in some provinces such a ban does not exist. Internationally, these provincial and territorial developments serve as microcosmic indicators of larger trends throughout North America and the world. The inter-relatedness of tobacco control initiatives across jurisdictions, sometimes referred to as the "domino effect," is a potential source of strength in the advancement of public health (Studlar 1999).

Litigation

In a number of Canadian provinces and territories, the legislative stage is being set for litigation against the tobacco industry. However, so far British Columbia is the only province with an active case about tobacco-related healthcare cost recovery before the courts. The outcome of the case in British Columbia will likely have an impact on the future of tobacco litigation in other parts of the country.

Selective Review of Tobacco Control by Provinces/Territories Other Than Ontario

Following is a selective review of provincial/territorial developments in tobacco control. The issues touched upon include tobacco taxes, secondhand smoke, youth retail access and possession, advertising (including point of sale), investments in tobacco control, cessation programs (including nicotine replacement therapy), litigation, and evaluation and monitoring research. Because tobacco control policy is an intensely active field, it is not possible to be comprehensive in this report. (A comprehensive review would be very lengthy.) This selective review is organized geographically from east to west, with the territories discussed at the end.

[76] http://www.ccsa.ca/CCSA/EN/Research/Research_Activities/TheCostsofSubstanceAbuseinCanada.htm

Atlantic Region

Newfoundland and Labrador

Burden

In 2005, the rate of current smoking among those aged 15 and older in Newfoundland and Labrador was 21%.[77] The CCSA (Rehm et al. 2006) estimated a cost of $363.7 million to the province in 2002 from tobacco-related problems, or $684 per person.[78]

Tobacco Control, Including Litigation

In Newfoundland and Labrador, the *Smoke-Free Environment Act* (Bill 20) came into force on July 1, 2005.[79] This legislation bans smoking in all indoor public places,[80] including bingo halls and bars, as well as decks and patios of licensed liquor and food premises. The *Smoke-Free Environment Act* allows the owners of workplaces to have designated smoking rooms for employee use, provided the designated smoking rooms meet regulated requirements.[81] If the designated smoking room is not located and ventilated in accordance with the *Act* and Regulations, then the workplace must be 100% smoke-free. Designated smoking areas for non-employees or the public are no longer permitted in Newfoundland and Labrador under the *Smoke-Free Environment Act*.

In the provincial budget delivered March 30, 2006,[82] cigarette taxes in Newfoundland and Labrador were increased by $2.00 per carton of 200 cigarettes and $5.00 per 200 roll-your-own cigarettes.[83] The increased tax on roll-your-own cigarettes was noteworthy because the lower price of roll-your-own cigarettes is a significant loophole that undermines efforts to discourage smoking, especially among young persons who are known to be price-sensitive (Zhang et al. 2006). Generally speaking, in Canada taxes on roll-your-own cigarettes are about one-third to one half the taxes on manufactured cigarettes[84] (Table 1.4, Table 1.5).

In Newfoundland and Labrador, the *Tobacco Control Act*[85] prohibits the sale of tobacco in pharmacies. There is no prohibition on the sale of tobacco in other places. Anyone selling tobacco must have a tobacco retail license.

Litigation

In Newfoundland and Labrador, healthcare costs recovery legislation has been proposed but not proclaimed into force.[86]

[77] OTRU derived variable based on CTUMS 2005
[78] http://www.ccsa.ca/CCSA/EN/Research/Research_Activities/TheCostsofSubstanceAbuseinCanada.htm
[79] http://www.hoa.gov.nl.ca/hoa/statutes/s26-2.htm
[80] Locations that were already smoke-free in Newfoundland and Labrador continue to be so under Bill 20, e.g., healthcare facilities, hotel and motel common areas, public libraries, recreation centres, transportation terminals, schools, hospitals, daycares and taxis.
[81] http://www.hoa.gov.nl.ca/hoa/regulations/rc050054.htm
[82] An excerpt from the budget speech of Mar. 30, 2006, delivered by the Newfoundland and Labrador Minister of Finance can be viewed at: http://www.budget.gov.nl.ca/budget2006/speech.htm
[83] Provincial taxation authority, courtesy of Canadian Cancer Society
[84] http://www.fin.gov.on.ca
[85] The *Tobacco Control Act* of Newfoundland and Labrador can be viewed at: http://www.hoa.gov.nl.ca/hoa/statutes/T04-1.htm
[86] *Tobacco Health Care Costs Recovery Act*, S.N. 2001, c.T-4.2, as amended by S.N.L. 2005, c.50, s.1. (Bill 9, Royal Assent May 24, 2001). http://www.hoa.gov.nl.ca/hoa/statutes/t04-2.htm

Table 1.4: Comparative Tobacco Tax Rates (Cigarette versus Roll-Your-Own), by Province/Territory, March 31, 2006

Province	200 Cigarettes	200 Roll-Your-Own (100g)
Northwest Territories	$42.00	$13.60
Newfoundland and Labrador	$40.96 ($35.00)	$31.03 ($27.50)
Saskatchewan	$40.15 ($35.00)	$19.73 ($17.50)
Manitoba	$40.15 ($35.00)	$18.70 ($16.50)
Nova Scotia	$36.61 ($31.04)	$16.53 ($14.24)
British Columbia	$35.80	$17.90
Prince Edward Island	$34.90	$14.00
Alberta	$32.00	$16.00
Nunavut	$31.20	$8.60
New Brunswick	$28.47 ($23.50)	$10.32 ($8.49)
Yukon	$26.40	$4.68
Ontario	$24.70	$12.35
Québec	$20.60	$10.30
Canada (approximate)	**$20.00 ($15.85)**	**$7.40 ($5.40)**

Notes: The rates include Provincial Sales Tax (PST) and Harmonized Sales Tax (HST) for Saskatchewan, Manitoba, Newfoundland and Labrador, Nova Scotia and New Brunswick. For these five provinces, the rate in parentheses represents the tobacco tax rate without PST/HST. For the federal tax, the number in parentheses represents tobacco taxes without GST. Federal GST varies slightly by province depending on provincial tobacco tax rates. There is no PST on tobacco products in British Columbia, Alberta, Ontario, Québec and Prince Edward Island.

The order of provinces/territories in the table is from highest to lowest tax on 200 cigarettes.

A detailed table on tobacco tax and price in Canada will be presented in Report Two of this series.

Source: Finance Canada (http://www.fin.gov.on.ca), courtesy of Canadian Cancer Society

Table 1.5: Comparative Tobacco Tax Increases (Cigarette versus Roll-Your-Own), by Province, Budget Rounds December 2003 to March 2006

Effective Date:	Province	200 Cigarettes	200 Roll-Your-Own (100g)
Dec. 20, 2003	BC	$3.80	$1.90
Mar. 17, 2004	NS	$5.00	$2.26
Mar. 31, 2004	N&L	$2.00	$5.00
Mar. 31, 2004	PEI	$5.00	$2.26
Apr. 1, 2004	SK	$3.00	$1.50
Apr. 20, 2004	MB	$4.00	$2.00
May 19, 2004	ON	$2.50	$1.25
Jan. 19, 2005	ON	$1.25	$0.63
Mar. 22, 2005	N&L	$2.00	$5.00
Feb. 1, 2006	ON	$1.25	$0.63
Mar. 31, 2006	N&L	$2.00	$5.00

Note: A detailed table on tobacco tax and price in Canada will be presented in Report Two of this series.

Source: Provincial taxation authorities, courtesy of Canadian Cancer Society

Prince Edward Island

Burden

In 2005, about 20% of persons aged 15 years or older in Prince Edward Island were current smokers (i.e., smoked daily or occasionally in the past month and had smoked at least 100 cigarettes in lifetime).[87] The 2005 CCHS[88] indicates that over 30% of Queen's County residents in Prince Edward Island work in places where smoking is not completely restricted (i.e., designated smoking rooms are allowed). The CCSA study (Rehm et al. 2006) estimates tobacco-related costs for Prince Edward Island at $78.6 million for the year 2002, or $562 per person[89] (Table 1.6).

Table 1.6: Estimated Tobacco-Related Financial Burden by Province/Territory and Canada, 2002

Province/Territory	Total Cost (CDN$)	Per Capita Cost (CDN$)
Atlantic Region		
Newfoundland/Labrador	$363.7 million	$684
Prince Edward Island	$78.6 million	$562
Nova Scotia	$625.5 million	$662
New Brunswick	$468.0 million	$618
Central Canada		
Québec	$4.0 billion	$532
Ontario	$6.1 billion	$502
Prairies		
Manitoba	$676.2 million	$588
Saskatchewan	$600.0 million	$593
Alberta	$1.8 billion	$573
British Columbia	$2.3 billion	$563
Territories		
Yukon	$10.8 million	$362
Northwest Territories	$19.1 million	$460
Nunavut	$20.0 million	$697
CANADA	**$17 billion**	**$541**

Notes: Per capita costs include all persons regardless of age or smoking status. Estimates for the territories are likely to be low because territorial residents often obtain specialized healthcare in nearby provinces.

Source: Rehm et al. (2006); the figures reported in this table are copied from The Costs of Substance Abuse in Canada 2002, Highlights, Table 3, pp. 10-11. See: http://www.ccsa.ca/CCSA/EN/Research/Research_Activities/TheCostsofSubstanceAbuseinCanada.htm

[87] OTRU derived variable based on CTUMS 2005
[88] Canadian Community Health Survey (total national sample for 2005 about 133,000 respondents)
[89] http://www.ccsa.ca/CCSA/EN/Research/Research_Activities/TheCostsofSubstanceAbuseinCanada.htm

Tobacco Control, Including Litigation

As of January 2006, under Bill 8, *An Act to Amend the Tobacco Sales and Access Act*,[90] Prince Edward Island became the seventh Canadian province or territory to ban the sale of tobacco products in pharmacies and establishments that contain a pharmacy. Prince Edward Island was the first Canadian province to curb tobacco kiosks, which are sometimes set up at the front of pharmacies, especially chain pharmacies. Prince Edward Island prohibits tobacco sales in a retail store if customers or employees of a pharmacy can pass into the retail store directly from the pharmacy or by use of a corridor or area used exclusively to connect the pharmacy with the retail store. Bill 8 contains new regulatory authority to prohibit tobacco sales in other classes of retail stores and to regulate price signs at point of sale.

