SMOKE-FREE ONTARIO MODERNIZATION

Report of the Executive Steering Committee

Final

8/23/2017

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PREFACE

In the spring of 2017, the Minister of Health and Long-Term Care (Minister) established the Executive Steering Committee (ESC) for the Modernization of Smoke-Free Ontario: a group of leaders and experts in tobacco and other harmful inhaled substances and products (see Appendix A).

The ESC's mandate was to:

- make recommendations that are: grounded in evidence and best practices, culturally appropriate, responsive to priority issues, and aligned with the government's strategic vision and priorities;
- provide advice on bold and innovative approaches;
- identify levers across all sectors that can have a fundamental impact on tobacco and other harmful inhaled substances and products; and
- submit a final report that will be used to consult with partners and stakeholders and form the basis for a new Smoke-Free Ontario strategy.

The ESC respectfully acknowledges the important role of the traditional and ceremonial use of tobacco use in Indigenous communities. None of the ESC's recommendations are intended to apply to or inhibit the traditional or ceremonial use of tobacco by Indigenous people.

At the same time that the Minister established the ESC, he recognized the need for a separate collaboration with First Nations and Indigenous communities and organizations. Indigenous communities are considering how to further address the harmful impact of commercial tobacco use on their health from a health promotion perspective and will provide leadership in continuing to identify their own health priorities and strategies.

This is the final report of the ESC.

The ESC gratefully acknowledges the work of the Smoke-Free Ontario Scientific Advisory Committee. Its recent exhaustive assessment of the evidence on effective, innovative and promising interventions, including advice on which could be adapted for use in Ontario, informed the ESC's recommendations. The ESC also acknowledges the work of the Ontario Tobacco Research Unit in developing the modeled forecasts and fact checking this report.

CALL TO ACTION

Over the past 20 years, Ontario has cut smoking rates by almost a third, drastically reducing the number of youth and young adults who smoke, and creating a wide range of smoke-free spaces that protect people from secondhand smoke.

Yet smoking is still the single greatest cause of avoidable disease and premature death in the province. Smoking currently kills about 13,000 Ontarians each year. They die of cardiovascular diseases, cancers and respiratory diseases caused by smoking.

The Smoke-Free Ontario Scientific Advisory Committee estimates that tobacco costs the province $7.5 billion in direct health ($2.2 billion) and other indirect costs, such as lost income and productivity ($5.3 billion).[1] New research from the Institute of Clinical Evaluative Sciences (ICES) shows that the health care impact alone may be much more than previously estimated: up to $3.65 billion each year or 41% of health care costs incurred by unhealthy behaviours in Ontario.[2] The total price tag of tobacco use is even higher because we have not yet calculated the environmental costs of toxic litter and smoke.

However, no financial figure can capture the true burden on the people of Ontario: too many of whom struggle with an addiction to nicotine. Tragically, too many of our family members, friends, colleagues and neighbours become patients and die unnecessarily and prematurely because of smoking.

It has taken far too long to stop a problem that we know how to solve. It is time to end the tobacco epidemic here and in other parts of the world – now.

As a recognized national and international leader in tobacco control, Ontario is ideally positioned to execute a bold, comprehensive 10-year strategy that will put the tobacco endgame goal – <5% smoking prevalence by 2035 – within our grasp. All the elements are in place:

- a public that is highly supportive of a tobacco endgame strategy;
- willing federal and municipal partners;
- strong evidence regarding effective prevention, protection and cessation strategies and interventions;
- highly committed non-governmental partner organizations;

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[1] Smoke-Free Ontario Scientific Advisory Committee, Ontario Agency for Health Protection and Promotion (Public Health Ontario). Evidence to Guide Action: Comprehensive Tobacco Control in Ontario (2016). Toronto, ON: Queen's Printer for Ontario.

[2] Manuel DG, Perez R, Bennett C, Laporte A, Wilton AS, Gandhi S, Yates EA, Henry DA. A $4.9 Billion Decrease in Health Care Expenditure: The Ten-Year Impact of Changing Smoking, Alcohol, Diet and Physical Activity on Health Care Use in Ontario (2016). Toronto, ON: Institute for Clinical Evaluative Sciences.

- an opportunity to expand the solid foundation of effective hospital and community-based tobacco cessation programs – many developed in Ontario;
- a committed public health system, with a strong base of comprehensive tobacco control programs;
- highly skilled health care providers; and
- support from other ministries.

To reach our targets – which include motivating and supporting more than 80,000 Ontarians who smoke to quit each year – Ontario must dramatically intensify its efforts and focus its approach.

The province must directly confront the tobacco industry, which continues to sell a lethal product that kills when used exactly as intended and exploits people's health and the public purse to optimize shareholder returns.

It must significantly increase its investment to motivate the two million Ontarians who use tobacco to quit and support them with compassionate, evidence-based cessation services to help them stay quit.

It must continue to aggressively pursue its highly effective efforts to keep young people from starting to use tobacco and to protect non-smokers from secondhand smoke.

