Excerpts from:

MONITORING THE ONTARIO TOBACCO STRATEGY

PROGRESS TOWARD OUR GOALS 2000/2001

SEVENTH ANNUAL MONITORING REPORT

EXECUTIVE SUMMARY AND SELECTED FIGURES

EXECUTIVE SUMMARY

Tobacco Control Highlights: Ontario and Beyond

Funding
Most of the new OTS initiatives implemented in January - March 2000 were continued with renewed funding for October 2000 – March 2001 (Section 1.1 and Tables B1 and B2). OTS funding levels remained unchanged at $19 million in 2000-01, or $1.65 per capita. This level was well below internationally recognized spending recommendations, which range from $5.46 to $15.05 per capita (Section 1.1).

Taxation
Despite a tax increase of $4 per carton of cigarettes at the end of the reporting period (April 2001), cigarette prices remained below 1990 levels. The price was 20% below the average of prices in other Canadian provinces, and 43% and 37% below neighbouring New York and Michigan, respectively (Section 1.1).

Consumption
Consumption of cigarettes in Ontario in 2000 was 1968 per person age 15+. This is 12% less than the recent high of 2225 cigarettes per capita in 1996 and is about the same level as in 1991 (Section 1.5).

Activities of Strategy Partners

Cessation Focus
Over the past year the agencies providing resources and infrastructure appeared to focus much of their efforts on cessation. This contrasts with the previous year, when most of these agencies centered their activities on protection from ETS and prevention (Section 2.1.1).

Target Groups
Agencies providing resources and infrastructure continued to focus on other OTS partner agencies and youth aged 12-19. Community programming agencies tended to direct their tobacco control efforts toward the general public and youth aged 12-19. Ethnic minorities, blue-collar workers, and lower literacy populations continued to receive less attention than other groups (Section 2.1.2).

Progress toward OTS Objectives

Health Burden
There were 11,656 deaths attributable to smoking in Ontario in 1997. Whereas smoking related deaths of men decreased by 6% from 1992 to 1997, those of women *increased* by 12%. The potential years of life lost (PYLL) because of premature mortality associated with these deaths are estimated at 173,158 years. In 1997, an estimated 511,105 hospital days were used in Ontario for the treatment of smoking-related conditions (Section 3.1).

Adult Smoking
In 2000, 26% of Ontario adults age 18+ smoked daily or occasionally. Men were

much more likely to smoke (31%) than women (21%) (Section 3.2.1).

Overall, there has been little change in the prevalence of smoking among Ontario adults over the last decade (Section 3.2). However, in the past five years, both current and daily smoking has decreased among women but not among men (Section 3.2.1).

In addition to men having a higher prevalence of smoking than women, men smoke more cigarettes (18.7 vs. 16.1 cigarettes/day among daily smokers), a level of consumption that has remained fairly constant for a decade (Section 3.2.2).

Overall, smoking continues to be most common in Northern Ontario and least prevalent in Toronto (Section 3.1.2).

Smoking prevalence and mean number of cigarettes smoked per day among daily smokers continues to be higher for adults with less than a high school education and for blue-collar workers than all Ontario adults combined, although the differences in 2000 were not statistically significant.

Cessation

Among current smokers in Canada, Ontario smokers were second only to those in British Columbia in seriously considering quitting within the next 30 days: 29% were considering quitting within the next 30 days. Over half of smokers (53%) were considering quitting within the next six months (Section 3.2.4).

Forty-three percent of current adult smokers had been advised by their doctor during the last 12 months to quit smoking (Section 3.2.4).

One in five Ontario smokers was aware of the Quit Smoking 2000 contest; slightly lower proportions knew of other quit programs (Section 3.2.4).

Youth Smoking

In 2000, Ontario youth aged 15-24 were slightly less likely to be smokers (27%) than their peers in the rest of Canada (30%). However, this was due entirely to the lower smoking level of young adults aged 20-24 in Ontario, as Ontario teens were just as likely to be smokers as teens elsewhere in Canada (25% in both cases, Section 3.3.1).