Under Bill 8, Prince Edward Island has new rules about the display and advertising of tobacco products, including cigarettes, cigars, smokeless tobacco and pipe tobacco (in force June 1, 2006). Retailers selling tobacco products must ensure that these products are hidden behind a curtain, in a cabinet or beneath the counter. Visible tobacco displays at retail are prohibited. Retail signs are not allowed outside. Stores are allowed to have a single sheet of paper with a list of tobacco products for sale and prices. This list may be affixed to the counter or wall, with a copy kept under the counter for reference by the cashier.

Other signage restrictions in effect in Prince Edward Island include:

- maximum one sign per cash register
- maximum size 968 square centimeters (150 square inches, i.e., about 12.25 inches by 12.25 inches)
- black text on white background
- no reference to brands[91]
- maximum letter height of 18 millimeters
- consistent font size and style in all parts of the sign (no italics, bolding, or underscoring)

Tobacconist shops are exempt from the legislation, but even they are not allowed to have tobacco product displays visible from the outside. A tobacconist shop is defined as a retail store where the primary business conducted is the sale of tobacco and to which persons under the age of 19 years are not permitted access.

Under the same legislation, grocery stores in Prince Edward Island can have smoke shops only if (a) the grocery stores do not house pharmacies and (b) there is no direct access to the smoke shops from the grocery stores.

New amendments to the regulations under the *Smoke-Free Places Act* prohibit smoking in any building or enclosed structure on the grounds of a hospital (as of May 20, 2006) or school (as of July 1, 2006).

Before the enactment of Bill 8, Prince Edward Island already had legislation in force to ban tobacco sales in universities, colleges, athletic and recreational facilities, hospitals and other healthcare facilities, amusement parks, theatres, and provincial and municipal government buildings.[92]

[90] To view Hansard of Nov. 25, 2005, regarding the recent PEI tobacco legislation, visit: http://www.assembly.pe.ca/hansard/2005fall/2005-11-25-hansard.pdf
The current version of PEI's Bill 8 is available at: http://www.assembly.pe.ca/bills/pdf_first/62/3/bill-8.pdf
Further information about the *Tobacco Sales and Access Act* and regulations for Prince Edward Island can be obtained from: Environmental Health, 16 Garfield Street, PO Box 2000, Charlottetown, Prince Edward Island C1A 7N8; phone (902) 368 4970; toll free 1 800 958 6400; fax (902) 368 6468

[91] The sign may indicate types of tobacco, such as whether the tobacco is in cigarette form, premium or discount, loose tobacco or pipe tobacco.

[92] Further information about tobacco controls in Prince Edward Island can be found under Statutes and Regulations, Tobacco Sales and Access, at the provincial government website: http://www.gov.pe.ca
The Alliance for Tobacco Reduction in Prince Edward Island publishes members' contact information in: http://www.gov.pe.ca/infopei/onelisting.php3?number=40077

Despite progress in tobacco control, there are still 67 designated smoking rooms on Prince Edward Island, mainly in bars, restaurants and workplaces. Two of the workplaces that have smoking rooms are hospitals. The PEI Division of the Canadian Cancer Society has called for a complete ban on designated smoking rooms on the Island (Thibodeau 2006).

Nova Scotia

Burden

In 2005, 21% of persons in Nova Scotia aged 15 and older were current smokers (i.e., smoked daily or occasionally in the past month and had smoked at least 100 cigarettes in lifetime).[93] Total measurable tobacco-related costs for 2002 were estimated at $625.5 million for this province, or $662 per person (Rehm et al. 2006).[94]

Tobacco Control, Including Litigation

At the time of writing, smoking is still allowed in casino complexes in Nova Scotia. Some municipalities, such as Sydney and Halifax, have bylaws banning smoking in casinos, though with designated smoking rooms permitted. As of December 2006, however, 100% smoke-free legislation will be enacted throughout the province. At that time, casino complexes will become smoke-free, with no designated smoking rooms permitted. The 2006 legislation will also ban smoking in enclosed public places and workplaces, including bars and restaurants. The 100% smoke-free requirement will extend to private clubs and patios, regardless of roof structure (Table 1.7).

Under the *Smoke-Free Places Act* (effective January 2003), youth possession of tobacco is illegal in Nova Scotia. However, a 2005 evaluation of Nova Scotia's youth tobacco possession law concluded that, despite good intentions, the possession law had thus far failed to reduce the prevalence of youth smoking. Reasons for this failure cited in the report include lack of awareness on the part of youth about the existence of the law, lack of enforcement, and minimal consequences (confiscation of products) for breaking the law.[95]

Litigation

In Nova Scotia, healthcare costs recovery legislation has been proposed but not proclaimed into force.[96]

In 2006, the governing Progressive Conservatives released an election campaign platform that included a commitment to move forward on medicare cost recovery.[97] An excerpt from the platform says, "Smoking continues to kill far too many Nova Scotians…[We are] taking action with Bill 222 to initiate the best possible legal action to recover the costs to our healthcare system caused by large multinational tobacco companies – with all net proceeds being applied to health promotion programs."

[93] OTRU derived variable based on CTUMS 2005
[94] http://www.ccsa.ca/CCSA/EN/Research/Research_Activities/TheCostsofSubstanceAbuseinCanada.htm
[95] The 31-page evaluation of the Nova Scotia youth tobacco possession law was funded by Health Canada and is entitled, "Is it making a difference? An evaluation of Nova Scotia's Youth Tobacco Possession Law," prepared for Smoke-Free Kings by Pyra Management Consulting Services Incorporated & Research Power Incorporated, June 2005.
[96] Nova Scotia: Tobacco Damages and Healthcare Costs Recovery Act, S.N.S. 2005, c.46 (Royal Assent Dec. 8, 2005) http://www.gov.ns.ca/legislature/legc/
[97] The tobacco-related measures are included under "Healthier People" (p. 9 of pdf version). See: http://www.rodneymacdonald.ca/content/view/64/57/pdf

Table 1.7: Smoke-Free Public Place Legislation in Canada, by Province/Territory, August 2006

Jurisdiction	Smoke-Free Legislation	Date in Effect	Specification(s)
FEDERAL	✓	06/1988	Smoking banned on Canadian carrier flights (1994); regulated in interprovincial transportation, financial buildings, public transit, government workplaces; DSAs and DSRs permitted
Yukon	✓	10/1994	No territorial legislation for workplaces and public places; smoking prohibited on premises owned or leased by Yukon government, including vehicles; smoke-free bylaws in Whitehorse and Dawson
British Columbia	✓	05/2002	Smoking prohibited in provincial government workplaces; regulated in public places considered workplaces, e.g., restaurants, bars, bingo halls, bowling alleys, casinos; DSRs permitted
Nunavut	✓	05/2004	Smoking banned in workplaces including restaurants, bars, bingo halls, bowling alleys, casinos; no DSRs for patrons; smoking prohibited within 3 m of entrances/exits and in all public places; DSRs permitted for people living within a workplace (e.g. hotels, elders' homes, fly-in mine sites); DSAs permitted in some mines
Manitoba	✓	10/2004	Smoking prohibited in all enclosed public places and workplaces including restaurants, bingo halls, bowling alleys, casinos; no DSRs permitted, except group living facilities, hotel guest rooms, tobacconist shops, and for Aboriginal spiritual/cultural purposes
New Brunswick	✓	10/2004	Smoking prohibited in all enclosed public places and workplaces, no DSRs permitted, including restaurants, bingo halls, bowling alleys, casinos, bars, and outdoor drinking areas within a bar; exceptions made for group living facilities and designated hotels rooms
Saskatchewan	✓	01/2005	Smoking banned in provincial government workplaces, restaurants, bars, bingo halls, bowling alleys, casinos, public places (patios, sports facilities, entry ways); DSRs and DSAs not permitted, except in some workplaces
Newfoundland and Labrador	✓	07/2005	Smoking prohibited in all enclosed workplaces and public places, including bingo halls, bars and patios; DSAs not permitted; owners of workplaces allowed to have DSRs for employees only, provided DSRs meet *Smoke-Free Environment Act* 2005 requirements
Alberta	✓	01/2006	Smoking banned in provincial govt workplaces and enclosed public places, except bars, casinos, bingo halls; DSRs and DSAs permitted
Prince Edward Island	✓	01/2006	Smoking prohibited in enclosed public places and workplaces; DSRs permitted; no smoking in any building on hospital or school grounds as of July 1, 2006
ONTARIO	✓	05/2006	100% smoke-free enclosed public places and workplaces, including schools, common areas of condominiums, university residences, casinos, bingo halls, bowling alleys, daycares, reserved seating sports and entertainment venues, bars, restaurants, pharmacies, financial institutions, stores, bus shelters, hair salons; DSAs and DSRs not permitted, except for residents of nursing homes, psychiatric facilities and guests of hotels; smoking on patios restricted; protection for home healthcare workers; no smoking at exits to healthcare facilities
Québec	✓	05/2006	Smoking prohibited in enclosed workplaces and public places, schools, healthcare facilities, nurseries, daycares, common areas of multi-unit dwellings, restaurants and bars, public transit, taxis, bus shelters and casinos; DSRs permitted (for employers and employees), except for schools, nurseries, daycares, and community and conservation centres; DSRs to be banned completely as of May 2008
Northwest Territories	✓	09/2006	Smoking prohibited in workplaces including restaurants, bars, bingo halls, bowling alleys, casinos; smoking prohibited in enclosed public places and restricted in outdoor patios; DSRs banned except in mines, prisons, nursing homes, and where workers live in enclosed worksite
Nova Scotia	✓	12/2006	100% smoke-free legislation, including restaurants, bars, casinos, and patios, no DSRs permitted, in effect Dec. 1, 2006

