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Snapshot of Tobacco Facts:

A Resource to Guide Tobacco Control Planning in Alberta

First Edition • September 2007 • Developed by

Division of Population Health & Information

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INTRODUCTION AND METHODOLOGY

By using evidence-based practice and a population health focus for cancer prevention, the Alberta Cancer Board (ACB) and Alberta Cancer Foundation (ACF) strive toward the common vision of the 2025 goals:

- 35% fewer people (than currently projected) developing cancer
- 50% fewer people (than currently projected) dying of cancer
- Support to eliminate or reduce the suffering of every Albertan living with cancer

In order to achieve these goals, the ACB Cancer Prevention Program is committed to a reduction in the incidence of cancer and other chronic diseases in Alberta. By developing comprehensive collaborative strategies that concentrate on known risk factors and targeted populations, the Cancer Prevention Program has a unique opportunity to make a positive change in the future health of all Albertans. As shown in the conceptual model (Figure 1), the ACB Prevention Team is focusing on four main areas:

1. Tobacco Control
2. Nutrition and Physical Activity
3. Environment
4. Special Populations

Tobacco is the leading cause of preventable disease. Tobacco use and exposure are responsible for more deaths (including both smokers and non-smokers) than alcohol consumption, motor vehicle accidents, illicit drug use, murder, suicide and AIDS combined through its linkage to cancer, heart disease, lung disease, fires and other consequences.¹ In fact, 30% of all cancer deaths can be attributed to tobacco.²

Each year, tobacco use costs the Canadian economy an estimated \$17 billion and the Alberta economy \$1.8 billion.³ In 2002, approximately \$470.6 million was spent in Alberta on tobacco-related illnesses. Societal costs arise from lost income due to premature death, disability, worker absenteeism and reduced productivity. Additional tobacco-related costs are incurred from tobacco subsidies, fires and increased utilization of the health care system. The consequences of tobacco use and exposure are expanded upon in Chapter 16 of this resource.

Health improvements resulting from tobacco control initiatives are credited to comprehensive tobacco control strategies coordinated elsewhere at provincial, national and international levels. Implementing effective tobacco control measures and comprehensive programming has the potential to generate myriad short-term benefits including a reduction in the incidence of heart attacks, strokes and low-birth weight babies. Furthermore, reducing tobacco use in Alberta will significantly reduce waiting times for emergency medical services and treatments while reducing bed shortages associated with tobacco-related diseases. Long-term benefits include dramatic reductions in cancer, heart disease and other tobacco-related diseases.

1 "Tobacco and the Health of Canadians," *Physicians for a Smoke-Free Canada*, 13 June 2007 <http://www.smoke-free.ca/Health/psciissues_health.htm>.

2 "Alberta Tobacco Statistics," *Canadian Cancer Society*, November 30, 2006, Canadian Cancer Society, 13 June 2007 <http://www.cancer.ca/ccs/internet/standard/0,3182,3225_445709__langId-en,00.html>.

3 Rehm J et al., "The Costs of Substance Abuse in Canada 2002," *Canadian Center on Substance Abuse*, 2006, Canadian Center on Substance Abuse, 13 June 2007 <<http://www.ccsa.ca/NR/rdonlyres/18F3415E-2CAC-4D21-86E2-CEE549EC47A9/0/ccsa0113322006.pdf>>.

Conceptual Model

In order to reach the 2025 goals, the Alberta Cancer Board has shifted from a mainly treatment-based model to a cancer-control model, thus shifting from a patient care approach to a comprehensive cancer-control approach. As part of these efforts ACB has developed a Conceptual Model (Figure 1) to guide the ACB Cancer Prevention Program in their efforts to maximize chronic disease prevention.

Figure 1: Conceptual Model for the Alberta Cancer Board Prevention Program

SITUATIONAL ANALYSIS

As the Conceptual Model shows, one component of the process is the Situational Analysis. A Situational Analysis has been defined by the Prevention Department as follows:

A strategic, multi-layered analytic process assessing community profiles, literature reviews and best-practice scans to identify gaps that will direct various initiatives in chronic-disease prevention. This includes analyzing provincial and regional needs and assets, problem diagnosis and examining relevant research, knowledge and experience, and identifying gaps.

The *who, what, when, where, why* and *how* of the Situational Analysis are described below.

Who

The population of Alberta, with consideration of factors such as gender, age, race, cultural variables, geographic location and settings.

What

Profiles:

Geographic Information Systems (GIS) maps, graphs and charts of disease prevalence, risk-factor prevalence, geographic factors, chronic-disease interventions and groups, health-care factors, economic factors, community factors, social determinants, and knowledge, attitudes and behaviours.

Literature review:

A review of existing local, provincial, national and international population-based strategies and frameworks; includes a priority-driven review of both academic and grey literature with reported effectiveness in priority areas.

Asset map:

Discovering which individuals and groups are currently working in chronic-disease prevention, how they interact and collaborate, and understanding what strengths and opportunities exist.

Needs assessment:

Systematic layering of above items to effectively fill in programmatic and research gaps for both planning and implementation purposes.

When

Data from several time points to estimate both the current chronic-disease situation as well as trends leading up to the current situation.

Where

Alberta-specific regional and provincial data.

Why

The Situational Analysis will provide the Prevention Department and partners (i.e. the regional health authorities, networks and coalitions, and government entities) with a comprehensive body of evidence and related strategies and interventions required to effectively identify, prioritize, plan and support population health chronic-disease prevention and the successful attainment of the ACB 2025 targets.

How

Individual, regional and community profiles of Albertans based on asset maps, literature reviews and needs assessments. This may include various published and non-published sources such as available governmental, public, private, community and other support systems data (e.g. Canadian Community Health Survey (CCHS), Census of Canada Registry).

The approach and components of the Situational Analysis are expanded in Figure 2.

Figure 2: Situational Analysis Approach for the Alberta Cancer Board Prevention Program

SITUATIONAL ANALYSIS OF TOBACCO

The purpose of this analysis is to assess the present state of tobacco control in Alberta in order to inform and provide direction to a comprehensive tobacco control strategy. Included in this resource are the results of the Situational Analysis (Figure 2).

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The aim of this resource is to layer and analyze the information included in the following chapters to guide various levels and aspects of Tobacco Control Planning in Alberta.

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CHAPTER 1

ALBERTA CENSUS

DATA

General demographic information for Alberta was obtained from the Census of Canada (2001 and 2006) released by Statistics Canada. A complete analysis of 2006 data was not available; therefore 2001 data were used in the absence of 2006 information. The Census of Canada provides a statistical portrait of our country and its people and includes nearly every man, woman

and child living in Canada on Census Day. The Census also includes Canadians who are abroad, either on a military base, attached to a diplomatic mission, at sea or in port aboard Canadian-registered merchant vessels. Persons in Canada including those holding a temporary resident permit, study permit or work permit, and their dependents are also part of the census.¹

The data presented below are detailed for Alberta in general and are not divided by gender. Gender specific demographic information is available on the Statistics Canada website.²

Table 1-1: Demographic information for Alberta (Census of Canada, 2001; 2006)

A: Population and Dwelling Counts, 2006³	n
Population in 2006	3,290,350
Population in 2001	2,974,807
Total private dwellings, 2006	1,335,745
Private dwellings occupied by usual residents, 2006	1,256,192
Population density per square kilometre, 2006	5.1
Land area (square km), 2006	640,044.57

From 2001 to 2006, Alberta experienced an estimated 11% growth in population.

B: Age Characteristics of the Population, 2001⁴	n	%
0-4	186,430	6.3
5-14	431,160	14.5
15-19	222,960	7.5
20-24	215,125	7.2
25-44	948,740	31.9
45-54	420,890	14.1
55-64	241,090	8.1
65-74	173,190	5.8
75-84	102,350	3.4
85 and over	32,860	1.1

In 2001, approximately 28% of Alberta's population was below the age of 20, 62% were between the ages of 20 and 64, and 10% were above the age of 65.

1 Statistics Canada, *Census of Canada*, 2006.

2 2006 gender specific demographics for Alberta available from: <<http://www12.statcan.ca/english/Profil01/CP01/Details/Page.cfm?Lang=E&Geo1=PR&Code1=48&Geo2=PR&Code2=01&Data=Count&SearchText=Alberta&SearchType=Begins&SearchPR=01&B1=All&GeoLevel=&GeoCode=48>>.

3 Statistics Canada, *Census of Canada*, 2006.

4 Statistics Canada, *Census of Canada*, 2001.

C: Marital Status, 2001⁵	n	%
Total - Population 15 years and over	2,357,215	
Single	770,340	32.7
Married	1,224,050	51.9
Separated	67,580	2.9
Divorced	177,985	7.6
Widowed	117,260	5.0

D: Language First Learned & Still Understood, 2001⁶	n	%
Total - All persons	2,941,150	
English only	2,379,515	80.9
French only	58,645	2.0
Both English and French	5,780	0.2
Other languages	497,205	16.9

In 2001, the majority (80.9%) of Alberta's population was English-speaking.

E: Immigration Characteristics, 2001⁷	n	%
Total - All persons	2,941,150	
Canadian-born population	2,485,535	84.5
Foreign-born population	438,335	14.9
<i>Immigrated before 1991</i>	<i>308,415</i>	<i>70.4</i>
<i>Immigrated between 1991 and 2001</i>	<i>129,920</i>	<i>29.6</i>
Non-permanent residents	17,275	0.6

In 2001, Alberta was composed of Canadian-born (84.5%), foreign-born (14.9%) and non-permanent (0.6%) residents. The majority of foreign-born residents (70.4%) arrived prior to 1991.

5 Statistics Canada, *Census of Canada, 2001*.

6 Statistics Canada, *Census of Canada, 2001*.

7 Statistics Canada, *Census of Canada, 2001*.

F: Aboriginal Population, 2001⁸	n	%
Total – All persons	2,941,150	
Aboriginal identity population ⁹	156,220	5.3
Non-Aboriginal population	2,784,925	94.7

In 2001, approximately 5% (156,000 individuals) of Alberta's population identified as Aboriginal.

G: Visible Minority Status, 2001¹⁰	n	%
Total non-visible minority population	2,611,220	88.8
Total visible minority population	329,930	11.2
Chinese	99,095	30.0
South Asian	69,580	21.1
Filipino	33,940	10.3
Black	31,395	9.5
Southeast Asian	23,740	7.2
Arab	19,320	5.9
Latin American	18,745	5.7
Japanese	9,950	3.0
Korean	7,800	2.4
West Asian	5,225	1.6
Visible minority, not included elsewhere	4,220	1.3
Multiple visible minorities	6,910	2.1

In 2001, the majority of Alberta's visible minority population was of Chinese (30.0%) or South Asian (21.1%) descent.

⁸ Statistics Canada, *Census of Canada*, 2001.

⁹ This is a grouping of the total population into non-Aboriginal or Aboriginal population, with Aboriginal persons further divided into Aboriginal groups, based on their responses to three questions on the 2001 Census form. Included in the Aboriginal population are those persons who reported identifying with at least one Aboriginal group, that is, "North American Indian", "Métis" or "Inuit (Eskimo)", and/or who reported being a Treaty Indian or a Registered Indian, as defined by the Indian Act of Canada, and/or who reported they were members of an Indian Band or First Nation.

¹⁰ Statistics Canada, *Census of Canada*, 2001.

H: Place of Work Status, 2001¹¹	n	%
Employed labour force 15 years and over	1,608,840	
Worked at usual place	1,247,035	77.5
No fixed workplace address	189,915	11.8
Worked at home	165,865	10.3
Worked outside Canada	6,020	0.4

In 2001, nearly four in five Albertans (77.5%) worked at their usual place of employment.

I: Labour Force Indicators, 2001¹²	%
Participation rate ¹³	73.1
Employment rate ¹⁴	69.3
Unemployment rate ¹⁵	5.2

In 2001, Alberta's unemployment rate was approximately 5%.

J: Industry, 2001¹⁶	n	%
Total - Experienced labour force	1,681,985	
Business services	316,265	18.8
Manufacturing and construction industries	264,940	15.8
Wholesale and retail trade	258,740	15.4
Health and education	259,050	15.4
Agriculture and other resource-based industries	184,105	10.9
Finance and real estate	84,335	5.0
Other services	314,545	18.7

In 2001, the largest proportion of Albertans worked in business services (18.8%), manufacturing and construction industries (15.8%), wholesale and retail trade (15.4%), or health and education (15.4%).

11 Statistics Canada, *Census of Canada*, 2001.

12 Statistics Canada, *Census of Canada*, 2001.

13 Refers to the labour force in the week (Sunday to Saturday) prior to Census Day (May 15, 2001), expressed as a percentage of the population 15 years of age and over.

14 Refers to the number of persons employed in the week (Sunday to Saturday) prior to Census Day (May 15, 2001), expressed as a percentage of the total population 15 years of age and over.

15 Refers to the unemployed expressed as a percentage of the labour force in the week (Sunday to Saturday) prior to Census Day (May 15, 2001).

16 Statistics Canada, *Census of Canada*, 2001.

K: Occupation, 2001¹⁷	n	%
Total - Experienced labour force	1,681,980	
Sales and service occupations	394,590	23.5
Business, finance and administration occupations	290,535	17.3
Trades, transport and equipment operators and related occupations	283,105	16.8
Management occupations	175,930	10.5
Natural and applied sciences and related occupations	118,015	7.0
Social science, education, government service and religion	117,525	7.0
Occupations unique to primary industry	116,625	6.9
Health occupations	81,785	4.9
Occupations unique to processing, manufacturing and utilities	66,265	3.9
Art, culture, recreation and sport	37,605	2.2

In 2001, the largest proportion of Albertans worked in sales and service occupations (23.5%), business, finance, and administration occupations (17.3%), or trades, transport and equipment operators, and related occupations (16.8%).

17 Statistics Canada, Census of Canada, 2001.

CHAPTER 2

TOBACCO DATA

MAIN DATA SOURCES AND DEFINITIONS

1) Statistics Canada, Canadian Community Health Survey Cycle 3.1 (CCHS 3.1), Public Use Microdata File (PUMF) – Weighted, 2005

- a. The CCHS is a cross-sectional survey that encompasses information related to health status, health-care utilization and health determinants for the Canadian population. The CCHS targets Canadians who are living in private dwellings in the ten provinces and the three territories. Persons living on Indian Reserves or Crown lands, residents of institutions, full-time members of the Canadian Armed Forces and residents of certain remote regions are excluded from this survey. The CCHS covers approximately 98% of the Canadian population aged 12 and older.¹ The CCHS PUMF is designed to make respondent-level-survey information available to a wide range of users.²

- b. Sample size for Alberta: n = 11,800

- c. Data were analyzed by the ACB Population Health and Information Unit. The data were weighted using the weighting variable provided by Statistics Canada, which stratifies by health region, age and gender.

- d. Unless otherwise indicated, smoking status is measured by current smoking status (daily smoker, occasional smoker, non-smoker) as assessed at the time of survey.

2) Health Canada, Canadian Tobacco Use Monitoring Survey (CTUMS), February – December 2006

- a. CTUMS is a cross-sectional survey used to collect data on tobacco use and related issues, and to track changes in smoking status for the Canadian population aged 15 years and over. Residents of the Yukon, Northwest Territories, Nunavut and full-time residents of institutions were excluded from this survey. The data for the year 2006 were collected between February and December 2006

and included data from 21,1976 respondents. CTUMS measures smoking behaviour over the 30 days prior to survey completion.³

- b. Sample size for Alberta: n = 2,093

- c. Although data for the year 2006 were the main CTUMS data used throughout this booklet, data from various other years have also been used throughout this document.

- d. Information used throughout this booklet was taken directly from data that were analyzed by CTUMS.

- e. Unless otherwise indicated, smoking status is measured by current type of smoking (daily smoker, occasional smoker, non-smoker) as assessed at the time of survey and over the 30 days prior to survey completion.

3) Alberta Alcohol and Drug Abuse Commission (AADAC), The Alberta Youth Experience Survey (TAYES), Summary Report, 2005

- a. AADAC initiated TAYES to measure youth substance use and gambling behaviour, as well as associated risk and protective factors, adolescent attitudes, perceptions and social networks. The population of the 2005 cycle of TAYES consisted of students in grades 7 through 12 in public, Catholic, and charter school systems throughout Alberta.⁴

- b. Sample size for Alberta: n = 3,915

- c. Information used throughout this booklet was taken from existing data published by AADAC.

- d. TAYES 2005 results should be interpreted with caution due to sampling limitations. Access to only a limited group of Edmonton high-school students was granted and AADAC was unable to obtain permission to survey Calgary students; therefore findings may not be representative of Alberta students.⁵

1 Statistics Canada, *Canadian Community Health Survey (CCHS 3.1)*, 2005.

2 Statistics Canada, *Canadian Community Health Survey (CCHS 3.1) PUMF – Weighted*, 2005.

3 Health Canada, *Canadian Tobacco Use Monitoring Survey (CTUMS)*, February – December 2006.

4 Alberta Alcohol and Drug Abuse Commission (AADAC), *The Alberta Youth Experience Survey (TAYES), Summary Report*, 2005.

5 Alberta Alcohol and Drug Abuse Commission (AADAC), *The Alberta Youth Experience Survey (TAYES), Summary Report*, 2005.

- e. Unless otherwise indicated, smoking status is measured by current smoking status (daily smoker, occasional smoker, non-smoker) as assessed at the time of survey and over the 30 days prior to survey completion.
- 4) Health Canada, Youth Smoking Survey (YSS), 2004-2005**
- a. The YSS provides information on the smoking behaviour of students in grades 5 to 9, as well as data on alcohol and drug use of students in grades 7 to 9.⁶ Specifically excluded from the survey's coverage are residents of the Yukon, Northwest Territories, Nunavut, Indian Reserves and federal and provincial penitentiaries. Also excluded are young persons attending special schools (e.g., schools for the blind, schools for deaf-mutes or schools located on military bases) and young people enrolled in small classes (less than 10 students) or living in remote areas. The exclusions represent approximately 2.3% of the population.⁷
 - b. Sample size for Alberta: n = 2,625
 - c. Information used throughout this booklet was taken from data pre-analyzed by the YSS.
 - d. Unless otherwise indicated, smoking status is measured by type of smoking (current daily smoker, current non-daily smoker, former smoker, experimental smoker, former experimental smoker, and puffer) as assessed over the 30 days prior to survey completion.
- 5) The College of Family Physicians of Canada, Canadian Family Physician Cancer and Chronic Diseases Prevention Survey (CFPCCDPS), 2007**
- a. The CFPCCDPS was prepared to gain an understanding of physicians' attitudes and practices toward cancer and chronic disease prevention from family doctors actively involved in office-based patient care. Physicians were sampled from Saskatchewan, Ontario, Quebec,
- Nova Scotia, Prince Edward Island, Newfoundland and Labrador, Yukon, Nunavut and Northwest Territories, plus a number equaling 15% each from British Columbia, Alberta, Manitoba, and New Brunswick.⁸
- b. Sample size for Alberta: n = 430
 - c. Data were analyzed by the Prevention Team at the ACB Population Health and Information Unit.
- 6) Alberta Health Care Insurance Plan (AHCIP) Stakeholder Registry, 2005**
- a. The AHCIP Stakeholder Registry is a listing of Alberta residents eligible for medical coverage for physician and hospital services through the AHCIP, including individuals who spend significant periods of time out of the province. The registry excludes members of the Armed Forces, RCMP, or inmates residing in federal penitentiaries or people who have decided not to register with the AHCIP.⁹
 - b. Unless otherwise indicated, 2005 population estimates for Alberta and each health region within Alberta (represented by a "T") were calculated using data from the AHCIP Stakeholder Registry. Calculated population estimates were rounded to the nearest thousand, with estimates less than two thousand rounded to the nearest hundred.
 - c. Population estimates have been provided for Chapters 6 to 14 only. Selected population estimates for Chapter 2 are available from ACB by request.

6 The grade designations are different in Quebec but the corresponding age range is similar.

7 Health Canada, *Youth Smoking Survey (YSS)*, 2004-2005.

8 The College of Family Physicians of Canada, *Canadian Family Physician Cancer and Chronic Diseases Prevention Survey (CFPCCDPS)*, 2007.

9 Alberta Health and Wellness, *Alberta Health Care Insurance Plan (AHCIP) Stakeholder Registry*, 2005.

2.1 TOBACCO USE

Prevalence of Smoking

Since 2002, there has been a steady increase in the volume of cigarettes and cigars sold in Alberta (Figure 2-1). Figure 2-2 shows a similar trend when assessing the volume of imported and domestic cigarettes and fine-cut tobacco sold in Alberta since 2003. Additionally, since 2003, per capita volume of cigarettes and cigarette equivalents (tobacco sticks and loose tobacco) sold has increased (Figure 2-3). Cigarette sales account for the bulk of tobacco sold in Alberta; for the Fiscal Year (FY) 2007, the volume of tobacco sold in Alberta generated tobacco tax revenues of \$7,755,626,00.¹⁰

Figure 2-1: Volume of cigarettes, loose tobacco, tobacco sticks and cigars sold in Alberta between 2001 and 2007 (Alberta Finance, 2006; 2007)¹¹

Figure 2-2: Imported and domestic cigarette and fine-cut tobacco sales in Alberta, 1990-2005 (Health Canada, 2006)¹²

10 Alberta Finance, Tax and Revenue Administration, 2007.

11 Alberta Finance, Tax and Revenue Administration, 2006; 2007.

12 "Domestic and Fine-cut Sales Charts Alberta - 1980-2005," *Healthy Living*, July 6, 2006, Health Canada, 22 June 2007 <http://www.hc-sc.gc.ca/hl-vs/tobac-tabac research-recherche/indust/sales-ventes/ab_e.html>.

Figure 2-3: Per capita volume of cigarettes and cigarette equivalents (tobacco sticks and loose tobacco) sold in Alberta between 2001 and 2007 – Ages 15 and over (Alberta Finance, 2007; Statistics Canada, 2007)^{13,14,15}

Just under 50% of Albertans (ages 12 and over) have smoked 100 or more cigarettes in their life.¹⁶ In Alberta, 22.8% of the population (ages 12 and over) are either current daily (17.7%) or occasional (5.1%) smokers (Figure 2-4). Approximately 998,000 (36.6%) of Albertans reported that they were former daily or occasional smokers.¹⁷ For Albertans (ages 12 and over) who have stopped smoking daily, over 70% stopped more than 3 years ago and approximately 12% stopped smoking daily less than a year ago.¹⁸

In Alberta approximately 60% of smokers (ages 15 and over) usually smoke light/mild cigarettes (males: 59.9%; females: 62.4%).¹⁹ Of smokers in Alberta (ages 15 and over) 31.6% reported buying discount brands of cigarettes²⁰ and 9.9% reported buying cigarettes from First Nation Reserves²¹ compared to Canadians overall (38.4% and 17.0%, respectively) in the past 6 months.

13 Per capita calculations based on population estimates for the year corresponding to the median of the fiscal year (e.g. per capita consumption for FY 2007 [April 1, 2006-March 31, 2007] calculated using population estimates for 2006).

14 Population estimates calculated using data from Statistics Canada, 2007.

15 Alberta Finance, Tax and Revenue Administration, 2007.

16 Statistics Canada, Canadian Community Health Survey (CCHS 3.1) PUMF – Weighted, 2005.

17 Statistics Canada, Canadian Community Health Survey (CCHS 3.1) PUMF – Weighted, 2005.

18 Statistics Canada, Canadian Community Health Survey (CCHS 3.1) PUMF – Weighted, 2005.

19 Health Canada, Canadian Tobacco Use Monitoring Survey (CTUMS), February – December 2006.

20 Health Canada, Canadian Tobacco Use Monitoring Survey (CTUMS), February – December 2006.

21 Health Canada, Canadian Tobacco Use Monitoring Survey (CTUMS), February – December 2005.

Figure 2-4: Prevalence of current and former daily and occasional smokers in Alberta – Ages 12 and over (CCHS 3.1 PUMF – Weighted, 2005)²²

Since 1999, the percentage of current daily and occasional smokers in Alberta (ages 15 and over) has declined overall (Figure 2-5), roughly paralleling the patterns found for Canada as a whole. Since 2003, smoking rates in Alberta have been quite stable, reflecting a slight increase in prevalence of smoking among males and a slight decrease among females (ages 12 and over; Figure 2-6).

Figure 2-5: Prevalence of current daily and occasional smokers in Alberta and Canada, by year – Ages 15 and over (CTUMS, February – December 1999-2006)²³

22 Statistics Canada, Canadian Community Health Survey (CCHS 3.1) PUMF – Weighted, 2005.

23 Health Canada, Canadian Tobacco Use Monitoring Survey (CTUMS), February – December, 1999-2006.

Figure 2-6: Prevalence of current daily and occasional smokers in Alberta, by year – Ages 12 and over (CCHS 1.1 Master File, 2001; CCHS 2.1 Master File, 2003; CCHS 3.1 PUMF – Weighted, 2005)^{24,25,26}

Of current daily and occasional smokers in Alberta who were thinking of quitting within the next six months, approximately 55% reported that they would consider quitting within the next 30 days.²⁷ Slightly more female smokers (56.2%) than male smokers (53.1%) in Alberta reported that they would consider quitting within the next 30 days.²⁸

Within the past 2 years, 32.2% of current daily and occasional and former smokers in Alberta (ages 15 and over) tried to quit.²⁹ In Alberta, 36.0% of current daily and occasional and former smokers (ages 15 and over) quit smoking for at least 24 hours two or more times in the past year, which is higher than the average for Canada (33.3%; Figure 2-7). Of current daily and occasional and former smokers in Alberta (ages 15 and over), 45.1% did not try quitting in the past year.

24 Statistics Canada, Canadian Community Health Survey (CCHS 1.1), 2001.

25 Statistics Canada, Canadian Community Health Survey (CCHS 2.1), 2003.

26 Statistics Canada, Canadian Community Health Survey (CCHS 3.1) PUMF – Weighted, 2005.

27 Health Canada, Canadian Tobacco Use Monitoring Survey (CTUMS), February – December 2006.

28 Health Canada, Canadian Tobacco Use Monitoring Survey (CTUMS), February – December 2006.

29 Health Canada, Canadian Tobacco Use Monitoring Survey (CTUMS), February – December 2006.

Figure 2-7: Percentage of current daily and occasional and former smokers in Alberta and Canada who stopped smoking for at least 24 hours over the past year because they were trying to quit – Ages 15 and over (CTUMS, February – December 2006)³⁰

Quit strategies included using a nicotine patch (31.5%), using nicotine gum (22.2%), making a deal with a family member or friend to quit together (29.7%) and reducing the number of cigarettes smoked per day (63.0%; Figure 2-8). Data to reflect use of a quitline as a strategy for quitting was not appropriate for analysis as the number of people reporting use of the Alberta quitline was too small.³¹

Figure 2-8: Quit strategies used by current daily and occasional and former smokers in Alberta who tried to quit or quit smoking in the past 2 years – Ages 15 and over (CTUMS, February – December 2006)³²

³⁰ Health Canada, Canadian Tobacco Use Monitoring Survey (CTUMS), February – December 2006.

³¹ Health Canada, Canadian Tobacco Use Monitoring Survey (CTUMS), February – December 2006.

³² Health Canada, Canadian Tobacco Use Monitoring Survey (CTUMS), February – December 2006.

In Canada, nearly three-quarters of former smokers (ages 15 and over) reported that health was the main factor in their decision to cease tobacco use (Figure 2-9).

Figure 2-9: Reasons for quitting smoking reported by former smokers in Canada who stopped smoking less than a year ago – Ages 15 and over (CTUMS, February – December 2006)³³

33 Health Canada, Canadian Tobacco Use Monitoring Survey (CTUMS), February – December 2006.

Daily Smoking Levels

Current daily smokers in Alberta (ages 12 and over) smoke an average of 15.08 cigarettes per day (Figure 2-10), with males smoking slightly more (16.55) than the overall average and females smoking slightly less (13.13) than the overall average.

Figure 2-10: Average number of cigarettes smoked per day by current daily smokers in Alberta, by gender – Ages 12 and over (CCHS 3.1 PUMF – Weighted, 2005)³⁴

Current daily smokers in Alberta (ages 12 and over) within the category 'single/never married' smoke less cigarettes per day, on average, than current daily smokers in Alberta overall (Figure 2-11). Current daily smokers (ages 12 and over) of all other types of marital status smoke more cigarettes per day than current daily smokers in Alberta overall.

While differences in the average number of cigarettes smoked per day were found by gender and marital status, there was no difference in average number of cigarettes smoked per day by current daily smokers according to income level.³⁵

³⁴ Statistics Canada, Canadian Community Health Survey (CCHS 3.1) PUMF – Weighted, 2005.

³⁵ Statistics Canada, Canadian Community Health Survey (CCHS 3.1) PUMF – Weighted, 2005.

Figure 2-11: Average number of cigarettes smoked per day by daily smokers in Alberta, by marital status – Ages 12 and over (CCHS 3.1 PUMF – Weighted, 2005)³⁶

Sixteen percent of current daily and occasional smokers in Alberta (ages 15 and over) reported that they smoked in bed during the past week compared to 9.5% of current daily and occasional smokers in Canada (Figure 2-12).

Figure 2-12: Percentage of current daily and occasional smokers in Alberta and Canada reporting smoking in bed in the past week – Ages 15 and over (CTUMS, February – December 2006)³⁷

36 Statistics Canada, Canadian Community Health Survey (CCHS 3.1) PUMF – Weighted, 2005.

37 Health Canada, Canadian Tobacco Use Monitoring Survey (CTUMS), February – December 2006.

Over half of current daily and occasional smokers in Alberta (ages 15 and over) smoke within 30 minutes of waking up (Figure 2-13) and less males (51.5%) than females (58.9%) reported smoking a cigarette within 30 minutes of waking (Figure 2-14).

Figure 2-13: Percentage of current daily and occasional smokers in Alberta and Canada reporting smoking soon after waking up – Ages 15 and over (CTUMS, February – December 2006)³⁸

Figure 2-14: Percentage of current daily and occasional smokers in Alberta reporting smoking soon after waking up, by gender – Ages 15 and over (CTUMS, February – December 2006)³⁹

38 Health Canada, *Canadian Tobacco Use Monitoring Survey (CTUMS)*, February – December 2006.

39 Health Canada, *Canadian Tobacco Use Monitoring Survey (CTUMS)*, February – December 2006.

Selected Target Populations

Pregnant Women

Among current daily and occasional and former female smokers in Alberta, ages 15 to 55, 25.0% smoked regularly (daily smokers: 11.8%, occasional smokers: 13.2%) during their most recent pregnancy (within the past 5 years; Figure 2-15).⁴⁰

Figure 2-15: Smoking status of current daily and occasional and former female smokers in Alberta during most recent pregnancy (within the past 5 years) – Ages 15 to 55 (CCHS 3.1 PUMF – Weighted, 2005)⁴¹

⁴⁰ Statistics Canada, Canadian Community Health Survey (CCHS 3.1) PUMF – Weighted, 2005.

⁴¹ Statistics Canada, Canadian Community Health Survey (CCHS 3.1) PUMF – Weighted, 2005.

Nearly 60% of current and former female smokers in Alberta, ages 15 to 55, who reported smoking daily during their most recent pregnancy (within the past 5 years), smoked between 6 and 15 cigarettes per day and roughly 10% reported smoking more than 15 cigarettes per day during their most recent pregnancy (Figure 2-16).

Figure 2-16: Percentage of current and former female smokers in Alberta reporting smoking daily during most recent pregnancy (within the past 5 years), by number of cigarettes smoked per day – Ages 15 to 55 (CCHS 3.1 PUMF – Weighted, 2005)⁴²

Just over 15% of females in Alberta, ages 15 to 55, reported being exposed to second-hand smoke during and up to six months after their most recent pregnancy (within the past 5 years);⁴³ however, more females that were current daily and occasional smokers during their most recent pregnancy reported exposure (49.3%) than females that were non-smokers during their most recent pregnancy (7.1%; Figure 2-17).

⁴² Statistics Canada, Canadian Community Health Survey (CCHS 3.1) PUMF – Weighted, 2005.

⁴³ Statistics Canada, Canadian Community Health Survey (CCHS 3.1) PUMF – Weighted, 2005.

Figure 2-17: Percentage of females in Alberta reporting exposure to second-hand smoke during and up to six months after most recent pregnancy (within the past 5 years), by smoking status – Ages 15 to 55 (CCHS 3.1 PUMF – Weighted, 2005)⁴⁴

Mental Health

More current daily and occasional smokers in Alberta (ages 12 and over) perceived their mental health to be poor or fair, as compared to non-smokers in Alberta (Figure 2-18). There was little difference between these groups with regard to the number of weeks they reported feeling sad, blue or depressed over the past 12 months (Figure 2-19).