Between 1999 and 2000, smoking prevalence decreased significantly for young adults aged 20-24 in Ontario, from 34% to 29%. In contrast, there was no improvement among Ontario teens aged 15-19. Meanwhile, youth aged 15-19 elsewhere in Canada reduced their smoking by four percentage points. As a result, only three provinces (QC, NB, and NF) had higher teen smoking rates than did Ontario (Section 3.3.1). Evidence suggests that smoking among youth aged 15-17 has been more resistant to change than that of 18-19-year-olds (Section 3.3.1).

Sales to Minors

In 2000, 16% of tobacco retailers would sell cigarettes to underage youth, down from 38% in 1998 and 21% in 1999. Compliance in Ontario was considerably better than the national average, but not all outlet types showed improvement. Cigarettes were most available to youth in gas stations and chain convenience stores in 2000 as both types were less compliant with the law than they were the year before. In 2000, youth aged 15-17 obtained cigarettes equally from social sources (friends or parents) and retail outlets (Section 3.4), both in violation of the Ontario Tobacco Control Act, which states that no person shall supply or sell tobacco products to youth under the age of 19 years.

Exposure to ETS
Almost half of trade and farm workers were at risk of being exposed to the harmful effects of ETS at work in 2000, whereas only one in five professionals/managers and white collar workers were at risk from ETS while on the job (Section 3.5).

Smoking restrictions at work are associated with the number of cigarettes smoked per day by daily smokers: the more extensive the restriction, the less these workers smoke per day. Similarly, smokers were much less likely than non-smokers to report a complete ban on smoking at their place of work (Section 3.5).

Public Attitudes toward Tobacco Control
There is widespread support for restricting smoking in public places, and it has been fairly constant since 1998. Approximately eight in ten adults support at least some smoking restrictions in workplaces, seven in ten adults agree with restrictions in restaurants, and four in ten support restrictions in bars (Section 3.6).

In 2000, 45% and 40% of Ontario adults were in favour of banning tobacco industry sponsorship and increasing cigarette taxes, respectively (Section 3.6). This moderate level of support has remained consistent since the mid-nineties.

Eighty-two percent of Ontario adults feel that tobacco products should be regulated as "hazardous" products (Section 3.6).

Implications for the OTS

Implications for Prevention
Overall, Ontario merchants are more likely than ever to comply with the sales-to-minors provisions of the Ontario Tobacco Control Act. Enforcement, however, needs to continue and should be intensified for those types of stores where violations are most likely to occur.

Smoking prevalence among Ontario youth aged 15-19, and especially 15-17, is not decreasing at the same rate as the rest of Canada. In 2000-01, Ontario had the cheapest cigarettes in Canada, merchant compliance was uneven, and only two OTS partners had a clear focus on prevention. Measures to address youth smoking that require heightened attention include higher tobacco prices, tighter enforcement of restrictions on tobacco sales to youth, efforts to educate retail and non-retail sources of tobacco products to minors about the need to curb youth smoking, increased time in school curricula for prevention programs, and leadership and commitment to make *existing* programs work in schools and in the community.

Implications for Cessation
Having the lowest price for cigarettes in Canada, a lack of smoking restrictions in many workplaces, and a tobacco control effort that is only modest, likely contribute to the lack of decline of smoking prevalence among adults in Ontario, as these factors have been shown to be strongly related to both prevalence and amount smoked (Stephens et al., 2001). Although large numbers of Ontario smokers express an intention to quit in the near future, only a small portion are aware of major provincial programs available to assist them in quitting, and only a minority have been advised by their doctors to quit. More visible cessation programs, and more widespread physician encouragement and advice, are called for.

Smoking continues to be more common among men, by a margin of 3:2, and men continue to smoke more each day than women. Although women have been designated a target group of the OTS for some years (their smoking prevalence has declined by six percentage points since 1995), men have not been targeted in any systematic manner. The time has come to recognize men's smoking as a challenge that requires new strategies to combat it. Smoking by blue-collar workers and low-literacy Ontarians also requires more focused attention.