Note: ✓ Provincial/territorial-wide smoke-free legislation, DSRs banned/soon to be banned/carefully restricted; ✓ Partial provincial/territorial smoke-free legislation, DSRs allowed or not carefully restricted; DSR=enclosed separately ventilated designated smoking room; DSA=unenclosed designated smoking area; ordered by effective date

Sources: Non-Smokers' Rights Association (http://www.nsra-adnf.ca); Canadian Council on Tobacco Control (http://www.cctc.ca); Canadian Cancer Society (http://www.cancer.ca)

New Brunswick

Burden

In 2005, the rate of current smoking in New Brunswick among those aged 15 or older was 22%.[98] New Brunswick shares the highest rate of current smoking in Canada along with Manitoba, Saskatchewan, and Québec (22% in all cases). The estimated cost of tobacco-related problems in New Brunswick was $468 million in 2002 (Rehm et al. 2006, Table 20), or $618 per person.[99]

Tobacco Control, Including Litigation

Tobacco control initiatives supported by the government of New Brunswick include the *Smoke-Free Places Act* (Bill 75),[100] the Tobacco-Free Schools Program, and the New Brunswick Anti-Tobacco Coalition.[101]

Litigation

In New Brunswick, the *Tobacco Damages and Health Care Costs Recovery Act* (Bill 5), modeled on British Columbia legislation of the same name, received Royal Assent on June 22, 2006.[102] This bill gives the province legal authority to sue the tobacco industry for past and future healthcare costs related to the use of tobacco products. New Brunswick could proceed alone in such a lawsuit or in cooperation with other provinces. New Brunswick was an intervener in support of British Columbia when the Supreme Court of Canada declared the British Columbia bill constitutional.

Québec

Burden

In Québec, it is estimated that about 13,000 persons still die every year from smoking-related illnesses, even though approximately 400,000 Québecers have quit smoking since 1997.[103] Of these deaths, about 5,000 are associated with tobacco-related lung cancer.[104] In 2005, 22% of the population of Québec aged 15 and older were current smokers (i.e., smoked daily or occasionally in the past month and had smoked at least 100 cigarettes in lifetime).[105] The CCSA estimate (Rehm et al. 2006) for tobacco-related costs to the province of Québec for the year 2002 was almost $4 billion[106] or $532 per capita. Montreal, Québec, is the headquarters of one of the three major tobacco companies in Canada.[107]

Tobacco Control, Including Litigation

Smoke-free legislation came into effect in Québec on May 31, 2006, including a province-wide ban on smoking in bars and restaurants, with designated smoking rooms permitted. As in Ontario, the reaction to the legislation was generally positive from the public health side and occasionally negative from some sectors of the business side, especially from some bar owners who feared loss of income. Shortly after enactment of the

[98] OTRU derived variable based on CTUMS 2005
[99] http://www.ccsa.ca/CCSA/EN/Research/Research_Activities/TheCostsofSubstanceAbuseinCanada.htm
[100] New Brunswick's *Smoke-Free Places Act* can be viewed at: http://www.gnb.ca/0062/acts/acts/s-09-5.htm
[101] Media contact for New Brunswick Tobacco Control, June 2006
[102] New Brunswick: *The Tobacco Damages and Health Care Costs Recovery Act* (Bill 5, first reading Dec. 7, 2005; second reading Dec. 9, 2005; approval in Committee of the Whole, June 20, 2006; third reading, June 21, 2006; Royal Assent June 22, 2006) http://www1.gnb.ca/legis/bill/editform-e.asp?ID=393&legi=55&num=3 and http://www.gnb.ca/legis/bill/pdf/55/3/Bill-05.pdf
[103] "Québec campaign puts stress on secondhand smoke," *The Montreal Gazette*, Jan. 16, 2006; posted on Globalink News & Information, Jan. 16, 2006 http://www.canada.com/montrealgazette/news/story.html?id=fb56820a-63ab-48e1-ab62-b5f734ecea62
[104] Globalink News & Information, Jan. 16, 2006; original item can be reviewed at: http://www.canada.com/montrealgazette/columnist/story.html?id=59adedc1-69b1-4110-8a05-6cce0f87693f&p=2
[105] OTRU derived variable based on CTUMS 2005
[106] Exact figure in millions of Canadian dollars: $3,963.5
[107] The three major tobacco companies in Canada are Imperial Tobacco, Rothmans, Benson & Hedges, and JTI-Macdonald Corporation. They have undergone many changes in recent years. For more detail, see: http://www.cctc.ca

smoke-free legislation, an association of bar owners in Montreal filed a request in Québec Superior Court to have the smoking ban temporarily lifted in bars until a constitutional challenge to the legislation could be heard later in the year. The temporary suspension would consist of permission for segregated smoking and nonsmoking sections in bars.[108]

In the initial version of Québec's 1998 *Tobacco Act*, designated smoking rooms were permitted in workplaces where smoking was banned. Depending on the size of the workplace, they had to be equipped with an independent ventilation system as of 2001 or 2003. In the recent version of the *Act*, designated smoking rooms are once again permitted in workplaces and even public places, such as bars and restaurants, but only for employers and employees. Customers are not allowed access to the designated smoking rooms. (This restriction does not apply to cigar lounges.) All designated smoking rooms must be equipped with an independent ventilation system. However, these designated smoking rooms will be permitted only until 2008 when they will all be banned.[109]

Retail displays of tobacco products will also be banned in Québec as of May 31, 2008. In the meantime, the recent version of the *Act* provides that a retail outlet where tobacco is sold must be "a fixed place permanently delimited by continuous floor-to-ceiling partitions or walls, which is accessible only through an opening equipped with a door and in which tobacco is sold by the operator of the place." Retail sales are forbidden to minors and also to adults who are attempting to purchase tobacco products for minors. Tobacco products must be kept at the retail point of sale in such a way that the purchaser has no access to them without the assistance of an employee (*Tobacco Act*, s. 14.1).

Litigation

In August 2004, JTI-Macdonald was ordered to pay $1.36 billion to the Québec government for unpaid taxes, penalties and interest, on matters arising from contraband (Spurgeon 2004). As a result, the tobacco company sought and obtained bankruptcy protection. Six other provinces, including Ontario,[110] have filed notices of claims, with total federal and provincial government civil contraband claims against JTI-Macdonald totaling $9.6 billion.[111]

In Québec, two class action healthcare cost recovery lawsuits against the tobacco industry have been certified (meaning the cases must go ahead). The claims are for $22.8 billion in damages (Spurgeon 2005).

Prairies

Manitoba

Burden

In 2005, 22% of the population of Manitoba aged 15 or over were current smokers (i.e., smoked daily or occasionally in the past month and had smoked at least 100 cigarettes in lifetime).[112] It is anticipated that tobacco will kill about 2000 Manitobans in 2006.[113] The CCSA cost study (Rehm et al. 2006) estimated annual tobacco-related costs in Manitoba to be $676.2 million, or $588 per capita.[114]

[108] "Québec bars want smoking allowed," *Barrie Examiner*, p. A9, July 15, 2006.
[109] E-mail from Québec Non-Smokers Rights Association, April 17, 2006.
[110] Tobacco-related litigation in Canada. A report prepared by the Smoking and Health Action Foundation and the Non-Smokers' Rights Association, March 2006, available at: http://www.nsra-adfn.ca
[111] For summary of the Québec decision, see: http://bmj.bmjjournals.com/cgi/content/full/329/7463/420-a [Cursor down to "related articles" for item on litigation in other Canadian provinces.]
[112] OTRU derived variable based on CTUMS 2005
[113] E-mail from Rob Cunningham, Senior Policy Analyst, Canadian Cancer Society, Mar. 16, 2006
[114] http://www.ccsa.ca/CCSA/EN/Research/Research_Activities/TheCostsofSubstanceAbuseinCanada.htm

Tobacco Control, Including Litigation

Manitoba's *Non-Smokers Health Protection Act* restricts the display, advertising and promotion of tobacco and tobacco-related products. Beginning in April 2003, tobacco enforcement officers have been providing tobacco retailers throughout the province with a Retailer Toolkit for Tobacco Sales to help retailers identify customers under the age of 18 years. A number of tobacco control campaigns in Manitoba are geared towards younger persons, such as the mass media campaign Review and Rate, the cessation program sponsored by the Manitoba Lung Association called Not on Tobacco (NOT), and a curriculum-based educational resource called the Tobacco Learning Resource Initiative (TLRI).

On January 1, 2004, Manitoba adopted legislation banning visible point-of-sale display of tobacco products, applying to premises accessible to minors under the age of 18. The government of Manitoba began to enforce this legislation as of August 15, 2005, after the Supreme Court of Canada upheld similar legislation in Saskatchewan.[115]

In October 2004, Manitoba became one of the first Canadian provinces (with New Brunswick) to ban smoking in all enclosed public places, including bars and restaurants, and in indoor workplaces, with no designated smoking rooms permitted.

In November 2005, a Manitoba bar owner appealed his conviction when he was fined $2,550 for letting customers smoke despite the province's ban on smoking in bars. He argued that the smoking ban was discriminatory because it did not apply to Aboriginal reserves. (The Manitoba government believed provincial smoking legislation could not be enforced in areas such as Aboriginal reserves, federal prisons and military bases.) The bar owner said many of his smoking customers had stopped coming to his bar in favour of Aboriginal bingo halls.