Figure 2-18: Percentage of Albertans who perceived their mental health to be poor or fair, by smoking status – Ages 12 and over (CCHS 3.1 PUMF – Weighted, 2005)⁴⁵

⁴⁴ Statistics Canada, Canadian Community Health Survey (CCHS 3.1) PUMF – Weighted, 2005.

⁴⁵ Statistics Canada, Canadian Community Health Survey (CCHS 3.1) PUMF – Weighted, 2005.

Figure 2-19: Number of weeks Albertans reported feeling sad, blue or depressed during the past 12 months, by smoking status – Ages 12 and over (CCHS 3.1 PUMF – Weighted, 2005)⁴⁶

Consistently, more current daily and occasional smokers in Alberta (ages 12 and over) reported feeling multiple types of distress, including feeling nervous, hopeless, depressed and worthless, than non-smokers (Figure 2-20). Current daily and occasional smokers in Alberta (ages 12 and over) also reported a higher frequency of feeling distressed than non-smokers.⁴⁷ In addition, more current daily and occasional smokers in Alberta (ages 12 and over) than non-smokers reported having considered suicide at least once over the past 12 months (Figure 2-21).

Figure 2-20: Percentage of Albertans reporting feeling various types of distress in the past month all of the time or most of the time, by smoking status – Ages 12 and over (CCHS 3.1 PUMF – Weighted, 2005)⁴⁸

46 Statistics Canada, Canadian Community Health Survey (CCHS 3.1) PUMF – Weighted, 2005.

47 Statistics Canada, Canadian Community Health Survey (CCHS 3.1) PUMF – Weighted, 2005.

48 Statistics Canada, Canadian Community Health Survey (CCHS 3.1) PUMF – Weighted, 2005.

Figure 2-21: Percentage of Albertans reporting having considered suicide during their lifetime and within that group, the percentage reporting have considered suicide over the past 12 months – Ages 12 and over (CCHS 3.1 PUMF – Weighted, 2005)⁴⁹

Health and Wellness

More than double the proportion of current daily and occasional smokers in Alberta (ages 12 and over) reported being dissatisfied or very dissatisfied with their life, in comparison to non-smokers (Figure 2-22). In addition, more current daily and occasional smokers in Alberta (ages 12 and over) than non-smokers indicated that most days are quite a bit or extremely stressful (Figure 2-23).

Figure 2-22: Percentage of Albertans reporting being dissatisfied or very dissatisfied with their life in general, by smoking status – Ages 12 and over (CCHS 3.1 PUMF – Weighted, 2005)⁵⁰

⁴⁹ Statistics Canada, Canadian Community Health Survey (CCHS 3.1) PUMF – Weighted, 2005.

⁵⁰ Statistics Canada, Canadian Community Health Survey (CCHS 3.1) PUMF – Weighted, 2005.

Figure 2-23: Percentage of Albertans reporting that most days were quite a bit or extremely stressful, by smoking status – Ages 12 and over (CCHS 3.1 PUMF – Weighted, 2005)⁵¹

A greater proportion of current daily and occasional smokers in Alberta (ages 12 and over) perceived their health to be fair or poor (13.2%) and perceived their health to be somewhat worse or much worse compared to a year ago (12.2%) compared to non-smokers in Alberta (9.8% and 9.5%, respectively; Figure 2-24).

Figure 2-24: Percentage of Albertans who perceive their health to be fair or poor, by smoking status – Ages 12 and over (CCHS 3.1 PUMF – Weighted, 2005)⁵²

51 Statistics Canada, Canadian Community Health Survey (CCHS 3.1) PUMF – Weighted, 2005.

52 Statistics Canada, Canadian Community Health Survey (CCHS 3.1) PUMF – Weighted, 2005.

Among adults in Alberta, approximately half of current daily and occasional smokers (48.6%) and half of non-smokers (52.8%) are overweight or obese (Figure 2-25).

Figure 2-25: Prevalence of overweight or obesity (Body Mass Index ≥ 25.0) among Albertans, by smoking status – Ages 18 and over (CCHS 3.1 PUMF – Weighted, 2005)⁵³

Physical inactivity levels among current daily and occasional smokers in Alberta (ages 12 and over) are higher than those of non-smokers in Alberta (Figure 2-26).

Figure 2-26: Prevalence of physical inactivity⁵⁴ among Albertans by smoking status – Ages 12 and over (CCHS 3.1 PUMF – Weighted, 2005)⁵⁵

⁵³ Statistics Canada, Canadian Community Health Survey (CCHS 3.1) PUMF – Weighted, 2005.

⁵⁴ CCHS 3.1 defines physical inactivity as a daily usual leisure-time energy expenditure of less than 1.5 kilocalories per kilogram of body weight per day.

⁵⁵ Statistics Canada, Canadian Community Health Survey (CCHS 3.1) PUMF – Weighted, 2005.

Prevalence of Smokeless Tobacco Use and Other Substances

The percentage of Albertans (ages 15 and over) who reported having tried chewing tobacco, pinch or snuff is 15.2% compared to that of Canada overall (8.4%; Figure 2-27). Only Saskatchewan has a higher proportion of its population (ages 15 and over) reporting having tried chewing tobacco, pinch or snuff (Figure 2-28).

Figure 2-27: Percentage of Albertans and Canadians reporting having tried chewing tobacco, pinch or snuff compared to Canadian levels – Ages 15 and over (CTUMS, February – December 2006)⁵⁶

Figure 2-28: Percentage of Canadians reporting having tried chewing/smokeless tobacco, by province – Ages 15 and over (CTUMS, February – December 2005)⁵⁷

⁵⁶ Health Canada, Canadian Tobacco Use Monitoring Survey (CTUMS), February – December 2006.

⁵⁷ Health Canada, Canadian Tobacco Use Monitoring Survey (CTUMS), February – December 2005.

More males than females in Alberta and Canada (ages 15 and over) reported having used chewing tobacco, pinch or snuff over the past 30 days. Use by males in Alberta exceeds Canadian levels, while use by females in Alberta is below Canadian levels (Figure 2-29).

Figure 2-29: Percentage of Albertans and Canadians reporting having used chewing tobacco, pinch or snuff in the last 30 days, by gender– Ages 15 and over (CTUMS, February – December 2005)⁵⁸

Use of marijuana, cannabis or hashish by Albertans (ages 15 and over) is below the national average for both having tried marijuana, cannabis or hashish once (6.6%) and above the national average for trying these substances more than once (35.8%; Figure 2-30). Use of marijuana, cannabis, or hashish in Alberta is still greater than use in British Columbia, Newfoundland and Labrador and Prince Edward Island for trying marijuana, cannabis or hashish once. For trying marijuana, cannabis or hashish more than once, only British Columbia has levels higher than Alberta.

Figure 2-30: Percentage of Canadians reporting have ever used or tried marijuana, cannabis or hashish, by province – Ages 15 and over (CTUMS, February – December 2006)⁵⁹

⁵⁸ Health Canada, *Canadian Tobacco Use Monitoring Survey (CTUMS)*, February – December 2005.

⁵⁹ Health Canada, *Canadian Tobacco Use Monitoring Survey (CTUMS)*, February – December 2006.

2.2 TOBACCO USE AMONG YOUTH

Prevalence of Smoking

In Alberta, 16.2% of students in grades 7 to 12 smoked in 2002 compared to 13.5% in 2005 (Figure 2-31). Alberta's smoking prevalence for grades 5 to 9 is above that of the provinces of British Columbia, Saskatchewan, Manitoba, Ontario and Prince Edward Island (Figure 2-32).

Figure 2-31: Percentage of students in Alberta who were current daily and occasional smokers in 2002 and 2005 – Grades 7 to 12 (TAYES, 2005)⁶⁰

Figure 2-32: Percentage of students in Canada who were current daily and occasional smokers in 1994, 2002 and 2004-2005, by province – Grades 5 to 9 (YSS, 2004-2005)⁶¹

60 Alberta Alcohol and Drug Abuse Commission (AADAC), *The Alberta Youth Experience Survey (TAYES), Summary Report*, 2005.

61 Health Canada, *Youth Smoking Survey (YSS)*, 2004-2005.

According to The Alberta Youth Experience Survey (TAYES; 2005), 4.6% of Albertans in grades 7 to 9 report smoking cigarettes over the past 30 days (Figure 2-33); however, that number jumps to 18.3% for grades 10 to 12.

Figure 2-33: Percentage of students in Alberta reporting having used cigarettes over the past 30 days – Grades 7 to 12 (TAYES, 2005)⁶²

Slightly more females than males in grades 7 to 9 in Alberta reported using cigarettes in the past 30 days (Figure 2-34); for grades 10 to 12, slightly more males than females reported using cigarettes over the past 30 days.

Figure 2-34: Percentage of students in Alberta reporting having used cigarettes over the past 30 days, by gender – Grades 7 to 12 (TAYES, 2005)⁶³

62 Alberta Alcohol and Drug Abuse Commission (AADAC), The Alberta Youth Experience Survey (TAYES), Summary Report, 2005.

63 Alberta Alcohol and Drug Abuse Commission (AADAC), The Alberta Youth Experience Survey (TAYES), Summary Report, 2005.

A smaller proportion of students (grades 5 to 9) in Alberta reported having ever tried smoking than the national average (Figure 2-35).

Figure 2-35: Percentage of students in Alberta and Canada reporting having ever tried smoking, by gender – Grades 5 to 9 (YSS, 2004-2005)⁶⁴

Among students in grades 5 to 9 in Alberta, 81.1% reported having never tried a cigarette. Of the remaining students, only 1.7% classified themselves as current daily and occasional smokers (Figure 2-36), while 2.3% and 10.2% said they were experimental smokers and puffers, respectively. Nearly 5% of students who have tried smoking considered themselves to be former smokers.

Figure 2-36: Smoking status of students in Canada - Grades 5 to 9 (YSS, 2004-2005)⁶⁵

⁶⁴ Health Canada, *Youth Smoking Survey (YSS)*, 2004-2005.

⁶⁵ Health Canada, *Youth Smoking Survey (YSS)*, 2004-2005.

The greatest proportion of current and former smokers in Alberta report smoking their first cigarette at ages 15 to 17 years (37.2%), followed by ages 12 to 14 years (30.8%) (reported by Albertans ages 12 and over; Figure 2-37 & Figure 2-38). Overall, 75.3% reported trying their first cigarette before their 18th birthday.

Figure 2-37: Age that current daily and occasional and former smokers in Alberta reported smoking their first cigarette – Ages 12 and over (CCHS 3.1 PUMF - Weighted, 2005)⁶⁶

Figure 2-38: Age that current daily and occasional and former smokers in Alberta reported smoking their first cigarette, by gender – Ages 12 and over (CCHS 3.1 PUMF - Weighted, 2005)⁶⁷

66 Statistics Canada, Canadian Community Health Survey (CCHS 3.1) PUMF – Weighted, 2005.

67 Statistics Canada, Canadian Community Health Survey (CCHS 3.1) PUMF – Weighted, 2005.

While only 5.6% of Albertans ages 12 to 17 years are current daily and occasional smokers (Figure 2-39), this statistic increases to 29.2% by 18 to 19 years of age and remains above 22.8% (the Alberta average) for adults younger than 50 years.

Figure 2-39: Percentage of Albertans who are current daily and occasional smokers, by age – Ages 12 and over (CCHS 3.1 PUMF – Weighted, 2005)⁶⁸

The average number of cigarettes smoked daily by current daily smokers ages 12 to 19 years in Alberta is below the overall average for Alberta (Figure 2-40). The average number of cigarettes smoked daily by Albertans ages 40 to 69 exceeds the total overall for Alberta.

Figure 2-40: Average number of cigarettes smoked per day by daily smokers in Alberta, by age – Ages 12 and over (CCHS 3.1 PUMF – Weighted, 2005)⁶⁹

68 Statistics Canada, Canadian Community Health Survey (CCHS 3.1) PUMF – Weighted, 2005.

69 Statistics Canada, Canadian Community Health Survey (CCHS 3.1) PUMF – Weighted, 2005.

Youth Access

Of the 5.6% of Albertans ages 12 to 17 years who are current daily and occasional smokers (Figure 2-39), only 14.9% reported purchasing cigarettes for themselves and others (Figure 2-41). Of the 29.2% of Albertans ages 18 to 19 years who are current daily and occasional smokers (Figure 2-39), 74.2% reported purchasing cigarettes for themselves and others (Figure 2-41).

Figure 2-41: Percentage of current daily and occasional smokers in Alberta reporting having purchased cigarettes for themselves or others – Ages 12 to 19 (CCHS 3.1 PUMF – Weighted, 2005)⁷⁰

In Alberta, 14.4% of current daily and occasional smokers (ages 12 to 19) reported having asked a stranger to buy cigarettes (Figure 2-42). The proportion of youth who have asked a stranger to buy cigarettes is much higher among 12 to 17 year olds (21.3%) than among 18 to 19 year olds (10.0%; Figure 2-43).

Figure 2-42: Percentage of current daily and occasional smokers in Alberta reporting having asked a stranger to buy cigarettes – Ages 12 to 19 (CCHS 3.1 PUMF - Weighted, 2005)⁷¹

70 Statistics Canada, Canadian Community Health Survey (CCHS 3.1) PUMF – Weighted, 2005.

71 Statistics Canada, Canadian Community Health Survey (CCHS 3.1) PUMF – Weighted, 2005.

Figure 2-43: Percentage of current daily and occasional smokers in Alberta reporting having asked a stranger to buy cigarettes, by age – Ages 12 to 19 (CCHS 3.1 PUMF - Weighted, 2005)⁷²

Only 51.1% of current daily and occasional smokers in Alberta aged 12 to 17 years and 26.3% aged 18 to 19 years reported being unsuccessful in their attempt to purchase cigarettes in retail outlets (Figure 2-44).

Figure 2-44: Percentage of current daily and occasional smokers in Alberta reporting that they were not allowed to purchase cigarettes – Ages 12 to 19 (CCHS 3.1 PUMF - Weighted, 2005)⁷³

72 Statistics Canada, Canadian Community Health Survey (CCHS 3.1) PUMF – Weighted, 2005.

73 Statistics Canada, Canadian Community Health Survey (CCHS 3.1) PUMF – Weighted, 2005.

Perceptions and Familial Factors

While only 18.3% of Alberta high school students (grades 10 to 12) reported using tobacco in the last 30 days (Figure 2-45), these students perceived that use among their peers over the last 30 days was 46.3%.

Figure 2-45: Perceived use of tobacco in the last 30 days by students in Alberta - Grades 10 to 12 (TAYES, 2005)⁷⁴

High school students in Alberta (grades 10 to 12) perceive access to cigarettes to be easy with 93.5% of current daily and occasional smokers and 67.8% of non-smokers believing that it is easy to access cigarettes (Figure 2-46).

Figure 2-46: Percentage of students in Alberta who perceive access to cigarettes is easy – Grades 10 to 12 (TAYES, 2005)⁷⁵

74 Alberta Alcohol and Drug Abuse Commission (AADAC), *The Alberta Youth Experience Survey (TAYES), Summary Report, 2005.*

75 Alberta Alcohol and Drug Abuse Commission (AADAC), *The Alberta Youth Experience Survey (TAYES), Summary Report, 2005.*

Alberta students (grades 7 to 12) who are current daily and occasional smokers reported having lower levels of parental monitoring than Alberta students of the same grades overall (Figure 2-47). Measures of parental monitoring included parental monitoring of after school activities, weekend night curfews, and knowledge of where their children go out at night and who with.

Figure 2-47: Percentage of students reporting low levels of parental monitoring, by students overall and current daily and occasional smokers – Grades 7 to 12 (TAYES, 2005)⁷⁶

When asked how easy it would be to get cigarettes from one's mother, father, closest friend, and second-closest friend, Alberta students (grades 7 to 12) reported that it would be easier to get cigarettes from those social members who smoked than those who did not smoke (Figure 2-48). Alberta students in grades 7 to 12 reported that it would be easiest to get cigarettes from closest friends who smoked; however, these students also reported ease of getting cigarettes from their parents who smoked.

⁷⁶ Alberta Alcohol and Drug Abuse Commission (AADAC), *The Alberta Youth Experience Survey (TAYES), Summary Report, 2005.*

Figure 2-48: Percentage of students in Alberta reporting that it would be easy or very easy to get cigarettes from social network members, by member smoking status – Grades 7 to 12 (TAYES, 2005)⁷⁷

A higher proportion of Alberta students in grades 7 to 12 who are current daily and occasional smokers perceive their grades to be below average and average than non-smokers and students overall (Figure 2-49). Conversely, less current daily and occasional smokers perceived their grades to be above average than non-smokers and students overall.

Figure 2-49: Perception of own grades relative to peers among students in Alberta by smoking status – Grades 7 to 12 (TAYES, 2005)⁷⁸

77 Alberta Alcohol and Drug Abuse Commission (AADAC), *The Alberta Youth Experience Survey (TAYES), Summary Report, 2005.*

78 Alberta Alcohol and Drug Abuse Commission (AADAC), *The Alberta Youth Experience Survey (TAYES), Summary Report, 2005.*

Among students in grades 7 to 12 in Alberta, more current daily and occasional smokers reported not liking school very much or at all (30.1%) compared to non-smokers (20.2%) and students overall (21.4%; Figure 2-50).

Figure 2-50: School enjoyment of students in Alberta by smoking status – Grades 7 to 12 (TAYES, 2005)⁷⁹

79 Alberta Alcohol and Drug Abuse Commission (AADAC), *The Alberta Youth Experience Survey (TAYES), Summary Report*, 2005.

2.3 SECOND-HAND SMOKE

Exposure in the Home

Over half of current daily and occasional smokers (55.0%) and nearly all non-smokers (91.9%) ages 12 and over report not being exposed to second-hand smoke in the home (Figure 2-51).

Figure 2-51: Prevalence of Albertans reporting exposure to second-hand smoke in the home every day or almost every day, by smoking status – Ages 12 and over (CCHS 3.1 PUMF - Weighted, 2005)⁸⁰

In both the 0 to 11 year and 12 to 17 year categories, a smaller proportion of Albertans (reported by ages 15 and over) are exposed to second-hand smoke in the home than in Canada as a whole (Figure 2-52). Ontario and British Columbia report proportionately lower levels of exposure than Alberta in both age categories. Newfoundland and Labrador and Prince Edward Island report proportionately lower levels of exposure than Alberta in the 0-11 age category only (Figure 2-53).

Figure 2-52: Prevalence of children in Alberta and Canada ages 0 to 17 years exposed to second-hand smoke at home (in the past month), by age range – Reported by Canadians ages 15 and over (CTUMS, February – December 2006)⁸¹

Figure 2-53: Prevalence of children ages 0 to 17 years in Canada exposed to second-hand smoke in the home (in the past month), by province – Reported by Canadians ages 15 and over (CTUMS, February – December 2006)⁸²

81 Health Canada, Canadian Tobacco Use Monitoring Survey (CTUMS), February – December 2006.

82 Health Canada, Canadian Tobacco Use Monitoring Survey (CTUMS), February – December 2006.

Among current daily and occasional smokers in Alberta (ages 12 and over), individuals within the marital category of widowed/separated/divorced are most exposed to second-hand smoke in the home (Figure 2-54).

Figure 2-54: Prevalence of current daily and occasional smokers in Alberta reporting exposure to second-hand smoke in the home, by marital status – Ages 12 and over (CCHS 3.1 PUMF - Weighted, 2005)⁸³

Exposure in a Vehicle

Overall, 9.2% of Albertans (ages 12 and over) are exposed to second-hand smoke in a vehicle (Figure 2-55); Young people represent the most exposed group (Figure 2-56) with 19.7% of 12 to 17 year olds, 21.0% of 18 to 19 year olds, and 13.5% of 20 to 29 years olds exposed.

Figure 2-55: Prevalence of Albertans reporting exposure to second-hand smoke in a vehicle – Ages 12 and over (CCHS 3.1 PUMF - Weighted, 2005)⁸⁴

⁸³ Statistics Canada, Canadian Community Health Survey (CCHS 3.1) PUMF – Weighted, 2005.

⁸⁴ Statistics Canada, Canadian Community Health Survey (CCHS 3.1) PUMF – Weighted, 2005.

Figure 2-56: Prevalence of Albertans reporting exposure to second-hand smoke in a vehicle, by age – Ages 12 and over (CCHS 3.1 PUMF - Weighted, 2005)⁸⁵

Exposure at Public Places

A substantial proportion of Albertans (ages 15 and over) report exposure to second hand smoke; 27.6% of Albertans report that they are exposed to second-hand smoke in places other than the home everyday or almost every day and 33.9% are exposed at least once a week (Figure 2-57). Public places that Albertans (ages 15 and over) report being exposed to second-hand smoke (in the past month) include outdoor patios or bars (27.1%), other public places (38.5%), building entrances (53.2%) and sidewalks or parks (55.7%; Figure 2-58).

Figure 2-57: Prevalence of Albertans reporting exposure to second-hand smoke (excluding own smoking) in places other than the home in the past month – Ages 15 and over (CTUMS, February – December 2006)⁸⁶

85 Statistics Canada, Canadian Community Health Survey (CCHS 3.1) PUMF – Weighted, 2005.

86 Health Canada, Canadian Tobacco Use Monitoring Survey (CTUMS), February – December 2006.

Figure 2-58: Prevalence of Albertans reporting exposure to second-hand smoke (excluding own smoking) in places other than the home in the past month – Ages 15 and over (CTUMS, February – December 2006)⁸⁷

2.4 HEALTH PROFESSIONALS AND TOBACCO

Utilization of Health Professional Services

Current daily and occasional smokers in Alberta (ages 12 and over; 47.7%) are more likely than non-smokers (35.1%) to report no visits to the dentist over the past year (Figure 2-59). Over half (52.3%) of current daily and occasional smokers in Alberta report visiting the dentist at least once over the past year, indicating that a dentist's office may be an effective place for smoking cessation advice to be conveyed.

Figure 2-59: Percentage of Albertans reporting having visited the dentist over the past 12 months, by smoking status – Ages 12 and over (CCHS 3.1 PUMF – Weighted, 2005)⁸⁸

87 Health Canada, Canadian Tobacco Use Monitoring Survey (CTUMS), February – December 2006.

88 Statistics Canada, Canadian Community Health Survey (CCHS 3.1) PUMF – Weighted, 2005.

More non-smokers ages 12 and over in Alberta (84.5%) reported having a regular medical doctor over the past 12 months than current daily and occasional smokers (75.7%; Figure 2-60). Similarly, more non-smokers in Alberta (80.2%) reported that they had seen or spoken with a family doctor or general practitioner about their physical, emotional or mental health over the past 12 months than current daily and occasional smokers (75.5%; Figure 2-61).

Figure 2-60: Percentage of Albertans reporting having a regular medical doctor over the past 12 months, by smoking status – Ages 12 and over (CCHS 3.1 PUMF – Weighted, 2005)⁸⁹

Figure 2-61: Percentage of Albertans reporting having seen or spoken with a family doctor or general practitioner about their physical, emotional or mental health over the past 12 months, by smoking status – Ages 12 and over (CCHS 3.1 PUMF-Weighted, 2005)⁹⁰

⁸⁹ Statistics Canada, Canadian Community Health Survey (CCHS 3.1) PUMF – Weighted, 2005.

⁹⁰ Statistics Canada, Canadian Community Health Survey (CCHS 3.1) PUMF – Weighted, 2005.

Compared to non-smokers in Alberta ages 12 and over (7.9%), a greater proportion of current daily and occasional smokers (11.4%) reported having consulted a mental health professional over the past 12 months (Figure 2-62).

Figure 2-62: Percentage of Albertans reporting having consulted a mental health professional over the past 12 months, by smoking status – Ages 12 and over (CCHS 3.1 PUMF – Weighted, 2005)⁹¹

Physician Monitoring of Tobacco Use and Second-hand Smoke

Approximately three in five family doctors in Alberta who are actively involved in office-based patient care (61.2%) indicated that they use a reminder system on a patient's chart to indicate tobacco use (Figure 2-63). Of these physicians, 63.9% reported that they always or often follow-up with patients at subsequent visits regarding their tobacco use. These practices coincide with those reported by family doctors nationwide.

Figure 2-63: Percentage of family doctors, actively involved in office-based patient care in Alberta and Canada, who monitor tobacco use in patients (CFPCCDPS, 2007)⁹²

⁹² College of Family Physicians of Canada, *Canadian Family Physician Cancer and Chronic Diseases Prevention Survey (CFPCCDPS)*, 2007.

Of family doctors actively involved in office-based patient care, nearly all surveyed in Alberta (97.0%) and Canada overall (96.5%) reported that they always or often inquire about tobacco use at annual check-ups (Figure 2-64). Furthermore, over half of survey respondents in Alberta (52.8%) and Canada overall (56.8%) reported that they always or often inquire regarding tobacco use at appointments unrelated to tobacco use.

Figure 2-64: Percentage of family doctors, actively involved in office-based patient care in Alberta and Canada, who inquire about tobacco use in patients (CFPCCDPS, 2007)⁹³

93 College of Family Physicians of Canada, *Canadian Family Physician Cancer and Chronic Diseases Prevention Survey (CFPCCDPS)*, 2007.

Over half of family doctors in Alberta actively involved in office-based patient care (55.3%) indicated that they always or often use an established counselling routine to encourage tobacco use cessation in their patients (Figure 2-65). One in three Alberta family doctors (34.4%) reported that they always or often distribute smoking cessation written material to patients who use tobacco. Only 9.5% of respondents reported that they always or often refer patients to an expert or specialist for counseling in smoking cessation.

Figure 2-65: Percentage of family doctors, actively involved in office-based patient care in Alberta and Canada, who encourage tobacco cessation (CFPCDPS, 2007)⁹⁴

⁹⁴ College of Family Physicians of Canada, Canadian Family Physician Cancer and Chronic Diseases Prevention Survey (CFPCDPS), 2007.

Over 90% of family doctors in Alberta who are actively involved in office-based patient care (93.3%) and Canada overall (93.3%) indicated that they always counsel pregnant patients to quit smoking (Figure 2-66). In addition, a substantial proportion of these physicians in Alberta and Canada overall indicated that they always or often target teens (70.9% and 70.9%, respectively) or 30 to 40 year olds (68.2% and 69.9%, respectively) for smoking cessation counseling.

Figure 2-66: Percentage of family doctors, actively involved in office-based patient care in Alberta and Canada, who target special populations for tobacco cessation (CFPCCDPS, 2007)⁹⁵

Just under three-quarters of family doctors in Alberta who are actively involved in office-based patient care (72.1%) and nationwide (72.3%) reported that they always or often prescribe nicotine replacement therapy (NRT) as a strategy to assist in smoking cessation (Figure 2-67). Also, 72.8% of these physicians in Alberta and 68.9% nationwide indicated that they always or often prescribe Zyban to their smoking patients.

Figure 2-67: Percentage of family doctors, actively involved in office-based patient care in Alberta and Canada, who prescribe nicotine replacement therapy (NRT) or Zyban to their patients (CFPCCDPS, 2007)⁹⁶

⁹⁶ College of Family Physicians of Canada, *Canadian Family Physician Cancer and Chronic Diseases Prevention Survey (CFPCCDPS)*, 2007.

Over half (55.1%) of Alberta family doctors actively involved in office-based patient care reported that they always or often warn patients regarding the dangers of second-hand smoke and more than half (59.2%) indicated that they always or often ask patients who smoke about their proximity while smoking to children of all ages (Figure 2-68). These practices coincide with reports from similar physicians across Canada.

Figure 2-68: Percentage of family doctors, actively involved in office-based patient care in Alberta and Canada, who inquire or educate about the hazards of second-hand smoke (CFPCCDPS, 2007)⁹⁷

97 College of Family Physicians of Canada, Canadian Family Physician Cancer and Chronic Diseases Prevention Survey (CFPCCDPS), 2007.

CHAPTER 3

TOBACCO CONTROL

PROGRAM INVENTORY

An inventory of Tobacco Control programs¹ offered in Alberta was collected by the Canadian Council for Tobacco Control (CCTC). The following information was gathered from September 2006 to January 2007, and updated in May and June 2007.

CCTC's *Pan-Canadian Inventory of Cessation Programs* (April 2006) along with the results of an on-line survey of Tobacco Control in Alberta (August 2006) was used as a starting point in the creation of the *Inventory of Tobacco Control Programs for Alberta*. This information was then augmented with web searches and interviews conducted in November 2006, December 2006, and January 2007. Updates to the Program Inventory were gathered in June 2007.

The inventory data provides us with a snapshot of Tobacco Control programs in Alberta. Over 55 organizations are engaged in Tobacco Control in Alberta with more than 103 tobacco reduction-related programs currently being delivered.

Various components of program information, including program settings, were collected in order to ascertain the extent of health professional involvement and the number of workplace programs offered. The distribution and evaluation of program delivery organizations in Alberta was also appraised.

PROGRAM DISTRIBUTION

Delivery Organizations

In Alberta, there is a wide range of organizations from diverse sectors providing Tobacco Control programs. These organizations include: friendship centers, Boys and Girls Clubs, Aboriginal groups, addiction treatment centers, provincial not-for-profit health organizations (e.g. The Lung Association – Alberta & NWT, Canadian Cancer Society), faith-based organizations, regional health authorities and community coalitions. The types of organizations and their geographic reach are noted in Table 3-1.

¹ A program has been defined as having an interactive component. This number does not include pamphlets or stand-alone self-help literature.

Table 3-1: Tobacco Control program delivery in Alberta, by organization reach and type (current as of June 2007)

Type of Organization	Reach of Organization	Total # of Organizations
Corporation	Local	1
Corporation	Provincial	1
Corporation	National	4
Government	Regional	10
Government	Provincial	2
Government	National	1
NGO ²	Unknown	2
NGO	Local	9
NGO	Provincial	10
NGO	National	6
Education	Local	3
Unspecified		6

Delivery Methods and Settings

There is a broad distribution of programs among a variety of delivery methods and settings as noted in Table 3-2.

Table 3-2: Number of Tobacco Control programs in Alberta, by delivery method and setting (current as of June 2007)

Distribution of program delivery method and settings			
Delivery Method	# of Programs	Settings	# of Programs
Curriculum	7	Community	23
Event/Presentation	17	Health Care	25
Group setting	23	Home	7
One-on-one counseling	14	Public Spaces	5
Policy funding	14	School	24
Telephone counseling	4	Workplace	12
Video	5	Call Centre	2
Web-based intervention	5	Undefined	1
Education/awareness	5		
Other	9		

² NGO = Non-Governmental Organization

Target Audiences

The number of programs identified for each target audience is noted in Table 3-3. There appears to be an extensive cross-section of populations represented in the inventory with the exception of the Lesbian, Gay, Bisexual, Transsexual (LGBT) community for which no programs were identified, and Street Youth/At-Risk Youth with one identified program.

Table 3-3: Target audiences for Tobacco Control programs in Alberta (current as of June 2007)

Target Audience	# of Programs
Aboriginal	11
Parents	9
General smokers	24
Health providers	12
Lesbian, Gay, Bisexual, Transsexual (LGBT)	0
Mental health	2
Pregnant/Post-partum women	10
Women	3
Teens	23
Young adults	9
Pre-teens	14
Clients/Residents/Patients	4
Employees	6
General population	10
Junior high school students	3
Individuals with developmental disabilities	2
Provincial/Municipal Governments	2
Street youth/At-risk youth	1
Tobacco retailers	2
Ethnic/Multicultural	2

Regional Health Authority Programs

Table 3-4 outlines the distribution of provincial programs within the individual Regional Health Authorities (RHA). As noted, some RHAs have considerably more programs in their region than others. A primary factor determining the number of programs is population distribution, in that the number of programs in an urban center is proportional to population size. For more detail on specific programs offered by each RHA, please see Chapters 6 to 14. Updates on programs offered by RHAs were completed in and are current as of June 2007.

Table 3-4: Distribution of Tobacco Control programs in Alberta, by health region (current as of June 2007)

Regional Health Authority	Number of Programs
Aspen Regional Health Authority	4
Calgary Health Region	4
Capital Health	13
David Thompson Regional Health Authority	6
Peace Country Health	6
Chinook Health	1
Northern Lights Health Region	7
Palliser Health Region	4
East Central Health	3
Total # of Programs offered by RHAs	48

Primary Tobacco Control Focus

Distribution of programs by Tobacco Control focus is outlined in Table 3-5. Because an existing database of cessation programs as well as a web-based directory was used for this report, it is possible that cessation programs are overrepresented. Alternatively, the relatively high number of tobacco cessation programs could be because of a greater demand for these types of programs.