There is a continued association between smoking restrictions at work, the likelihood of being a smoker, and the amount smoked daily. Also, a continuing, substantial proportion of Ontario workers still do not have meaningful restrictions on smoking in the workplace. Provincial legislation to introduce such restrictions would offer not only protection to non-smokers, but would also encourage smokers to cut down and eventually quit altogether.

Implications for Protection

Provincial legislation is needed to provide workplace protection to the 20% of white-collar workers and the 48% of blue-collar workers, among others, exposed to ETS while on the job. There is also a need for increased education directed toward policy makers, the hospitality sector, and the general public about the failure of ventilation to provide adequate protection from ETS, and the lack of choice imposed on non-smokers when there is no provision for smoke-free public places.

Implications for Denormalization

Because the province's lawsuit against the tobacco companies in a U.S. federal court was not successful, Ontario should follow the lead of British Columbia, Quebec, and Newfoundland, as well as several private parties, and initiate proceedings within its own jurisdiction to recover health care costs due to smoking.

There has been little change since 1994 in the public's support for increasing tobacco taxes. More effort could be made to explain to the Ontario public that this is not just another tax, but a very effective means to prevent smoking and encourage cessation. The public also needs to be aware that higher taxes in Ontario will not lead to smuggling.

Public education messages about the role and responsibility of the tobacco industry in sustaining the tobacco epidemic need to be strengthened.

Implications for Monitoring, Evaluation, and Research

The most effective allocation of effort to prevention, cessation, protection, denormalization, and infrastructure development needs to be carefully assessed, with routine monitoring, in-depth evaluation, and ongoing dialogue with the Ministry of Health and Long-Term Care (MOHLTC).

A system needs to be established for collecting timely reports from Public Health Units (PHUs) on their tobacco-control activities. While the PHUs play a vital role in education, cessation services, enforcement, and the development of smoke-free public places, the current method of monitoring these activities used by the MOHLTC does not provide timely data for this annual report.

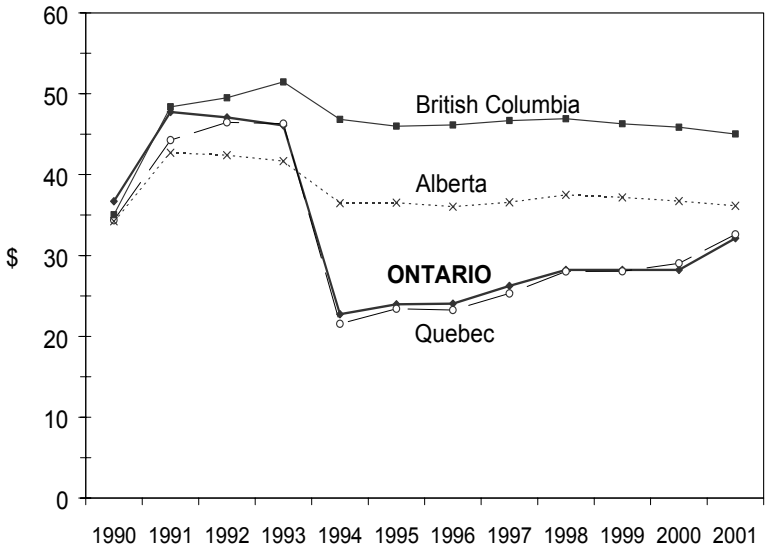
Given the limitations in existing surveys used for monitoring, particularly regarding content, sample design, and sample size and thus reliable local-level data, a survey dedicated to tobacco control issues in Ontario needs to be initiated, with reliable funding from the MOHLTC.

Implications for the OTS as a Whole

A more intensive tobacco control effort is called for, with funding increasing from current levels to amounts approaching internationally recognized standards. Increasing tobacco taxes to the Canadian average would provide more than enough new revenue for this purpose, while serving as a useful tobacco-control measure in its own right.