In August 2006, Justice Albert Clearwater ruled that Manitoba's smoke-free law must apply to Aboriginal reserves. He said the Manitoba government was wrong to think it does not have jurisdiction over smoking on reserves since an exemption for reserves would be discriminatory under Section 15 of the Charter of Rights and Freedoms, which guarantees that all people receive equal treatment under the law. The judge overturned the conviction of the bar owner and ordered the province of Manitoba to start applying its smoking ban on reserves after a "reasonable but short" period of time.[116]

In Winnipeg, Manitoba, a smoking ban for new tenants of about 5000 apartment units managed by Globe General Agencies came into effect on October 1, 2006. The president of Globe General Agencies says the smoking ban in apartments will offer a cleaner and healthier environment. Existing tenants who smoke will be allowed to continue to do so.[117]

Litigation

In March 2006, proposed legislation that would enable the government of Manitoba to hold multinational tobacco companies accountable through the courts was introduced by the provincial Health Minister. The proposed *Tobacco Damages and Health Care Costs Recovery Act* (Bill 27[118]) would:

- give the government a direct and distinct action against a manufacturer of tobacco products to recover the costs of healthcare benefits for tobacco-related illnesses

[115] http://www.gov.mb.ca
[116] For further details on the Jenkinson ruling, see: http://www.cbc.ca/cp/health/060815/x081526.html
[117] "Smoking banned in apartments," *The Sudbury Star* (Sudbury, ON), p. A8, Sept. 20, 2006.
[118] To see the bill, visit:
English: http://web2.gov.mb.ca/bills/sess/b027e.php
French: http://web2.gov.mb.ca/bills/sess/b027f.php
To see the news release, visit: http://www.gov.mb.ca/chc/press/top/2006/03/2006-03-16-03.html

- allow government to claim for both past and reasonably expected future costs of healthcare needed because of tobacco-related illnesses
- allow the government to file a lawsuit on behalf of one person or all of the people affected by a tobacco-related illness and
- ensure the definition of manufacturer captures tobacco companies that are resident in other jurisdictions but sell in Manitoba

In June 2006, the Manitoba Legislative Assembly gave unanimous all-party approval at third reading to Bill 27 and it received Royal Assent on June 14.[119] Upon proclamation of the proposed legislation, the government will have two years to begin a lawsuit.

Manitoba acted as intervener in the 2005 British Columbia action known as *Imperial Tobacco Canada Ltd* vs. *British Columbia*.[120]

Saskatchewan

Burden

In 2002, according to the CCSA study (Rehm et al. 2006), tobacco-related costs to the province of Saskatchewan were almost $600 million, or $593 per person.[121] The rate of current smoking among those aged 15 or more in Saskatchewan was 22% in 2005.[122]

Tobacco Control

Under Section 77 of the 1996 Occupational Health and Safety Regulations, employers, contractors and owners in Saskatchewan have a duty to prohibit smoking in enclosed places where workers are present, but designated smoking areas are permitted. As of January 1, 2005, the *Tobacco Control Amendment Act* in Saskatchewan banned smoking in enclosed public places, with no designated smoking rooms permitted.

The smoke-free provisions of the 2005 *Tobacco Control Amendment Act* cover workplaces in Saskatchewan provided they are enclosed public places to which the general public has access. However, for those workplaces to which the general public has no access (and which therefore are not covered by the *Tobacco Control Amendment Act*), Occupational Health and Safety regulations regarding smoking apply. There is provision for these workplaces under the Occupational Health and Safety regulations to have a designated smoking area.

In March 2006, the Saskatchewan Coalition for Tobacco Reduction launched a campaign to raise public awareness of the need for 100% smoke-free workplaces, regardless of public access, with no designated smoking areas permitted.

In Saskatchewan, it is illegal to sell tobacco products in healthcare facilities, residential care facilities and schools (Table 1.8).

[119] To view debate, visit:
May 31, 2006: http://www.gov.mb.ca/legislature/hansard/4th-38th/vol_80/h80.html#b27
June 5, 2006: http://www.gov.mb.ca/legislature/hansard/4th-38th/vol_83/h83.html#b27
June 13, 2006 (*Act* not yet proclaimed into force): http://web2.gov.mb.ca/bills/sess/b027e.php
[120] In September 2005, the Supreme Court of Canada unanimously (nine to zero) found the legislation underpinning the B.C. lawsuit against the major tobacco companies to be constitutional.
[121] http://www.ccsa.ca/CCSA/EN/Research/Research_Activities/TheCostsofSubstanceAbuseinCanada.htm
[122] OTRU derived variable based on CTUMS 2005

Table 1.8: Prohibitions on the Sale of Cigarettes in Specific Canadian Venues, by Province and Territory, June 2006

Jurisdiction	Vending Machines	Pharmacies	Healthcare Facilities	Residential Care Facilities	Schools	Child Care Facilities
Nunavut	✓	✓	✓	✓		✓
Northwest Territories	✓	✓				
Yukon						
British Columbia		†				
Alberta						
Saskatchewan	✓		✓	✓	✓	
Manitoba						
ONTARIO	✓	✓	✓	✓		
Québec	✓	✓	✓	✓	✓	✓
New Brunswick		✓				
Nova Scotia	✓	✓				
Prince Edward Island	✓	✓	✓	✓	✓	
Newfoundland		✓				

Note: ✓Total ban; ✓ Provisions more restrictive than federal policy, but not total ban; †Legislation not yet proclaimed. Ordered by geographical location (territories and then west to east)

Source: Canadian Council on Tobacco Control (http://www.cctc.ca) and provincial government websites

Saskatchewan was the first jurisdiction in North America to ban point-of-sale advertising. Since March 2002, Saskatchewan has had legislation in place (the provincial *Tobacco Control Act*) banning the visible display of tobacco products at the point of sale, applying to premises accessible to minors under the age of 18. Due to legal proceedings, the legislation experienced a period of non-enforcement after enactment. However, in January 2005, the Supreme Court of Canada unanimously upheld the Saskatchewan point-of-sale legislation, ruling that it does not conflict with the federal *Tobacco Act*. (This had been the issue to be decided.) Therefore, the government of Saskatchewan began uninterrupted enforcement of the legislation as of January 19, 2005.

The main provisions of Section 6 of Saskatchewan's *Tobacco Control Act* concerning display of tobacco products at the point of sale are as follows:[123]

- any person is prohibited from advertising or promoting tobacco or tobacco-related products in a place or premises if young persons under the age of 18 are permitted access to the place or premises
- if a retailer chooses to display tobacco products in a retail establishment, young persons under the age of 18 must be prohibited from entering the retail establishment
- tobacco advertising cannot be placed in the windows of a retail establishment if the advertising is visible from outside
- options for keeping tobacco products hidden from public view include cabinets, doors, shelves, drawers, frosted glass and curtains
- retailers selling tobacco products are required to post signs supplied by Health Canada or Saskatchewan Health regarding the legal age of purchase of tobacco and health warnings about tobacco

[123] For further details about the Saskatchewan point-of-sale legislation, see:
http://www.health.gov.sk.ca/ps_tobacco_reduction.html
http://www.health.gov.sk.ca/ps_tobacco_control_signs.pdf
http://www.health.gov.sk.ca/ps_tobacco-control.html (Bulletins #1 and 2)

- tobacco products must be kept out of view except for the period of time reasonably required to serve a customer, stock shelves, or take inventory
- a tobacco product can be shown to a person over the age of 18 for inspection prior to purchase

Alberta

Burden

According to the CCSA study (Rehm et al. 2006), tobacco-related problems cost the province of Alberta about $1.8 billion in 2002, or $573 per person.[124] The rate of current smoking among Albertans aged 15 or over was 21% in 2005.[125]

Tobacco Control

Some tobacco control spokespersons believe Alberta is lagging behind the other provinces in terms of tobacco policy measures. For example, an Edmonton news release from the Campaign for a Smoke-Free Alberta[126] dated May 31, 2006 (World No Tobacco Day) quoted the Executive Director of Action on Smoking and Health as complaining that:

> Alberta's tobacco taxes are the third lowest among provinces,[127] we have the weakest smoking restrictions in Canada, and we are the only province without any laws to restrict tobacco sales and marketing. These policy omissions are having a significant impact on our quality of life in Alberta and we cannot allow another generation of Albertans to fall prey to the tobacco industry.

Results from a survey of 14 Alberta politicians were released on May 31, 2006, showing their opinions on tobacco taxation, smoke-free workplaces, restrictions on tobacco sales and marketing and healthcare cost litigation.[128] According to the Executive Director of the Canadian Cancer Society Alberta/NWT Division, the overall response to the survey was positive (i.e., in favour of tobacco controls). The survey was seen as a way of putting tobacco at the top of the list of leadership issues in the province.

Towards the end of 2005, a controversy arose in Alberta concerning the issue of allowing smoking in the legislature, despite smoke-free legislation which was to come into effect January 2006.[129] Tobacco control advocates objected to the private permission the caucus had given for smokers to smoke in special smoking rooms as well as offices in the legislature. However, on December 9, 2005, it was announced that the Alberta government had decided to ban smoking in the legislature and cabinet ministers' offices, after all.

Edmonton and Banff are examples of cities in Alberta that have smoke-free bylaws which are stricter than the provincial legislation. However, the legislature, which is located in Edmonton, is not obligated to follow local bylaws. As a reaction to the Edmonton bylaw, which includes banning smoking in bars, some bar owners have provided parked buses as places where patrons can smoke.[130]

Calgary is planning to enact smoke-free legislation in January 2008, but, in the meantime, smoking is permitted in restaurants and public places. Some Calgary citizens have petitioned City Hall to have the date

[124] http://www.ccsa.ca/CCSA/EN/Research/Research_Activities/TheCostsofSubstanceAbuseinCanada.htm
[125] OTRU derived variable based on CTUMS 2005
[126] The Campaign for a Smoke-Free Alberta is supported by 17 provincial organizations that are working to reduce tobacco use.
[127] According to the 2004-2005 OTRU Monitoring and Evaluation Series, Vol. 11, No. 3, Figure 2.10, using a simple average and including the territories as well as the provinces, Alberta has the sixth lowest tax level in Canada on a carton of 200 cigarettes ($32.00); lower tax levels are reported for Nunavut ($31.20), New Brunswick ($28.83), Yukon ($26.40), Ontario ($23.45), and Québec ($20.60).
[128] The survey results can be viewed at: http://www.smokefreealberta.com/survey
[129] The January 2006 smoke-free legislation in Alberta allows designated smoking rooms.
[130] "Pub owner told to ditch butt bus," *The Toronto Star*, Dec. 20, 2005: http://www.thestar.com

for the smoke-free bylaw moved forward to January 2007 (Ebner 2006).

Youth possession of tobacco is illegal in Alberta (Table 1.9).