While most programs have more than one mandate, their primary focus is listed in Table 3-5. The primary focus is fairly evenly distributed overall, with the exception of *denormalization*, *advocacy* and the *sacred use of tobacco*.

Table 3-5: Distribution of Tobacco Control programs in Alberta, by Primary Tobacco Control Focus

Primary Focus	Number of Programs
Cessation	35
Prevention	22
Protection	14
Capacity Building	19
Denormalization	1
Harm / Tobacco Reduction	11
Other - Advocacy	1
Other - Sacred Use of Tobacco	1

Gaps and Limitations of Program Inventory

The *Inventory of Tobacco Control Programs for Alberta* is not an endorsement for any particular program. This inventory is part of an ongoing process as more data are collected and evaluated. Some limitations need to be addressed.

It was difficult to obtain information on operating costs, the number of staff involved and the number of clients enrolled in each program. It was unclear if the information was not readily available or if the contacts were unwilling to share the information they had. Where the program cost was identified as expensive vs. inexpensive, it was a subjective assessment with no guidelines or definition.

In addition, it was also difficult to ascertain how program success was measured and why it was believed the program was either successful or not successful. Again, the information may not have been readily available or it was too time consuming to document and divulge. Other programs may not have considered how they measure success. One of the challenges in determining efficacy is that there is no consistent evaluation for all programs; thus, it is difficult to compare and assess a program's effectiveness. This is particularly true if the program has not been formally evaluated. Approximately half the programs have an assessment component in place and half do not. There is a need to develop a systematic evaluation process for these and future programs.

An up-to-date inventory is essential as a means to track and evaluate the effectiveness of all Tobacco Control programs. This inventory is the first step in providing us with the ability to effectively appraise and consider expansion and/or revision of core programs throughout the province. By keeping this resource current, the ACB can continue its mandate to support and encourage comprehensive Tobacco Control programming in Alberta.

CHAPTER 4

TOBACCO CONTROL POLICY

"People do not make behaviour choices in isolation, but rather in a larger, complex context that includes the family, community, and culture; the economy and physical environment, formal and informal government policy, and the prevailing legal atmosphere."¹

The International Union for Health Promotion and Education (IUHPE) has developed model legislation covering all aspects of tobacco control based on research into best practices and the experiences of countries around the world.² The IUHPE,³ World Health Organization's (WHO) Framework Convention on Tobacco Control (FCTC),^{4,5} the Centers for Disease Control and Prevention (CDC)⁶ and Health Canada⁷ have all made recommendations which support higher tobacco taxes; 100% smoke-free workplace and public place legislation; a prohibition of all retail tobacco displays; and a ban on the sale of tobacco products in pharmacies and healthcare facilities.

To assess the current state of Tobacco Control policy in Alberta, a review of the following was conducted:

- i. Provincial Tobacco Control Legislation and Regulations
- ii. Municipal Smoking Bylaws
- iii. Educational Institution Policies
- iv. Regional Health Authority Tobacco Policies

- 1 US Department of Health and Human Services, 'Reducing tobacco use: a report of the Surgeon General', Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2000, <http://www.cdc.gov/tobacco/data_statistics/sgr/sgr_2000/index.htm#full>, viewed May 16, 2007.
- 2 Nathan R, "Model legislation for tobacco control: A policy development and legislative drafting manual," International Union for Health Promotion and Education (IUHPE), November 2003, <<http://fctc.org/documents/IUHPE-Text.pdf>>, viewed May 16, 2007>.
- 3 Nathan R, "Model legislation for tobacco control: A policy development and legislative drafting manual," International Union for Health Promotion and Education (IUHPE), November 2003, <<http://fctc.org/documents/IUHPE-Text.pdf>>, viewed May 16, 2007>.
- 4 World Health Organization, "WHO Framework Convention on Tobacco Control," WHO Framework Convention on Tobacco Control, Updated 2005, World Health Organization, 16 May 2007 <http://www.who.int/tobacco/framework/WHO_FCTC_english.pdf>.
- 5 World Health Organization, "WHO Framework Convention on Tobacco Control," WHO Framework Convention on Tobacco Control, Updated 2005, World Health Organization, 16 May 2007 <http://www.who.int/tobacco/framework/WHO_FCTC_english.pdf>.
- 6 Centers for Disease Control and Prevention, "Strategies for reducing exposure to environmental tobacco smoke, increasing tobacco-use cessation, and reducing initiation in communities and health-care systems: A report on recommendations of the Task Force on Community and Preventive Services," MMWR, 49 (2000), RR-12 16 May 2007 <<http://www.cdc.gov/mmwr/preview/mmwrhtml/rr4912a1.htm>>.
- 7 The Tobacco Control Liaison Committee of the Federal Provincial Territorial Advisory Committee on Population Health and Health Security, "The National Strategy: Moving Forward. The 2005 Progress Report on Tobacco Control," Healthy Living, 2005, Health Canada, 16 May 2007 <http://www.hc-sc.gc.ca/hl-vs/alt_formats/hecs-sesc/pdf/pubs/tobac-tabac/foward-avant/foward-avant_e.pdf>.

4.1 PROVINCIAL TOBACCO CONTROL LEGISLATION AND REGULATIONS

The ACB reviewed existing provincial/territorial tobacco control legislation and tobacco taxes (Table 4.1).

Table 4-1: Current provincial/territorial tobacco control legislation and tobacco taxes (as of April 20, 2007)

	Tax on 200 Cigarettes	100% Smoke-free Workplaces	Retail Marketing Ban	Pharmacy Sales Ban	Health Care Cost Recovery Legislation
Newfoundland and Labrador	\$40.96	Almost ⁸	No	Yes	Yes
New Brunswick	\$28.47	Yes	Partial	Yes	Yes
Nova Scotia	\$38.75	Yes	Yes	Yes	No
Prince Edward Island	\$34.90	Almost ⁹	Yes	Yes	No
Quebec	\$20.60	Yes	Yes	Yes	No
Ontario	\$24.70	Yes	Yes	Yes	No
Manitoba	\$40.15	Yes	Yes	No	Yes
Saskatchewan	\$40.35	Almost ¹⁰	Yes	No	In Process
Alberta	\$37.00	No	No	No	No
British Columbia	\$35.80	Yes ¹¹	Yes ¹²	No	Yes
Yukon	\$26.40	No	No	No	No
Northwest Territories	\$42.00	Yes	Yes ¹³	Yes	No
Nunavut	\$42.00	Yes	Yes	Yes	No

⁸ Restaurants and bars 100% smoke-free, Designated Smoking Room's (DSR's) in office workplaces.

⁹ DSR's in bars, restaurants and workplaces.

¹⁰ All restaurants and bars 100% smoke-free, restrictions in workplaces.

¹¹ Expected to be effective 2008.

¹² Expected to be effective 2008.

¹³ Awaiting proclamation.

As of April 20, 2007, federal and provincial taxes in Alberta resulted in the final retail price of cigarettes, tobacco sticks and loose tobacco to be over 3 times the actual product cost (Figure 4-1). Figure 4-1 includes the cost of buying a carton of cigarettes; the cost of a single pack is proportionately higher than the cost of a carton of cigarettes and estimated at over \$10.50 per pack.

Figure 4-1: Federal and provincial taxes per 200 cigarettes, 200 tobacco sticks, and 200 grams loose tobacco sold in Alberta (current as of April 20, 2007; Alberta Finance, 2006-2007)^{14,15}

The World Bank has concluded that raising tobacco taxes is the single most important step that governments can take to reduce smoking among both adults and young people, particularly in lower socio-economic groups.¹⁶

Increased price reduces cigarette consumption by helping to prevent initiation of tobacco use and increasing motivation to quit. For instance, a 10% price increase (which in Alberta would be approximately a \$1.50 increase) on tobacco products has been shown to reduce demand by 4% in adults and 16% in youth.¹⁷

It is important to note that an increase in the real price of cigarettes does not necessarily mean that cigarettes are less affordable (or more costly) since increases in income levels are not taken into account. Generally, income is positively related to cigarette consumption.¹⁸ That is, everything else remaining the same, an increase in income will lead to an increase in tobacco consumption. In other words, even if the real price increased, increased income may offset, partially or even fully, the increase in real price.¹⁹

14 Alberta Finance, *Tax and Revenue Administration*, 2006.

15 Alberta Finance, *Tax and Revenue Administration*, 2007.

16 Chaloupka FJ et al. "Tobacco Control in Developing Countries: The Taxation of Tobacco Products," *The World Bank*, Ed. Jha P and Chaloupka FJ, 2000, The World Bank, 28 June 2007 <<http://www1.worldbank.org/tobacco/tcdc/237T0272.PDF>>.

17 Chaloupka FJ et al. "Tobacco Control in Developing Countries: The Taxation of Tobacco Products," *The World Bank*, Ed. Jha P and Chaloupka FJ, 2000, The World Bank, 28 June 2007 <<http://www1.worldbank.org/tobacco/tcdc/237T0272.PDF>>.

18 Chaloupka FJ, Warner KE "The Economics of Smoking," In: Culyer AJ, Newhouse JP, eds. *Handbook of health economics*, Amsterdam: Elsevier, 2000.

19 Guinon GE, Tobin S, Yach D, "Trends and Affordability of Cigarette Prices: Ample Room for Tax Increases and Related Health Gains," *Tobacco Control*, 11 (2002); 35-43.

Table 4-2 and Figures 4-2 & 4-3 illustrate the number of minutes of labour required to purchase a pack of cigarettes in Alberta and across Canada.

Table 4-2: Number of Albertans employed in Alberta and average wages (per hour and per minute) in 2007, by age range (Statistics Canada, 2007)²⁰

Age Range	Number Employed in Alberta	Average Hourly Wage (Dollars)	Calculated Average Wage Per Minute (Dollars)
Total: 15 and over	1,565,500	\$22.19	\$0.370
15 to 24	350,800	\$14.32	\$0.239
25 to 54	1,045,300	\$24.31	\$0.405
55 and over	196,300	\$24.56	\$0.409

Figure 4-2: Number of minutes of labour required for employed Albertans to purchase one pack of cigarettes (25 cigarettes/pack)²¹ in 2007, by age range (Statistics Canada, 2007; Canadian Cancer Society, 2007)^{22,23}

²⁰ Statistics Canada, Labour Force Survey, July 2007.

²¹ Based on average hourly wages and a final retail cost for one pack of cigarettes (25 cigarettes/pack) of \$10.95. (Calculated from a total cost of 200 cigarettes equaling \$87.61 in 2007); current as of September, 2007.

²² Statistics Canada, Labour Force Survey, July 2007.

²³ Rob Cunningham, Canadian Cancer Society, 2007.

Figure 4-3: Number of minutes of labour required for employed Canadians to purchase one pack of cigarettes (25 cigarettes/pack)²⁴ in 2007, by province (Statistics Canada, 2007; Canadian Cancer Society, 2007)^{25,26}

The following tables (pages 67-70) from the Canadian Council for Tobacco Control provide a detailed breakdown of federal, provincial and territorial (FTP) legislation that exists within Canada as of September 2007.

24 Based on average hourly wages and a final retail cost for one pack of cigarettes (25 cigarettes/ pack), calculated from a total cost of 200 cigarettes in 2007: Newfoundland = \$93.08 (\$11.64/pack); Prince Edward Island = \$85.38 (\$10.67/pack); Nova Scotia = \$89.71 (\$11.21/pack); New Brunswick = \$78.83 (\$9.85/pack); Quebec = \$70.23 (\$8.78/pack); Ontario = \$74.57 (\$9.32/pack); Manitoba = \$93.13 (\$11.39/pack); Saskatchewan = \$91.30 (\$11.41); Alberta = \$87.61 (\$10.95/pack); British Columbia = \$86.34 (\$10.79/pack); current as of September, 2007.

25 Statistics Canada, Labour Force Survey, July 2007.

26 Rob Cunningham, Canadian Cancer Society, 2007.

Table 4-3: Federal, provincial and territorial (FPT) tobacco restrictions in Canada (current as of September 2007)
... Continued on Pages 68-70

Smoking Restrictions – Public Places Smoking Prohibited													
September 2007													
Provision	Geographical Region												
	Alberta	British Columbia	Saskatchewan	Manitoba	Ontario	Quebec	New Brunswick	Nova Scotia	Prince Edward Island	Newfoundland and Labrador	Northwest Territories	Nunavut	Canada
General provisions	•	•	•	•	•	•	•	•	•	•	•	•	
Schools	•	•	•	•	•	•	•	•	•	•	•	•	
School grounds						•	•	•	•		•	•	
Post-secondary		•	•	•	•	•	•	•		•	•	•	
Childcare facilities	•	•	•	•	•	•		•	•	•	•	•	
Recreation facilities	•	•	•	•	•	•	•	•	•	•	•	•	
Residential care facilities					•	•	•	•		•	•	•	
Acute care facilities		•	•	•	•	•	•	•	•	•	•	•	
Retail stores	•	•	•	•	•	•	•	•	•	•	•	•	
Shopping malls	•	•	•	•	•	•	•	•	•	•	•	•	
Financial institutions	•	•	•	•	•	•	•			•	•	•	•
Broadcasting facilities													•
Restaurants			•	•	•	•	•	•	•	•	•	•	
Licensed drinking establishments			•	•	•	•	•	•	•	•	•	•	
Private clubs			•	•	•	•	•	•		•	•	•	
Enclosed patios				•	•		•						
Licensed gaming facilities			•	•	•	•	•	•	•		•	•	
Public vehicles	•	•	•	•	•	•	•	•	•	•	•	•	
Public transit	•	•	•	•	•	•	•	•	•	•	•	•	•
Transit stations		•	•	•	•	•	•	•	•	•	•	•	
Commercial aircraft													•
Designated smoking rooms	•	•	•	•	•		•		•	•	•	•	
Government workplaces smoking prohibited	•	•	•	•	•	•	•	•		•	•	•	•
Private sector workplaces 100% Smoke-free				•	•	•	•	•			•	•	
Whistle-blower protection				•	•				•	•	•		
Municipal authority	•	•	•	•	•			•		•			

• indicates provision is in place

Restrictions on Promotion, Packaging and Products

September 2007

Provision	Geographical Region												Canada
	Alberta	British Columbia	Saskatchewan	Manitoba	Ontario	Quebec	New Brunswick	Nova Scotia	Prince Edward Island	Newfoundland and Labrador	Northwest Territories	Nunavut	
Advertising restrictions		•	•	•		•							•
Lifestyle						•							•
Trademarks						•							•
Sponsorship		•				•							•
Ads directed at minors						•							•
Newspaper and magazines with youth readership						•							
Misleading						•							•
Testimonials and endorsements						•							•
Reference to real or fictional persons, characters or animals						•							•
Health warning							•	•					
Minimum number of cigarettes		•	•		•	•	•	•	•	•		•	•
Open package		•				•		•					
Package warning		•		•	•	•							•
Package insert		•			•	•							•
Plain package		•		•	•	•							
Toxic constituents													•
Enabling authority						•							•
Fire safety standards													•
Product testing and analysis		•											•

• indicates provision is in place

Point of Sale Restrictions

September 2007

	Geographical Region												
Provision	Alberta	British Columbia	Saskatchewan	Manitoba	Ontario	Quebec	New Brunswick	Nova Scotia	Prince Edward Island	Newfoundland and Labrador	Northwest Territories	Nunavut	Canada
Minimum Age (19)		•			•		•	•	•	•			
Photo ID			•	•	•	•	•	•	•	•	•	•	•
Demand ID from under 25's					•								
Written policy required												•	
Employee training required												•	
Internal monitoring required												•	
Signage		•	•	•	•	•	•	•	•	•	•	•	•
Possession	•							•					
Ticketing									•	•			
Vending ban			•		•	•	•	•	•		•	•	•
Self-Serve ban						•	•	•			•		•
Prohibit countertop displays							•	•					
Restrict retail displays					•		•	•			•	•	•
Prohibit retail displays			•	•	•	•		•	•				
Prohibit retail promotions			•	•	•	•		•	•		•	•	
Prohibit tobacco industry signage			•	•	•			•	•				
Sales suspensions		•	•	•	•	•	•	•	•	•	•	•	•
Signs indicating suspensions		•			•				•		•	•	
Publish notice of retail suspension		•									•	•	
Face-to-face sales						•					•	•	
Health warning signage		•			•	•	•	•	•	•	•	•	•
Prohibited sales: Health facilities			•		•	•			•			•	
Prohibited sales: Pharmacies					•	•	•	•	•	•	•	•	
Prohibited sales: Education facilities			•			•		•	•				
Prohibited sales: Restaurants						•		•					
Prohibited sales: Bars						•		•					
Retail license required				•		•	•		•	•	•	•	
Recreational facilities								•					

• indicates provision is in place

September 2007

Provision	Alberta	Geographical Region											Canada
		British Columbia	Saskatchewan	Manitoba	Ontario	Quebec	New Brunswick	Nova Scotia	Prince Edward Island	Newfoundland and Labrador	Northwest Territories	Nunavut	
Reporting: Sales					•	•							•
Reporting: Marketing information						•							•
Reporting: Research activities													•
Reporting: Ingredients		•				•							•
Reporting: Constituents													•
Reporting: Emissions		•											•
Reporting: New products						•							•
Reporting: Health hazards		•											
Reporting: Promotional activities													•
Medicare cost recovery suits		•		•			•	•		•			
Tobacco price controls						•							

- indicates provision is in place

Most Canadian jurisdictions have passed comprehensive tobacco control legislation including 100% smoke-free workplaces and 100% smoke-free public places, removing tobacco marketing from retail stores and removing tobacco sales from pharmacies. British Columbia, Newfoundland and Labrador, Nova Scotia, New Brunswick, Manitoba and Saskatchewan²⁷ have also passed legislation to allow their respective provinces to recover health care costs from the tobacco industry.

The ACB contracted the Canadian Council for Tobacco Control (CCTC) to compile information on tobacco policies of Municipalities, Regional Health Authorities, Post-Secondary Educational Institutions and School Boards. Selected policy elements were collected by Action on Smoking and Health (ASH). The compiled information was used as the source in Sections 4.2 – 4.4.

4.2 MUNICIPAL SMOKING BYLAWS

Information on Alberta's municipal smoking bylaws is current as of June 1, 2007. In this document, the municipal smoking bylaw inventory distinguishes smoking bylaws as:

Table 4-4: Gold, silver and bronze standardization of municipal smoking bylaws

Gold	Silver	Bronze
<ul style="list-style-type: none">• 100% smoke-free public places including restaurants and drinking establishments.• Offer reasonable workplace protection.	<ul style="list-style-type: none">• Prohibit or restrict smoking in many places, including restaurants.• May allow designated smoking rooms (DSRs).	<ul style="list-style-type: none">• Partial public place and/or workplace protection.• Protection may be limited to designated smoking rooms (DSRs) in some locations.

Although the gold, silver and bronze standardization has been used by various organizations both in Canada and internationally, the precise definitions for this document have been developed by CCTC to compare jurisdictions in policies regarding smoke-free protection.

27 In process.

Table 4-5: Municipal smoking bylaws across Alberta (current as of June 1, 2007) ... Continued on Pages 73-75

Municipalities	Indoor Places																			Outdoor Places							
	Enclosed public spaces	Retail stores	Shopping malls	Restaurants	Licensed drinking establishments	Licensed gaming facilities	Hotels and lodging	Educational facilities	Elevators, escalators and stairways	Hospitals and health care facilities	Municipal offices and buildings	Municipal-owned facilities	Passages, hallways and pedways	Places of public assembly	Public washrooms	Reception areas	Service counters and service lines	Workplaces	Private social functions	Patios	Entranceways	School buses	Taxis	Public transit	Public transit shelters	Municipal vehicles	
Airdrie	A	A	A	A	A	A		A	A	A	A	A	A	A	A	A	A	A		A	E	A	A	A	A	A	
Athabasca				B					A		A	A					A	B				A	A	A			
Banff	A	A	A	A	A	A		A	A	A	A	A	A	A	A	A		B,C,(3)		A		A	A	A	A	A	
Barrhead											A	A															
Bashaw											C	C															
Beaumont	A	A	A	A	A	A		A	A	A	A	A	A	A	A	A	A	A				E	A	A	A	A	A
Black Diamond												(arena, fire hall)															
Bonnyville				A								C							A(1)								
Brooks				B,J																							
Bruderheim											A	A										E(4)					
Calgary	(3)(1)	A	A	B(3)	B(3)	B(3)		B(3)	A	B(3)	C	C	A	A	A	A	A	C		A	E		D	A	A	D	
Calmar												(arena)															
Camrose		A	A	A		J		C	A	C	A	A	A	A	A	A	A	C			E		A	A	A		
Canmore	A	A	A	A	A		A	A	A	A	A	A	A	A	A	A	A	F		C	E(1)	A	A	A	A	A	
Cardston	A																										
Claresholm				B,J																							
Coaldale		A	J	J				J	A	J	J	J	A	J	A	A	A	T		A	J						
Cochrane	A	A	A	A	A	A		A	A	A	A	A	A	A	A	A		A,E			E	A	A	A	A		
Cold Lake				A				A			A	A										A				A	
Crowsnest Pass											A	A															
Devon		A	A	J		A		A	A		A	A	A	A	A	A		B,G		A	A(1)	A		A	A		
Didsbury			K	K							K	K				K								K			
Drayton Valley		A	A					A	A	A	A	A	A	A	A	A		J		T		A		A	A		
Drumheller											A	A															

Municipalities	Indoor Places																	Outdoor Places									
	Enclosed public spaces	Retail stores	Shopping malls	Restaurants	Licensed drinking establishments	Licensed gaming facilities	Hotels and lodging	Educational facilities	Elevators, escalators and stairways	Hospitals and health care facilities	Municipal offices and buildings	Municipal-owned facilities	Passages, hallways and pedways	Places of public assembly	Public washrooms	Reception areas	Service counters and service lines	Workplaces	Private social functions	Patios	Entranceways	School buses	Taxis	Public transit	Public transit shelters	Municipal vehicles	
Edmonton	A	A	A	A	A	A			A		A	A	A	A	A	A	A	B, F	A	A	A	A	A	A	A		
Edson											C	C														A	
Elk Point											A(1)	A(1)														A	
Fishing Lake											C	C															
Fort Saskatchewan									A		A, C	A, C		C	C	C	A									A	
Grande Prairie		A	A	A	J	J		A	A	B	A	A	A	B	A	A	A	B				A	A	A	A	A	A
Hanna	A(4)										A	A		A(1)	A				A(4)			E(4)					
Hardisty											A	A															
High Level											A	A(1)															
High River		A	A	T				A	A	A	A	A	A	A	A	A	A		A	J	A	A	A	A	A	A	
Hinton		A	A(1)	G				A							A	A	A					A		A			
Innisfail			A(1)	F(1)				C	A	C	B	B	A	A	A	A	A	C				A	T	A			
Jasper	A	A	A	A	A	A		A	A	A	A	A	A	A	A	A	A	A		A		A	A	A	A	A	
Killam												C															
Lac La Biche				C, H					A	C, F				C, F		A	A	C, F				A	T				
Leduc	A(1)		B	B(1)	B(1)			B(1)	A	B(1)	A	A(1)	B	B(1)	A	B	B					E	A	A	A	A	
Lethbridge	A	A	A	A	A	A		A	A	A	A	A	A	A	A	A	A	B, G		J, L		A	A	A	A	A	
Lloydminster	A	A	A	A	A	A		A	A	A	A	A	A	A	A	A	A	A	A			A	D	A	A		
Magrath	A(2)																										
Manning												C															
Mayerthorpe												A(1)															
Medicine Hat	A	A	A	A	A	A		A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	
Millet											B	B															
Morinville									A				A		A	A	A				A						
Nanton											A(1)	C(1)															

Municipalities	Indoor Places																			Outdoor Places							
	Enclosed public spaces	Retail stores	Shopping malls	Restaurants	Licensed drinking establishments	Licensed gaming facilities	Hotels and lodging	Educational facilities	Elevators, escalators and stairways	Hospitals and health care facilities	Municipal offices and buildings	Municipal-owned facilities	Passages, hallways and pedways	Places of public assembly	Public washrooms	Reception areas	Service counters and service lines	Workplaces	Private social functions	Patios	Entranceways	School buses	Taxis	Public transit	Public transit shelters	Municipal vehicles	
Okotoks											A	C															
Olds			A		J	J			A			A	A		A	A	A				A	A	A	A			
Oyen			B	B		C		B	A	B	B	B	A	B	A	A		B							A		
Paddle Prairie	A(1)													B													
Pincher Creek		A	A	J(1)				A	A	A	A	A	A	A	A	A				A		A	A(1)	A	A		
Ponoka												A(1)										A		A	A	A	
Rainbow Lake									A		A	A(1)		A(1)	A				A(1)			A(1)				A(1)	
Red Deer	A	A	A	A	A	A		A	A	A	A	A	A	A	A	A	A	A		A	A	A	A	A	A	A	
Redcliff	A	A	A	J				A	A		A	A	A	J	A	A				J		A	A	A	A	A	
Rocky View		A	A	J,G	C,G			A	A		A	A	A	A	A	A						A	A	A	A		
Sexsmith											A	A		A	A							A			A		
Slave Lake		A	A	F,J				A	A	A	A	E,F	A	F	A	A	A			F		A	A	A	A		
Spirit River												A(1)															
Spruce Grove		A	A	A				A	A	A	A	A	A	A	A	A	A	B,G	F(1)		A		A				
St. Albert	A	A	A	A	A	A		A	A		A	A	A	A	A	A	A	B		A	E	A	A	A	A	A	
St. Paul		A	C,G	H				A	A		A(1)	A(1)		C,G	A	A	A	C,G									
Stettler	A	A	A	A	A	A		A	A	A	A	A	A	A	A	A	A	A	A(1)	A	E	A	A	A	A	A	
Stony Plain																											
Strathcona County	A	A	A	A	A	A		B(2)	A	B(2)	A	A	A	C(1)	A	A	A	C,F(1)			E	A	A	A	A		
Strathmore												A(1)															
Summer Village of Itaska Beach											A	A															
Summer Village of Sundance Beach	A													A	A				A								
Summer Village of White Gull													A(1)														

Municipalities	Indoor Places																			Outdoor Places						
	Enclosed public spaces	Retail stores	Shopping malls	Restaurants	Licensed drinking establishments	Licensed gaming facilities	Hotels and lodging	Educational facilities	Elevators, escalators and stairways	Hospitals and health care facilities	Municipal offices and buildings	Municipal-owned facilities	Passages, hallways and pedways	Places of public assembly	Public washrooms	Reception areas	Service counters and service lines	Workplaces	Private social functions	Patios	Entranceways	School buses	Taxis	Public transit	Public transit shelters	Municipal vehicles
Sylvan Lake	A	A	A	A	A	A		A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A
Taber					J	J																				
Three Hills	B(1)					C(1)				C(1)									E(1)							
Vermillion			C, G	B, J	C(1)	C(1)		B	A	B	C, G	C, G		C, G				C				A		A		A
Village of Bittern Lake											A	A														A
Village of Boyle											A	A														A
Village of Munson											A	A														
Village of Wabamun												A(1)														
Vulcan				C						C								B								
Wembley											A	A(1)														
Westlock	A	A	A	A	A	A		A	A	A	A	A	A	A	A	A	A	A	A	A	A					
Wetaskiwin	E													C				C					D			
Whitecourt	A	A	A	A				A	A	A	A	A	A	A	A	A	A	C		J		A	A	A	A	
Wood Buffalo	A(2, B)	A	A	J, B(1, 3)				A	A	A			A	A	A	A	A	B(1)				E	A	A	A	A

LEGEND

A = 100% Smoke Free

B = Designated smoking rooms

C = Smoking in designated areas only (but no special ventilation)

D = Smoking permitted with consent of driver & all passengers

E = No smoking within 3 metres (or more) of an entrance or exit to a public premises

F = Smoking in designated area not to exceed 50% of total area

G = At least 50% of the area must be non-smoking

H = At least 25% of the area must be non-smoking

I = At least 10% of the area must be non-smoking

J = Smoking prohibited where minors permitted

K = Smoking prohibited where no-smoking sign is posted

(1) Some exceptions apply

(2) Except where students are permitted

(3) 100% smoke-free when "Future Policy Implementation" takes effect

(4) City owned, leased, operated or occupied buildings only

The information provided in this report has been interpreted by Action on Smoking and Health (ASH) staff from existing municipal bylaws. Please note that these bylaws may be amended from time to time. ASH assumes no responsibility for the accuracy of the information contained herein. For complete clarification, please refer to the actual bylaw, or speak with the appropriate municipality. Bylaw information was unavailable for municipalities not included in this table, as of May 23, 2007.

Disclaimer: Inventory of Alberta Municipal Bylaws, updated May 23, 2007

indicates that there is a prohibition

indicates that there are restrictions

indicates that there are no prohibitions or restrictions

Twenty-one (out of 368) municipalities have passed (or are set to pass) gold standard bylaws, providing approximately 70% of Alberta's population with protection from second-hand smoke:²⁸

1. Cardston	June 1, 2002
2. Sundance Beach	July 1, 2003
3. Banff	August 1, 2004
4. Jasper	April 15, 2005
5. Beaumont	June 1, 2005
6. Strathcona County	July 1, 2005
7. Edmonton	July 1, 2005
8. St. Albert	July 1, 2005
9. Stettler	June 1, 2005
10. Airdrie	June 1, 2005
11. Red Deer	June 1, 2006
12. Canmore	October 1, 2006
13. Cochrane	January 1, 2007
14. Lethbridge	January 1, 2007
15. Whitecourt	January 1, 2007
16. Lloydminster	January 1, 2007
17. Medicine Hat	May 31, 2007
18. Sylvan Lake	June 1, 2007
19. Wood Buffalo Region
(Fort McMurray,
Fort Chipewyan,
Janvier, Conklin,
Fort MacKay, Anzac)	September 1, 2007
20. Calgary	Effective January 1, 2008
21. Westlock	Effective January 1, 2008

²⁸ Compiled by Action on Smoking and Health (ASH), 2007

4.3 EDUCATIONAL INSTITUTION POLICIES

Post-secondary Campus Tobacco Policies

Post-secondary data were compiled between July and September 2006. Information is up-to-date as of September 2006. Post-secondary institutions were asked about written policies regarding indoor and outdoor tobacco use, tobacco industry distribution, sales and marketing and sponsorship, support for tobacco cessation and written positions on tobacco industry funding and investment. All 21 post-secondary campuses were surveyed; 19 surveys were returned (90% response rate).

We are in the process of establishing standards for post-secondary campuses.

School boards were surveyed for existing tobacco control policies; however, due to low response rates, information on school board tobacco control policies were not included.

Of the 23 campuses none have a comprehensive campus tobacco control policy in place.

Table 4-6: Post-secondary campus tobacco policies across Alberta (current as of September 2007)

[illegible]

	Alberta College of Art and Design	Bow Valley College	Fairview College	Grande Prairie Regional College	Grant MacEwan College	Keyano College	Lakeland College	Athabasca University	University of Alberta	University of Calgary	University of Lethbridge	The Banff Centre	Northern Alberta Institute of Technology (NAIT)	Southern Alberta Institute of Technology (SAIT)	Lethbridge Community College	Medicine Hat College	Mount Royal College	NorQuest College	Northern Lakes College	Olds College	Portage College	Red Crow College	Red Deer College
No Financial Gain																							
Acceptance of all monies from tobacco companies whether gifts, donations or grants is prohibited									• +														
Institutional investment in stocks with holdings in tobacco companies is prohibited										•													
Sale of tobacco products prohibited	N/A		N/A																N/A	N/A			
No Promotion																							
Tobacco industry advertisements prohibited in all campus run publications																							
Tobacco industry advertisements prohibited in all student run publications																							
Promotion of all tobacco products is prohibited																			N/A				
Tobacco industry sponsored events are prohibited																							

• indicates provision is in place

* Student health plan coverage only

+ In the following departments: Medicine, Dentistry, Nursing, Public Health

4.4 REGIONAL HEALTH AUTHORITY TOBACCO POLICIES

The information in this section was collected from Regional Health Authority (RHA) policies and is accurate to June 18, 2007.

Traditionally, the gold, silver and bronze standardization has been used to define smoke-free indoor places, and was initially developed for municipalities. Most RHAs would have obtained the Gold standard if the municipal bylaw grading system had been used, but since RHAs are health-based organizations, a higher standard was employed. In order to illustrate the differences between health authorities a more stringent regime has been adopted by the CCTC.