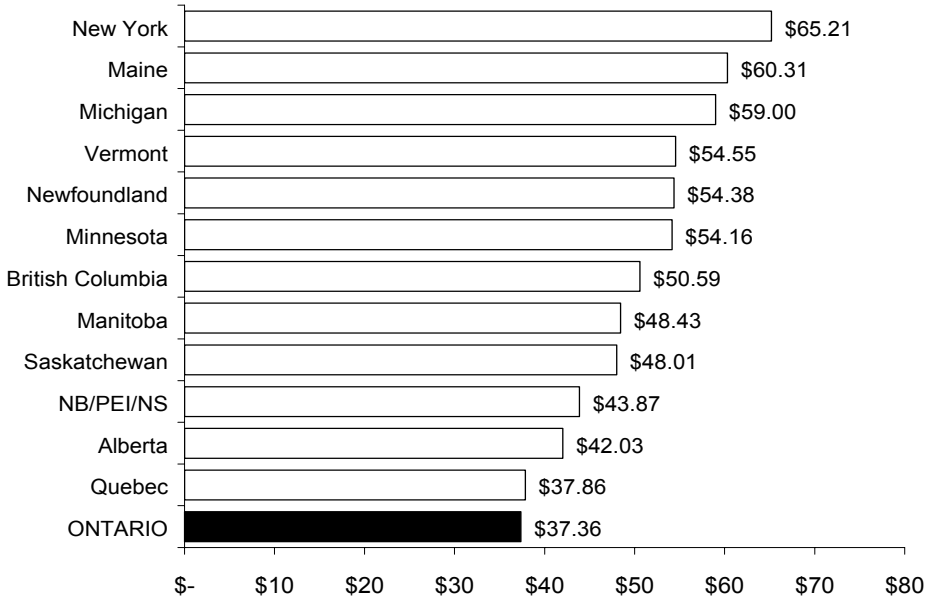
Major strategic opportunities remain, and critical target groups have yet to be addressed. A multi-year plan with assured funding from the Ministry is needed, as is a more visible role to complement and strengthen that of the partners whose activities are described in Chapter 2.

Figure 2. Price per Carton of 200 Cigarettes in Four Provinces 1990-2001



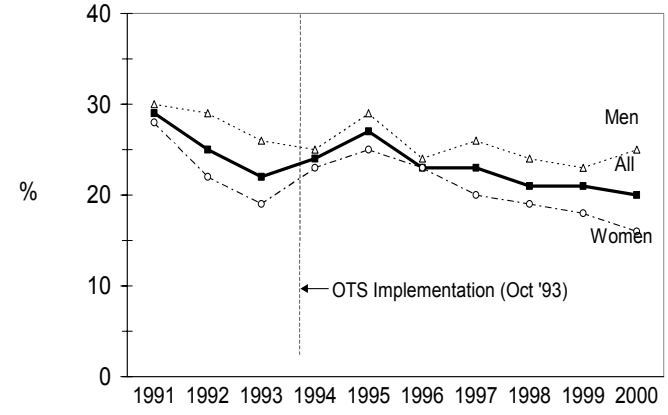
Note: In 1993 constant dollars.
Source: Statistics Canada Price Division, custom tabulations based on city average.

Figure 3. Price per Carton of Cigarettes, by Province and U.S. Border States, April 2001



Source: Smoking and Health Action Foundation, April 2001.