Table 1.9: Youth Access to Tobacco Provisions, by Province and Territory, May 2006

Jurisdiction	Legal Age	Minimum Age Laws	Possession Laws
Nunavut	19	✓	
Northwest Territories	18	✓	
Yukon	18	✓	
British Columbia	19	✓	
Alberta	18	✓	✓
Saskatchewan	18	✓+	
Manitoba	18	✓+	
ONTARIO	19	✓	
Québec	18	✓	
New Brunswick	19	✓+	
Nova Scotia	19	✓	✓
Prince Edward Island	19	✓	
Newfoundland	19	✓	

Note: ✓+ Provisions more restrictive than federal policy, but not total provincial/territorial ban; ✓ Equivalent provincial/territorial law to the federal law; ✓ Provincial/territorial ban on underage sales. Ordered by geographical location. "Legal age" means it is illegal to sell tobacco to someone under the age listed

Source: CCTC Website (http://www.cctc.ca): Canadian Law and Tobacco

British Columbia

Burden

Compared to the other Canadian provinces and territories, British Columbia can boast the lowest rate of current smoking (14%) among persons aged 15 years and older.[131] Nevertheless, annual costs to the province related to the use of tobacco are estimated at $2.3 billion, or $563 per capita (Rehm et al. 2006).[132]

Tobacco Control, Including Litigation

In British Columbia, the *Workers Compensation Act*[133] (effective April 15, 1998) prohibits smoking in workplaces or restricts it to designated smoking areas/rooms. Local governments have the authority to pass bylaws restricting or prohibiting smoking in various places. More than twenty local governments in British Columbia have done so.

Amendments to British Columbia's *Tobacco Sales Act* in the spring of 2006 allowed for administrative enforcement of the province's legislation regarding sales to minors.[134] Monetary penalties and store suspensions can be issued by government-appointed administrators against non-compliant retailers without the need for charges to be laid, thus avoiding potentially lengthy and costly court proceedings.

[131] OTRU derived variable based on CTUMS 2005
[132] http://www.ccsa.ca/CCSA/EN/Research/Research_Activities/TheCostsofSubstanceAbuseinCanada.htm
[133] http://www.cctc.ca
[134] To see the bill (Bill 12 Tobacco Sales—Preventing Youth Access to Tobacco): http://www.legis.gov.bc.ca/38th2nd/3rd_read/gov12-3.htm

Litigation

In British Columbia, the *Tobacco Damages and Health Care Costs Recovery Act* (Bill 15, Royal Assent July 6, 2000), modeled to some extent on a Florida law, came into force in January 2001 and was amended in 2005.[135] In September 2005, the Supreme Court of Canada unanimously (9-0) upheld the constitutionality of the British Columbia healthcare costs recovery legislation (Sibbald 2005a).

The British Columbia Supreme Court dismissed an application by foreign tobacco companies to be removed as defendants in a healthcare cost recovery lawsuit in February 2006. On September 15, 2006, the British Columbia Court of Appeal unanimously upheld the decision that the foreign tobacco manufacturers must stand trial in the British Columbia government's healthcare cost recovery lawsuit.[136]

In February 2006, the British Columbia Court of Appeal heard an appeal by Imperial Tobacco Canada Ltd. The appeal concerned an earlier Supreme Court decision to certify[137] the case of Knight v. Imperial Tobacco Canada Ltd. regarding the use of the label "light" cigarettes. Later in the same month, the British Columbia Supreme Court heard an application by the federal government to be removed as a Third Party defendant in the Knight v. Imperial Tobacco Canada Ltd. "lights" class action.[138]

In March 2006, private members' Bill M203 was introduced into the British Columbia Legislative Assembly to prohibit the sale of tobacco in pharmacies.

At the time of writing, British Columbia is the only province with a lawsuit before the courts in the matter of healthcare costs recovery.

Territories

Yukon

Burden

Tobacco-related healthcare and other costs in the Yukon for the year 2002 were estimated at $10.8 million, or $362 per person (Rehm et al. 2006).[139] This estimate is potentially misleading because residents of Canadian territories often obtain specialized healthcare in nearby provinces.

According to an electronic government document entitled Yukon Tobacco Reduction Strategy,[140] the Yukon has the third highest smoking rate in Canada, surpassed only by Nunavut and the Northwest Territories. The document states that approximately 33.4% of Yukon residents aged 12 years or older are daily smokers.

Tobacco Control

As indicated on the website of the Canadian Council for Tobacco Control (CCTC),[141] the Yukon has no territorial tobacco-related legislation. Therefore, tobacco-related restrictions in this territory depend on federal legislation and municipal bylaws. A municipal smoke-free bylaw for bars and restaurants is in force in Whitehorse and a partial smoke-free bylaw for bars and restaurants is in force in Dawson.[142]

[135] To see the bill, visit: http://www.qp.gov.bc.ca/statreg/stat/T/00030_01.htm
[136] To view the Sept. 2006 judgment confirming that foreign tobacco companies must stand trial in the B.C. healthcare cost recovery lawsuit, see: http://www.courts.gov.bc.ca/Jdb-txt/CA/06/03/2006BCCA0398.htm
[137] To certify a case means to rule that it must proceed. This case was to proceed as a class action.
[138] More information about deceptive labeling, as in "light" and "mild" cigarettes, can be found at the website of the Non-Smokers' Rights Association: http://www.nsra-adnf.ca
[139] http://www.ccsa.ca/CCSA/EN/Research/Research_Activities/TheCostsofSubstanceAbuseinCanada.htm
[140] http://www.smokersline.ca; e-mail: health.promotion@gov.yk.ca
[141] http://www.cctc.ca
[142] Information forwarded by Community Health Programs, Health and Social Services, Yukon Territorial Government, May 15, 2006

The Yukon Tobacco Reduction Strategy aims to prevent initiation of smoking among children and adolescents and to help smokers to quit and remain smoke-free. In partnership with various government departments, public organizations and interest groups, the strategy is committed to promotion of smoke-free lifestyles and denormalization of the tobacco industry. At the community level, the strategy supports smoke-free groups and initiatives such as Students Working Against Tobacco (SWAT), Project: Moving Target, Active Yukon Schools, and Yukon Education Students Network (YESNET). In partnership with the Canadian Cancer Society and Health Canada, the strategy launched a mass media campaign to help current smokers in the Yukon to quit.

The Yukon reported the highest level of per capita funding for tobacco control among the Canadian provinces and territories in fiscal year 2005-2006.

Table 1.10: Per Capita Tobacco Control Funding Commitment, by Province/Territory, Fiscal 2005-2006

Jurisdictions	2005-2006 Funding (CDN$)	Population	Per Capita Funding (CDN$)
Yukon	$206,750§	30,862	$6.70
Northwest Territories	$205,000	43,015	$4.77
ONTARIO	**$50,000,000**	**12,462,445**	**$4.01**
Québec	$29,480,929*	7,573,726	$3.89
Alberta	$10,400,000	3,226,301	$3.22
Nunavut	$80,000	29,710	$2.69
Nova Scotia	$2,300,000	938,339	$2.45
British Columbia	$5,700,000#	4,225, 623	$1.35
Newfoundland and Labrador	$596,850	517,339	$1.15
Saskatchewan	$584,000†	994, 687	$0.59
Manitoba	$588,000	1,174,959	$0.50
New Brunswick	Not Available‖	752,266	Not Available
Prince Edward Island	Not Available‖	137,771	Not Available
Average Per Capita Funding across Canada (excluding NB & PEI)			**$2.85**
CDC Recommended Per Capita Funding, 1999 ($U.S.)			**$5.00-$16.00**
CDC-Based Recommended Funding for ON 2005-2006 ($U.S.)			**$62,000,000-$199,000,000**

Note: Ordered by per capita funding. The amounts quoted are the best approximations available. Funding commitments are the funding levels committed through political announcements and/or budgetary commitments. They may not correspond to actual expenditures in fiscal 2005-2006.
§ Yukon's estimate does not include personnel time or miscellaneous expenses dedicated to tobacco control
*Québec's tobacco control budget includes reimbursement for nicotine replacement therapy under the provincial drug insurance program when prescribed by a physician: in 2005-2006, the government of Québec spent $20 million directly on tobacco control and $9,480,929 on nicotine replacement therapy
#The amount for British Columbia does not include litigation costs
† Saskatchewan's funding estimate does not include staff time dedicated to tobacco control
‖ Did not disclose funding amount

Source: Yukon – S. Ross (Aug. 10, 2006); Northwest Territories – M. Wideman (Aug. 16, 2006); Ontario – MHLTC News Release (May 31, 2005); Québec – Y. Archambault (Sept. 19, 2006); Alberta -- L. Carr (Aug. 16, 2006); Nunavut – K. Loubert (Aug. 16, 2006); Nova Scotia – S. Machat (Aug. 16, 2006); British Columbia – G. Downey (Aug. 16, 2006); Newfoundland and Labrador – B. Squires (Aug. 15, 2006); Saskatchewan – M. Martin-Smith (August 8, 2006); Manitoba – A. Loughead (Aug. 22, 2006)

CDC tobacco control funding recommendations in U.S. dollars from "Best Practices for Comprehensive Tobacco Control Programs, August 1999"; CDC expresses funding recommendations as range of values, based on population and other factors; values extrapolated for Ontario are based on population over 7 million; available at: http://www.cdc.gov/tobacco/research_data/stat_nat_data/bestprac-execsummay.htm

Population figures from Statistics Canada, updated postcensal estimates, January 1, 2005. *The Daily: Demographic statistics Canada's population*. Ottawa: Statistics Canada; 2006. Available from: http://www.statcan.ca/Daily/English/060328/d060328e.htm.

Northwest Territories

Burden

The CCSA (Rehm et al. 2006) estimated a cost of $19.1 million to the Northwest Territories for the year 2002 due to tobacco-related problems, or $460 per person. As with the other Canadian territories, a note of caution should be observed about such estimates in so far as many territorial residents obtain specialized healthcare provincially.

According to 1999 data from the School Use Tobacco Survey cited in the Northwest Territories Action on Tobacco document of May 2002, 34% of all youth aged 10 to 17 years in the Northwest Territories are current smokers. Aboriginal youth are more likely than non-Aboriginal youth to be current smokers.