The analysis of RHA tobacco policy is categorized into three groups with key elements for each categorization as follows:

Table 4-7: Gold, silver and bronze standardization of Regional Health Authority (RHA) policies

Gold	Silver	Bronze
<ul style="list-style-type: none">• Smoke-free indoor spaces, properties and vehicles	<ul style="list-style-type: none">• Smoke-free indoor spaces and vehicles	<ul style="list-style-type: none">• Smoke-free indoor spaces
<ul style="list-style-type: none">• Cessation support	<ul style="list-style-type: none">• Restrictions on entrances or near windows, air intake or external ventilation ducts and/or air handling equipment	<ul style="list-style-type: none">• Restrictions on properties and/or vehicles

Table 4-8: Tobacco policies for Regional Health Authorities (RHAs) in Alberta (current as of June 1, 2007)

		Regional Health Authority (RHA)								
		Aspen Regional Health Authority	Calgary Health Region	Capital Health	Chinook Health	David Thompson Regional Health Authority	East Central Health	Northern Lights Health Region	Palliser Health Region	Peace Country Health
Smoking Restrictions										
All RHA owned or operated buildings and facilities are smoke-free		•	•	•	•	•	•	•	•	•
All RHA owned or leased vehicles are designated smoke-free		•	•	•	•	•	•	**	•	•
100% of RHA grounds including parking lots are smoke-free			•	•	•*	•*	•	•	•	
The use of all tobacco products, including but not exclusive to cigarettes, all forms of spit and chew tobacco, pipes and cigars, are prohibited on RHA property					•	•	•		•	
For home visits, clients are asked to refrain from smoking 1 hour prior to and during a home visit		•	•	•	•	•	•	**	•	•
If smoking is permitted on grounds, it is permitted in outdoor designated spaces only		•	N/A	N/A	N/A	•	N/A	N/A	N/A	•
If smoking is permitted on grounds, it is prohibited near building entrances (and within X meters of an entrance, if applicable)		5 m for staff entrances	N/A	N/A	N/A	•	N/A	N/A	N/A	3m
If smoking is permitted on grounds, it is prohibited near windows, air intake or external ventilation ducts and/or air handling equipment			N/A	N/A	N/A	N/A	N/A	N/A	N/A	
Smoking is permitted in designated smoking areas (or separately ventilated smoking rooms) for special client populations which may include:	Continuing care patients/residents	•	•		•		•	•	•	•+
	Mental health inpatients				•			**		•+
	Palliative care patients						•	**	•	•+
	Some designated patients					•	•	**		•+
	Emergency department patients							**		•+
Cultural/spiritual use			•	•	•	•	**	•**	•+	•+

	Regional Health Authority (RHA)								
	Aspen Regional Health Authority	Calgary Health Region	Capital Health	Chinook Health	David Thompson Regional Health Authority	East Central Health	Northern Lights Health Region	Palliser Health Region	Peace Country Health
Smoking Cessation Support									
<i>Staff</i>									
Financial support provided to attend cessation program		•	•	•	•	•	**	•	
Cessation aids available through employee benefits plan	•	•	•	•	•		**	•	
Cessation program information and self-help resources available	•	•	•	•	•		**	•	•
<i>Patients</i>									
Cessation aids are on hospital formulary	•	•	•	•	•		**	•	•
Cessation program information available	•	•	•	•	•			•	
Financial support provided for cessation program costs				•					
<i>Visitors</i>									
Nicotine Replacement Therapy (NRT) available at outpatient pharmacy	N/A	•	•				N/A		
Enforcement and Signage									
Smoke-free policy posted in prominent locations	•	•	•	•	•		•	•	•
Compliance protocol in place for staff		•	•	•	•			•	
Compliance protocol in place for patients		•	•	•	•			•	
Compliance protocol in place for visitors		•	•	•	•			•	
Notification									
Patients/clients advised of smoke-free policy at time of admission		•	•	•	•	•	**	•	•
Homecare clients advised of smoking policy (if there is a 1 hour no smoking prior to visit policy in place)	•	•	•	•	•		**	•	•
All employees/candidates advised of smoke-free policy	•	•	•	•	•	•	•	•	•
Visitors advised of smoke-free policy		•	•	•	•	•	•	•	•
Tobacco Industry Sales, Marketing, Donations									
Tobacco sales are not permitted on RHA property	•		•	•	•		**	•	•
Tobacco marketing is not permitted on RHA property	•		•	•	•		**	•	•
Tobacco industry donations, of any nature, are not accepted	•		•	•	•		•	•	•

CHAPTER 5

REGIONAL OVERVIEWS

The following nine sections of this booklet present a picture of the population and relevant details pertaining to tobacco use and prevention for each health region in Alberta:

Chapter 6:	Chinook Health
Chapter 7:	Palliser Health Region
Chapter 8:	Calgary Health Region
Chapter 9:	David Thompson Regional Health Authority
Chapter 10:	East Central Health
Chapter 11:	Capital Health
Chapter 12:	Aspen Regional Health Authority
Chapter 13:	Peace Country Health
Chapter 14:	Northern Lights Health Region

Two main data sources were used to provide statistical information representing demographic and tobacco use in the following nine chapters:

1) Statistics Canada, Canadian Community Health Survey Cycle 3.1 (CCHS 3.1), Public Use Microdata File (PUMF) – Weighted, 2005

- a. The CCHS is a cross-sectional survey that collects information related to health status, health care utilization and health determinants for the Canadian population. The CCHS targets Canadians who are living in private dwellings in the ten provinces and the three territories. Persons living on Indian Reserves or Crown lands, residents of institutions, full-time members of the Canadian Armed Forces and residents of certain remote regions are excluded from this survey. The CCHS covers approximately 98% of the Canadian population aged 12 and older.¹ The CCHS PUMF is designed to make respondent level survey information available to a wide range of users.²
- b. Data were analyzed by the Prevention Team at the ACB Population Health and Information Unit. The data were weighted using the weighting variable provided by Statistics Canada, which stratifies by Health Region, Age, and Gender.
- c. Unless otherwise indicated, smoking status is measured by current type of smoking (daily, occasional, non-smoker) assessed at the time of survey.
- d. Sample size for Alberta: $n = 11,800$
Sample size for Chinook Health: $n = 1,031$
Sample size for Palliser Health Region: $n = 813$
Sample size for Calgary Health Region: $n = 2,648$
Sample size for David Thompson Regional Health Authority: $n = 1,303$
Sample size for East Central Health: $n = 884$
Sample size for Capital Health: $n = 2,543$
Sample size for Aspen Regional Health Authority: $n = 1,019$
Sample size for Peace Country Health/Northern Lights Health Region: $n = 1,559$

1 Statistics Canada, *Canadian Community Health Survey (CCHS 3.1)*, 2005.

2 Statistics Canada, *Canadian Community Health Survey (CCHS 3.1) PUMF – Weighted*, 2005.

2) Alberta Health Care Insurance Plan (AHCIP) Stakeholder Registry, 2005

- a. The AHCIP Stakeholder Registry is a listing of Alberta residents eligible for medical coverage for physician and hospital services through the AHCIP. It also includes individuals who spend significant periods of time out of the province. The registry excludes members of the Armed Forces, RCMP, or inmates residing in Federal Penitentiaries or people who have decided not to register with the AHCIP.³
- b. Unless otherwise indicated, 2005 population estimates for Alberta (represented by a "T") were calculated using data from the AHCIP Stakeholder Registry. Calculated population estimates were rounded to the nearest thousand, with estimates less than two thousand rounded to the nearest hundred.

In addition to the statistical information representing demographic and tobacco use for a specific health region, each of the health region sections include detailed program and policy information obtained from the Canadian Council for Tobacco Control (CCTC) and updated by the Alberta Cancer Board in June 2007. Only those programs and policies in place prior to June 20th, 2007⁴ are represented in this booklet; programs and policies instituted after this date were not included.

Figure 5-1 details the prevalence of current daily and occasional smokers (ages 12 and over) for all nine health regions (Note: the overall current daily and occasional smoking prevalence for Albertans ages 12 and over is 22.8%).⁵

3 Alberta Health and Wellness, Alberta Health Care Insurance Plan (AHCIP) Stakeholder Registry, 2005.

4 Due to the nature of this document being a working product and subject to updates and insertions/deletions, all programs and policies in place by a specific health region may not be represented.

5 Statistics Canada, Canadian Community Health Survey (CCHS 3.1) PUMF – Weighted, 2005.

Figure 5 1: Prevalence of current daily and occasional smokers in each health region in Alberta (CCHS 3.1 PUMF – Weighted, 2005)⁶

6 Statistics Canada, Canadian Community Health Survey (CCHS 3.1) PUMF – Weighted, 2005.

CHAPTER 6

CHINOOK HEALTH

The information presented throughout this chapter has been compiled using data obtained from the Canadian Community Health Survey Cycle 3.1 (CCHS 3.1), Public Use Microdata File (PUMF) – Weighted (2005) and the Alberta Health Care Insurance Plan (AHCIP) Stakeholder Registry (2005). Please refer to Chapter 5 for a more detailed description of these data sources.

6.1 REGIONAL DEMOGRAPHICS

Chinook Health: Demographic Highlights*

- The estimated population in Chinook Health is 130,000, accounting for roughly 4.8% of Alberta's population (T~2,727,000)
- An estimated one-half (50.2%) of residents in Chinook Health are between 20 and 50 years of age (Figure 6-1).
- Approximately 66,000 females and 64,000 males reside in Chinook Health (Figure 6-2).
- The majority of Chinook Health residents aged 14 and over (70.0%; T~87,000) have graduated from a post-secondary institution (Figure 6-3).
- Over half of Chinook Health residents (53.8%) accrue less than \$30,000 per year, in comparison with 47.3% of Albertans who fall in that income category (Figure 6-4).

* Unless otherwise specified, all calculated percentages and population estimates represent the population ages 12 and over only.

Figure 6-1: Age distribution of Chinook Health and Alberta - Ages 12 and over (CCHS 3.1 PUMF - Weighted, 2005)^{1,2}

1 Statistics Canada, Canadian Community Health Survey (CCHS 3.1) PUMF – Weighted, 2005.

2 Population estimates calculated using data from Alberta Health and Wellness, Alberta Health Care Insurance Plan (AHCIP) Stakeholder Registry, 2005.

Figure 6-2: Gender distribution of Chinook Health and Alberta - Ages 12 and over (AHCIP Stakeholder Registry, 2005)³

Figure 6-3: Highest personal education level attained by residents of Chinook Health and Alberta - Ages 14 and over (CCHS 3.1 PUMF - Weighted, 2005)^{4,5}

3 Population estimates calculated using data from Alberta Health and Wellness, Alberta Health Care Insurance Plan (AHCIP) Stakeholder Registry, 2005.

4 Statistics Canada, Canadian Community Health Survey (CCHS 3.1) PUMF - Weighted, 2005.

5 Population estimates calculated using data from Alberta Health and Wellness, Alberta Health Care Insurance Plan (AHCIP) Stakeholder Registry, 2005.

Figure 6-4: Annual personal income accrued by residents of Chinook Health and Alberta - Ages 12 and over (CCHS 3.1 PUMF - Weighted, 2005)^{6,7}

6.2 TOBACCO USE

Chinook Health: Tobacco Use Highlights*

- Chinook Health is home to approximately 26,000 of Alberta's 622,000 smokers (Figure 6-5) and 104,000 non-smokers.
- The smoking prevalence is greater for females (21.6%) than males (18.5%) in Chinook Health. This translates to approximately 14,000 females and 12,000 males (Figure 6-6).
- The smoking prevalence of youth in Chinook Health (ages 12 to 17) is 14.2%. This is higher than the same prevalence in Alberta (5.6%) and corresponds to approximately 2,000 smokers (Figure 6-7).
- Approximately 24,000 smokers in Chinook Health are above the age of 18 years. Of these, approximately 10,000 are overweight or obese (Figure 6-8).
- Approximately 13,000 of Chinook's 26,000 smokers are physically inactive (Figure 6-9).

* Unless otherwise specified, all calculated percentages and population estimates represent the population ages 12 and over only.

6 Statistics Canada, Canadian Community Health Survey (CCHS 3.1) PUMF - Weighted, 2005.

7 Population estimates calculated using data from Alberta Health and Wellness, Alberta Health Care Insurance Plan (AHCIP) Stakeholder Registry, 2005.

Figure 6-5: Prevalence of current daily and occasional smokers in Alberta, by health region - Ages 12 and over (CCHS 3.1 PUMF - Weighted, 2005)^{8,9}

Figure 6-6: Prevalence of current daily and occasional smokers in Chinook Health and Alberta, by gender - Ages 12 and over (CCHS 3.1 PUMF - Weighted, 2005)^{10,11}

8 Statistics Canada, Canadian Community Health Survey (CCHS 3.1) PUMF - Weighted, 2005.

9 Population estimates calculated using data from Alberta Health and Wellness, Alberta Health Care Insurance Plan (AHCIP) Stakeholder Registry, 2005.

10 Statistics Canada, Canadian Community Health Survey (CCHS 3.1) PUMF - Weighted, 2005.

11 Population estimates calculated using data from Alberta Health and Wellness, Alberta Health Care Insurance Plan (AHCIP) Stakeholder Registry, 2005.

Figure 6-7: Prevalence of current daily and occasional smokers in Chinook Health and Alberta, by age – Ages 12 and over (CCHS 3.1 PUMF - Weighted, 2005)^{12,13}

Figure 6-8: Prevalence of overweight or obesity (Body Mass Index ≥ 25) among current daily and occasional smokers in Alberta, by health region – Ages 18 and over (CCHS 3.1 PUMF - Weighted, 2005)^{14,15}

12 Statistics Canada, Canadian Community Health Survey (CCHS 3.1) PUMF – Weighted, 2005.

13 Population estimates calculated using data from Alberta Health and Wellness, Alberta Health Care Insurance Plan (AHCIP) Stakeholder Registry, 2005.

14 Statistics Canada, Canadian Community Health Survey (CCHS 3.1) PUMF – Weighted, 2005.

15 Population estimates calculated using data from Alberta Health and Wellness, Alberta Health Care Insurance Plan (AHCIP) Stakeholder Registry, 2005.

Figure 6-9: Prevalence of physical inactivity¹⁶ among current daily and occasional smokers in Alberta, by health region – Ages 12 and over (CCHS 3.1 PUMF - Weighted, 2005)^{17,18}

6.3 POLICIES

RHA policy:

- Tobacco use is prohibited in or on all Chinook Health owned or operated property, facilities and vehicles.
- Clients and others in the home and community are requested to refrain from smoking one hour prior to and during a home visit by an employee or volunteer of Chinook Health.

Number of municipalities in region with gold standard rating: 2

Gold standard municipalities include:

- Lethbridge
- Cardston

RHA policy: Gold

16 CCHS 3.1 defines physical inactivity as a daily usual leisure-time energy expenditure of less than 1.5 kilocalories per kilogram of body weight per day.

17 Statistics Canada, Canadian Community Health Survey (CCHS 3.1) PUMF – Weighted, 2005.

18 Population estimates calculated using data from Alberta Health and Wellness, Alberta Health Care Insurance Plan (AHCIP) Stakeholder Registry, 2005.

Post-secondary policy:

Lethbridge Community College

- Smoking cessation programs for students are available on campus (or referral to existing off-campus programs is provided).
- Smoking cessation programs for faculty and staff are available on campus (or referral to existing off-campus programs is provided).
- Sale of tobacco products is prohibited.

Bow Valley College

- Smoking is restricted on campus grounds.
- Bow Valley College is investigating the idea of prohibiting acceptance of all monies from tobacco companies whether gifts, donations or grants.

University of Lethbridge

- Sale of tobacco products is prohibited.
- University of Lethbridge does not invest in the tobacco industry.

Red Crow College

- Policy information for this institution was not available at time of printing.

6.4 PROGRAMS

1. **Better Beginnings** – A community-based initiative that offers support and healthy lifestyle choices for pregnant and parenting women. Better Beginnings supports women experiencing an at-risk pregnancy due to inadequate financial supports and/or isolation. (Evaluated)

Chinook Health also referenced the following:

Networks and Committees

1. Campaign for a Smoke-Free Alberta (CSFA)
2. Action on Smoking and Health (ASH)
3. Chinook Tobacco Reduction Network

Community Programs

1. Sik-Ooh-kotoki Friendship Society's DVD "Sacred Use of Tobacco" (Evaluated)
2. Teaming Up for Tobacco-Free Kids
3. Building Leadership for Action in Schools Today (BLAST)

Chinook Health also indicated that the 5 A's (Ask, Advise, Assess, Assist and Arrange) are standard procedure as part of their admissions.

6.5 ECONOMIC IMPACT

Each year, tobacco use costs the Canadian economy an estimated \$17 billion and the Alberta economy \$1.8 billion.¹⁹ Societal costs arise from lost income due to premature death, disability, worker absenteeism and reduced productivity. Additional tobacco-related costs are incurred from tobacco subsidies, fires and increased utilization of the health care system. In 2002, approximately \$470.6 million was spent in Alberta on tobacco-related illnesses. Tobacco users place extra burden on the health care system in terms of increased costs related to hospitalization, ambulatory care, physician fees, family physician visits, and prescription drugs.²⁰ Studies show that smokers are more likely to use inpatient, emergency and outpatient services; to heal less quickly; and to be admitted after surgical procedures to intensive care than non-smokers.²¹ Using methodology developed by Girgis and Ward,²² hospitalization for tobacco-attributed disease²³ for the 2005-2006 Fiscal Year (FY) cost an estimated \$6.2 million in Chinook Health (females: \$2.0 million; males: \$4.2 million) and \$118.8 million in Alberta overall (females: \$43.44 million; males: \$75.33 million). For more detailed information please refer to Chapter 16.

19 Rehm J et al., "The Costs of Substance Abuse in Canada 2002," Canadian Center on Substance Abuse, 2006, Canadian Center on Substance Abuse, 13 June 2007 <<http://www.ccsa.ca/NR/rdonlyres/18F3415E-2CAC-4D21-86E2-CEE549EC47A9/0/ccsa0113322006.pdf>>.

20 "The Costs of Substance Abuse in Canada 2002," Physicians for a Smoke-free Canada, 4 July 2007 <<http://www.smoke-free.ca/factsheets/pdf/costsoftobacco-ccsaresults.pdf>>.

21 Girgis ST and Ward JE, "A Financial Case to Enable State Health Jurisdictions to Invest in Tobacco Control," *The Medical Journal of Australia*, 179(2003): 539-542.

22 Girgis ST and Ward JE, "A Financial Case to Enable State Health Jurisdictions to Invest in Tobacco Control," *The Medical Journal of Australia*, 179(2003): 539-542.

23 Cost estimate reflects tobacco-attributed hospital bed-stays only, and does not reflect additional costs to the health care system such as the cost of physician visits, prescription drugs, etc.

CHAPTER 7

PALLISER HEALTH REGION

The information presented throughout this chapter has been compiled using data obtained from the Canadian Community Health Survey Cycle 3.1 (CCHS 3.1), Public Use Microdata File (PUMF) – Weighted (2005) and the Alberta Health Care Insurance Plan (AHCIP) Stakeholder Registry (2005). Please see Chapter 5 for a more detailed description of these data sources.

7.1 REGIONAL DEMOGRAPHICS

Palliser Health Region: Demographic Highlights*

- The estimated population in Palliser Health Region is 85,000, accounting for roughly 3.1% of Alberta's population of approximately 2,727,000.
- Over half (51.7%) of residents in Palliser Health Region are between 20 and 50 years of age (Figure 7-1).
- Palliser Health Region has the same gender distribution as Alberta overall, comprised of approximately 42,000 females and 43,000 males (Figure 7-2).
- The majority of Palliser Health Region residents aged 14 and over (68.1%; T~56,000) have graduated from a post-secondary institution (Figure 7-3).
- Over half of Palliser Health Region residents (54.1%) accrue less than \$30,000 per year, in comparison with 47.3% of Albertans who fall in that income category (Figure 7-4).

* Unless otherwise specified, all calculated percentages and population estimates represent the population ages 12 and over only.

Figure 7-1: Age distribution of Palliser Health Region and Alberta - Ages 12 and over (CCHS 3.1 PUMF - Weighted, 2005)^{1,2}

1 Statistics Canada, Canadian Community Health Survey (CCHS 3.1) PUMF – Weighted, 2005.

2 Population estimates calculated using data from Alberta Health and Wellness, Alberta Health Care Insurance Plan (AHCIP) Stakeholder Registry, 2005.

Figure 7-2: Gender distribution of Palliser Health Region and Alberta - Ages 12 and over (AHCIP Stakeholder Registry, 2005)³

Figure 7-3: Highest personal education level attained in Palliser Health Region and Alberta - Ages 14 and over (CCHS 3.1 PUMF - Weighted, 2005)^{4,5}

3 Population estimates calculated using data from Alberta Health and Wellness, Alberta Health Care Insurance Plan (AHCIP) Stakeholder Registry, 2005.

4 Statistics Canada, Canadian Community Health Survey (CCHS 3.1) PUMF - Weighted, 2005.

5 Population estimates calculated using data from Alberta Health and Wellness, Alberta Health Care Insurance Plan (AHCIP) Stakeholder Registry, 2005.

Figure 7-4: Annual personal income in Palliser Health Region and Alberta - Ages 12 and over (CCHS 3.1 PUMF - Weighted, 2005)^{6,7}

7.2 TOBACCO USE

Palliser Health Region: Tobacco Use Highlights*

- Palliser Health Region is home to approximately 25,000 of Alberta's 622,000 smokers (Figure 7-5) and 60,000 non-smokers. At 29.0%, this is one of the highest smoking rates in Alberta.
- The smoking prevalence is greater for males (33.7%) than females (24.3%) in Palliser Health Region. This translates to approximately 14,000 males and 10,000 females (Figure 7-6).
- The smoking prevalence for Palliser Health Region youth (ages 12 to 17) is 8.4%. This corresponds to approximately 700 smokers (Figure 7-7).
- Approximately half (47.7%) of adult smokers in Palliser Health Region are overweight or obese (Figure 7-8).
- Palliser Health Region has the highest level of physical inactivity among smokers when compared to all health regions in Alberta (Figure 7-9). Three in five smokers (60.8%) indicate they are physically inactive, which is equivalent to approximately 15,000 people.

* Unless otherwise specified, all calculated percentages and population estimates represent the population ages 12 and over only.

6 Statistics Canada, Canadian Community Health Survey (CCHS 3.1) PUMF - Weighted, 2005.

7 Population estimates calculated using data from Alberta Health and Wellness, Alberta Health Care Insurance Plan (AHCIP) Stakeholder Registry, 2005.

Figure 7-5: Prevalence of current daily and occasional smokers in Alberta, by health region - Ages 12 and over (CCHS 3.1 PUMF - Weighted, 2005)^{8,9}

Figure 7-6: Prevalence of current daily and occasional smokers in Palliser Health Region and Alberta, by gender - Ages 12 and over (CCHS 3.1 PUMF - Weighted, 2005)^{10,11}

8 Statistics Canada, Canadian Community Health Survey (CCHS 3.1) PUMF - Weighted, 2005.

9 Population estimates calculated using data from Alberta Health and Wellness, Alberta Health Care Insurance Plan (AHCIP) Stakeholder Registry, 2005.

10 Statistics Canada, Canadian Community Health Survey (CCHS 3.1) PUMF - Weighted, 2005.

11 Population estimates calculated using data from Alberta Health and Wellness, Alberta Health Care Insurance Plan (AHCIP) Stakeholder Registry, 2005.

Figure 7-7: Prevalence of current daily and occasional smokers in Palliser Health Region and Alberta, by age – Ages 12 and over (CCHS 3.1 PUMF - Weighted, 2005)^{12,13}

Figure 7-8: Prevalence of overweight or obesity (Body Mass Index ≥ 25) among current daily and occasional smokers in Alberta, by health region – Ages 18 and over (CCHS 3.1 PUMF - Weighted, 2005)^{14,15}

12 Statistics Canada, Canadian Community Health Survey (CCHS 3.1) PUMF – Weighted, 2005.

13 Population estimates calculated using data from Alberta Health and Wellness, Alberta Health Care Insurance Plan (AHCIP) Stakeholder Registry, 2005.

14 Statistics Canada, Canadian Community Health Survey (CCHS 3.1) PUMF – Weighted, 2005.

15 Population estimates calculated using data from Alberta Health and Wellness, Alberta Health Care Insurance Plan (AHCIP) Stakeholder Registry, 2005.

Figure 7-9: Prevalence of physical inactivity¹⁶ among current daily and occasional smokers in Alberta, by health region – Ages 12 and over (CCHS 3.1 PUMF - Weighted, 2005)^{17,18}

7.3 POLICIES

RHA policy:

- Clients and others in the home are requested to postpone smoking one hour prior to and during a visit by a Palliser Health Region employee. If a client indicates they are unable or unwilling to comply with this request, the authorized home-based services will still be provided.
- However, if staff (either an individual staff member and/or staff group) express unwillingness to provide service to the client under these circumstances, then every effort will be made to determine an alternative way to accommodate the needs of staff and provide services to the client.

Number of municipalities in region with gold standard rating: 1

Gold standard municipalities include:

- Medicine Hat

RHA policy: Gold

¹⁶ CCHS 3.1 defines physical inactivity as a daily usual leisure-time energy expenditure of less than 1.5 kilocalories per kilogram of body weight per day.

¹⁷ Statistics Canada, Canadian Community Health Survey (CCHS 3.1) PUMF – Weighted, 2005.

¹⁸ Population estimates calculated using data from Alberta Health and Wellness, Alberta Health Care Insurance Plan (AHCIP) Stakeholder Registry, 2005.

Post-secondary policy:

Medicine Hat College

- Smoking is restricted on campus grounds, inside common areas of campus student residences (e.g., hallways, lobbies, function rooms, laundry rooms), and in individual student rooms.
- Smoking cessation programs for students are available on campus (or referral to existing off-campus programs is provided).
- Smoking cessation programs for faculty and staff are available on campus (or referral to existing off-campus programs is provided).
- Sale of tobacco products is prohibited.

Bow Valley College (Medicine Hat)

- Smoking is restricted on campus grounds.
- Bow Valley College is investigating the idea of prohibiting acceptance of all monies from tobacco companies, including gifts, donations or grants.

7.4 PROGRAMS

Cessation:

1. **One to One Cessation Support** – Tobacco cessation and reduction counseling and services.
2. **Group Cessation Support** – Group cessation programs, 6 to 8 weeks in length, offered to community at large and in partnership with other organizations and businesses.
3. **Tom Baker Cancer Center Telehealth Smoking Cessation Program** – Group smoking cessation program, run through telehealth. The program consists of eight 90-minute sessions over the course of three months. (Evaluated)
4. **Staff Cessation Support** – Quit resources and financial assistance for nicotine replacement therapies available to Palliser Health Region staff.
5. **Group Cessation Group for Home Visitation Clients** – Cessation support, provision of child care, nicotine replacement, and transportation assistance.
6. **Physician support** – Resources and information provided to doctors' offices through Primary Care Network.

Prevention:

1. **Tobacco Control Education and Training for Groups/Schools** – Presentations and resource material available to schools and groups.
2. **Prenatal Education** – Brief presentation about tobacco cessation and second-hand smoke as part of prenatal classes.

Palliser Health Region also referenced the following:

Committees

1. Campaign for a Smoke-Free Alberta (CSFA)

Community Programs

1. Teaming Up for Tobacco-Free Kids
2. Building Leadership for Action in Schools Today (BLAST)
3. Kick the Nic

Key Activities

1. Policy and bylaw development
2. Special projects and events to recognize World No Tobacco Day and National Non-Smoking Week

7.5 ECONOMIC IMPACT

Each year, tobacco use costs the Canadian economy an estimated \$17 billion and the Alberta economy \$1.8 billion.¹⁹ Societal costs arise from lost income due to premature death, disability, worker absenteeism and reduced productivity. Additional tobacco-related costs are incurred from tobacco subsidies, fires and increased utilization of the health care system. In 2002, approximately \$470.6 million was spent in Alberta on tobacco-related illnesses. Tobacco users place extra burden on the health care system in terms of increased costs related to hospitalization, ambulatory care, physician fees, family physician visits, and prescription drugs.²⁰ Studies show that smokers are more likely to use inpatient, emergency and outpatient services; to heal less quickly; and to be admitted after surgical procedures to intensive care than non-smokers.²¹ Using methodology developed by Girgis and Ward,²² hospitalization for tobacco-attributed disease²³ for the 2005-2006 Fiscal Year (FY) cost an estimated \$3.9 million in Palliser Health Region (females: \$1.2 million; males: \$2.7 million) and \$118.8 million in Alberta overall (females: \$43.44 million; males: \$75.33 million). For more detailed information please refer to Chapter 16.

19 Rehm J et al., "The Costs of Substance Abuse in Canada 2002," Canadian Center on Substance Abuse, 2006, [Canadian Center on Substance Abuse](http://www.ccsa.ca/NR/rdonlyres/18F3415E-2CAC-4D21-86E2-CEE549EC47A9/0/ccsa0113322006.pdf), 13 June 2007 <<http://www.ccsa.ca/NR/rdonlyres/18F3415E-2CAC-4D21-86E2-CEE549EC47A9/0/ccsa0113322006.pdf>>.

20 "The Costs of Substance Abuse in Canada 2002," [Physicians for a Smoke-free Canada](http://www.smoke-free.ca/factsheets/pdf/costsoftobacco-ccsaresults.pdf), 4 July 2007 <<http://www.smoke-free.ca/factsheets/pdf/costsoftobacco-ccsaresults.pdf>>.

21 Girgis ST and Ward JE, "A Financial Case to Enable State Health Jurisdictions to Invest in Tobacco Control," *The Medical Journal of Australia*, 179(2003): 539-542.

22 Girgis ST and Ward JE, "A Financial Case to Enable State Health Jurisdictions to Invest in Tobacco Control," *The Medical Journal of Australia*, 179(2003): 539-542.

23 Cost estimate reflects tobacco-attributed hospital bed-stays only, and does not reflect additional costs to the health care system such as the cost of physician visits, prescription drugs, etc.

CHAPTER 8

CALGARY HEALTH REGION

The information presented throughout this chapter has been compiled using data obtained from the Canadian Community Health Survey Cycle 3.1 (CCHS 3.1), Public Use Microdata File (PUMF) – Weighted (2005) and the Alberta Health Care Insurance Plan (AHCIP) Stakeholder Registry (2005). Please refer to Chapter 5 for a more detailed description of these data sources.

8.1 REGIONAL DEMOGRAPHICS

Calgary Health Region: Demographic Highlights*

- The estimated population in Calgary Health Region is 997,000, accounting for roughly 36.6% of Alberta's population of 2,727,000.
- Over half (58.4%) of residents in Calgary Health Region are between 20 and 50 years of age (Figure 8-1).
- Calgary Health Region has a similar gender distribution to Alberta overall, with approximately 503,000 females and 494,000 males (Figure 8-2).
- The majority of Calgary Health Region residents aged 14 and over (79.4%; T~767,000) have graduated from a post-secondary institution (Figure 8-3).
- Over half of Calgary Health Region residents (56.9%) accrue more than \$30,000 per year (Figure 8-4).

* Unless otherwise specified, all calculated percentages and population estimates represent the population ages 12 and over only.

Figure 8-1: Age distribution of Calgary Health Region and Alberta - Ages 12 and over (CCHS 3.1 PUMF - Weighted, 2005)^{1,2}

1 Statistics Canada, Canadian Community Health Survey (CCHS 3.1) PUMF – Weighted, 2005.

2 Population estimates calculated using data from Alberta Health and Wellness, Alberta Health Care Insurance Plan (AHCIP) Stakeholder Registry, 2005.

Figure 8-2: Gender distribution of Calgary Health Region and Alberta - Ages 12 and over (AHCIP Stakeholder Registry, 2005)³

Figure 8-3: Highest personal education level attained in Calgary Health Region and Alberta - Ages 14 and over (CCHS 3.1 PUMF - Weighted, 2005)^{4,5}

3 Population estimates calculated using data from Alberta Health and Wellness, Alberta Health Care Insurance Plan (AHCIP) Stakeholder Registry, 2005.

4 Statistics Canada, Canadian Community Health Survey (CCHS 3.1) PUMF - Weighted, 2005.

5 Population estimates calculated using data from Alberta Health and Wellness, Alberta Health Care Insurance Plan (AHCIP) Stakeholder Registry, 2005.

Figure 8-4: Annual personal income in Calgary Health Region and Alberta - Ages 12 and over (CCHS 3.1 PUMF - Weighted, 2005)^{6,7}

8.2 TOBACCO USE

Calgary Health Region: Tobacco Use Highlights*

- Calgary Health Region is home to approximately 198,000 of Alberta's 622,000 smokers (Figure 8-5) and 799,000 non-smokers.
- The smoking prevalence is greater for males (22.2%) than females (17.6%) in Calgary Health Region. This translates to approximately 110,000 males and 89,000 females (Figure 8-6).
- The smoking prevalence for youth in Calgary Health Region (ages 12 to 17) is 5.5%. This corresponds to approximately 5,000 smokers (Figure 8-7).
- Approximately 193,000 smokers in Calgary Health Region are above the age of 18 years. Of these, approximately 84,000 are overweight or obese (Figure 8-8).
- Approximately half (51.3%) of Calgary Health Region's smokers are physically inactive, accounting for approximately 102,000 individuals (Figure 8-9).