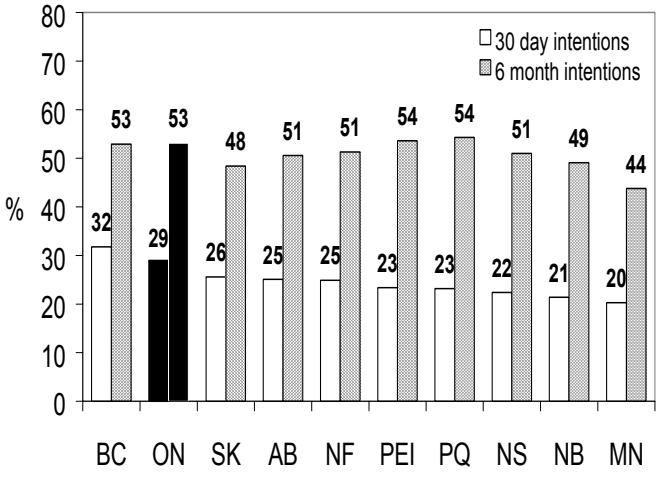
Figure 7. Daily Cigarette Smoking, by Sex, Age 18+, Ontario 1991-2000



	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000
Men	30	29	26	25	29	24	26	24	23	25
All Adults	29	25	22	24	27	23	23	21	21	20
Women	28	22	19	23	25	23	20	19	18	16

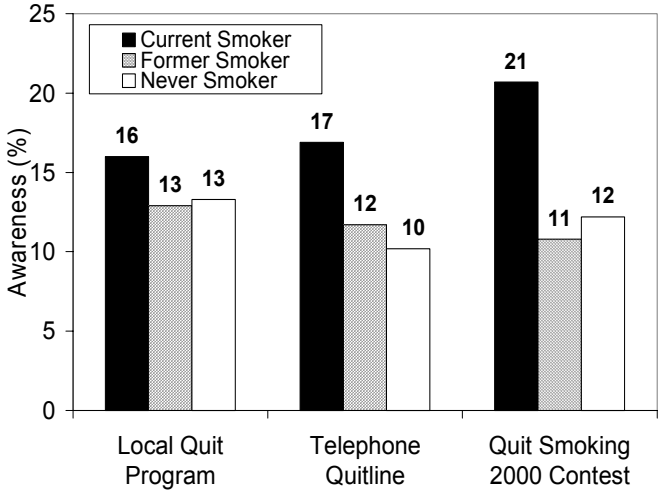
Source: CAMH Monitor, Centre for Addiction and Mental Health.

Figure 11. Intentions to Quit Smoking within next 30 Days, 6 Months, by Province, Age 15+, Canada 2000



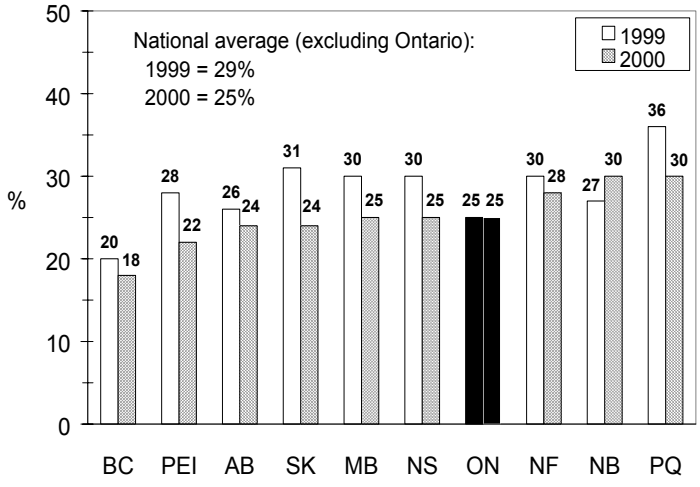
Note: Ordered by prevalence of highest 30-day quit plans.
Source: CTUMS, Health Canada.