Tobacco Control

On March 2, 2006, the Northwest Territories Legislative Assembly gave unanimous and final approval to Bill 16, the *Tobacco Control Act*.[143] Key provisions in the *Act* include:

- prohibition of visible display of tobacco products in retail stores where minors under 18 have access and prohibition of signage inside these stores
- prohibition of sales in pharmacies and in establishments containing a pharmacy as well as athletic and recreational facilities
- establishment of regulatory authority to ban tobacco sales in other designated places
- stipulation that tobacco cannot be sold to any person under the age of 18 years
- authority to suspend retailers who are repeat offenders for selling to minors or who have sold contraband tobacco products
- prohibition of vending machines
- prohibition of smoking in public places,[144] confirming worker compensation regulations
- prohibition of smoking on outdoor patios of restaurants and bars

The Northwest Territories has a Territorial Strategy for Tobacco Control, embracing the four goals of prevention, protection, cessation and denormalization.[145]

Nunavut

Burden

The CCSA (Rehm et al. 2006) estimated a cost of $20 million to Nunavut for the year 2002 due to tobacco-related problems, or $697 per person. It is to be borne in mind that residents of Nunavut, like residents of the other Canadian territories, tend to seek specialized healthcare provincially. Therefore, some of the care received by residents of Nunavut in connection with tobacco-related illness would end up being recorded as an expense to another jurisdiction.

The preamble to the *Tobacco Control Act* expresses concern about high rates of smoking among Nunavummiut youth ("the bearers of our future and our culture") in comparison with the rates of smoking among other Canadian youth.[146]

[143] To view the English/French version of Bill 16 at Third Reading, visit: http://www.assembly.gov.nt.ca/HouseBusiness/Legislation/bills
[144] Bill 16 defines public place as "all or any part of a building, structure, vehicle or conveyance, whether covered by a roof or not, to which the public has access as of right or by express or implied invitation."
[145] http://www.cctc.ca
[146] http://www.cctc.ca/EN/lawandtobacco/byregion/

Tobacco Control

Tobacco control legislation in Nunavut consists of the *Tobacco Control Act*, the *Safety Act* (Environmental Tobacco Smoke Worksite Regulations), and the *Mine Health and Safety Act* (Environmental Tobacco Smoke Worksite Regulations). Consolidations of these *Acts* are available on the website of the Canadian Council on Tobacco Control (CCTC)[147] and their provisions are summarized in Table 1.7 of this report.

Legislation banning the visible display of tobacco products at point of sale was adopted in Nunavut on February 1, 2004.

[147] To view summaries of Nunavut tobacco legislation, see http://www.cctc: home page, Canadian Law & Tobacco, Legislation by Region, Nunavut

D. The United States: A Brief Perspective

Burden

Recent estimates show that 44.5 million adults and 3 million adolescents aged 12 to 17 years are current smokers in the United States (Cokkinides et al. 2006). Of these, roughly half are expected to die from causes associated with their addiction to cigarettes, unless they quit. In the United States, tobacco use is responsible for about one in five deaths overall, which means 438,000 premature deaths annually, and 30% of all cancer deaths (Centers for Disease Control and Prevention 2005; Department of Health and Human Services 2004).

Cigarette smoking is the leading cause of preventable death in the United States (Friedan and Blakeman 2005). Lung cancer, the most preventable of all cancer deaths, afflicts a disproportionate percentage of African Americans, killing more African Americans than any other cancer. Most of these cancer deaths are smoking-related (Green and Davis 2004). A rapid increase in lung cancer mortality has been observed among women in the United States, as the rates of smoking for men (23%) and women (19%) converge (Pauk et al. 2005).

Tobacco is by far the strongest risk factor for the development of lung cancer in the United States, as elsewhere. Therefore, tobacco control is central to U.S. public policies for cancer prevention (Greenwald 2005). Even though current smoking in the United States is at its lowest level since the Second World War (about 21% of adults), it is associated with a massive burden of illness, death and economic costs.

The authors of the 2005 California Environmental Tobacco Smoke (ETS) Report estimate that in the United States secondhand smoke is responsible for an annual excess of 3,400 lung cancer deaths and an annual excess of 46,000 deaths from ischemic heart disease.[148] These and other estimates of the overall harm caused by secondhand smoke are of course in addition to the direct negative health impact of smoking on smokers.

Tobacco Control, Including Litigation

The United States and Canada

Progress in tobacco control in the United States is of special interest to Canada because of a shared border,[149] free trade arrangements, and similar values amongst public health professionals between the two nations. Even though Canada's health system is based on public insurance whereas the U.S. system is based largely on private insurance, the two countries have much in common in terms of health problems, spending and outcomes (Studlar 1999). Researchers speak of policy copying, policy borrowing, policy transfer, emulation, and lesson drawing to describe the way Canada affects tobacco control in the United States and vice versa (Studlar 1999).

Despite smuggling-related setbacks in the mid-1990s,[150] the United States has generally regarded Canada as a leader in the area of taxation on tobacco products (Studlar 1999). In 2005, U.S. tobacco excise taxes generated $10.2 billion in revenue or about 1.2% of all states' revenue (McKinley 2005). From 2001 to 2005, tobacco excise taxes increased in an unprecedented number of states; the increases ranged from $0.12 per

[148] State of California Air Resources Board, Appendix III, Proposed Identification of Environmental Tobacco Smoke as a Toxic Air Contaminant, Part B--Health Effects. As approved by the Scientific Review Panel on June 24, 2005; see especially Table 1.1 "Attributable Risks Associated with ETS," p. 1-18, available at: http://www.arb.ca.gov/toxics/ets/finalreport/finalreport.htm

[149] About 80% of the Canadian population lives within 200 miles of the U.S. border (Studlar 1999).

[150] In 1994, tobacco taxes declined in Canada in the wake of a smuggling crisis, which has since been rectified. For a discussion of this issue, see Breton et al. (2006).

pack in Louisiana to $0.75 per pack in Massachusetts and Michigan (McKinley 2005). In 2005, the nationwide state tax per pack of cigarettes ranged from a low of $0.07 in South Carolina to a high of $2.46 in Rhode Island, the mean tobacco excise tax for the nation being about $0.92 (McKinley 2005). Politically, tobacco taxes are regarded as advantageous in the United States, even with respect to voters who are otherwise anti-tax. Tobacco taxes are considered effective in deterring price-sensitive adolescents from using tobacco (McKinley 2005).[151]

For a review of current tobacco control laws in the United States, including smoke-free workplace legislation, trends in tobacco excise taxes, youth access laws, tobacco control program funding and other regulatory efforts at the national, state, and municipal level, see Stoner and Foley (2006).[152]

Litigation

In the United States, when legal action against the tobacco industry began to be adopted in the 1950s, it was largely because legislative and administrative avenues were persistently blocked, especially at the federal level, by the political power of tobacco companies (Studlar 1999, p. 75).[153]

Canada often looks to the United States as a leader in the area of litigation against the tobacco industry (Studlar 1999). Since the 1990s, there have been numerous actions in the United States against the tobacco industry (e.g., Rabin 2001; Daynard 2003; Sweda 2001, 2004) to hold them accountable for the loss suffered by the state in paying for healthcare costs. In some cases, the tobacco industry has suffered substantial losses as a result of these actions (Jacobson and Soliman 2002, p. 231). Tobacco companies agreed to pay more than $200 billion over 25 years to defray smoking-related health costs (Sibbald 2005b).[154]

On August 17, 2006, the U.S. federal court ruled that tobacco companies could be prosecuted as racketeers under the *Racketeer-Influenced and Corrupt Organizations Act*. As part of the ruling, the court found that "light" and "mild" cigarette labels were deceptive.[155]

Selected Examples from Particular U.S. States[156]

The following examples of recent tobacco control activity in the United States are selected to highlight some of the interesting developments that have occurred, especially during the time period 2005 to 2006. The examples are not comprehensive.

California

To a large extent, California is known as a leader in the realm of tobacco control initiatives. For example, in the spring of 2006, the city of Calabasas, California, banned smoking everywhere outdoors where a nonsmoker could get within 20 feet of a smoker.[157]

In order to combat the health hazard caused by secondhand smoke and the litter caused by discarded cigarette butts, an increasing number of cities in California have passed ordinances banning smoking in parks and on beaches. In July 2006, San Diego was added to the list of at least 35 California cities, including

[151] For current information on U.S. tobacco taxes, see also: http://www.tobaccofreekids.org
[152] For more information on tobacco policy in the United States, see also: http://.www.cctc.ca; http://www.apps.nccd.cdc.gov/statesystem; and http://www.scld-nci.net
[153] In Canada, because of a different legal culture, it is much more difficult to generate large tort awards (Studlar 1999).
[154] http://www.cbc.ca/toronto/story/to-tobacco20060619.html
[155] http://www.courts.gov.bc.ca
[156] The U.S. states used as examples are listed in alphabetical order.
[157] "Secondhand Smoke," Globalink News & Information, May 17, 2006; original item can be viewed at: http://www.abcnews.go.com/2020/Stossel/story?id=1955237&page=1

Malibu, Santa Monica and Long Beach, where smoking on beaches is forbidden.[158]

As a reflection of smoke-free success in California, a cross-sectional trend study of attitudes on the part of U.S. bar and restaurant workers, all other workers, smokers and nonsmokers (total n = 90,661) showed that public acceptance of smoke-free bars was especially high in California (45% preferring smoke-free bars in 1999, an increase of 15% in 6 years) compared to other U.S. states (Feigelman and Lee 2006).