* Unless otherwise specified, all calculated percentages and population estimates represent the population ages 12 and over only.

6 Statistics Canada, Canadian Community Health Survey (CCHS 3.1) PUMF - Weighted, 2005.

7 Population estimates calculated using data from Alberta Health and Wellness, Alberta Health Care Insurance Plan (AHCIP) Stakeholder Registry, 2005.

Figure 8-5: Prevalence of current daily and occasional smokers in Alberta, by health region - Ages 12 and over (CCHS 3.1 PUMF - Weighted, 2005)^{8,9}

Figure 8-6: Prevalence of current daily and occasional smokers in Calgary Health Region and Alberta, by gender - Ages 12 and over (CCHS 3.1 PUMF - Weighted, 2005)^{10,11}

8 Statistics Canada, Canadian Community Health Survey (CCHS 3.1) PUMF - Weighted, 2005.

9 Population estimates calculated using data from Alberta Health and Wellness, Alberta Health Care Insurance Plan (AHCIP) Stakeholder Registry, 2005.

10 Statistics Canada, Canadian Community Health Survey (CCHS 3.1) PUMF - Weighted, 2005.

11 Population estimates calculated using data from Alberta Health and Wellness, Alberta Health Care Insurance Plan (AHCIP) Stakeholder Registry, 2005.

Figure 8-7: Prevalence of current daily and occasional smokers in Calgary Health Region and Alberta, by age – Ages 12 and over (CCHS 3.1 PUMF - Weighted, 2005)^{12,13}

Figure 8-8: Prevalence of overweight or obesity (Body Mass Index ≥ 25) among current daily and occasional smokers in Alberta, by health region – Ages 18 and over (CCHS 3.1 PUMF - Weighted, 2005)^{14,15}

12 Statistics Canada, Canadian Community Health Survey (CCHS 3.1) PUMF – Weighted, 2005.

13 Population estimates calculated using data from Alberta Health and Wellness, Alberta Health Care Insurance Plan (AHCIP) Stakeholder Registry, 2005.

14 Statistics Canada, Canadian Community Health Survey (CCHS 3.1) PUMF – Weighted, 2005.

15 Population estimates calculated using data from Alberta Health and Wellness, Alberta Health Care Insurance Plan (AHCIP) Stakeholder Registry, 2005.

Figure 8-9: Prevalence of physical inactivity¹⁶ among current daily and occasional smokers in Alberta, by health region – Ages 12 and over (CCHS 3.1 PUMF - Weighted, 2005)^{17,18}

8.3 POLICIES

RHA policy:

- Tobacco use is prohibited in or on all Calgary Health Region owned, funded or operated premises and facilities with the following exceptions:
 1. Outside designated shelters for resident smoking will be permitted for home-like facilities (e.g. long-term facilities) - Subject to ongoing review;
 2. Culturally related ceremonial use of tobacco will be permitted;
 3. Other extending circumstances approved by Calgary Health Region;
 4. All future agreements with agencies or facilities funded primarily by the Calgary Health Region shall require the agency or facility to have a similar non-smoking policy.

Number of municipalities in region with gold standard rating: 5

Gold standard municipalities include:

- Airdrie
 - Banff
 - Canmore
 - Cochrane
 - Calgary
- (effective January 1, 2008)

RHA policy: Gold

¹⁶ CCHS 3.1 defines physical inactivity as a daily usual leisure-time energy expenditure of less than 1.5 kilocalories per kilogram of body weight per day.

¹⁷ Statistics Canada, *Canadian Community Health Survey (CCHS 3.1) PUMF – Weighted, 2005*.

¹⁸ Population estimates calculated using data from Alberta Health and Wellness, *Alberta Health Care Insurance Plan (AHCIP) Stakeholder Registry, 2005*.

Post-secondary policy:

University of Calgary

- Sale of tobacco products is prohibited.

Mount Royal College

- Student health plan coverage includes stop smoking aids.

Southern Alberta Institute of Technology (SAIT)

- Sale of tobacco products is prohibited.

Bow Valley College

- Bow Valley College is investigating the idea of prohibiting acceptance of all monies from tobacco companies whether gifts, donations or grants.

Alberta College of Art and Design

- All academic and administrative buildings are smoke-free.

The Banff Centre

- All academic and administrative buildings are smoke-free.
- Common areas in student residences are smoke-free.

Athabasca University

- All academic and administrative buildings are smoke-free.

8.4 PROGRAMS

Cessation:

1. **Expecting to Quit** – Cessation program for pregnant and post-partum women. (Evaluated)
2. **Young Adult Tobacco Reduction (Age 18 to 24)** – Advocacy and cessation promotion.

Prevention:

1. **Health In Perspective/Teens 'n' Transitions** – Youth Mentorship. (Evaluated)
2. **Resource Support Program** – Public health nurses give presentations, set up displays, etc. Print resources are also available.

Calgary Health Region also referenced the following:

Networks and Committees

1. Campaign for a Smoke-Free Alberta (CSFA)
2. Smoke-Free Calgary (SFC)
3. Young Adult Tobacco Reduction Committee (YATRC)
4. Calgary Health Region's public health nurses in the schools

Community Programs

1. Teaming Up for Tobacco-Free Kids
2. Building Leadership for Action in Schools Today (BLAST)
3. Aventa Addiction Treatment Centre's "Smoking Cessation for Women" (Group Format & Evaluated)
4. Vocational and Rehabilitation Research Institute's program for people with developmental disabilities, "SmokeTalk" (Evaluated)
5. HIP/Teens 'n' Transition

8.5 ECONOMIC IMPACT

Each year, tobacco use costs the Canadian economy an estimated \$17 billion and the Alberta economy \$1.8 billion.¹⁹ Societal costs arise from lost income due to premature death, disability, worker absenteeism and reduced productivity. Additional tobacco-related costs are incurred from tobacco subsidies, fires and increased utilization of the health care system. In 2002, approximately \$470.6 million was spent in Alberta on tobacco-related illnesses. Tobacco users place extra burden on the health care system in terms of increased costs related to hospitalization, ambulatory care, physician fees, family physician visits, and prescription drugs.²⁰ Studies show that smokers are more likely to use inpatient, emergency and outpatient services; to heal less quickly; and to be admitted after surgical procedures to intensive care than non-smokers.²¹ Using methodology developed by Girgis and Ward,²² hospitalization for tobacco-attributed disease²³ for the 2005-2006 Fiscal Year (FY) cost an estimated \$36.2 million in Calgary Health Region (females: \$12.9 million; males: \$23.3 million) and \$118.8 million in Alberta overall (females: \$43.44 million; males: \$75.33 million). For more detailed information please refer to Chapter 16.

19 Rehm J et al., "The Costs of Substance Abuse in Canada 2002," *Canadian Center on Substance Abuse*, 2006, Canadian Center on Substance Abuse, 13 June 2007 <<http://www.ccsa.ca/NR/rdonlyres/18F3415E-2CAC-4D21-86E2-CEE549EC47A9/0/ccsa0113322006.pdf>>.

20 "The Costs of Substance Abuse in Canada 2002," *Physicians for a Smoke-free Canada*, 4 July 2007 <<http://www.smoke-free.ca/factsheets/pdf/costsoftobacco-ccsaresults.pdf>>.

21 Girgis ST and Ward JE, "A Financial Case to Enable State Health Jurisdictions to Invest in Tobacco Control," *The Medical Journal of Australia*, 179(2003): 539-542.

22 Girgis ST and Ward JE, "A Financial Case to Enable State Health Jurisdictions to Invest in Tobacco Control," *The Medical Journal of Australia*, 179(2003): 539-542.

23 Cost estimate reflects tobacco-attributed hospital bed-stays only, and does not reflect additional costs to the health care system such as the cost of physician visits, prescription drugs, etc.

CHAPTER 9

DAVID THOMPSON

REGIONAL HEALTH

AUTHORITY

The information presented throughout this chapter has been compiled using data obtained from the Canadian Community Health Survey Cycle 3.1 (CCHS 3.1), Public Use Microdata File (PUMF) – Weighted (2005) and the Alberta Health Care Insurance Plan (AHCIP) Stakeholder Registry (2005). Please refer to Chapter 5 for a more detailed description of these data sources.

9.1 REGIONAL DEMOGRAPHICS

David Thompson Regional Health Authority: Demographic Highlights*

- The estimated population in David Thompson Regional Health Authority is 247,000, accounting for roughly 9.0% of Alberta's population of 2,727,000.
- About half (52.2%) of residents in David Thompson Regional Health Authority are between 20 and 50 years of age (Figure 9-1).
- David Thompson Regional Health Authority has a similar gender distribution to Alberta overall, comprised of approximately 124,000 females and 123,000 males (Figure 9-2).
- The majority of David Thompson Regional Health Authority residents aged 14 and above (69.9%; T~166,000) have graduated from a post-secondary institution (Figure 9-3).
- About half of David Thompson Regional Health Authority residents (50.2%) accrue less than \$30,000 per year (Figure 9-4).

* Unless otherwise specified, all calculated percentages and population estimates represent the population ages 12 and over only.

Figure 9-1: Age distribution of David Thompson Regional Health Authority and Alberta - Ages 12 and over (CCHS 3.1 PUMF - Weighted, 2005)^{1,2}

1 Statistics Canada, Canadian Community Health Survey (CCHS 3.1) PUMF – Weighted, 2005.

2 Population estimates calculated using data from Alberta Health and Wellness, Alberta Health Care Insurance Plan (AHCIP) Stakeholder Registry, 2005.

Figure 9-2: Gender distribution of David Thompson Regional Health Authority and Alberta - Ages 12 and over (AHCIP Stakeholder Registry, 2005)³

Figure 9-3: Highest personal education level attained in David Thompson Regional Health Authority and Alberta - Ages 14 and over (CCHS 3.1 PUMF - Weighted, 2005)^{4,5}

3 Population estimates calculated using data from Alberta Health and Wellness, Alberta Health Care Insurance Plan (AHCIP) Stakeholder Registry, 2005.

4 Statistics Canada, Canadian Community Health Survey (CCHS 3.1) PUMF - Weighted, 2005.

5 Population estimates calculated using data from Alberta Health and Wellness, Alberta Health Care Insurance Plan (AHCIP) Stakeholder Registry, 2005.

Figure 9-4: Annual personal income in David Thompson Regional Health Authority and Alberta - Ages 12 and over (CCHS 3.1 PUMF - Weighted, 2005)^{6,7}

9.2 TOBACCO USE

David Thompson Regional Health Authority: Tobacco Use Highlights*

- David Thompson Regional Health Authority is home to approximately 63,000 of Alberta's 622,000 smokers (Figure 9-5) and 184,000 non-smokers.
- The smoking prevalence is similar for males (25.7%) and females (25.2%) in David Thompson Regional Health Authority. This translates to approximately 32,000 males and 31,000 females (Figure 9-6).
- The smoking prevalence of youth in David Thompson Regional Health Authority (ages 12 to 17) is 4.5%. This corresponds to approximately 1,200 smokers (Figure 9-7).
- Approximately 61,000 smokers in David Thompson Regional Health Authority are above the age of 18 years. Of these, approximately 51.4%, or 32,000 individuals, are overweight or obese (Figure 9-8).
- Over half (55.4%) of David Thompson Regional Health Authority's smokers (ages 12 and over) are physically inactive, accounting for approximately 35,000 individuals (Figure 9-9).

* Unless otherwise specified, all calculated percentages and population estimates represent the population ages 12 and over only.

6 Statistics Canada, Canadian Community Health Survey (CCHS 3.1) PUMF - Weighted, 2005.

7 Population estimates calculated using data from Alberta Health and Wellness, Alberta Health Care Insurance Plan (AHCIP) Stakeholder Registry, 2005.

Figure 9-5: Prevalence of current daily and occasional smokers in Alberta, by health region - Ages 12 and over (CCHS 3.1 PUMF - Weighted, 2005)^{8,9}

Figure 9-6: Prevalence of current daily and occasional smokers in David Thompson Regional Health Authority and Alberta, by gender - Ages 12 and over (CCHS 3.1 PUMF - Weighted, 2005)^{10,11}

8 Statistics Canada, Canadian Community Health Survey (CCHS 3.1) PUMF - Weighted, 2005.

9 Population estimates calculated using data from Alberta Health and Wellness, Alberta Health Care Insurance Plan (AHCIP) Stakeholder Registry, 2005.

10 Statistics Canada, Canadian Community Health Survey (CCHS 3.1) PUMF - Weighted, 2005.

11 Population estimates calculated using data from Alberta Health and Wellness, Alberta Health Care Insurance Plan (AHCIP) Stakeholder Registry, 2005.

Figure 9-7: Prevalence of current daily and occasional smokers in David Thompson Regional Health Authority and Alberta, by age – Ages 12 and over (CCHS 3.1 PUMF - Weighted, 2005)^{12,13}

Figure 9-8: Prevalence of overweight or obesity (Body Mass Index ≥ 25) among current daily and occasional smokers in Alberta, by health region – Ages 18 and over (CCHS 3.1 PUMF - Weighted, 2005)^{14,15}

12 Statistics Canada, Canadian Community Health Survey (CCHS 3.1) PUMF – Weighted, 2005.

13 Population estimates calculated using data from Alberta Health and Wellness, Alberta Health Care Insurance Plan (AHCIP) Stakeholder Registry, 2005.

14 Statistics Canada, Canadian Community Health Survey (CCHS 3.1) PUMF – Weighted, 2005.

15 Population estimates calculated using data from Alberta Health and Wellness, Alberta Health Care Insurance Plan (AHCIP) Stakeholder Registry, 2005.

Figure 9-9: Prevalence of physical inactivity¹⁶ among current daily and occasional smokers in Alberta, by health region – Ages 12 and over (CCHS 3.1 PUMF - Weighted, 2005)^{17,18}

9.3 POLICIES

RHA policy:

- The use of all tobacco products is prohibited indoors, on RHA grounds and in RHA vehicles.

Post-secondary policy:

Red Deer College

- Common areas in student residences are smoke-free.

Number of municipalities in region with gold standard rating: 3

Gold standard municipalities include:

- Red Deer
- Stettler
- Sylvan Lake

RHA policy: Gold

¹⁶ CCHS 3.1 defines physical inactivity as a daily usual leisure-time energy expenditure of less than 1.5 kilocalories per kilogram of body weight per day.

¹⁷ Statistics Canada, Canadian Community Health Survey (CCHS 3.1) PUMF – Weighted, 2005.

¹⁸ Population estimates calculated using data from Alberta Health and Wellness, *Alberta Health Care Insurance Plan (AHCIPI) Stakeholder Registry*, 2005.

Olds College

- Faculty and staff health plan coverage includes stop smoking aids.
- Olds College has proposed prohibiting acceptance of all monies from tobacco companies, including gifts, donations or grants.
- No tobacco sales on campus.

NorQuest College

- Smoking cessation programs for students are available on campus (or referral to existing off-campus programs is provided).

9.4 PROGRAMS

Capacity Building:

1. **Helping People to Become Tobacco Free** – Course on brief cessation interventions for clinical settings.
2. **Tobacco Basics** – Internal staff training course.
3. **Red Deer College Nursing students** – Provides support to tobacco reduction and brief intervention education that has been built into their curriculum.
4. **Public Health Tobacco Reduction Program** – Focusing on education/resource provision, cessation, advocacy and healthy public policy in David Thompson Regional Health Authority and includes work with local community coalitions, provincial agencies/coalitions, schools, community agencies and municipalities.

Protection:

1. **Smoke Free Homes** – Protection program targeting young families.
2. **Tobacco Talk for Two** – A brief intervention program consisting of a tobacco reduction tool kit for pregnant and post-partum moms; operated through partnership with Canada Prenatal Nutrition Program (CPNP) staff and clients. (Evaluated)

Cessation:

1. **ACB Tom Baker Telehealth Smoking Cessation Program** – Offered to staff and to the public at sites in Drumheller, Hanna and Stettler with possible expansion to other communities in 2008. (Evaluated)

David Thompson Regional Health Authority also referenced the following:

Networks and Committees

1. Campaign for a Smoke-Free Alberta (CSFA)
2. Central Alberta Tobacco Reduction Coalition (CATRAC)
3. Local tobacco reduction coalitions (Stettler & Drumheller)
4. Action on Smoking and Health (ASH)

Community Programs

1. Butt Ugly peer-mentoring program* - tobacco use prevention program utilizing a social issue drama format created and performed by teens for teens. Their mission is to prevent youth tobacco use through peer education, modeling and support. (Evaluated) Some funding is provided by the region to provide drama sessions in Red Deer area schools targeting Grade Six.
2. Blue Ribbon Babies Society Program (Evaluated)
3. Teaming Up for Tobacco-Free Kids
4. Building Leadership for Action in Schools Today (BLAST)

Key Activities

1. Olds and Red Deer College campuses support student extracurricular activities related to tobacco hazards awareness and tobacco cessation.
2. Health Promotion/Prevention activities in partnership with AADAC, Alberta Cancer Board, Canadian Cancer Society, and Alberta Spit Tobacco Education Program:
 - a. National Non-Smoking Week promotion
 - b. Thru With Chew promotion
 - c. Educational sessions in schools and communities
 - d. Awareness campaigns through local media
 - e. Aligning evidence based resources with school curriculum

**Supported by an external funding source; thus, program sustainability is vulnerable to funding or lack thereof.*

9.5 ECONOMIC IMPACT

Each year, tobacco use costs the Canadian economy an estimated \$17 billion and the Alberta economy \$1.8 billion.¹⁹ Societal costs arise from lost income due to premature death, disability, worker absenteeism and reduced productivity. Additional tobacco-related costs are incurred from tobacco subsidies, fires and increased utilization of the health care system. In 2002, approximately \$470.6 million was spent in Alberta on tobacco-related illnesses. Tobacco users place extra burden on the health care system in terms of increased costs related to hospitalization, ambulatory care, physician fees, family physician visits, and prescription drugs.²⁰ Studies show that smokers are more likely to use inpatient, emergency and outpatient services; to heal less quickly; and to be admitted after surgical procedures to intensive care than non-smokers.²¹ Using methodology developed by Girgis and Ward,²² hospitalization for tobacco-attributed disease²³ for the 2005-2006 Fiscal Year (FY) cost an estimated \$14.3 million in David Thompson Regional Health Authority (females: \$5.2 million; males: \$9.1 million) and \$118.8 million in Alberta overall (females: \$43.44 million; males: \$75.33 million). For more detailed information please refer to Chapter 16.

19 Rehm J et al., "The Costs of Substance Abuse in Canada 2002," Canadian Center on Substance Abuse, 2006, Canadian Center on Substance Abuse, 13 June 2007 <<http://www.ccsa.ca/NR/rdonlyres/18F3415E-2CAC-4D21-86E2-CEE549EC47A9/0/ccsa0113322006.pdf>>.

20 "The Costs of Substance Abuse in Canada 2002," Physicians for a Smoke-free Canada, 4 July 2007 <<http://www.smoke-free.ca/factsheets/pdf/costsoftobacco-ccsaresults.pdf>>.

21 Girgis ST and Ward JE, "A Financial Case to Enable State Health Jurisdictions to Invest in Tobacco Control," The Medical Journal of Australia 179(2003): 539-542.

22 Girgis ST and Ward JE, "A Financial Case to Enable State Health Jurisdictions to Invest in Tobacco Control," The Medical Journal of Australia 179(2003): 539-542.

23 Cost estimate reflects tobacco-attributed hospital bed-stays only, and does not reflect additional costs to the health care system such as the cost of physician visits, prescription drugs, etc.

CHAPTER 10

EAST CENTRAL

HEALTH

The information presented throughout this chapter has been compiled using data obtained from the Canadian Community Health Survey Cycle 3.1 (CCHS 3.1), Public Use Microdata File (PUMF) – Weighted (2005) and the Alberta Health Care Insurance Plan (AHCIP) Stakeholder Registry (2005). Please refer to Chapter 5 for a more detailed description of these data sources.

10.1 REGIONAL DEMOGRAPHICS

East Central Health: Demographic Highlights*

- The estimated population in East Central Health is 94,000, accounting for roughly 3.4% of Alberta's population of approximately 2,727,000.
- About half (49.1%) of residents in East Central Health are between 20 and 50 years of age (Figure 10-1).
- East Central Health has a similar gender distribution to Alberta overall, consisting of approximately 47,000 females and 46,000 males (Figure 10-2).
- The majority of East Central Health residents aged 14 and over (67.4%; T~61,000) have graduated from a post-secondary institution (Figure 10-3).
- About half of East Central Health residents (52.6%) accrue less than \$30,000 per year (Figure 10-4).

* Unless otherwise specified, all calculated percentages and population estimates represent the population ages 12 and over only.

Figure 10-1: Age distribution of East Central Health and Alberta - Ages 12 and over (CCHS 3.1 PUMF - Weighted, 2005)^{1,2}

1 Statistics Canada, Canadian Community Health Survey (CCHS 3.1) PUMF – Weighted, 2005.

2 Population estimates calculated using data from Alberta Health and Wellness, Alberta Health Care Insurance Plan (AHCIP) Stakeholder Registry, 2005.

Figure 10-2: Gender distribution of East Central Health and Alberta - Ages 12 and over (AHCIP Stakeholder Registry, 2005)³

Figure 10-3: Highest personal education level attained in East Central Health and Alberta - Ages 14 and over (CCHS 3.1 PUMF - Weighted, 2005)^{4,5}

3 Population estimates calculated using data from Alberta Health and Wellness, Alberta Health Care Insurance Plan (AHCIP) Stakeholder Registry, 2005.

4 Statistics Canada, Canadian Community Health Survey (CCHS 3.1) PUMF - Weighted, 2005.

5 Population estimates calculated using data from Alberta Health and Wellness, Alberta Health Care Insurance Plan (AHCIP) Stakeholder Registry, 2005.

Figure 10-4: Annual personal income in East Central Health and Alberta - Ages 12 and over (CCHS 3.1 PUMF - Weighted, 2005)^{6,7}

10.2 TOBACCO USE

East Central Health: Tobacco Use Highlights*

- East Central Health is home to approximately 23,000 of Alberta's 622,000 smokers (Figure 10-5) and 71,000 non-smokers.
- The smoking prevalence is greater for males (27.6%) than females (21.9%) in East Central Health. This translates to approximately 13,000 male and 10,000 female smokers (Figure 10-6).
- The smoking prevalence for youth in East Central Health (ages 12 to 17) is 6.7%. This corresponds to approximately 700 smokers (Figure 10-7).
- Approximately 23,000 smokers in East Central Health are above the age of 18 years. Of these, approximately 52%, or 12,000 individuals, are overweight or obese (Figure 10-8).
- Over half (56.3%) of East Central Health's smokers are physically inactive, accounting for approximately 13,000 individuals (Figure 10-9).

* Unless otherwise specified, all calculated percentages and population estimates represent the population ages 12 and over only.

6 Statistics Canada, Canadian Community Health Survey (CCHS 3.1) PUMF - Weighted, 2005.

7 Population estimates calculated using data from Alberta Health and Wellness, Alberta Health Care Insurance Plan (AHCIP) Stakeholder Registry, 2005.

Figure 10-5: Prevalence of current daily and occasional smokers in Alberta, by health region - Ages 12 and over (CCHS 3.1 PUMF - Weighted, 2005)^{8,9}

Figure 10-6: Prevalence of current daily and occasional smokers in East Central Health and Alberta, by gender - Ages 12 and over (CCHS 3.1 PUMF - Weighted, 2005)^{10,11}

8 Statistics Canada, Canadian Community Health Survey (CCHS 3.1) PUMF - Weighted, 2005.

9 Population estimates calculated using data from Alberta Health and Wellness, Alberta Health Care Insurance Plan (AHCIP) Stakeholder Registry, 2005.

10 Statistics Canada, Canadian Community Health Survey (CCHS 3.1) PUMF - Weighted, 2005.

11 Population estimates calculated using data from Alberta Health and Wellness, Alberta Health Care Insurance Plan (AHCIP) Stakeholder Registry, 2005.

Figure 10-7: Prevalence of current daily and occasional smokers in East Central Health and Alberta, by age – Ages 12 and over (CCHS 3.1 PUMF - Weighted, 2005)^{12,13}

Figure 10-8: Prevalence of overweight or obesity (Body Mass Index ≥ 25) among current daily and occasional smokers in Alberta, by health region – Ages 18 and over (CCHS 3.1 PUMF - Weighted, 2005)^{14,15}

12 Statistics Canada, Canadian Community Health Survey (CCHS 3.1) PUMF – Weighted, 2005.

13 Population estimates calculated using data from Alberta Health and Wellness, Alberta Health Care Insurance Plan (AHCIP) Stakeholder Registry, 2005.

14 Statistics Canada, Canadian Community Health Survey (CCHS 3.1) PUMF – Weighted, 2005.

15 Population estimates calculated using data from Alberta Health and Wellness, Alberta Health Care Insurance Plan (AHCIP) Stakeholder Registry, 2005.

Figure 10-9: Prevalence of physical inactivity¹⁶ among current daily and occasional smokers in Alberta, by health region – Ages 12 and over (CCHS 3.1 PUMF - Weighted, 2005)^{17,18}

10.3 POLICIES

RHA policy:

- All East Central Health owned and operated facilities including all outside properties and parkades are smoke-free. All vehicles owned, rented or leased by East Central Health are designated as non-smoking. All East Central Health employees who are current smokers are offered support to quit smoking.

Number of municipalities in region with gold standard rating: 1

Gold standard municipalities include:

- Lloydminster

RHA policy: Gold

¹⁶ CCHS 3.1 defines physical inactivity as a daily usual leisure-time energy expenditure of less than 1.5 kilocalories per kilogram of body weight per day.

¹⁷ Statistics Canada, Canadian Community Health Survey (CCHS 3.1) PUMF – Weighted, 2005.

¹⁸ Population estimates calculated using data from Alberta Health and Wellness, Alberta Health Care Insurance Plan (AHCIP) Stakeholder Registry, 2005.

Post-secondary policy:

Lakeland College

- Smoking is restricted on campus grounds.
- Student health plan coverage includes smoking cessation aids.
- Faculty and staff health plan coverage includes smoking cessation aids.

10.4 PROGRAMS

Capacity Building:

1. **Support Group for Mothers in Camrose** – Education and awareness.
2. **Tobacco Reduction Planning** – Health promotion partnership with AADAC.

Cessation:

3. **Quit Kits** – Provided to pharmacies on a request basis – Brief Intervention.

East Central Health referenced the following:

Networks and Committees

1. Action on Smoking or Health (ASH)
2. F.A.N.S. (Fresh Air No Smoke) – Camrose Tobacco Reduction Coalition
3. Smoke Free Wainwright Coalition
4. AADAC drug coalitions that target addictions, including tobacco (Tofield, Vegreville, Camrose, Wainwright, Vermilion)

Community Programs

1. Teaming Up for Tobacco-Free Kids
2. Building Leadership for Action in Schools Today (BLAST)
3. Kick the Nic

Key Activities

1. Links with AADAC connections in the region
2. Promotes the Smoker's Help Line
3. Supports tobacco reduction education and awareness
 - a. World No Tobacco Day activities
 - b. Weedless Wednesday events
 - c. Displays such as "Gross Mouth" at sporting events

10.5 ECONOMIC IMPACT

Each year, tobacco use costs the Canadian economy an estimated \$17 billion and the Alberta economy \$1.8 billion.¹⁹ Societal costs arise from lost income due to premature death, disability, worker absenteeism and reduced productivity. Additional tobacco-related costs are incurred from tobacco subsidies, fires and increased utilization of the health care system. In 2002, approximately \$470.6 million was spent in Alberta on tobacco-related illnesses. Tobacco users place extra burden on the health care system in terms of increased costs related to hospitalization, ambulatory care, physician fees, family physician visits, and prescription drugs.²⁰ Studies show that smokers are more likely to use inpatient, emergency and outpatient services; to heal less quickly; and to be admitted after surgical procedures to intensive care than non-smokers.²¹ Using methodology developed by Girgis and Ward,²² hospitalization for tobacco-attributed disease²³ for the 2005-2006 Fiscal Year (FY) cost an estimated \$6.0 million in East Central Health (females: \$2.4 million; males: \$3.6 million) and \$118.8 million in Alberta overall (females: \$43.44 million; males: \$75.33 million). For more detailed information please refer to Chapter 16.

19 Rehm J et al., "The Costs of Substance Abuse in Canada 2002," *Canadian Center on Substance Abuse*, 2006, Canadian Center on Substance Abuse, 13 June 2007 <<http://www.ccsa.ca/NR/rdonlyres/18F3415E-2CAC-4D21-86E2-CEE549EC47A9/0/ccsa0113322006.pdf>>.

20 "The Costs of Substance Abuse in Canada 2002," *Physicians for a Smoke-free Canada*, 4 July 2007 <<http://www.smoke-free.ca/factsheets/pdf/costsoftobacco-ccsaresults.pdf>>.

21 Girgis ST and Ward JE, "A Financial Case to Enable State Health Jurisdictions to Invest in Tobacco Control," *The Medical Journal of Australia*, 179(2003): 539-542.

22 Girgis ST and Ward JE, "A Financial Case to Enable State Health Jurisdictions to Invest in Tobacco Control," *The Medical Journal of Australia*, 179(2003): 539-542.

23 Cost estimate reflects tobacco-attributed hospital bed-stays only, and does not reflect additional costs to the health care system such as the cost of physician visits, prescription drugs, etc.

CHAPTER 11

CAPITAL HEALTH

The information presented throughout this chapter has been compiled using data obtained from the Canadian Community Health Survey Cycle 3.1 (CCHS 3.1), Public Use Microdata File (PUMF) – Weighted (2005) and the Alberta Health Care Insurance Plan (AHCIP) Stakeholder Registry (2005). Please refer to Chapter 5 for a more detailed description of these data sources.

11.1 REGIONAL DEMOGRAPHICS

Capital Health: Demographic Highlights*

- The estimated population in Capital Health is 860,000, accounting for roughly 31.5% of Alberta's population of 2,727,000.
- About half (54.1%) of residents in Capital Health are between 20 and 50 years of age (Figure 11-1).
- Capital Health has a similar gender distribution to Alberta overall, comprised of approximately 437,000 females and 423,000 males (Figure 11-2).
- The majority of Capital Health residents aged 14 and over (76.6%; T~638,000) have graduated from a post-secondary institution (Figure 11-3).
- About half of Capital Health residents (54.0%) accrue more than \$30,000 per year (Figure 11-4).

* Unless otherwise specified, all calculated percentages and population estimates represent the population ages 12 and over only.

Figure 11-1: Age distribution of Capital Health and Alberta - Ages 12 and over (CCHS 3.1 PUMF - Weighted, 2005)^{1,2}

1 Statistics Canada, Canadian Community Health Survey (CCHS 3.1) PUMF – Weighted, 2005.

2 Population estimates calculated using data from Alberta Health and Wellness, Alberta Health Care Insurance Plan (AHCIP) Stakeholder Registry, 2005.

Figure 11-2: Gender distribution of Capital Health and Alberta - Ages 12 and over (AHCIP Stakeholder Registry, 2005)³

Figure 11-3: Highest personal education level attained in Capital Health and Alberta - Ages 14 and over (CCHS 3.1 PUMF - Weighted, 2005)^{4,5}

3 Population estimates calculated using data from Alberta Health and Wellness, Alberta Health Care Insurance Plan (AHCIP) Stakeholder Registry, 2005.

4 Statistics Canada, Canadian Community Health Survey (CCHS 3.1) PUMF - Weighted, 2005.

5 Population estimates calculated using data from Alberta Health and Wellness, Alberta Health Care Insurance Plan (AHCIP) Stakeholder Registry, 2005.

Figure 11-4: Annual personal income in Capital Health and Alberta - Ages 12 and over (CCHS 3.1 PUMF - Weighted, 2005)^{6,7}

11.2 Tobacco Use

Capital Health: Tobacco Use Highlights*

- Capital Health is home to approximately 202,000 of Alberta's 622,000 smokers (Figure 11-5) and 658,000 non-smokers.
- The smoking prevalence is greater for males (28.1%) than females (18.9%) in Capital Health. This translates to approximately 119,000 males and 83,000 females (Figure 11-6).
- The smoking prevalence among youth in Capital Health (ages 12 to 17) is 4.4%. This corresponds to approximately 4,000 smokers (Figure 11-7).
- Approximately 198,000 smokers in Capital Health are above the age of 18 years. Of these, approximately 51.3%, or 102,000 individuals, are overweight or obese (Figure 11-8).
- About half (51.0%) of Capital Health's smokers are physically inactive, accounting for approximately 103,000 individuals (Figure 11-9).