Figure 12. Awareness of Smoking Cessation Programs, by Smoking Status, Age 18+, Ontario 2000



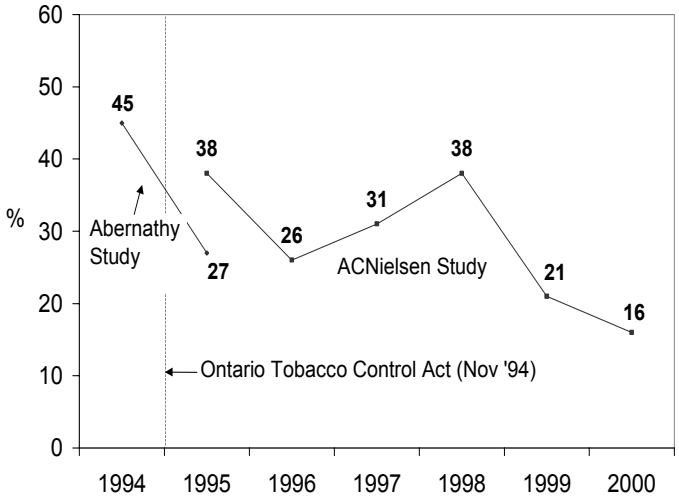
Source: CAMH Monitor, Centre for Addiction and Mental Health.

Figure 14. Current Smoking, by Province, Age 15-19, Canada 1999-2000



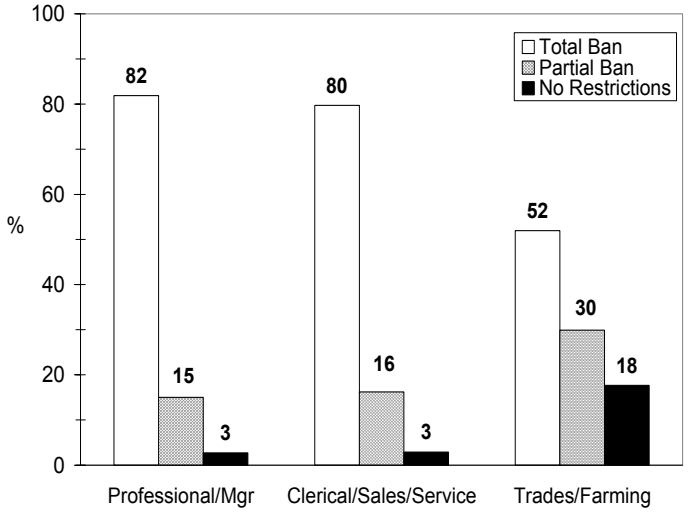
Note: Ordered by 2000 smoking prevalence.
Source: CTUMS, Health Canada.

Figure 21. Sales to Minors, Vendor Non-Compliance (all sites), Ontario 1994-2000



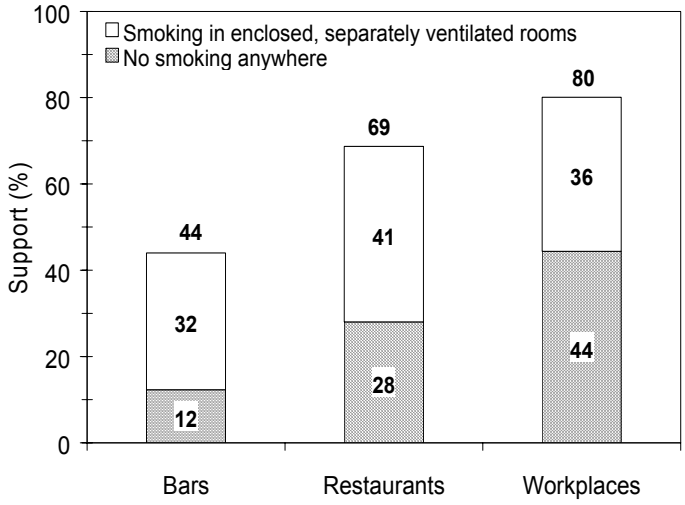
Source: Abernathy 1994, 1996; AC Nielson 1995-2000.

Figure 24. Smoking Restrictions at Work, by Occupation, Age 18+, Ontario 2000



Source: CAMH Monitor, Centre for Addiction and Mental Health.

Figure 26. Support for Smoking Restrictions, Age 18+, Ontario 2000



Source: CAMH Monitor, Centre for Addiction and Mental Health.