California has also taken a lead role in proposed legislation regarding the issue of secondhand smoke. As of January 2006, the state has been considering a proposal to identify environmental tobacco smoke as a toxic air contaminant.[159]

In California, in 2006, the U. S. Supreme Court refused to dismiss a $50 million damage award to the family of a smoker who had died of cancer and who had previously won $3 billion in punitive damages against the tobacco industry, which was found guilty of negligence, misrepresentation, fraud and selling a defective product.[160]

Hawaii

The governor of Hawaii signed comprehensive smoke-free workplace legislation to take effect November 16, 2006, requiring clean air for all workers, including restaurant and bar employees, and smoke-free building entrances.[161]

Massachusetts

The Massachusetts Tobacco Control Program (MTCP) began more than a decade ago after Massachusetts passed a 1992 ballot initiative raising cigarette excise taxes to fund the program. The MTCP made a promising start and was associated with statewide reductions in tobacco consumption. However, the benefits of the program declined when funding was cut. The MTCP has been studied as a source of lessons to be learned for the future of tobacco control (Koh et al. 2005). For example, it is a matter of prudence to plan ahead as to how to sustain important tobacco control initiatives at a time when funding is not being threatened, anticipating that funding cuts may eventually occur (LaPelle et al. 2006).

The consequences of the deep cuts to the Massachusetts Tobacco Control Program (MTCP) are not yet fully understood. However, it is likely they will have a substantial impact on avoidable premature disease, disability and death as well as unnecessary healthcare costs being incurred by public and private insurance providers.

In July 2006, Massachusetts became the sixth state to pass fire-safe cigarette legislation, joining New York, Vermont, California, Illinois and New Hampshire. Fire-safe cigarettes are wrapped in special paper that contains fire-retardant bands, or speed bumps, that cause cigarettes to extinguish if left unpuffed.[162]

Missouri

Although this report emphasizes progress in tobacco control, in some cases public recognition of inadequate tobacco control can be worth noting as a potential trigger of improvement. For example, Everett et al. (2006) lament the neglect of tobacco control efforts in the state of Missouri, despite the health burden imposed on the

[158] "Smoking banned on San Diego beaches," *The London Free Press*, p. B5, July 14, 2006.
[159]To view the proposed California legislation about environmental tobacco smoke as a toxic air contaminant as well as public comments and other related materials on the issue, see: http://www.arb.ca.gov/regact/ets2006/ets2006.htm
[160] Philip Morris vs. Boeken 05-594 and Boeken vs. Philip Morris 05-600, details available at: http://www.sfgate.com/cgi-bin/article.cgi?file=/c/a/2006/03/21/TOBACCO.TMP; story also appeared in: *Kitchener-Waterloo Record*. "Top court lets stand $50M award in smoker's death," Mar. 21, 2006.
[161] http://www.smokefree.net
[162] "Massachusetts Enacts Fire-Safe Cigarette Law," July 10, 2006; available from: http://www.smokefree.net

population of this state by the use of tobacco products and the feasibility of effective prevention and cessation programs. The authors believe better communication and collaboration between medical and public health professionals in Missouri would improve the situation. It is to be hoped that by publishing their concerns, these authors are paving the way towards better tobacco control efforts in Missouri.

New York

In July 2003, New York State implemented the *Clean Indoor Air Act* to reduce exposure to secondhand smoke among working persons. In order to test the effectiveness of the legislation, a cross-sectional study of New York State workers was conducted (Abrams et al. 2006). Of the 168 nonsmoking currently employed participants, 14 were casino workers,[163] 63 were non-casino hospitality workers and 91 were non-hospitality workers. The non-casino hospitality workers represented more than 55 workplaces covered by the legislation and were the main focus of interest in the study.

Some study participants were recruited before implementation of the *Clean Indoor Air Act* ($n = 107$) and some were recruited after ($n = 61$). A structured interview was used to identify exposure to secondhand smoke on each of the previous 4 days and on the day of the interview. The results showed a significant (71%) reduction in reported exposures to secondhand smoke among non-casino hospitality workers after implementation of the *Act*. Undetectable urine cotinine[164] levels increased significantly post-legislation among both non-casino hospitality workers and non-hospitality workers. The results suggest an improvement in protection for hospitality workers based on the legislation, but these results need to be confirmed using a statewide representative sample of hospitality workers.

In 2002, New York City implemented a multi-faceted tobacco control strategy. This strategy consisted of increased cigarette excise taxes, smoke-free workplace legislation (including bars and restaurants), increased cessation services (including a large-scale free nicotine-patch program), public education campaigns, and evaluation. The New York City health department also began annual surveys on a broad array of health measures, including smoking. In 2003, following implementation of the strategy, smoking prevalence among New York City adults decreased from 22% to 19% and smoking prevalence decreased among all age groups, both sexes, and all educational levels (Frieden et al. 2005). The authors conclude that local tobacco control strategies can be an effective way to reduce smoking prevalence at the local level. However, national strategies are also indispensable for overall progress in tobacco control.

North Carolina

Plaintiffs from North Carolina as well as other U.S. states are involved in a $200 billion lawsuit against tobacco companies. The plaintiff attorney argues that for three decades tobacco companies engaged in a cynical marketing strategy promoting "light" cigarettes as a lower-risk alternative to regular cigarettes, even though the tobacco companies knew the health risks were about the same for both types of cigarette. On September 25, 2006, a judge granted class-action certification to the case, setting a trial date of January 22, 2007.[165] The judge said there was no practical way apart from class action to handle the claims of tens of millions of smokers. He also expressed a willingness to entertain a motion to extend the class to encompass smokers of "low tar" brands. Having been filed under civil provisions of the *Racketeer Influenced and Corrupt Organizations Act*, there is potential for the damages associated with this lawsuit to rise as high as $600 billion.[166]

[163] Casino workers were considered separately from other hospitality workers because all casino workers in the study were employed in Aboriginal-owned casinos, which are exempt from the *Clean Indoor Air Act.*
[164] Cotinine is a metabolite of nicotine produced in animals as it is processed in the body. It is an indicator that nicotine has been inhaled or otherwise introduced into the body.
[165] "'Light' cigarette smokers win class-action status," *Globe and Mail*, p. B17, Sept. 26, 2006.
[166] "NY Judge Questions Light-Cigarette Smokers' Bid for Class Action Lawsuits," posted on Globalink News & Information, under Lawsuits, Sept. 15, 2006.

Pennsylvania

Following the lead of New York City (2002), in January 2007 the city of Philadelphia will become one of over 400 U.S. municipalities to ban smoking in most public places, including restaurants and bars. Violators could face fines of $25 to $300. Neighbourhood taverns (defined as those that derive at least 90% of their revenue from selling alcoholic drinks alone) have two years before they are obliged to comply with the legislation. Sidewalk cafes, specialty tobacco establishments, private clubs and casinos are exempt.[167] This example is noted because each municipality that joins the smoke-free trend, especially in regard to restaurants and bars, strengthens the tobacco control climate in the United States overall and paves the way for further progress. It is interesting to keep track of particular exemptions from smoke-free requirements because these exemptions may form the basis for future stronger initiatives.

Smoke-Free Workplace Legislation

Fourteen U.S. states have adopted comprehensive smoke-free legislation affecting bars and restaurants, with designated smoking rooms and designated smoking areas completely prohibited. The implementation dates of such legislation range from 1995 to 2009. California was the first to adopt such legislation (restaurants 1995, bars 1998). In chronological order, the states to follow with similar legislation were Delaware, New York, Maine, Connecticut, Massachusetts, Rhode Island, Vermont, Washington, New Jersey, Colorado, District of Columbia, Monatana and Utah.[168]

[167] "Mayor Signs Smoking Ban in Philadelphia," posted on Globalink News & Information, under Legislation and Politics, Sept. 15, 2006.

[168] Implementation dates for U.S. smoke-free legislation affecting bars and restaurants, no DSRs allowed: California: restaurants Jan. 1, 1995, bars Jan. 1, 1998; Delaware: Nov. 27, 2002; New York: July 24, 2003; Maine: Jan. 1, 2004; Connecticut: restaurants Oct. 1, 2003, bars Apr. 1, 2004; Massachusetts: July 5, 2004; Rhode Island: restaurants and most bars Mar. 1, 2005; other bars Mar. 31, 2005; Vermont: restaurants July 1, 1995, bars Sept. 1, 2005; Washington: Dec. 8, 2005; New Jersey: Apr. 15, 2006; Colorado: July 1, 2006; District of Columbia: Jan. 2, 2007; Montana: restaurants Oct. 1, 2005, bars Oct. 1, 2009; Utah: restaurants Jan. 1, 1995, bars Jan. 1, 2009.

E. International Jurisdictions: A Brief Perspective

Burden

The majority of the world's smokers (84%) live in developing nations (Sibbald 2005b). Diseases related to tobacco use kill nearly 5 million people worldwide every year. About 12% of women throughout the world smoke versus about 48% of men. According to the International Network of Women Against Tobacco, the global percentage of women who smoke is expected to rise to 20% by the year 2025 whereas the percentage of men who smoke is expected to decline. The difference in projected trends for women versus men is attributed to tobacco company marketing in developing countries, which often displays attractive, modern-looking women engaged in smoking behaviour. This type of tobacco marketing is illegal in Canada.

Tobacco Control, Including Litigation

Framework Convention on Tobacco Control

In order to address the international tobacco epidemic, the World Health Organization (WHO) developed the Framework Convention on Tobacco Control (FCTC) in 2005.[169] This legally binding treaty (in effect February 27, 2005) encourages nations to implement research-based policies in areas such as secondhand smoke protection, tobacco taxation, product regulation, cigarette smuggling, public education, and cessation treatment. Article 6(1) of the FCTC says the parties recognize that price and tax measures are an effective and important means of reducing consumption by various sectors of the population, especially young persons.

In the absence of constitutional impediments, the treaty requires signatories to ban tobacco advertising and promotion and requires warning labels that cover 30% of cigarette packages. Canada ratified the treaty on November 26, 2004 and was the 38th country to do so.[170] According to the FCTC website, as of September 30, 2006, 168 countries had signed and 140 had become Parties.[171] (Forty ratifications were needed for the treaty to come into force.) Paraguay became a Party on September 26, 2006. At the time of writing, the United States has signed but not ratified the treaty and Russia has neither signed nor ratified.