* Unless otherwise specified, all calculated percentages and population estimates represent the population ages 12 and over only.

6 Statistics Canada, Canadian Community Health Survey (CCHS 3.1) PUMF - Weighted, 2005.

7 Population estimates calculated using data from Alberta Health and Wellness, Alberta Health Care Insurance Plan (AHCIP) Stakeholder Registry, 2005.

Figure 11-5: Prevalence of current daily and occasional smokers in Alberta, by health region - Ages 12 and over (CCHS 3.1 PUMF - Weighted, 2005)^{8,9}

Figure 11-6: Prevalence of current daily and occasional smokers in Capital Health and Alberta, by gender - Ages 12 and over (CCHS 3.1 PUMF - Weighted, 2005)^{10,11}

8 Statistics Canada, Canadian Community Health Survey (CCHS 3.1) PUMF - Weighted, 2005.

9 Population estimates calculated using data from Alberta Health and Wellness, Alberta Health Care Insurance Plan (AHCIP) Stakeholder Registry, 2005.

10 Statistics Canada, Canadian Community Health Survey (CCHS 3.1) PUMF - Weighted, 2005.

11 Population estimates calculated using data from Alberta Health and Wellness, Alberta Health Care Insurance Plan (AHCIP) Stakeholder Registry, 2005.

Figure 11-7: Prevalence of current daily and occasional smokers in Capital Health and Alberta, by age – Ages 12 and over (CCHS 3.1 PUMF - Weighted, 2005)^{12,13}

Figure 11-8: Prevalence of overweight or obesity (Body Mass Index ≥ 25) among current daily and occasional smokers in Alberta, by health region – Ages 18 and over (CCHS 3.1 PUMF - Weighted, 2005)^{14,15}

12 Statistics Canada, Canadian Community Health Survey (CCHS 3.1) PUMF – Weighted, 2005.

13 Population estimates calculated using data from Alberta Health and Wellness, Alberta Health Care Insurance Plan (AHICIP) Stakeholder Registry, 2005.

14 Statistics Canada, Canadian Community Health Survey (CCHS 3.1) PUMF – Weighted, 2005.

15 Population estimates calculated using data from Alberta Health and Wellness, Alberta Health Care Insurance Plan (AHICIP) Stakeholder Registry, 2005.

Figure 11-9: Prevalence of physical inactivity¹⁶ among current daily and occasional smokers in Alberta, by health region – Ages 12 and over (CCHS 3.1 PUMF - Weighted, 2005)^{17,18}

11.3 POLICIES

RHA policy:

- Capital Health has banned smoking on all its properties, including facilities, buildings, parking lots, parkades and vehicles owned or leased by Capital Health.
- Capital Health will not accept funding or support of any kind from:
 1. Organizations or groups engaged in the manufacture of tobacco goods;
 2. Organizations or entities that provide funds in the name of a tobacco brand, whether or not the brand name is used solely for tobacco goods;

Number of municipalities in region with gold standard rating: 5

Gold standard municipalities include:

- Beaumont
- Edmonton
- St. Albert
- Strathcona County
- Summer Village of Sundance Beach

RHA policy: Gold

16 CCHS 3.1 defines physical inactivity as a daily usual leisure-time energy expenditure of less than 1.5 kilocalories per kilogram of body weight per day.

17 Statistics Canada, Canadian Community Health Survey (CCHS 3.1) PUMF – Weighted, 2005.

18 Population estimates calculated using data from Alberta Health and Wellness, Alberta Health Care Insurance Plan (AHCIP) Stakeholder Registry, 2005.

3. Corporate entities set up by the tobacco industry or by one or more companies engaged in the manufacture of tobacco goods.
- Capital Health clients/patients who receive home-based services will be requested to maintain a smoke-free community/home environment when Capital Health staff is present.

Post-secondary policy:

Lakeland College

- Smoking is restricted on campus grounds.
- Student health plan coverage includes smoking cessation aids.
- Faculty and staff health plan coverage includes smoking cessation aids.

Grant MacEwan College

- Smoking is restricted on campus grounds.

NorQuest College

- Smoking is restricted on campus grounds.

Northern Alberta Institute of Technology (NAIT)

- Smoking cessation programs for students are available on campus (or referral to existing off-campus programs is provided).

University of Alberta

- Faculty and staff health plan coverage includes smoking cessation aids.
- Sale of tobacco products is prohibited.

11.4 PROGRAMS

Cessation – More Intensive Tobacco Cessation Services:

1. Capital Health Edmonton Area Tobacco Reduction Clinic* – Tobacco cessation and reduction counseling and services (Northeast Community Health Centre; future expansion to other sites). Target: general population. (Evaluated)
2. Alberta Hospital, Edmonton: Tobacco Reduction Program – Individual and group tobacco cessation and reduction counseling, staff education, and capacity building. Target: clients with mental illness.
3. Tobacco Cessation Program: Mental Health, Capital Region* – Tobacco cessation-reduction services in group setting. Target: clients with mental health problems.
4. PRIISME Project* – Unit 61, Royal Alexander Hospital, multidisciplinary program that works with COPD patients to improve health outcomes.

Cessation – Brief Interventions:

1. **Medical Fax Referral** - Brief tobacco cessation-reduction intervention targeting the general population; accessed through health providers and community agencies.
2. **Reduce My Risk Program*** - Brief intervention targeting clients scheduled for surgery. (Evaluated)
3. **Prevention of Postpartum Relapse** - Brief intervention, using motivational interviewing strategies integrated into the Healthy Beginnings Program. Target: Women who quit smoking during pregnancy.
4. **Smoke-free Families** - Brief intervention targeting new parents to address smoking in the home.

Capacity Building

1. **Tobacco Reduction Initiative** - Motivational Counseling for Healthy Young Families team as part of orientation. (Evaluated)
2. **Tool Kit for the Time Pressured Provider: for smokers not ready to quit** - Motivational Counseling. (Evaluated)
3. **Grant MacEwan Nursing Students** - Work with the nursing students on tobacco control and reduction education including brief interventions.
4. **Expecting Respect Peer Education Program** - Tobacco use prevention and capacity building program targeting junior high students. (Evaluated)
5. **Tom Baker Cancer Center Telehealth Smoking Cessation Program** (hosted by City of Redwater using Capital Health equipment and facilities) - Group. (Evaluated)

Capital Health also referenced the following:

Networks and Committees

1. Edmonton Area Tobacco Reduction NetWork
2. Action on Smoking or Health (ASH)
3. Campaign for a Smoke-Free Alberta (CSFA)
4. Smoking Policy Steering Committee

Community Programs

1. Nechi Training, Research & Health Promotion Institute's "Ditch the Spit" Smokeless Education Kit and Alberta Aboriginal Spit Tobacco Project.
2. Teaming Up for Tobacco-Free Kids
3. Building Leadership for Action in Schools Today (BLAST)
4. Moving Forward*: Terra Association for Pregnant and Parenting Teens
5. Strathcona Youth Society's tobacco reduction program targeted at street youth*
6. The Red Road Healing Society's "Honouring Our Breath, Honouring Tobacco" Group (Evaluated)

7. University of Alberta:

- a. Tobacco Cessation Program (Department of Dentistry, Motivational Counseling)
 - b. Butt Out Program (prevention program involving first and second year medical students to mentor grade six students from high-risk schools)
 - c. University of Alberta Hospital's Tobacco Reduction and Cessation* (TRaC-Motivational Counseling, and Evaluated)
8. Nicotine Anonymous Groups

**Supported by external funding source; thus, program sustainability is vulnerable to funding or lack thereof.*

11.5 ECONOMIC IMPACT

Each year, tobacco use costs the Canadian economy an estimated \$17 billion and the Alberta economy \$1.8 billion.¹⁹ Societal costs arise from lost income due to premature death, disability, worker absenteeism and reduced productivity. Additional tobacco-related costs are incurred from tobacco subsidies, fires and increased utilization of the health care system. In 2002, approximately \$470.6 million was spent in Alberta on tobacco-related illnesses. Tobacco users place extra burden on the health care system in terms of increased costs related to hospitalization, ambulatory care, physician fees, family physician visits, and prescription drugs.²⁰ Studies show that smokers are more likely to use inpatient, emergency and outpatient services; to heal less quickly; and to be admitted after surgical procedures to intensive care than non-smokers.²¹ Using methodology developed by Girgis and Ward,²² hospitalization for tobacco-attributed disease²³ for the 2005-2006 Fiscal Year (FY) cost an estimated \$37.4 million in Capital Health (females: \$14.2 million; males: \$23.2 million) and \$118.8 million in Alberta overall (females: \$43.44 million; males: \$75.33 million). For more detailed information please refer to Chapter 16.

19 Rehm J et al., "The Costs of Substance Abuse in Canada 2002," Canadian Center on Substance Abuse, 2006, Canadian Center on Substance Abuse, 13 June 2007 <<http://www.ccsa.ca/NR/rdonlyres/18F3415E-2CAC-4D21-86E2-CEE549EC47A9/0/ccsa0113322006.pdf>>.

20 "The Costs of Substance Abuse in Canada 2002," Physicians for a Smoke-free Canada, 4 July 2007 <<http://www.smoke-free.ca/factsheets/pdf/costsoftobacco-ccsaresults.pdf>>.

21 Girgis ST and Ward JE, "A Financial Case to Enable State Health Jurisdictions to Invest in Tobacco Control," *The Medical Journal of Australia*, 179(2003): 539-542.

22 Girgis ST and Ward JE, "A Financial Case to Enable State Health Jurisdictions to Invest in Tobacco Control," *The Medical Journal of Australia*, 179(2003): 539-542.

23 Cost estimate reflects tobacco-attributed hospital bed-stays only, and does not reflect additional costs to the health care system such as the cost of physician visits, prescription drugs, etc.

CHAPTER 12

ASPEN REGIONAL HEALTH AUTHORITY

The information presented throughout this chapter has been compiled using data obtained from the Canadian Community Health Survey Cycle 3.1 (CCHS 3.1), Public Use Microdata File (PUMF) – Weighted (2005) and the Alberta Health Care Insurance Plan (AHCIP) Stakeholder Registry (2005). Please refer to Chapter 5 for a more detailed description of these data sources.

12.1 REGIONAL DEMOGRAPHICS

Aspen Regional Health Authority: Demographic Highlights*

- The estimated population in Aspen Regional Health Authority is 146,000, accounting for roughly 5.3% of Alberta's population of 2,727,000.
- About half (49.9%) of residents in Aspen Regional Health Authority are between 20 and 50 years of age (Figure 12-1).
- Aspen Regional Health Authority has a similar gender distribution to Alberta overall, consisting of approximately 72,000 females and 74,000 males (Figure 12-2).
- The majority of Aspen Regional Health Authority residents aged 14 and over (69.1%; T~96,000) have graduated from a post-secondary institution (Figure 12-3).
- About half of Aspen Regional Health Authority residents (51.5%) accrue less than \$30,000 per year (Figure 12-4).

* Unless otherwise specified, all calculated percentages and population estimates represent the population ages 12 and over only.

Figure 12-1: Age distribution of Aspen Regional Health Authority and Alberta - Ages 12 and over (CCHS 3.1 PUMF - Weighted, 2005)^{1,2}

1 Statistics Canada, Canadian Community Health Survey (CCHS 3.1) PUMF – Weighted, 2005.

2 Population estimates calculated using data from Alberta Health and Wellness, Alberta Health Care Insurance Plan (AHCIP) Stakeholder Registry, 2005.

Figure 12-2: Gender distribution of Aspen Regional Health Authority and Alberta - Ages 12 and over (AHCIIP Stakeholder Registry, 2005)³

Figure 12-3: Highest personal education level attained in Aspen Regional Health Authority and Alberta - Ages 14 and over (CCHS 3.1 PUMF - Weighted, 2005)^{4,5}

3 Population estimates calculated using data from Alberta Health and Wellness, Alberta Health Care Insurance Plan (AHCIIP) Stakeholder Registry, 2005.

4 Statistics Canada, Canadian Community Health Survey (CCHS 3.1) PUMF - Weighted, 2005.

5 Population estimates calculated using data from Alberta Health and Wellness, Alberta Health Care Insurance Plan (AHCIIP) Stakeholder Registry, 2005.

Figure 12-4: Annual personal income in Aspen Regional Health Authority and Alberta - Ages 12 and over (CCHS 3.1 PUMF - Weighted, 2005)^{6,7}

12.2 TOBACCO USE

Aspen Regional Health Authority: Tobacco Use Highlights*

- Aspen Regional Health Authority is home to approximately 37,000 of Alberta's 622,000 smokers (Figure 12-5) and 109,000 non-smokers.
- The smoking prevalence is greater for males (27.1%) than females (23.6%) in Aspen Regional Health Authority. This translates to approximately 20,000 males and 17,000 females (Figure 12-6).
- The smoking prevalence of youth in Aspen Regional Health Authority (ages 12 to 17) is 2.3%. This corresponds to approximately 400 smokers (Figure 12-7).
- Approximately 37,000 smokers in Aspen Regional Health Authority are above the age of 18 years. Of these, approximately 49%, or 18,000 individuals, are overweight or obese (Figure 12-8).
- Over half (55.8%) of Aspen Regional Health Authority's smokers are physically inactive, accounting for approximately 21,000 individuals (Figure 12-9).

* Unless otherwise specified, all calculated percentages and population estimates represent the population ages 12 and over only.

6 Statistics Canada, Canadian Community Health Survey (CCHS 3.1) PUMF - Weighted, 2005.

7 Population estimates calculated using data from Alberta Health and Wellness, Alberta Health Care Insurance Plan (AHCIP) Stakeholder Registry, 2005.

Figure 12-5: Prevalence of current daily and occasional smokers in Alberta, by health region - Ages 12 and over (CCHS 3.1 PUMF - Weighted, 2005)^{8,9}

Figure 12-6: Prevalence of current daily and occasional smokers in Aspen Regional Health Authority and Alberta, by gender - Ages 12 and over (CCHS 3.1 PUMF - Weighted, 2005)^{10,11}

8 Statistics Canada, Canadian Community Health Survey (CCHS 3.1) PUMF - Weighted, 2005.

9 Population estimates calculated using data from Alberta Health and Wellness, Alberta Health Care Insurance Plan (AHICIP) Stakeholder Registry, 2005.

10 Statistics Canada, Canadian Community Health Survey (CCHS 3.1) PUMF - Weighted, 2005.

11 Population estimates calculated using data from Alberta Health and Wellness, Alberta Health Care Insurance Plan (AHICIP) Stakeholder Registry, 2005.

Figure 12-7: Prevalence of current daily and occasional smokers in Aspen Regional Health Authority and Alberta, by age – Ages 12 and over (CCHS 3.1 PUMF - Weighted, 2005)^{12,13}

Figure 12-8: Prevalence of overweight or obesity (Body Mass Index ≥ 25) among current daily and occasional smokers in Alberta, by health region – Ages 18 and over (CCHS 3.1 PUMF - Weighted, 2005)^{14,15}

12 Statistics Canada, Canadian Community Health Survey (CCHS 3.1) PUMF – Weighted, 2005.

13 Population estimates calculated using data from Alberta Health and Wellness, Alberta Health Care Insurance Plan (AHCIP) Stakeholder Registry, 2005.

14 Statistics Canada, Canadian Community Health Survey (CCHS 3.1) PUMF – Weighted, 2005.

15 Population estimates calculated using data from Alberta Health and Wellness, Alberta Health Care Insurance Plan (AHCIP) Stakeholder Registry, 2005.

Figure 12-9: Prevalence of physical inactivity¹⁶ among current daily and occasional smokers in Alberta, by health region – Ages 12 and over (CCHS 3.1 PUMF - Weighted, 2005)^{17,18}

12.3 POLICIES

RHA policy:

- Patients, clients, volunteers, staff and the general public will be protected from exposure to environmental tobacco smoke while in or on Aspen Regional Health Authority owned or operated premises or facilities providing services funded by Aspen Regional Health Authority. Clients, their families and visitors shall be requested to postpone smoking one hour prior to and during a visit by an Aspen Regional Health Authority employee.
- Smoking is restricted on Aspen Regional Health Authority grounds.

Number of municipalities in region with gold standard rating: 3

Gold standard municipalities include:

- Jasper
 - Whitecourt
 - Westlock
- (effective January 1, 2008)

RHA policy: Silver

16 CCHS 3.1 defines physical inactivity as a daily usual leisure-time energy expenditure of less than 1.5 kilocalories per kilogram of body weight per day.

17 Statistics Canada, Canadian Community Health Survey (CCHS 3.1) PUMF – Weighted, 2005.

18 Population estimates calculated using data from Alberta Health and Wellness, Alberta Health Care Insurance Plan (AHCIP) Stakeholder Registry, 2005.

Post-secondary policy:

Athabasca University

- Smoking is restricted on campus grounds.

NorQuest College

- Smoking is restricted on campus grounds.
- Smoking cessation programs for students are available on campus (or referral to existing off-campus programs is provided).
- Smoking cessation programs for faculty and staff are available on campus (or referral to existing off-campus programs is provided).

Northern Lakes College

- Smoking is restricted on campus grounds.
- No tobacco sales are permitted on campus.

Portage College

- Smoking is restricted on campus grounds.

12.4 PROGRAMS

Cessation:

1. **Tobacco Education in the Schools** - Respiratory appointment with cessation counseling and survival kit for initiative (Bonnyville).
2. **Tom Baker Cancer Center Telehealth Smoking Cessation Program** – Group. (Evaluated)

Aspen Regional Health Authority also referenced the following:

Networks and Committees

1. Bonnyville and Cold Lake Coalitions for Addiction Free Living: Aspen staff participates as members of the coalitions and support the work undertaken. A sample of project work includes supporting a pub to go smoke-free, planning a conference with youth, assisting with resources to produce Quit Kits for the community, and National Non-Smoking Week and World No Tobacco Day event planning. (Evaluated)

Community Programs

1. Teaming Up for Tobacco-Free Kids
2. Building Leadership for Action in Schools Today (BLAST)
3. Community Based Initiatives*: Minor Hockey Week, Cold Turkey Challenge, Drug Coalitions
4. Chronic Disease Self Management Program (CDSMP): The CDSMP is a standardized, research-proven six-week program. Several communities across the region offer this group course and the principles of self-management are discussed. Some clients identify tobacco use as health concern and people are assisted with skills, self confidence and support to manage their health problems.
5. Youth and Resiliency Programs*: Several innovative approaches with youth are provided. The True to Myself Program (TTM) is one program that trains teen coaches (girls from grades 11 and 12) to work with girls from grades 7 and 8. Meetings are held twice a month from November through to May. Topics covered include bullying, personal safety, and body image. A weekend retreat is also part of the program. A healthy sense of self and decision making are also discussed and choices about tobacco use are impacted in this way. TTM is offered only in the community of Athabasca and surrounding area. Other program efforts of this nature include Go Girl Conferences, Tres Chic and P.A.R.T.Y. programs that may have an impact on young people's choices with respect to tobacco use.

Key Activities

1. Staff support of awareness and education, advocacy and bylaw development in the community
 - Education and Awareness: Staff receives a variety of requests for presentations over the program year to raise awareness about tobacco control. If in a school setting, they partner with teaching staff to help develop their skills and confidence in the subject matter. They also plan to engage students to the best of their ability considering grade level. Other requests for supports to raise awareness are received and they may be in the form of presentations, displays or directing to other resources to help meet the need identified.
 - Bylaw Development: Staff provides consultation and support for a community interested in tackling bylaw development and assist with the process undertaken. (Evaluated)
2. Promotional events for National Non Smoking Week and World No Tobacco Day.
3. Respiratory education in Bonnyville area schools.

Aspen Regional Health Authority indicated that tobacco control measures are varied across the region depending on community interest, needs, strengths and partners available to collaborate.

**Supported by an external funding source; thus, program sustainability is vulnerable to funding or lack thereof.*

12.5 ECONOMIC IMPACT

Each year, tobacco use costs the Canadian economy an estimated \$17 billion and the Alberta economy \$1.8 billion.¹⁹ Societal costs arise from lost income due to premature death, disability, worker absenteeism and reduced productivity. Additional tobacco-related costs are incurred from tobacco subsidies, fires and increased utilization of the health care system. In 2002, approximately \$470.6 million was spent in Alberta on tobacco-related illnesses. Tobacco users place extra burden on the health care system in terms of increased costs related to hospitalization, ambulatory care, physician fees, family physician visits, and prescription drugs.²⁰ Studies show that smokers are more likely to use inpatient, emergency and outpatient services; to heal less quickly; and to be admitted after surgical procedures to intensive care than non-smokers.²¹ Using methodology developed by Girgis and Ward,²² hospitalization for tobacco-attributed disease²³ for the 2005-2006 Fiscal Year (FY) cost an estimated \$7.6 million in Aspen Regional Health Authority (females: \$2.6 million; males: \$5.0 million) and \$118.8 million in Alberta overall (females: \$43.44 million; males: \$75.33 million). For more detailed information please refer to Chapter 16.

19 Rehm J et al., "The Costs of Substance Abuse in Canada 2002," *Canadian Center on Substance Abuse*, 2006, Canadian Center on Substance Abuse, 13 June 2007 <<http://www.ccsa.ca/NR/rdonlyres/18F3415E-2CAC-4D21-86E2-CEE549EC47A9/0/ccsa0113322006.pdf>>.

20 "The Costs of Substance Abuse in Canada 2002," *Physicians for a Smoke-free Canada*, 4 July 2007 <<http://www.smoke-free.ca/factsheets/pdf/costsoftobacco-ccsaresults.pdf>>.

21 Girgis ST and Ward JE, "A Financial Case to Enable State Health Jurisdictions to Invest in Tobacco Control," *The Medical Journal of Australia*, 179(2003): 539-542.

22 Girgis ST and Ward JE, "A Financial Case to Enable State Health Jurisdictions to Invest in Tobacco Control," *The Medical Journal of Australia*, 179(2003): 539-542.

23 Cost estimate reflects tobacco-attributed hospital bed-stays only, and does not reflect additional costs to the health care system such as the cost of physician visits, prescription drugs, etc.

CHAPTER 13

PEACE COUNTRY

HEALTH

The information presented throughout this chapter has been compiled using data obtained from the Canadian Community Health Survey Cycle 3.1 (CCHS 3.1), Public Use Microdata File (PUMF) – Weighted (2005) and the Alberta Health Care Insurance Plan (AHCIP) Stakeholder Registry (2005). Please refer to Chapter 5 for a more detailed description of these data sources.

Please note that Statistics Canada combines Peace Country Health and Northern Lights Health Region in the analysis of the CCHS 3.1 (2005) due to small sample sizes. As a result, all percentages presented in this chapter are calculated for the combined regions. However, population estimates are calculated separately for Peace Country Health.

13.1 REGIONAL DEMOGRAPHICS

Peace Country Health: Demographic Highlights*

- The estimated population in Peace Country Health is 111,000, accounting for roughly 4.1% of Alberta's population of 2,727,000.
- Three in five residents in Peace Country Health (60.1%) are between 20 and 50 years of age (Figure 13-1).
- Peace Country Health has a similar gender distribution to Alberta overall, with approximately 54,000 females and 57,000 males (Figure 13-2).
- The majority of Peace Country Health residents aged 14 and over (70.4%; T~75,000) have graduated from a post-secondary institution (Figure 13-3).
- Over half of Peace Country Health residents (56.3%) accrue more than \$30,000 per year (Figure 13-4).

** Unless otherwise specified, all calculated percentages and population estimates represent the population ages 12 and over only.*

Figure 13-1: Age distribution of Peace Country Health and Alberta - Ages 12 and over (CCHS 3.1 PUMF - Weighted, 2005)^{1,2}

Figure 13-2: Gender distribution of Peace Country Health and Alberta - Ages 12 and over (AHCIP Stakeholder Registry, 2005)³

1 Statistics Canada, Canadian Community Health Survey (CCHS 3.1) PUMF - Weighted, 2005.

2 Population estimates calculated using data from Alberta Health and Wellness, Alberta Health Care Insurance Plan (AHCIP) Stakeholder Registry, 2005 (for Peace Country Health only).

3 Population estimates calculated using data from Alberta Health and Wellness, Alberta Health Care Insurance Plan (AHCIP) Stakeholder Registry, 2005 (for Peace Country Health only).

Figure 13-3: Highest personal education level attained in Peace Country Health and Alberta – Ages 14 and over (CCHS 3.1 PUMF - Weighted, 2005)^{4,5}

Figure 13-4: Annual personal income in Peace Country Health and Alberta - Ages 12 and over (CCHS 3.1 PUMF - Weighted, 2005)^{6,7}

4 Statistics Canada, Canadian Community Health Survey (CCHS 3.1) PUMF - Weighted, 2005.

5 Population estimates calculated using data from Alberta Health and Wellness, Alberta Health Care Insurance Plan (AHCIP) Stakeholder Registry, 2005 (for Peace Country Health only).

6 Statistics Canada, Canadian Community Health Survey (CCHS 3.1) PUMF - Weighted, 2005.

7 Population estimates calculated using data from Alberta Health and Wellness, Alberta Health Care Insurance Plan (AHCIP) Stakeholder Registry, 2005 (for Peace Country Health only).

13.2 TOBACCO USE

Peace Country Health: Tobacco Use Highlights*

- Peace Country Health is home to approximately 32,000 of Alberta's 622,000 smokers (Figure 13-5) and 79,000 non-smokers. At 29%, this is one of the highest smoking rates in Alberta.
- The smoking prevalence is greater for males (31.7%) than females (25.9%) in Peace Country Health. This translates to approximately 18,000 males and 14,000 females (Figure 13-6).
- The smoking prevalence among youth in Peace Country Health (ages 12 to 17) is 8.2%. This corresponds to approximately 1,100 smokers (Figure 13-7).
- Approximately 31,000 smokers in Peace Country Health are above the age of 18 years. Of these, approximately 57%, or 18,000 individuals, are overweight or obese (Figure 13-8). This is the highest rate in Alberta.
- Over half (58.5%) of Peace Country Health's smokers are physically inactive, accounting for approximately 19,000 individuals (Figure 13-9).

* Unless otherwise specified, all calculated percentages and population estimates represent the population ages 12 and over only.

Figure 13-5: Prevalence of current daily and occasional smokers in Alberta, by health region - Ages 12 and over (CCHS 3.1 PUMF - Weighted, 2005)^{8,9}

8 Statistics Canada, Canadian Community Health Survey (CCHS 3.1) PUMF - Weighted, 2005.

9 Population estimates calculated using data from Alberta Health and Wellness, Alberta Health Care Insurance Plan (AHCIP) Stakeholder Registry, 2005 (for Peace Country Health only).

Figure 13-6: Prevalence of current daily and occasional smokers in Peace Country Health and Alberta, by gender – Ages 12 and over (CCHS 3.1 PUMF - Weighted, 2005)^{10,11}

Figure 13-7: Prevalence of current daily and occasional smokers in Peace Country Health and Alberta, by age – Ages 12 and over (CCHS 3.1 PUMF - Weighted, 2005)^{12,13}

10 Statistics Canada, Canadian Community Health Survey (CCHS 3.1) PUMF – Weighted, 2005.

11 Population estimates calculated using data from Alberta Health and Wellness, Alberta Health Care Insurance Plan (AHCIP) Stakeholder Registry, 2005 (for Peace Country Health only).

12 Statistics Canada, Canadian Community Health Survey (CCHS 3.1) PUMF – Weighted, 2005.

13 Population estimates calculated using data from Alberta Health and Wellness, Alberta Health Care Insurance Plan (AHCIP) Stakeholder Registry, 2005 (for Peace Country Health only).

Figure 13-8: Prevalence of overweight or obesity (Body Mass Index ≥ 25) among current daily and occasional smokers in Alberta, by health region – Ages 18 and over (CCHS 3.1 PUMF - Weighted, 2005)^{14,15}

Figure 13-9: Prevalence of physical inactivity¹⁶ among current daily and occasional smokers in Alberta, by health region – Ages 12 and over (CCHS 3.1 PUMF - Weighted, 2005)^{17,18}

14 Statistics Canada, Canadian Community Health Survey (CCHS 3.1) PUMF – Weighted, 2005.

15 Population estimates calculated using data from Alberta Health and Wellness, Alberta Health Care Insurance Plan (AHCIP) Stakeholder Registry, 2005 (for Peace Country Health only).

16 CCHS 3.1 defines physical inactivity as a daily usual leisure-time energy expenditure of less than 1.5 kilocalories per kilogram of body weight per day.

17 Statistics Canada, Canadian Community Health Survey (CCHS 3.1) PUMF – Weighted, 2005.

18 Population estimates calculated using data from Alberta Health and Wellness, Alberta Health Care Insurance Plan (AHCIP) Stakeholder Registry, 2005 (for Peace Country Health only).

13.3 POLICIES

RHA policy

- Smoking by staff, physicians, volunteers and visitors is strictly prohibited within Peace Country Health facilities. Smoking on facility grounds is prohibited except in designated areas at each facility. Each site may designate a smoking area outside of the building. This site must at least three meters away from all entry doors.

Post-secondary policy:

Grande Prairie Regional College

- Smoking is restricted on campus grounds.
- Smoking is restricted within 6 meters of entrances and air intakes.

Northern Alberta Institute of Technology (NAIT)

- Smoking is prohibited in front of entrances and air intakes.
- Smoking cessation programs for students are available on campus (or referral to existing off-campus programs is provided).
- Smoking cessation programs for faculty and staff are available on campus (or referral to existing off-campus programs is provided).

Northern Lakes College

- Common areas of on-campus student residences are smoke-free.

Fairview College

- Common areas of on-campus student residences and individual student rooms are smoke-free.

**Number of municipalities in region
with gold standard rating: 0**

RHA policy: Silver

13.4 PROGRAMS

Prevention:

1. **Tobacco Free Sport** – Peer mentoring. (Evaluated)
2. **Prevention Presentations to all Grades** – Curriculum based prevention program.

Cessation:

1. **Brief Intervention for Tobacco Reduction (BIT)** – Stages of Change. (Evaluated)
2. **Stop Smoking** – 6-week program for Junior and Senior High school students.
3. **Tom Baker Cancer Centre Smoking Cessation Rural Tele-Health Initiative** – Group. (Evaluated)

Peace Country Health also referenced the following:

Networks and Committees

1. Campaign for a Smoke-Free Alberta (CSFA)
2. Peace Association for Lifelong Learning
3. Grande Prairie Tobacco Reduction Coalition

Community Programs

1. Teaming Up for Tobacco-Free Kids
2. Building Leadership for Action in Schools Today (BLAST)

Key Activities

1. Going for Gold Campaign – Advocacy, awareness and education

13.5 ECONOMIC IMPACT

Each year, tobacco use costs the Canadian economy an estimated \$17 billion and the Alberta economy \$1.8 billion.¹⁹ Societal costs arise from lost income due to premature death, disability, worker absenteeism and reduced productivity. Additional tobacco-related costs are incurred from tobacco subsidies, fires and increased utilization of the health care system. In 2002, approximately \$470.6 million was spent in Alberta on tobacco-related illnesses. Tobacco users place extra burden on the health care system in terms of increased costs related to hospitalization, ambulatory care, physician fees, family physician visits, and prescription drugs.²⁰ Studies show that smokers are more likely to use inpatient, emergency and outpatient services; to heal less quickly; and to be admitted after surgical procedures to intensive care than non-smokers.²¹ Using methodology developed by Girgis and Ward,²² hospitalization for tobacco-attributed disease²³ for the 2005-2006 Fiscal Year (FY) cost an estimated \$5.6 million in Peace Country Health (females: \$2.2 million; males: \$3.4 million) and \$118.8 million in Alberta overall (females: \$43.44 million; males: \$75.33 million). For more detailed information please refer to Chapter 16.

19 Rehm J et al., "The Costs of Substance Abuse in Canada 2002," *Canadian Center on Substance Abuse*, 2006, Canadian Center on Substance Abuse, 13 June 2007 <<http://www.ccsa.ca/NR/rdonlyres/18F3415E-2CAC-4D21-86E2-CEE549EC47A9/0/ccsa0113322006.pdf>>.

20 "The Costs of Substance Abuse in Canada 2002," *Physicians for a Smoke-free Canada*, 4 July 2007 <<http://www.smoke-free.ca/factsheets/pdf/costsoftobacco-ccsareresults.pdf>>.

21 Girgis ST and Ward JE, "A Financial Case to Enable State Health Jurisdictions to Invest in Tobacco Control," *The Medical Journal of Australia*, 179(2003): 539-542.

22 Girgis ST and Ward JE, "A Financial Case to Enable State Health Jurisdictions to Invest in Tobacco Control," *The Medical Journal of Australia*, 179(2003): 539-542.

23 Cost estimate reflects tobacco-attributed hospital bed-stays only, and does not reflect additional costs to the health care system such as the cost of physician visits, prescription drugs, etc.

CHAPTER 14

NORTHERN LIGHTS

HEALTH REGION

The information presented throughout this chapter has been compiled using data obtained from the Canadian Community Health Survey Cycle 3.1 (CCHS 3.1), Public Use Microdata File (PUMF) – Weighted (2005) and the Alberta Health Care Insurance Plan (AHCIP) Stakeholder Registry (2005). Please refer to Chapter 5 for a more detailed description of these data sources.

Please note that Statistics Canada combines Peace Country Health and Northern Lights Health Region in the CCHS 3.1 (2005) due to small sample sizes. As a result, all percentages presented in this chapter are calculated for the combined regions. However, population estimates are calculated separately for Northern Lights Health Region.

14.1 REGIONAL DEMOGRAPHICS

Northern Lights Health Region: Demographic Highlights*

- The estimated population in Northern Lights Health Region is 59,000, accounting for roughly 2.1% of Alberta's population of 2,727,000.
- Three in five residents in Northern Lights Health Region (60.1%) are between 20 and 50 years of age (Figure 14-1).
- Northern Lights Health Region has a similar gender distribution to Alberta overall, with approximately 28,000 females and 31,000 males (Figure 14-2).
- The majority of Northern Lights Health Region residents aged 14 and over (70.4%; T~39,000) have graduated from a post-secondary institution (Figure 14-3).
- Over half of Northern Lights Health Region residents (56.3%) accrue more than \$30,000 per year (Figure 14-4).

** Unless otherwise specified, all calculated percentages and population estimates represent the population ages 12 and over only.*

Figure 14-1: Age distribution of Northern Lights Health Region and Alberta - Ages 12 and over (CCHS 3.1 PUMF - Weighted, 2005)^{1,2}

Figure 14-2: Gender distribution of Northern Lights Health Region and Alberta - Ages 12 and over (AHCIP Stakeholder Registry, 2005)³

1 Statistics Canada, Canadian Community Health Survey (CCHS 3.1) PUMF - Weighted, 2005.

2 Population estimates calculated using data from Alberta Health and Wellness, Alberta Health Care Insurance Plan (AHCIP) Stakeholder Registry, 2005 (for Northern Lights Health Region only).

3 Population estimates calculated using data from Alberta Health and Wellness, Alberta Health Care Insurance Plan (AHCIP) Stakeholder Registry, 2005 (for Northern Lights Health Region only).

Figure 14-3: Highest personal education level attained in Northern Lights Health Region and Alberta - Ages 14 and over (CCHS 3.1 PUMF - Weighted, 2005)^{4,5}

Figure 14-4: Annual personal income in Northern Lights Health Region and Alberta - Ages 12 and over (CCHS 3.1 PUMF - Weighted, 2005)^{6,7}

4 Statistics Canada, Canadian Community Health Survey (CCHS 3.1) PUMF - Weighted, 2005.

5 Population estimates calculated using data from Alberta Health and Wellness, Alberta Health Care Insurance Plan (AHCIP) Stakeholder Registry, 2005 (for Northern Lights Health Region only).

6 Statistics Canada, Canadian Community Health Survey (CCHS 3.1) PUMF - Weighted, 2005.

7 Population estimates calculated using data from Alberta Health and Wellness, Alberta Health Care Insurance Plan (AHCIP) Stakeholder Registry, 2005 (for Northern Lights Health Region only).

14.2 TOBACCO USE

Northern Lights Health Region: Tobacco Use Highlights*

- Northern Lights Health Region is home to approximately 17,000 of Alberta's 622,000 smokers (Figure 14-5) and 42,000 non-smokers. At 29%, this is one of the highest smoking rates in Alberta.
- The smoking prevalence is greater for males (31.7%) than females (25.9%) in Northern Lights Health Region. This translates to approximately 10,000 males and 7,000 females (Figure 14-6).
- The smoking prevalence among youth in Northern Lights Health Region (ages 12 to 17) is 8.2%. This corresponds to approximately 600 smokers (Figure 14-7).
- Approximately 16,000 smokers in Northern Lights Health Region are above the age of 18 years. Of these, approximately 57%, or 9,000 individuals, are overweight or obese (Figure 14-8). This is the highest rate in Alberta.
- Over half (58.5%) of Northern Lights Health Region's smokers are physically inactive, accounting for approximately 10,000 individuals (Figure 14-9).

* Unless otherwise specified, all calculated percentages and population estimates represent the population ages 12 and over only.

Figure 14-5: Prevalence of current daily and occasional smokers in Alberta, by health region - Ages 12 and over (CCHS 3.1 PUMF - Weighted, 2005)^{8,9}

8 Statistics Canada, Canadian Community Health Survey (CCHS 3.1) PUMF - Weighted, 2005.

9 Population estimates calculated using data from Alberta Health and Wellness, Alberta Health Care Insurance Plan (AHCIP) Stakeholder Registry, 2005 (for Northern Lights Health Region only).

Figure 14-6: Prevalence of current daily and occasional smokers in Northern Lights Health Region and Alberta, by gender – Ages 12 and over (CCHS 3.1 PUMF - Weighted, 2005)^{10,11}

Figure 14-7: Prevalence of current daily and occasional smokers in Northern Lights Health Region and Alberta, by age – Ages 12 and over (CCHS 3.1 PUMF - Weighted, 2005)^{12,13}

10 Statistics Canada, Canadian Community Health Survey (CCHS 3.1) PUMF – Weighted, 2005.

11 Population estimates calculated using data from Alberta Health and Wellness, Alberta Health Care Insurance Plan (AHCIP) Stakeholder Registry, 2005 (for Northern Lights Health Region only).

12 Statistics Canada, Canadian Community Health Survey (CCHS 3.1) PUMF – Weighted, 2005.

13 Population estimates calculated using data from Alberta Health and Wellness, Alberta Health Care Insurance Plan (AHCIP) Stakeholder Registry, 2005 (for Northern Lights Health Region only).

Figure 14-8: Prevalence of overweight or obesity (Body Mass Index ≥ 25) among current daily and occasional smokers in Alberta, by health region – Ages 18 and over (CCHS 3.1 PUMF - Weighted, 2005)^{14,15}

Figure 14-9: Prevalence of physical inactivity¹⁶ among current daily and occasional smokers in Alberta, by health region – Ages 12 and over (CCHS 3.1 PUMF - Weighted, 2005)^{17,18}

14 Statistics Canada, Canadian Community Health Survey (CCHS 3.1) PUMF – Weighted, 2005.

15 Population estimates calculated using data from Alberta Health and Wellness, Alberta Health Care Insurance Plan (AHICIP) Stakeholder Registry, 2005 (for Northern Lights Health Region only).

16 CCHS 3.1 defines physical inactivity as a daily usual leisure-time energy expenditure of less than 1.5 kilocalories per kilogram of body weight per day.

17 Statistics Canada, Canadian Community Health Survey (CCHS 3.1) PUMF – Weighted, 2005.

18 Population estimates calculated using data from Alberta Health and Wellness, Alberta Health Care Insurance Plan (AHICIP) Stakeholder Registry, 2005 (for Northern Lights Health Region only).

14.3 POLICIES

RHA policy

- All Northern Lights Health Region buildings and grounds are smoke-free.

Post-secondary policy:

Northern Alberta Institute of Technology (NAIT)

- Smoking cessation programs for students are available on campus (or referral to existing off-campus programs is provided).
- Smoking cessation programs for faculty and staff are available on campus (or referral to existing off-campus programs is provided).

Keyano College

- Smoking is restricted on campus grounds.
- Smoking is restricted within 10 meters of entrances and air intakes.

Number of municipalities in region
with gold standard rating: 1

Gold standard municipalities include:

- Regional Municipality of
Wood Buffalo

RHA policy: Gold

14.4 PROGRAMS

Education and Awareness:

1. **Take It Outside** – Informational based program, in which parents are provided information on the effects of smoking in homes. Information packages are given out to parents during Car Seat Clinics held in the Regional Municipality of Wood Buffalo. (Evaluated)
2. **From School to Site*** – A comprehensive approach to tobacco education in the College and Workplace College based program, continuing to promote tobacco awareness with a primary focus on the future employees of the oil and gas industries. This collaborative project is between Keyano College and the Northern Lights Regional Health Center.

Prevention:

1. **Tobacco Reduction Education for Grade 9 Students*** – Information on smoking and spit tobacco covered over two sessions.

Protection:

1. **Smoke Free Homes for Babies*** – Information based program, in which parents are provided information on the effects of smoking in homes. Information packages are given out to parents during Car Seat Clinics held in the Regional Municipality of Wood Buffalo. (In the process of being evaluated)

Cessation:

1. **Tom Baker Cancer Center Telehealth Smoking Cessation Program** – Group smoking cessation program, run through Telehealth. The program consists of eight 90 minute sessions over the course of three months. This program is currently being run in Fort McMurray, as well as High Level. (Evaluated)
2. **One to One Smoking Cessation Counseling** – The local Primary Care Network in Fort McMurray does one-to-one smoking cessation counseling, whereby the public can self-refer to this service as long as they have a family physician.

Northern Lights Health Region also referenced the following:

Networks and Committees

1. Wood Buffalo Tobacco Reduction Coalition
2. Action on Smoking and Health (ASH)
3. Campaign for a Smoke-Free Alberta (CSFA)

Community Programs

1. Teaming Up for Tobacco-Free Kids
2. Building Leadership for Action in Schools Today (BLAST)
3. Kick the Nic
4. AADAC's Adolescent & Adult Information Series

Key Activities

1. Go for the Gold Campaign – a successful community based campaign through Wood Buffalo Tobacco Reduction Coalition (WBTRC) to change current municipal bylaw to gold standard.

**Supported by an external funding source; thus, program sustainability is vulnerable to funding or lack thereof.*

14.5 ECONOMIC IMPACT

Each year, tobacco use costs the Canadian economy an estimated \$17 billion and the Alberta economy \$1.8 billion.¹⁹ Societal costs arise from lost income due to premature death, disability, worker absenteeism and reduced productivity. Additional tobacco-related costs are incurred from tobacco subsidies, fires and increased utilization of the health care system. In 2002, approximately \$470.6 million was spent in Alberta on tobacco-related illnesses. Tobacco users place extra burden on the health care system in terms of increased costs related to hospitalization, ambulatory care, physician fees, family physician visits, and prescription drugs.²⁰ Studies show that smokers are more likely to use inpatient, emergency and outpatient services; to heal less quickly; and to be admitted after surgical procedures to intensive care than non-smokers.²¹ Using methodology developed by Girgis and Ward,²² hospitalization for tobacco-attributed disease²³ for the 2005-2006 Fiscal Year (FY) cost an estimated \$1.7 million in Northern Lights Health Region (females: \$0.8 million; males: \$0.9 million) and \$118.8 million in Alberta overall (females: \$43.44 million; males: \$75.33 million). For more detailed information please refer to Chapter 16.

19 Rehm J et al., "The Costs of Substance Abuse in Canada 2002," *Canadian Center on Substance Abuse*, 2006, Canadian Center on Substance Abuse, 13 June 2007 <<http://www.ccsa.ca/NR/rdonlyres/18F3415E-2CAC-4D21-86E2-CEE549EC47A9/0/ccsa0113322006.pdf>>.

20 "The Costs of Substance Abuse in Canada 2002," *Physicians for a Smoke-free Canada*, 4 July 2007 <<http://www.smoke-free.ca/factsheets/pdf/costsoftobacco-ccsaresults.pdf>>.

21 Girgis ST and Ward JE, "A Financial Case to Enable State Health Jurisdictions to Invest in Tobacco Control," *The Medical Journal of Australia*, 179(2003): 539-542.

22 Girgis ST and Ward JE, "A Financial Case to Enable State Health Jurisdictions to Invest in Tobacco Control," *The Medical Journal of Australia*, 179(2003): 539-542.

23 Cost estimate reflects tobacco-attributed hospital bed-stays only, and does not reflect additional costs to the health care system such as the cost of physician visits, prescription drugs, etc.

CHAPTER 15

TOBACCO CONTROL STRATEGIES AND FRAMEWORKS

15.1 OVERVIEW

Twenty-three comprehensive Tobacco Control frameworks and strategies (hereon referred to as Tobacco Control strategies) across Canada, the United States and internationally were reviewed. The completeness of the strategies varies. Some documents provide detailed information including a vision, goals and objectives, actions and indicators, and methods of surveillance and evaluation. Many strategies, however, are lacking in one or more of these components. Tobacco Control strategies revealing, within their documented strategy, a plan attending to most or all of the above-mentioned criteria include those in place by Newfoundland,¹ Florida,² Massachusetts³ and New Zealand.⁴ Additionally, strategies in place by the World Health Organization,⁵ Centers for Disease Control and Prevention⁶ and Australia⁷ documented a well-rounded, comprehensive strategy targeting multiple avenues of Tobacco Control and reduction.

- 1 The Alliance of the Control of Tobacco, "Provincial Tobacco Reduction Strategy 2005 - 2008: A Partnership Plan to Reduce Tobacco Use," Go Healthy, 2005, Go Healthy, 16 February 2007 <<http://www.gohealthy.ca/public/files/ACTguts.pdf>>.
- 2 "Florida Tobacco Prevention and Control Program, Strategic plan 2005 - 2010," Florida Department of Health, 2007, Florida Department of Health, 22 February 2007 <http://www.doh.state.fl.us/Tobacco/PDF_Files/TobaccoPlan.pdf>.
- 3 Strategic Planning Steering Committee, "Strategic Plan: Tobacco Control in Massachusetts," Office of Health and Human Services, June 2006, Commonwealth of Massachusetts, 22 February 2007 <http://www.mass.gov/Eeohhs2/docs/dph/tobacco_control/strategic_plan.pdf>.
- 4 Ministry of Health, "Clearing the Smoke: A Five-year Plan for Tobacco Control in New Zealand (2004 -2009)," New Zealand Ministry of Health, 2004, New Zealand Ministry of Health, 22 February 2007 <[http://www.moh.govt.nz/moh.nsf/0/AAFC588B348744B9CC256F39006EB29E/\\$File/clearingthesmoke.pdf](http://www.moh.govt.nz/moh.nsf/0/AAFC588B348744B9CC256F39006EB29E/$File/clearingthesmoke.pdf)>.
- 5 World Health Organization, "WHO Framework Convention on Tobacco Control," WHO Framework Convention on Tobacco Control, Updated 2005, World Health Organization, 12 February 2007 <http://www.who.int/tobacco/framework/WHO_FCTC_english.pdf>.
- 6 National Centre for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, "Best Practices for Comprehensive Tobacco Control Programs," Centers for Disease Control and Prevention (CDC), 1999, US Department of Health and Human Services, 22 February 2007 <http://www.cdc.gov/tobacco/tobacco_control_programs/stateandcommunity/best_practices/index.htm>.
- 7 Ministerial Council on Drug Strategy, "National Tobacco Strategy, 2004 - 2009: The Strategy," New South Wales Government, 2004, New South Wales Government, 12 February 2007 <http://www.health.nsw.gov.au/public-health/health-promotion/tobacco/pdf/national_tobacco_strategy_2004-2009.pdf>.

Specific aims of Tobacco Control were consistent among the majority of documents evaluated: Protection, Prevention, Cessation and Harm Reduction. As it pertains to Tobacco Control:

1. Protection refers to the creation of an environment (physical, legal, and regulatory) that supports non-smoking⁸ and protects against exposure to second-hand smoke;⁹
2. Prevention discourages individuals and groups, with particular emphasis on youths, from initiating smoking;¹⁰
3. Cessation involves encouraging and assisting smokers to stop using tobacco products;¹¹
4. Harm reduction aims at reducing the health hazards of tobacco products¹² and reducing the risk factors for tobacco-related diseases (other than tobacco use).¹³

Table 15-1 displays each Tobacco Control strategy reviewed and the various elements incorporated within a specific framework or strategy.¹⁴⁻³⁷ These elements are categorized under each area of Tobacco Control with the elements that were applicable to multiple areas of Tobacco Control assigned to one category only. Elements that were relevant to all four areas of Tobacco Control were grouped under a separate (Miscellaneous) category in the table.

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- 8 Health Canada, "The Federal Tobacco Control Policy: A Framework for Action," *Healthy Living*, 2002, Health Canada, 12 February 2007 <http://www.hc-sc.gc.ca/hl-vs/pubs/tobac-tabac/ffa-ca/index_e.html>.
- 9 British Columbia Ministry of Health Services, "BC's Tobacco Control Strategy: Targeting Our Efforts," *British Columbia Ministry of Health*, May 31, 2004, Government of British Columbia, 12 February 2007 <http://www.tobaccofacts.org/pdf/bc_strategy.pdf>.
- 10 Alberta Interdepartmental Committee on Tobacco Reduction, "Reducing Tobacco Use in Alberta: A Comprehensive Strategy," Alberta Alcohol and Drug Abuse Commission, June 2001, *Alberta Alcohol and Drug Abuse Commission*, 12 February 2007 <http://tobacco.aadac.com/whats_alberta_doing/reducing_tobacco_use_in_alberta_report_june2001.pdf>.
- 11 Ministerial Council on Drug Strategy, "National Tobacco Strategy, 2004 - 2009: The Strategy," *New South Wales Government*, 2004, New South Wales Government, 12 February 2007 <http://www.health.nsw.gov.au/public-health/health-promotion/tobacco/pdf/national_tobacco_strategy_2004-2009.pdf>.
- 12 Health Canada, "The Federal Tobacco Control Policy: A Framework For Action," *Healthy Living*, 2002, Health Canada, 12 February 2007 <http://www.hc-sc.gc.ca/hl-vs/pubs/tobac-tabac/ffa-ca/index_e.html>.
- 13 National Centre for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, "Best Practices for Comprehensive Tobacco Control Programs," *Centers for Disease Control and Prevention (CDC)*, 1999, US Department of Health and Human Services, 12 February 2007 <http://www.cdc.gov/tobacco/tobacco_control_programs/stateandcommunity/best_practices/index.htm>.
- 14-37 Refer to Table 15-1

Table 15-1: Canada, U.S.A. and International Summary Table of Common Elements of Selected Comprehensive Tobacco Reduction Strategies ... Continued on Pages 183-185

	Misc.			Protection									Prevention											Cessation										Harm Reduction				
	Research to guide program activities	Monitoring and Evaluation	Mass Media/Social Marketing	Restricting second-hand smoke in public places/ workplaces	Education on health hazards of second-hand smoke	Promotion of smoke-free schools	Promotion of smoke-free post-sec campus	Promotion of smoke-free events/ activities	Promotion of smoke-free homes	Enforce restriction of sale to minors	Limit access to youth (includes access to displays & promotion; vendor restrictions)		Partner with various government entities and organizations	Develop/build community capacity	Community-based programs/initiatives	Programs specific for Aboriginal populations (for USA and International: programs specific for high-risk/priority ethnic populations)	Programs specific for women	Programs specific for youth	Creation of youth consult/advocacy group	Taxation	Counter-marketing/ info on industry practices	Denormalization	Youth dedicated websites	Post-secondary programs/initiatives	School programs/materials	Public access to information	Population/age specific tools or resources	Access to anti-smoking aids	Access to anti-smoking treatment	Dedicated addictions staff	Guidelines/training for HCP interventions	Telephone Quit-line	Various cessation programs (one-on-one, group, etc.)	Cessation website	Peri- & post-operative programs	Pre- & post-natal programs for women	Reduce health hazards of continued tobacco use	Ensure misleading information re: tobacco not provided
TOTAL (/ 23)	16	19	19	20	11	7	4	6	11	17	14	22	16	13	16	4	14	7	14	12	14	8	2	19	14	2	8	7	2	16	17	15	5	1	6	5	4	4
Canada																																						
TOTAL (/ 13)	8	9	11	11	6	3	2	5	6	9	7	13	8	8	7	3	9	3	7	6	10	5	2	11	8	2	2	2	1	8	11	10	3	1	3	1	1	0
National – The Federal Tobacco Control Strategy (FTSC) ¹⁴ (2002)	X	X	X	X	X					X		X	X				X		X	X	X				X					X	X					X	X	
Alberta – Reducing Tobacco Use in Alberta: A Comprehensive Strategy ¹⁵ (June, 2001)	X	X	X	X						X	X	X	X		X			X		X				X						X	X							
Alberta – Framework for Developing Tobacco Reduction Strategies for Young Adults ¹⁶ (May 20, 2003)			X	X	X						X				X	X				X	X		X		X		X				X	X						
British Columbia – BC’s Tobacco Control Strategy: Targeting our Efforts ¹⁷ (May 31, 2004)	X	X		X	X	X		X	X	X		X		X	X	X			X		X	X		X	X	X	X				X	X	X		X			
British Columbia – Vancouver – Tobacco Reduction Strategy: Targeting a Smoke Free Future ¹⁸ (February, 2004)		X	X	X	X			X	X	X		X	X	X			X	X	X	X	X			X	X					X	X	X		X				
British Columbia – An Aboriginal Tobacco Strategy for British Columbia: Honouring Our Health ¹⁹ (January, 2001)	X	X	X					X	X			X	X	X	X	X								X	X					X	X			X				

Note: 1) Elements not listed as present within a specific strategy may be in place but not explicitly specified.

2) Elements listed are not intended to represent an exhaustive list of strategy elements.

3) Certain elements may be applicable for designation under multiple categories.

	Misc.			Protection							Prevention										Cessation							Harm Reduction										
	Research to guide program activities	Monitoring and Evaluation	Mass Media/Social Marketing	Restricting second-hand smoke in public places/ workplaces	Education on health hazards of second-hand smoke	Promotion of smoke-free schools	Promotion of smoke-free post-sec campus	Promotion of smoke-free events/ activities	Promotion of smoke-free homes	Enforce restriction of sale to minors	Limit access to youth (includes access to displays & promotion; vendor restrictions)	Partner with various government entities and organizations	Develop/build community capacity	Community-based programs/initiatives	Programs specific for Aboriginal populations (for USA and International: programs specific for high-risk/priority ethnic populations)	Programs specific for women	Programs specific for youth	Creation of youth consult/advocacy group	Taxation	Counter-marketing/ info on industry practices	Denormalization	Youth dedicated websites	Post-secondary programs/initiatives	School programs/materials	Public access to information	Population/age specific tools or resources	Access to anti-smoking aids	Access to anti-smoking treatment	Dedicated addictions staff	Guidelines/training for HCP interventions	Telephone Quit-line	Various cessation programs (one-on-one, group, etc.)	Cessation website	Peri- & post-operative programs	Pre- & post-natal programs for women	Reduce health hazards of continued tobacco use	Ensure misleading information re: tobacco not provided	Reduction of risk factors (e.g. poor nutrition, lack of exercise) for tobacco-related diseases
Manitoba – Cutting Through the Smoke: The Manitoba Provincial Tobacco Control Strategy ²⁰ (January, 2002)			X	X						X		X					X	X			X			X														
New Brunswick – New Brunswick Anti-Tobacco Strategy ²¹ (April, 2004)	X	X		X					X	X	X	X	X	X	X		X	X		X		X		X	X					X		X						
Newfoundland and Labrador – Provincial Tobacco Reduction Strategy 2005-2008: A Partnership Plan to Reduce Tobacco Use ²² (not dated)	X	X	X	X	X	X	X	X		X	X	X		X	X	X	X			X	X			X		X				X	X	X			X			
Nova Scotia – A Comprehensive Tobacco Strategy for Nova Scotia ²³ (October 11, 2001)	X	X	X	X	X	X			X	X		X	X	X					X		X	X		X	X					X	X	X						
Ontario – Ontario Tobacco Strategy* ²⁴ (June, 2005) * detailed strategy not available – elements listed represents restricted list retrieved from CTRU progress report ²⁵	X	X	X	X			X		X		X		X	X	X		X		X			X	X	X						X	X	X						
Northwest Territories – Action on Tobacco: A Territorial Strategy for Tobacco Control ²⁶ (May, 2002)			X	X				X		X	X	X	X								X			X		X	X	X		X	X							

Note: 1) Elements not listed as present within a specific strategy may be in place but not explicitly specified.

2) Elements listed are not intended to represent an exhaustive list of strategy elements.

3) Certain elements may be applicable for designation under multiple categories.

	Misc.			Protection										Prevention												Cessation												Harm Reduction		
	Research to guide program activities	Monitoring and Evaluation	Mass Media/Social Marketing	Restricting second-hand smoke in public places/ workplaces	Education on health hazards of second-hand smoke	Promotion of smoke-free schools	Promotion of smoke-free post-sec campus	Promotion of smoke-free events/ activities	Promotion of smoke-free homes	Enforce restriction of sale to minors	Limit access to youth (includes access to displays & promotion; vendor restrictions)	Partner with various government entities and organizations		Develop/build community capacity	Community-based programs/initiatives	Programs specific for Aboriginal populations (for USA and International: programs specific for high-risk/priority ethnic populations)	Programs specific for women	Programs specific for youth	Creation of youth consult/advocacy group	Taxation	Counter-marketing/ info on industry practices	Denormalization	Youth dedicated websites	Post-secondary programs/initiatives	School programs/materials	Public access to information	Population/age specific tools or resources	Access to anti-smoking aids	Access to anti-smoking treatment	Dedicated addictions staff	Guidelines/training for HCP interventions	Telephone Quit-line	Various cessation programs (one-on-one, group, etc.)	Cessation website	Peri- & post-operative programs	Pre- & post-natal programs for women	Reduce health hazards of continued tobacco use	Ensure misleading information re: tobacco not provided	Reduction of risk factors (e.g. poor nutrition, lack of exercise) for tobacco-related diseases	
Yukon – Yukon Tobacco Reduction Strategy ²⁷ (not dated)			X									X					X		X	X	X	X		X						X	X									
U.S.A.																																								
TOTAL (/6)	4	6	5	5	1	3	2	0	3	5	4	5	6	3	6	0	3	4	4	4	2	2	0	5	3	0	2	3	0	4	5	2	1	0	1	0	0	2		
National - Best Practices for Comprehensive Tobacco Control Programs ²⁸ (CDC) (August, 1999)		X	X									X	X	X	X			X		X				X				X		X	X								X	
California – A Model for Change: the California experience in Tobacco Control ²⁹ (October, 1998) <small>* detailed strategy not available – elements listed represents restricted list retrieved from model</small>		X	X	X									X		X				X	X					X						X									
Florida – Florida Tobacco Prevention and Control Program Strategic Plan 2005-2010 ³⁰ (not dated)	X	X	X			X	X					X	X	X	X		X	X	X	X		X		X						X					X					
Massachusetts – Strategic Plan: Tobacco Control in Massachusetts ³¹ (June, 2006)	X	X	X	X		X						X	X		X		X	X	X	X	X	X		X	X		X	X		X	X	X	X							
Oregon – Taking Action for a Tobacco-Free Oregon: Oregon Statewide Tobacco Control Plan 2005-2010 ³² (not dated)	X	X	X			X						X	X		X		X	X	X					X				X	X		X									

	Misc.			Protection								Prevention												Cessation										Harm Reduction				
	Research to guide program activities	Monitoring and Evaluation	Mass Media/Social Marketing	Restricting second-hand smoke in public places/workplaces	Education on health hazards of second-hand smoke	Promotion of smoke-free schools	Promotion of smoke-free post-sec campus	Promotion of smoke-free events/ activities	Promotion of smoke-free homes	Enforce restriction of sale to minors	Limit access to youth (includes access to displays & promotion; vendor restrictions)	Partner with various government entities and organizations	Develop/build community capacity	Community-based programs/initiatives	Programs specific for Aboriginal populations (for USA and International: programs specific for high-risk/priority ethnic populations)	Programs specific for women	Programs specific for youth	Creation of youth consult/advocacy group	Taxation	Counter-marketing/ info on industry practices	Denormalization	Youth dedicated websites	Post-secondary programs/initiatives	School programs/materials	Public access to information	Population/age specific tools or resources	Access to anti-smoking aids	Access to anti-smoking treatment	Dedicated addictions staff	Guidelines/training for HCP interventions	Telephone Quit-line	Various cessation programs (one-on-one, group, etc.)	Cessation website	Peri- & post-operative programs	Pre- & post-natal programs for women	Reduce health hazards of continued tobacco use	Ensure misleading information re: tobacco not provided	Reduction of risk factors (e.g. poor nutrition, lack of exercise) for tobacco-related diseases
Texas – Tobacco Prevention and Control: Strategic Plan 2003-2008 ³³ (December, 2002)			X									X					X		X	X	X	X		X						X	X		X					
International																																						
TOTAL (/4)	4	4	3	4	4	1	0	1	2	3	3	4	2	2	4	1	2	0	4	2	2	0	0	3	3	0	4	2	1	4	1	3	1	0	2	4	3	2
WHO- WHO Framework Convention on Tobacco Control ³⁴ (2003; updated 2005)	X	X		X	X					X	X	X			X				X	X					X		X	X	X	X		X				X	X	
Australia – National Tobacco Strategy, 2004-2009: The Strategy ³⁵ (November 12, 2004)	X	X	X	X	X				X	X	X	X		X	X				X		X			X	X	X		X	X		X				X	X		X
Glasgow – Glasgow Tobacco Strategy ³⁶ (2003)	X	X	X	X	X							X	X	X	X	X	X				X			X				X			X		X			X	X	
New Zealand – Clearing the Smoke: A Five-year Plan for Tobacco Control in New Zealand (2004-2009) ³⁷ (September, 2004)	X	X	X	X	X	X		X	X	X	X	X	X		X		X		X	X				X	X	X		X			X	X	X	X		X	X	X

Note: 1) Elements not listed as present within a specific strategy may be in place but not explicitly specified.
2) Elements listed are not intended to represent an exhaustive list of strategy elements.
3) Certain elements may be applicable for designation under multiple categories.

15.2 TOBACCO CONTROL COMPONENTS

For the purposes of this booklet, the elements falling under the four Tobacco Control areas and miscellaneous category will be discussed according to six broader and more specifically defined topics relevant to Tobacco Control in Alberta: Leadership and Coordination; Media; Cessation; Research, Evaluation, and Surveillance; Policy; and Prevention.

Leadership and Coordination

Nearly all of the strategies included in the review integrated partnering with various government entities and other organizations as an essential element in Tobacco Control. Partnering across jurisdictions and with multiple partners and agencies ensures that tobacco reduction is managed collaboratively and ensures avenues for coordinated Tobacco Control initiatives by multiple groups and organizations.³⁸

Sixteen of the twenty-three strategies reviewed recognized the value of developing or building community capacity as an important Tobacco Control element. Capacity building in relation to Tobacco Control is intended to increase the ability of individuals, health intermediaries, youth and communities to take action on Tobacco Control. Capacity building can be characterized by facilitating collaboration, transfer of knowledge, enriched community problem-solving ability, full coordination of efforts and infrastructure support.³⁹

Leadership and Coordination Issues

- *Tobacco Control roles and responsibilities*
- *Strategy coordination*
- *Partnership development*
- *Tobacco Control training*
- *Modeling leadership and community capacity*
- *Successful collaboration and integration*
- *Funding*
- *Sustainability*
- *Economic impact*

38 Alberta Interdepartmental Committee on Tobacco Reduction, "Reducing tobacco use in Alberta: a comprehensive strategy," Alberta Alcohol and Drug Abuse Commission, June 2001, Alberta Alcohol and Drug Abuse Commission, 12 February 2007 <http://tobacco.aadac.com/whats_alberta_doing/reducing_tobacco_use_in_alberta_report_june2001.pdf>.

39 Health Canada, "The federal Tobacco Control policy: a framework for action," *Healthy Living*, 2002, Health Canada, 12 February 2007 <http://www.hc-sc.gc.ca/hl-vs/pubs/tobac-tabac/ffa-ca/index_e.html>.

Media

The inclusion of mass media and social marketing techniques is an important element in the majority of Tobacco Control strategies. Social marketing in relation to tobacco use is the utilization of commercial marketing (i.e. mass media) techniques such as radio, television, newsprint, the Internet, billboards, etc. to promote the adoption of non-smoking so as to improve the health and well-being of society.^{40,41,42} Additionally, approximately half of the Tobacco Control strategies reviewed included as part of their social marketing technique information intended to denormalize tobacco use and/or counter-market against tobacco use.