Smoke-Free Policies

Worldwide, from 2004 to 2006,[172] the entire countries of Ireland, Norway, New Zealand, Bhutan and Uruguay enacted comprehensive smoke-free legislation for the inside of restaurants and bars, with no designated smoking rooms and no designated smoking areas permitted. Similar 100% smoke-free legislation is in force in four Australian states/territories and is slated for implementation before the end of 2007 in three more Australian states/territories. In Scotland (part of the United Kingdom), Bermuda (British territory), and Puerto Rico (U.S. territory in the Caribbean), equivalent comprehensive smoke-free legislation has been implemented. In the United Kingdom, a similar smoke-free bill has been adopted by the House of Commons and is before the House of Lords at the time of writing.[173]

[169] Rivero et al. (2006) have published a progress report on implementation of the Framework Convention on Tobacco Control, saying good progress has been made but the ultimate goal—which they define as a total global ban on indoor smoking—is far from certain.
[170] Framework Convention Alliance. Framework Convention Alliance for Tobacco Control; 2005. "Current signatories to the FCTC," available from: http://fctc.org/treaty/currentsigs.php
[171] There are two ways of becoming a Party: ratification for countries that signed the FCTC and accession for countries that did not sign. The end result is the same (e-mail from Framework Convention Alliance, Oct. 11, 2006).
[172] Effective implementation dates for international smoke-free legislation:
Ireland: Mar. 27, 2004; Norway: June 1, 2004; New Zealand: Dec. 10, 2004; Bhutan: circa Mar. 2005; Uruguay: Mar. 1, 2006; Tasmania: Jan. 1, 2006; Queensland: July 1, 2006; Western Australia: July 31, 2006; Australian Capital Territory: Dec. 1, 2006; New South Wales: July 2, 2007; Victoria: July 1, 2007; South Australia: Nov. 1, 2007; Scotland: Mar. 26, 2006; Bermuda: Oct. 1, 2006; Puerto Rico: Mar. 2, 2007.
[173] http://www.smokefreeaction.org.uk

Taxes and Price

Despite the higher cost of cigarettes in developed nations, the high levels of income in these nations can make cigarettes more affordable than they are in developing nations (Blecher and Van Walbeek 2004). Affordability (cost relative to per capita income) is more important than just price in determining consumption and it fluctuates over time. In a study of 70 countries from 1990 to 2001, Blecher and Van Walbeek (2004) found that affordability had increased in 11 of 28 developed countries and in 24 of 42 developing countries.

Selected Tobacco Control Stories from Around the World[174]

Australia

On August 7, 2006, the State Government of Australia announced its intention to ban smoking in cars to protect passengers, especially children, and to tighten restrictions on point-of-sale advertising. Australia has used graphic anti-smoking advertisements on television depicting a woman with mouth cancer. During the first week of these shocking advertisements, calls to Australia's Quitline, the special service designed to help people quit smoking, jumped from 220 to 422.[175]

Belgium

Belgium will be the first European country to introduce obligatory picture-based health warnings on all cigarette packages, effective May 31, 2007. A series of 14 combined warnings (text and picture) will be used the first year, a second series the second year, and a third series the third year.[176]

Korea

As of June 2006, the rate of current smoking for adult males in Korea was reported to be 48%. This figure was a reduction compared to the previous year. In response to the high rate of smoking, the Korean Ministry of Health and Welfare launched a campaign of public service advertisements on national television and cable networks, beginning August 2006. The public service messages centre on friendship, love and family, urging people to persuade their loved ones to quit smoking. The Ministry's goal is to reduce the national smoking rate to 30% by the year 2010.[177]

Nigeria

Speaking at a press conference in early August 2006, the National Coordinator of the Nigeria Tobacco Control Alliance complained about government reluctance in domesticating the Framework Convention on Tobacco Control (FCTC), inadequate taxation of tobacco products in Nigeria, and the "disappearance" of the Tobacco Advertisement Prohibition Bill, which was passed on March 22, 2002.[178] The lack of progress in tobacco control in Nigeria, as described by this speaker, contrasts with impressive progress in South Africa (discussed below). The example of Nigeria is presented because a public complaint about inadequate tobacco control can sometimes be a precursor of progress.

South Africa

South Africa has become a world leader in progressive tobacco control policy.[179] In addition to mandated health warnings on cigarette packaging and advertising material and prohibition of smoking in public places,

[174] The selected international jurisdictions used as examples are listed in alphabetical order.
[175] "Ads show the horrors of smoking" (Editorial). *The Adelaide Advertiser*. August 8, 2006: http://www.news.com.au/; for tobacco control in South Australia, see: http://www.tobaccolaws.sa.gov.au/
[176] "Royal Decree Published Today on Picture-Based Health Warnings in Belgium," e-mail to OTRU listserv, Nov. 30, 2006.
[177] "New anti-smoking ads hit the air," Globalink News & Information, Aug. 10, 2006; original item can be viewed at: http://www.koreaherald.co.kr/
[178] Nigeria: Tax Tobacco, Save Lives. *This Day* (Lagos), Aug. 8, 2006: http://www.allafrica.com/
[179] See, for example, "Political change in South Africa: new tobacco control and public health policies," 2003, available at: http://www1.worldbank.org/tobacco/pdf/2850-Ch06.pdf

South Africa has introduced and sustained sizeable increases in the taxation of tobacco products. For example, from 1994 to 1997, the specific excise tax on cigarettes was raised from 32% to 50% of the retail price; by 2004, this tax accounted for 52% of the retail price of cigarettes (Van Walbeek 2006). As an indicator of the successful public health impact of these increased taxes, smoking prevalence among adults aged 15 and older in South Africa decreased from 32% in 1993 to 24% in 2004 (Van Walbeek 2006).

Spain

The Spanish government estimates that about 30% of its citizens smoke, about 50,000 Spaniards die every year from tobacco-related illnesses, and about 700 die every year from the ill effects of secondhand smoke. Smoking is the biggest cause of premature death in Spain.

On January 1, 2006, the Spanish Parliament enacted smoke-free legislation, making it illegal to smoke in enclosed spaces such as office buildings, shopping malls, and public transportation. For restaurants and bars, the law created a two-tier system based on size. Establishments with less than 1,100 square feet of floor space were free to choose between smoke-free and not smoke-free. Most chose to continue to allow smoking.

Larger establishments had until September 1, 2006, to ensure self-contained nonsmoking areas with separate ventilation were in place. However, many Spanish business owners have not complied with the requirement for nonsmoking areas, partly because enforcement of the national smoke-free law is up to regional governments. These regional governments are not always rigorous.[180]

Taiwan

With relatively high smoking rates and associated mortality,[181] Taiwan is known for the amount and types of tobacco control activity it has experienced and the scientific studies that have been done to assess the impact of this tobacco control.

In 1987, the cigarette market opened up to foreign companies in Taiwan. By 2000, the market share of foreign cigarettes exceeded that of domestic cigarettes by three to one among young smokers. During the first five years after the market opened, the smoking rate among young adults increased and the age of initiation decreased. Smuggling, with associated loss of government revenue, also became a problem. An investigation of tobacco industry documents confirmed increased advertising expenditures by foreign tobacco companies and the use of aggressive strategies targeting young persons in this country, especially by establishing new point-of-sale retail stores and promotional activities at point of sale (Hsu et al. 2005; Wen et al. 2005a; 2005b).

In 2002, Taiwan increased the excise tax on cigarettes, which brought about an average annual 10.5% reduction in cigarette smoking among current smokers (i.e., a reduction of 13.27 packs per smoker per year) (Lee et al. 2004). Male smokers[182] with low income or who smoke "light" cigarettes have been especially responsive to the changes in price.

Thailand

With the implementation of its 1992 *Tobacco Products Control Act*, Thailand became a global leader in enacting national public health legislation requiring disclosure of the ingredients contained in cigarettes. According to MacKenzie et al. (2004), transnational tobacco companies identified this legislation as a significant threat to their operations in Thailand. The 1992 *Act* also prohibited tobacco advertising. In November 2002, Thailand banned smoking in public places, including restaurants (Hamann 2003). In November 2005, Thailand banned

[180] "Spain: bars fret over new smoking law," Globalink News & Information, Legislation & Politics, Sept. 1, 2006.
[181] In 2001, among middle-aged men (35-69 years old) in Taiwan, 18,803 deaths or 1 out of 4 deaths (27%) were attributable to smoking (Wen et al. 2005d).
[182] According to the 2001 National Health Interview Survey (NHIS) of Taiwan, 47% of adult males and 14% of teenage males in Taiwan were current smokers (Wen et al. 2005c).

the visual display of tobacco products at retail point of sale, including walls of cigarette packages behind cash registers; since then, all tobacco products in Thailand must be kept out of sight under the counter or in special storage closets (Hamann 2006).

Like South Africa, Thailand is noted for strong and effective tobacco control policies with respect to taxation and relative price of cigarettes, i.e., cost relative to per capita income (Blecher and Van Walbeek 2004).

International Litigation

International jurisdictions where litigation against the tobacco industry has been active include Argentina (Flores et al. 2006[183]), Australia (Penman 2001; Carter and Chapman 2003; LeGresley et al. 2005), Bangladesh (Tahin 2002), Finland (Hiilamo 2005), Israel (Siegel-Itzkovich 2005) and Turkey (Karlikaya 2006).

Concluding Note To Report One

As a function of the domino effect known to occur in the realm of tobacco control (Studlar 1999), one jurisdiction tends to imitate what has been successful in another jurisdiction. Therefore, beneficial effects from legislation like the *Smoke-Free Ontario Act* can be expected ultimately to benefit the public health of other Canadian provinces and territories as well as neighbouring U.S. states.

During the time period 2005 to 2006, tobacco control activity has been developing rapidly and in a positive direction in many parts of the world. Ontario is well positioned within this context. Improvements in funding for tobacco control in Ontario and the implementation of the *Smoke-Free Ontario Act* are two major sources of hope for substantial reductions in tobacco-related illness, lost productivity and death.

[183] Based on a systematic search of tobacco industry documents posted on the internet from 1978 to 2002, Flores et al. (2006) report at least 15 failed litigation cases in Argentina. According to the authors, the tobacco industry used prestigious international and Argentinean law firms and "litigation prevention programs" to combat anti-tobacco litigation.

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