Denormalization aims to reinforce the fact that tobacco use is not a mainstream or normal activity in our society⁴³ while counter-marketing refers to countering pro-tobacco influences⁴⁴ and revealing the industry's areas, tactics and activities.⁴⁵

Cessation

All of the Tobacco Control strategies reviewed included the presence or proposal of various cessation strategies and programs. The most common cessation elements among the reviewed Tobacco Control strategies included telephone quitlines; guidelines or training for intervention and cessation assistance by health care professionals/students; specific cessation programs, such as one-on-one counselling or group counselling; and readily accessible tobacco and cessation information for the public.

Media Target Areas

- *Denormalization*
- *Social marketing*
- *Counter-marketing*
- *Provincial coordination*
- *Quitline advertisements*

Methods to Target Cessation

- *Best-practice-treatment/guidelines*
- *Counselling*
- *Pharmacotherapy*
- *Triage models*
- *Treatment clinics*
- *Quitlines*

40 National Centre for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, "Best Practices for Comprehensive Tobacco Control Programs," *Centers for Disease Control and Prevention (CDC)*, 1999, US Department of Health and Human Services, 12 February 2007 <http://www.cdc.gov/tobacco/tobacco_control_programs/stateandcommunity/best_practices/index.htm>.

41 Alberta Interdepartmental Committee on Tobacco Reduction, "Reducing tobacco use in Alberta: a comprehensive strategy," Alberta Alcohol and Drug Abuse Commission, June 2001, *Alberta Alcohol and Drug Abuse Commission*, 12 February 2007 <http://tobacco.aadac.com/whats_alberta_doing/reducing_tobacco_use_in_alberta_report_june2001.pdf>.

42 Ministerial Council on Drug Strategy, "National Tobacco Strategy, 2004 - 2009: The Strategy," *New South Wales Government*, 2004, New South Wales Government, 12 February 2007 <http://www.health.nsw.gov.au/public-health/health-promotion/tobacco/pdf/national_tobacco_strategy_2004-2009.pdf>.

43 Health Canada, "The Federal Tobacco Control Policy: A Framework For Action," *Healthy Living*, 2002, Health Canada, 12 February 2007 <http://www.hc-sc.gc.ca/hl-vs/pubs/tobac-tabac/ffa-ca/index_e.html>.

44 National Centre for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, "Best Practices for Comprehensive Tobacco Control Programs," *Centers for Disease Control and Prevention (CDC)*, 1999, US Department of Health and Human Services, 12 February 2007 <http://www.cdc.gov/tobacco/tobacco_control_programs/stateandcommunity/best_practices/index.htm>.

45 Tobacco Control Section, "A Model of Change: The California Experience in Tobacco Control," California Department of Health Services, October 1998, *California Department of Health Services*, 12 February 2007 <<http://www.dhs.ca.gov/tobacco/documents/pubs/modelforchange.pdf>>.

Additional cessation elements, although not widely adopted, include:

- production and availability of population or age-specific tools/resources
- better or more affordable access to anti-smoking pharmaceutical aids
- better or more affordable access to anti-smoking treatment
- creation of a dedicated tobacco addictions staff
- development of a cessation website
- peri & post-operative cessation programs
- pre & post-natal cessation programs for women

Health Professionals and Cessation Components

- *Coordination of health professionals*
- *Improving percentage of health professionals engaged in brief intervention (3A's and 5A's)*
- *Fax-back programs*
- *Stickers, smoking as a vital sign*
- *Specific research in each health profession*
- *Targeting specific groups*

Research, Evaluation and Surveillance

The overall effectiveness of Tobacco Control strategies and their programs depends on utilizing best practices such as monitoring or surveillance, evaluation, and research.⁴⁶ Research to guide program activities, such as policy development,⁴⁷ social marketing, cessation, etc. was identified as a Tobacco Control element in sixteen Tobacco Control strategies. The diligence of the research conducted prior to the development of the strategies, as well as the intention to continually use research to modify strategy components of programs, varied considerably across Tobacco Control strategies reviewed.

Research, Evaluation and Surveillance Components

- *Data collection*
- *Data analysis*
- *Literature reviews*
- *Clinical and applied investigations*
- *Establishing evaluation standards*
- *Updating and improving the "Snapshot of Tobacco Facts: A Resource to Guide Tobacco Control Planning in Alberta"*

Comprehensive Tobacco Control programs must have a surveillance and evaluation system that can monitor and document program accountability, provide formative feedback to the program and furnish data that can demonstrate the program's impact and effectiveness. While nineteen of the twenty-three Tobacco Control strategies included surveillance and evaluation as an important element within their strategy, the comprehensiveness of the surveillance and evaluation activities detailed varied greatly amongst the different Tobacco Control strategies.

46 British Columbia Ministry of Health Services, "BC's Tobacco Control Strategy: Targeting Our Efforts," British Columbia Ministry of Health, May 31, 2004, Government of British Columbia, 12 February 2007 <http://www.tobaccofacts.org/pdf/bc_strategy.pdf>.

47 Ministry of Health, "Clearing the smoke: a five-year plan for Tobacco Control in New Zealand (2004 -2009)," New Zealand Ministry of Health, 2004, New Zealand Ministry of Health, 22 February 2007 <[http://www.moh.govt.nz/moh.nsf/0/AAFC588B348744B9CC256F39006EB29E/\\$File/clearingthesmoke.pdf](http://www.moh.govt.nz/moh.nsf/0/AAFC588B348744B9CC256F39006EB29E/$File/clearingthesmoke.pdf)>.

Policy

Policy advocacy is a historic component of public health education. Changes in policy in relation to Tobacco Control can help to build capacity at a community level and enable an organized response against tobacco.⁴⁸ Policy-related elements that are common to the majority of Tobacco Control strategies include restricting exposure to second-hand tobacco smoke in public places or workplaces; enforcement of restricting the sale of tobacco products to minors; taxation of tobacco products; limiting the access of youth to tobacco (i.e. limiting access to tobacco displays or "powerwalls", vending machines, tobacco promotions, tobacco vendors, etc.); provision of education on the health hazards of second-hand smoke; and the promotion of smoke-free homes.

Additional, but less widely adopted, policy actions suggested by some of the Tobacco Control strategies include:

- promotion of smoke-free recreational events and activities, schools, and post-secondary campuses
- reducing the health hazards of continued tobacco use
- ensuring misleading information related to tobacco products (e.g. terminology use such as "light" or "mild") is not provided by the tobacco industry
- cost recovery efforts using litigation directed at the tobacco industry.

Policy Areas

- *Taxation*
- *Point of sale*
- *Smoke-free spaces*
- *Advertising bans*
- *Enforcement*
- *Discount cigarettes*
- *National issues*
- *Quit messages at point of sale*
- *Tobacco industry lawsuits*

⁴⁸ California Department of Health Services/ Tobacco Control Section., A model of change: the California experience in Tobacco Control, 1998

Prevention

Many of the prevention elements detailed in Table 15-1 have already been described above as prevention activities related to leadership and coordination or policy. Of the remaining prevention elements, the most frequently included element is the development of school programs or materials related to tobacco risk and hazards. Also prevalent among various Tobacco Control strategies is the provision of prevention programs specific for Aboriginal populations (in Canada) or high-risk/priority ethnic populations (in the United States and internationally); the development of prevention programs specific for youth; and the creation of community-based programs and initiatives.

Additional prevention activities included:

- development of programs specific for women
- development of programs specific for youth
- creation of a youth consult or advocacy group
- implementation of post-secondary programs/initiatives
- creation of a youth-dedicated website
- reduction of risk-factors (e.g. poor nutrition, lack of exercise) for tobacco-related diseases

Prevention Areas and Target Populations

- *Interventions*
- *School programs*
- *Community programs*
- *Targeted groups*
 - *Aboriginals*
 - *Youth*
 - *Mentally Ill*

CHAPTER 16

IMPACTS OF TOBACCO USE

Tobacco products such as cigarettes and spit tobacco kill approximately 3,400 Albertans and 47,000 Canadians annually, making it the leading preventable cause of disease and death in Canada.^{1,2} In addition to its devastating impact on human life, tobacco usage exerts distressing effects on the economy. Over \$15 billion is expended annually in the treatment of tobacco-related illnesses and lost productivity of smoking employees.³ Finally, tobacco is responsible for loss of life and substantial property damage as a result of fires caused by misuse of cigarettes, accounting for one in four fire deaths in Alberta annually.⁴

16.1 IMPACTS ON HEALTH

Tobacco exposure kills more adults, children, smokers, and non-smokers than alcohol, car accidents, illicit drug use, murder, suicide, and AIDS combined through its linkage to cancer, heart disease, lung disease and other ailments.^{5,6} As will be discussed in the subsequent sections, tobacco exerts ill effects directly to the smoker, as well as indirectly through transmission of second-hand tobacco smoke to non-smokers and to unborn babies.

- 1 Canadian Cancer Society, "Believe: Report to the Community 2005-2006," *Canadian Cancer Society: Alberta/NWT Division*, 2005, Canadian Cancer Society, 22 June 2007 <http://www.cancer.ca/vgn/images/portal/cit_86751114/1/9/1242212681abi_publicaffairs-CCS_annual_july28.pdf>.
- 2 The Tobacco Control Liaison Committee of the Federal Provincial Territorial Advisory Committee on Population Health and Health Security, "The National Strategy: Moving Forward. The 2005 Progress Report on Tobacco Control," *Healthy Living*, 2005, Health Canada, 22 June 2007 <http://www.hc-sc.gc.ca/hl-vs/alt_formats/hecs-sesc/pdf/pubs/tobac-tabac/foward-avant/foward-avant_e.pdf>.
- 3 Health Canada, "The Federal Tobacco Control Policy: A Framework for Action," *Healthy Living*, 2002, Health Canada, 12 February 2007 <http://www.hc-sc.gc.ca/hl-vs/pubs/tobac-tabac/ffa-ca/index_e.html>.
- 4 "Smoking Deaths," *Alberta Alcohol and Drug Abuse Commission*, March 19, 2007, Alberta Alcohol and Drug Abuse Commission, 20 October 2006 <http://www.aadac.com/87_458.asp>.
- 5 Canadian Cancer Society, "Believe: Report to the Community 2005-2006," *Canadian Cancer Society: Alberta/NWT Division*, 2005, Canadian Cancer Society, 22 June 2007 <http://www.cancer.ca/vgn/images/portal/cit_86751114/1/9/1242212681abi_publicaffairs-CCS_annual_july28.pdf>.
- 6 The Tobacco Control Liaison Committee of the Federal Provincial Territorial Advisory Committee on Population Health and Health Security, "The National Strategy: Moving Forward. The 2005 Progress Report on Tobacco Control," *Healthy Living*, 2005, Health Canada, 22 June 2007 <http://www.hc-sc.gc.ca/hl-vs/alt_formats/hecs-sesc/pdf/pubs/tobac-tabac/foward-avant/foward-avant_e.pdf>.

Second-hand Smoke

Two-thirds of smoke from a cigarette is not inhaled by the smoker but rather enters the environment in the form of second-hand smoke.⁷ Second-hand smoke (also referred to as Tobacco Smoke Pollution - TSP)⁸ contains over 4,000 chemicals, at least twice the amount of nicotine and tar, five times the amount of carbon monoxide, and higher levels of ammonia and other toxic substances than smoke inhaled by a smoker.⁹ Measures of air quality in vehicles, bars and other public places have shown that smoking in an enclosed or even partially ventilated space yields air quality readings well above what the United States Environmental Protection Agency (EPA) would classify as hazardous. According to the Air Quality Index, this indicates a potential health hazard consistent with emergency conditions likely to effect the entire population.¹⁰ As such, exposure to second-hand smoke is linked to the deaths of at least 1,100 Canadians each year from lung cancer, heart disease, nasal sinus cancer, emphysema, chronic bronchitis, asthma and other diseases.¹¹ There is no risk-free level of exposure to second-hand smoke. Non-smokers exposed to second-hand smoke increase their risk of developing heart disease by 25% to 30% and lung cancer by 20 to 30%.¹² Ventilation, air cleaning or spatial separation are ineffective control measures for second-hand smoke:¹³ "Ventilation cannot control tobacco smoke except at impossible, tornado-force wind speeds. The best ventilation or air cleaning system cannot capture the smoke which reaches [an individual's] nose before it reaches the exhaust grille."¹⁴ Spatial separation of smokers from non-smokers within a space does not affect either the smoker density nor the ventilation rate and thus, cannot reduce the average concentration of second-hand smoke.¹⁵

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- 7 "Smoking & Tobacco: Second-hand Smoke," Canadian Lung Association, September 28, 2006, Canadian Lung Association, 20 October 2006 <http://www.lung.ca/protect-protegez/tobacco-tabagisme/second-secontaire/index_e.php#what>.
 - 8 Fong, GT, "Creating Smoke-Free Environments at the Local, National, and International Level: Recent Successes, Current Challenges, and Possibilities for the Future", World No Tobacco Day Provincial Celebration, hosted by the Alberta Alcohol and Drug Abuse Commission, 28 May 2007.
 - 9 "Smoking & Tobacco: Second-hand Smoke," Canadian Lung Association, September 28, 2006, Canadian Lung Association, 20 October 2006 <http://www.lung.ca/protect-protegez/tobacco-tabagisme/second-secontaire/index_e.php#what>.
 - 10 Fong, GT, "Creating Smoke-Free Environments at the Local, National, and International Level: Recent Successes, Current Challenges, and Possibilities for the Future", World No Tobacco Day Provincial Celebration, hosted by the Alberta Alcohol and Drug Abuse Commission, 28 May 2007.
 - 11 Canadian Cancer Society, "Believe: Report to the Community 2005-2006," Canadian Cancer Society: Alberta/NWT Division, 2005, Canadian Cancer Society, 22 June 2007 <http://www.cancer.ca/vgn/images/portal/cit_86751114/1/9/1242212681abi_publicaffairs-CCS_annual_july28.pdf>.
 - 12 National Centre for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, "The Health Consequences of Involuntary Exposure to Tobacco smoke: A Report of the Surgeon General," Centres for Disease Control and Prevention (CDC), US Department of Health and Human Services, 2006.
 - 13 Repace J, Kawachi I, Glantz S, "Fact Sheet On Second-hand Smoke," Repace and Associates, Inc., Prepared for the 2nd European Conference on Tobacco or Health and the 1st Iberoamerican Conference on Tobacco or Health Canary Islands, Spain, 23-27 February 1999, Repace and Associates, Inc., 3 July 2007 <<http://www.repace.com/SHSFactsheet.pdf>>.
 - 14 Repace J, Repace and Associates Inc., Second-hand Smoke Consultant, 3 July 2007 <<http://leas.ca/Smoke-Quotes.htm>>.
 - 15 Repace J, Kawachi I, Glantz S, "Fact Sheet On Second-hand Smoke," Repace and Associates, Inc., Prepared for the 2nd European Conference on Tobacco or Health and the 1st Iberoamerican Conference on Tobacco or Health Canary Islands, Spain, 23-27 February 1999, Repace and Associates, Inc., 3 July 2007 <<http://www.repace.com/SHSFactsheet.pdf>>.

Infants are particularly vulnerable to second-hand smoke. In addition to the long-term effects of second-hand smoke exposure, exposure to tobacco during pregnancy has been linked to Sudden Infant Death Syndrome (SIDS), miscarriage and fetal growth impairments such as low-birth weight.¹⁶ For example, the current mortality rate of Alberta-born babies ranged from 3.9 among non-smokers to 13.0 for heavy smokers and 11.1 for light smokers.¹⁷ In addition, Albertans who smoke during pregnancy increase the risk of their infant dying of SIDS by 1.4 to 4.4 times.¹⁸

Cancer

Two in five tobacco-related deaths occur as a result of various forms of cancer. Examples include lung cancer, pancreatic cancer and kidney cancer, as well as cancers of the urinary bladder, mouth, pharynx and esophagus. For example, an estimated 82% of all lung cancer cases are caused by smoking.¹⁹ As such, tobacco-related cancers are responsible for approximately 17,700 deaths annually in Canada.²⁰

Respiratory

Respiratory diseases account for one in five tobacco-related deaths, accumulating to approximately 9,500 deaths in Canada each year.²¹ Examples of tobacco-related respiratory diseases include chronic airways obstruction, chronic bronchitis and emphysema, pneumonia and influenza. For instance, smoking is responsible for an estimated 81% of all Chronic Obstructive Pulmonary Disease (COPD) cases among Albertans aged 30 and older.²²

16 "Tobacco Basics Handbook," Alberta Alcohol and Drug Abuse Commission, 2004, Alberta Alcohol and Drug Abuse Commission, 22 June 2006 <http://www.aadac.com/documents/tobacco_basics_handbook.pdf>.

17 Svenson L, Schopflocher D and Tough S, "Maternal Risk Factors in Relationship to Birth Outcome," Population Health Surveillance Branch, July 1999, Alberta Health and Wellness, 22 June 2007 <http://www.health.gov.ab.ca/resources/publications/maternal_risk_factor.PDF>.

18 Svenson L, Schopflocher D and Tough S, "Maternal Risk Factors in Relationship to Birth Outcome," Population Health Surveillance Branch, July 1999, Alberta Health and Wellness, 22 June 2007 <http://www.health.gov.ab.ca/resources/publications/maternal_risk_factor.PDF>.

19 The Tobacco Control Liaison Committee of the Federal Provincial Territorial Advisory Committee on Population Health and Health Security, "The National Strategy: Moving Forward. The 2005 Progress Report on Tobacco Control," Healthy Living, 2005, Health Canada, 22 June 2007 <http://www.hc-sc.gc.ca/hl-vs/alt_formats/hecs-sesc/pdf/pubs/tobac-tabac/foward-avant/foward-avant_e.pdf>.

20 Canadian Council for Tobacco Control, "What are the General Health Effects of Smoking?," Canadian Council for Tobacco Control, November 2001, Canadian Council for Tobacco Control, 20 October 2006 <<http://www.nnsw.ca/Factsheets/Health%20effects%20of%20smoking.pdf>>.

21 Canadian Council for Tobacco Control, "What are the General Health Effects of Smoking?," Canadian Council for Tobacco Control, November 2001, Canadian Council for Tobacco Control, 20 October 2006 <<http://www.nnsw.ca/Factsheets/Health%20effects%20of%20smoking.pdf>>.

22 The Tobacco Control Liaison Committee of the Federal Provincial Territorial Advisory Committee on Population Health and Health Security, "The National Strategy: Moving Forward. The 2005 Progress Report on Tobacco Control," Healthy Living, 2005, Health Canada, 22 June 2007 <http://www.hc-sc.gc.ca/hl-vs/alt_formats/hecs-sesc/pdf/pubs/tobac-tabac/foward-avant/foward-avant_e.pdf>.

Other Chronic Diseases

In addition to cancer and respiratory diseases, smoking exerts negative consequences for oral health, cardiac health, overall appearance, and general health and wellness. Tobacco use often results in tooth decay, cavities, gum disease, increased susceptibility to periodontal diseases, reduced response to both surgical and non-surgical periodontal therapies, an increased risk of dental implant failure, and a higher risk for oral cancer and pre-cancerous lesions.²³ In addition, smokeless tobacco use may result in bone loss around teeth as well as hypersensitive gums to hot and cold stimuli. Tobacco use can impose esthetic consequences as well, including lost teeth, bad breath, abrasions on the tooth surface and painful sores. Unfortunately, in many instances, such damage is irreversible.

Approximately 17,500 deaths nationally are a result of tobacco-induced cardiac ailments, accounting for two in five tobacco-related deaths. Examples of such cardiac problems may include heart attacks, stroke, hardening of the arteries (atherosclerosis) and dilation/rupture of the aorta (aortic aneurysms).²⁴ For instance, smoking is estimated to cause 29% of all ischemic heart disease cases.²⁵ Smokers may also experience heightened heart rate, elevated blood pressure and irregular heartbeats. In addition, nicotine-induced constriction of blood vessels may slow reaction time and cause dizziness, thereby increasing risk of accidental injuries.²⁶ As such, smoking imposes dangerous consequences to one's health and general well-being.

Other consequences of smoking include premature aging as a result of decreased blood flow in vessels; a reduction in bone density which may lead to osteoporosis and bone fractures; and earlier onset of menopause. Smoking also increases one's susceptibility to chronic bowel disease (Crohn's disease) and peptic ulcer disease. Moreover, ulcers are slower to heal and more likely to reoccur in smokers. Lastly, impotence is more likely to occur among smokers than non-smokers.²⁷

23 Al-Shammari K et al. "Dental Patient Awareness of Smoking Effects on Oral Health: Comparison of Smokers and Non-smokers," *Journal of Dentistry*, 34 (2005): 173-178.

24 Canadian Council for Tobacco Control, "What are the General Health Effects of Smoking?," Canadian Council for Tobacco Control, November 2001, Canadian Council for Tobacco Control, 20 October 2006 <<http://www.nnsw.ca/Factsheets/Health%20effects%20of%20smoking.pdf>>.

25 The Tobacco Control Liaison Committee of the Federal Provincial Territorial Advisory Committee on Population Health and Health Security, "The National Strategy: Moving Forward. The 2005 Progress Report on Tobacco Control," *Healthy Living*, 2005, Health Canada, 22 June 2007 <http://www.hc-sc.gc.ca/hl-vs/alt_formats/hecs-sesc/pdf/pubs/tobac-tabac/foward-avant/foward-avant_e.pdf>.

26 Canadian Council for Tobacco Control, "What are the General Health Effects of Smoking?," Canadian Council for Tobacco Control, November 2001, Canadian Council for Tobacco Control, 20 October 2006 <<http://www.nnsw.ca/Factsheets/Health%20effects%20of%20smoking.pdf>>.

27 Canadian Council for Tobacco Control, November 2001, Canadian Council for Tobacco Control, 20 October 2006 <<http://www.nnsw.ca/Factsheets/Health%20effects%20of%20smoking.pdf>>.

16.2 ENVIRONMENTAL IMPACTS

Cigarettes have long been recognized as a source of air pollution. Burning tobacco is the main source of indoor air pollution in the developed world; tobacco smoke contains about 4,000 chemicals, including 50 that are known to cause cancer.^{28,29} Attention, however, has begun to focus on cigarettes as a source of street pollution and water pollution.^{30,31}

Cigarette filters or butts are made from fibrous material designed to trap tar and other toxic chemicals before they reach the smoker's lungs. The filters are made from cellulose acetate (a material similar to rayon) and are coated with paper. Each butt contains the remnants of tobacco, chemicals, paper and a filter.³² Every day, Canadians throw away millions of cigarette butts and packages, and many of these end up on the ground.³³ These cigarette butts and other litter are regularly flushed from urban and suburban streets, parking lots and other surface areas through the storm drain system by rain and other water run-off and ultimately into waterways via drain inlets and pipe networks.³⁴ The residue in the butts contains toxic, soluble chemicals which are deadly and add to the existing cocktail of environmental pollution by degrading water quality, wildlife habitat, and the recreational enjoyment of our rivers, lakes and oceans. The chemicals from discarded cigarette butts are capable of leaching into surrounding water where they can harm aquatic life.^{35,36} The best way to reduce cigarette butt littering is to reduce cigarette smoking.³⁷

28 Chapman S, "Butt Clean Up Campaigns: Wolves in Sheep's Clothing?" *Tobacco Control*, 15(2006):273

29 "Tobacco and the Environment," *Alberta Alcohol and Drug Abuse Commission*, February 26, 2007, Alberta Alcohol and Drug Abuse Commission, 3 July 2007 <http://www.aadac.com/87_447.asp>.

30 "Eliminating Cigarette Butt Litter," *Californians Against Waste: Conserving Resources. Preventing Pollution. Protecting the Environment*, 2007, Californians Against Waste, 3 July 2007 <http://www.cawrecycles.org/take_action/cigarette_butt_litter>.

31 "Tobacco and the Environment," *Alberta Alcohol and Drug Abuse Commission*, February 26, 2007, Alberta Alcohol and Drug Abuse Commission, 3 July 2007 <http://www.aadac.com/87_447.asp>.

32 "Cigarette Butts and Stormwater," *Clean Up Australia Limited*, 3 July 2007 <<http://www.cleanup.org.au/PDF/au/cua-cigarette-butts-fact-sheet.pdf>>.

33 "Tobacco and the Environment," *Alberta Alcohol and Drug Abuse Commission*, February 26, 2007, Alberta Alcohol and Drug Abuse Commission, 3 July 2007 <http://www.aadac.com/87_447.asp>.

34 "Eliminating Cigarette Butt Litter," *Californians Against Waste: Conserving Resources. Preventing Pollution. Protecting the Environment*, 2007, Californians Against Waste, 3 July 2007 <http://www.cawrecycles.org/take_action/cigarette_butt_litter>.

35 "Cigarette Butts and Stormwater," *Clean Up Australia Limited*, Clean Up Australia Limited, 3 July 2007 <<http://www.cleanup.org.au/PDF/au/cua-cigarette-butts-fact-sheet.pdf>>.

36 "Eliminating Cigarette Butt Litter," *Californians Against Waste: Conserving Resources. Preventing Pollution. Protecting the Environment*, 2007, Californians Against Waste, 3 July 2007 <http://www.cawrecycles.org/take_action/cigarette_butt_litter>.

37 Chapman S, "Butt Clean Up Campaigns: Wolves in Sheep's Clothing?" *Tobacco Control*, 15(2006):273.

16.3 ECONOMIC IMPACTS

The financial costs experienced by the smoker are considerable. Tobacco use impacts the individual with regard to the costs incurred by tobacco taxes, increased life insurance premiums for smokers and property damaged by smoking, such as furniture, clothes and car interiors. Moreover, the cost of cigarettes can accumulate quickly. Based on an average price of \$10.50 per pack, a pack-a-day smoker spends approximately \$3,800 on cigarettes annually.³⁸

Tobacco use affects not only the smoker, but results in substantial costs to the economy as well. Each year, tobacco use costs the global economy approximately \$200 billion, the Canadian economy an estimated \$17 billion and the Alberta economy \$1.8 billion.^{39,40} For example, over \$4.4 billion was expended nationally in 2002 in caring for tobacco-related illnesses, with approximately \$470.6 million lost in Alberta. Additional societal costs arise from lost income due to premature death, disability, worker absenteeism, reduced productivity and tobacco subsidies. In fact, it has been estimated that it costs employers about \$3,396 more annually to employ a smoker than a non-smoker due to absenteeism and lost productivity.⁴¹

A substantial proportion of home fires (and home fire deaths) in Canada are caused by careless smoking and use of smokers' materials such as pipes, matches, cigarettes, cigars and lighters.⁴² A recent review concluded that fires started by cigarettes are responsible for one in five fire fatalities in Canada and one in four fire fatalities in Alberta.⁴³ In 2002, smokers' materials caused 9,414 fires nationally with losses of over \$231.4 million and contributed to nearly 700 injuries and 100 deaths.⁴⁴

38 "Economic Costs," Alberta Alcohol and Drug Abuse Commission, March 19, 2007, Alberta Alcohol and Drug Abuse Commission, 20 October 2006 <http://www.aadac.com/87_454.asp>.

39 "Economic Costs," Alberta Alcohol and Drug Abuse Commission, March 19, 2007, Alberta Alcohol and Drug Abuse Commission, 20 October 2006 <http://www.aadac.com/87_454.asp>.

40 Health Canada, "The Federal Tobacco Control Policy: A Framework for Action," Healthy Living, 2002, Health Canada, 12 February 2007 <http://www.hc-sc.gc.ca/hl-vs/pubs/tobac-tabac/ffa-ca/index_e.html>.

41 Hallamore C, "Smoking and the Bottom Line: Updating the Costs of Smoking in the Workplace," The Conference Board of Canada, August 2006, The Conference Board of Canada, 22 June 2007 <<http://www.conferenceboard.ca/documents.asp?next=1754>>.

42 "Annual Report 2001: Annual Fire Losses in Canada," Council of Canadian Fire Marshals and Fire Commissioners, 2004, Canada Safety Council: Canada, 03 July 2007 <http://www.ccfmfc.ca/stats/en/report_e_01.pdf>.

43 "Smoking Deaths," Alberta Alcohol and Drug Abuse Commission, March 19, 2007, Alberta Alcohol and Drug Abuse Commission, 20 October 2006 <http://www.aadac.com/87_458.asp>.

44 "Annual Report 2002: Annual Fire Losses in Canada," Council of Canadian Fire Marshals and Fire Commissioners, 2007, Canada Safety Council: Canada, 03 July 2007 <http://www.ccfmfc.ca/stats/en/report_e_02.pdf>.

In addition to the economic impact that fire-related injuries and deaths caused by smokers' materials have on the health system, use of tobacco has significant economic impacts on the health care system. Tobacco users place extra burden on the health care system in terms of increased costs related to hospitalization, ambulatory care, physician fees, family physician visits and prescription drugs.⁴⁵ Studies show that smokers are more likely to use inpatient, emergency and outpatient services; to heal less quickly; and to be admitted after surgical procedures to intensive care than non-smokers.⁴⁶ Using methodology developed by Girgis and Ward,⁴⁷ hospitalization for tobacco-attributed disease⁴⁸ for the 2005-2006 Fiscal Year (FY) in Alberta cost an estimated \$118.8 million (see text insert to the right and Table 16-1 for more detailed information).

Tobacco-attributed disease hospitalization cost estimates for the 2005-2006 Fiscal Year (FY) in Alberta:

Hospitalization costs for tobacco-attributed disease in Alberta were derived from separation and length of stay figures provided by Alberta Health & Wellness for each of the nine Regional Health Authorities (RHAs). Using the procedure of Girgis and Ward, 46 separations for each disease code (ICD-10) were multiplied by an etiological fraction or attribution factor to estimate hospitalization rates resulting from tobacco use. These figures were then multiplied by the average length of stay per separation to give the number of tobacco-attributed hospital bed-days used. Using an estimated bed-day cost (inpatient, acute care) of \$924.00 per day, the total cost of tobacco-attributed hospitalization in Alberta for the FY 2005-2006 was over \$118.8 million (see Table 16-1). The bed-day cost cited is the amount a resident of Canada without a valid health care would pay for inpatient care. A non-resident of Canada would pay \$2,079, suggesting the more realistic cost of tobacco-attributed hospitalization would be closer to \$267.0 million.

Note: This cost estimate reflects the cost utilization of hospital beds used only, and does not take into account the increased burden smokers incur on the health care system with respect to the cost of physician visits, pharmaceuticals, etc.

45 "The Costs of Substance Abuse in Canada 2002," *Physicians for a Smoke-free Canada*, 4 July 2007 <<http://www.smoke-free.ca/factsheets/pdf/costsoftobacco-ccsaresults.pdf>>.

46 Girgis ST and Ward JE, "A Financial Case to Enable State Health Jurisdictions to Invest in Tobacco Control," *The Medical Journal of Australia*, 179(2003): 539-542.

47 Girgis ST and Ward JE, "A Financial Case to Enable State Health Jurisdictions to Invest in Tobacco Control," *The Medical Journal of Australia*, 179(2003): 539-542.

48 Cost estimate reflects tobacco-attributed hospital bed-stays only, and does not reflect additional costs to the health care system such as the cost of physician visits, prescription drugs, etc.

Table 1: Hospitalization costs (in terms of hospital bed-days used) for tobacco-attributed disease for the 2005-2006 Fiscal Year (FY) in Alberta, by gender and Regional Health Authority (RHA)

Regional Health Authority	Costs (\$)		
	Females	Males	Total
Chinook Health	\$1,950,417	\$4,185,157	\$6,135,574
Palliser Health Region	\$1,162,137	\$2,715,077	\$3,877,214
Calgary Health Region	\$12,902,912	\$23,338,512	\$36,241,424
David Thompson Regional Health Authority	\$5,230,244	\$9,073,131	\$14,303,375
East Central Health	\$2,411,744	\$3,564,100	\$5,975,844
Capital Health	\$14,157,916	\$23,213,146	\$37,371,062
Aspen Regional Health Authority	\$2,609,811	\$4,962,038	\$7,571,849
Peace Country Health	\$2,239,135	\$3,385,511	\$5,624,646
Northern Lights Health Region	\$777,750	\$889,422	\$1,667,172
Alberta Overall (Total)	\$43,442,066	\$75,326,094	\$118,768,160

Based on the rising costs associated with its usage, tobacco reduction makes economic sense.

In addition, several effective tobacco reduction measures such as raising tobacco taxes, restricting tobacco advertising and promotions, restricting smoking in public places and workplaces, and providing cessation information and treatment programs are cost-effective. For instance, a 10% price increase on tobacco products has been illustrated to reduce demand by 4%.⁴⁹

⁴⁹ "Economic Costs," Alberta Alcohol and Drug Abuse Commission, March 19, 2007, Alberta Alcohol and Drug Abuse Commission, 20 October 2006 <http://www.aadac.com/87_454.asp>.

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