To be executed effectively, the strategy must have the right mix of resources, system enablers and commitment – including evidence, surveillance information, monitoring and evaluation, skills and competencies, an engaged public, and strong leadership and coordination. Those involved in implementing the strategy must be held accountable for investing public resources where they will have the greatest impact, reporting publicly on its progress and meeting clearly defined targets.

Currently, Ontario is investing up to $60 million a year in Smoke-Free Ontario initiatives. The proposed strategy will require more – and a significant portion of those costs should be borne by the tobacco industry, which continues to profit from marketing products that are the single greatest threat to health.

Ontario is closer to ending the tobacco epidemic now than it has ever been. The task is urgent and it will not be easy. It may be complicated by emerging technologies, such as e-cigarettes and heat-not-burn tobacco, and the growing use of other harmful inhaled products, such as shisha and cannabis. It will be impeded by a tobacco industry that has consistently demonstrated a profound, self-serving disinterest in its customers' health and a calculating, sophisticated determination to resist any regulation. It may also face obstacles from the gaming, entertainment, advertising, investment and hospitality industries which are unmindful of the destructive consequences of nicotine addiction.

But it can be done. Ontario has an opportunity to leave an incredible legacy for the next generation: a healthier, more productive population with enhanced quality of life, reduced health care costs and a much less toxic environment. With bold committed leadership from government, Ontario can be one of the first jurisdictions in the world to reach the tobacco endgame goals.

THE CASE FOR A COMPREHENSIVE SMOKE-FREE ONTARIO STRATEGY

Tobacco products[3] are still the single greatest threat to public health and the leading cause of preventable disease and death in Ontario. They create massive personal, health, economic and social costs, and cause significant environmental damage. Ontario must act now to provide high quality, evidence-based, compassionate cessation services that help people who smoke to quit. The province must take bold steps to end the tobacco epidemic.

THE HEALTH IMPACT OF SMOKING TOBACCO

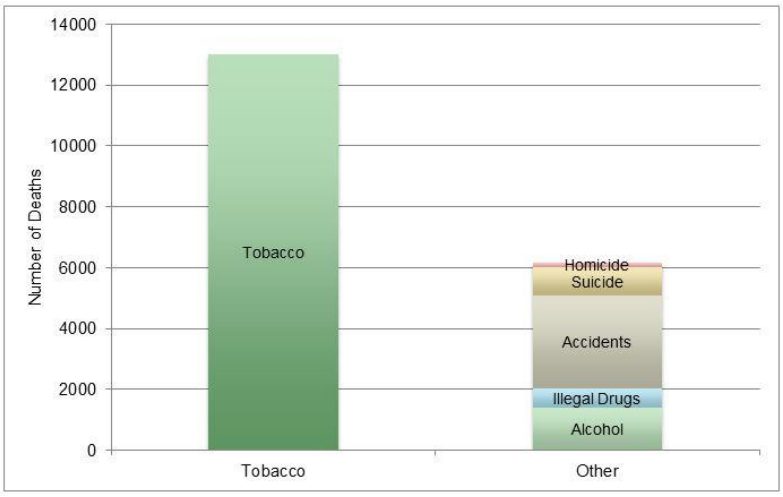
The cigarette is one of the cheapest, most efficient and most deadly drug delivery systems.

Smoking a cigarette delivers large quantities of highly addictive nicotine into the arterial system and to nicotine receptors in the brain. Addiction occurs rapidly, creating dependence and cravings that drive people to seek more of this drug.

The inhalation of tobacco smoke and the distribution of its constituents in the arterial system produces an attack on all major body systems. Virtually all organ systems are adversely affected by smoking. The resulting respiratory, cardiac, vascular, neurological, metabolic, obstetric and pediatric calamities create an almost incalculable burden on public health and health care resources. People who smoke crowd Ontario's respiratory clinics, cancer centres, operating rooms and intensive care units. They also die young. People who smoke die, on average, 11.5 years earlier than non-smokers, leaving behind families devastated by their loss. Those exposed to the smoke of others also suffer significant disease and disability.

Figure 1: Smoking Kills More Ontarians than Alcohol, Illegal Drugs, Accidents, Suicides and Homicides Combined

* Source: Ontario Tobacco Research Unit and Statscan table 1020563 (2002).



[3] Tobacco products include: cigarettes, cigars, cigarillos, roll-your-own tobacco, pipe tobacco, chewing tobacco, spit tobacco and snuff.

TOBACCO BY THE NUMBERS IN ONTARIO

13,000	**13,000** Ontarians killed by smoking each year – about **36 each day**
1 in 6	**1 in 6** Lifetime chance of a man who smokes developing lung cancer – compared to **1 in 77** for a man who never smoked regularly
$3,650,000,000	**$3,650,000,000** Health care costs related to smoking each year – or **41%** of costs incurred by unhealthy behaviours [4]
$5,300,000,000	**$5,300,000,000** Social and economic costs of smoking (i.e. lost income, lost productivity) each year
$1,200,000,000	**$1,200,000,000** Annual tax revenue from the tobacco industry – or **1/8** of what smoking costs Ontario society

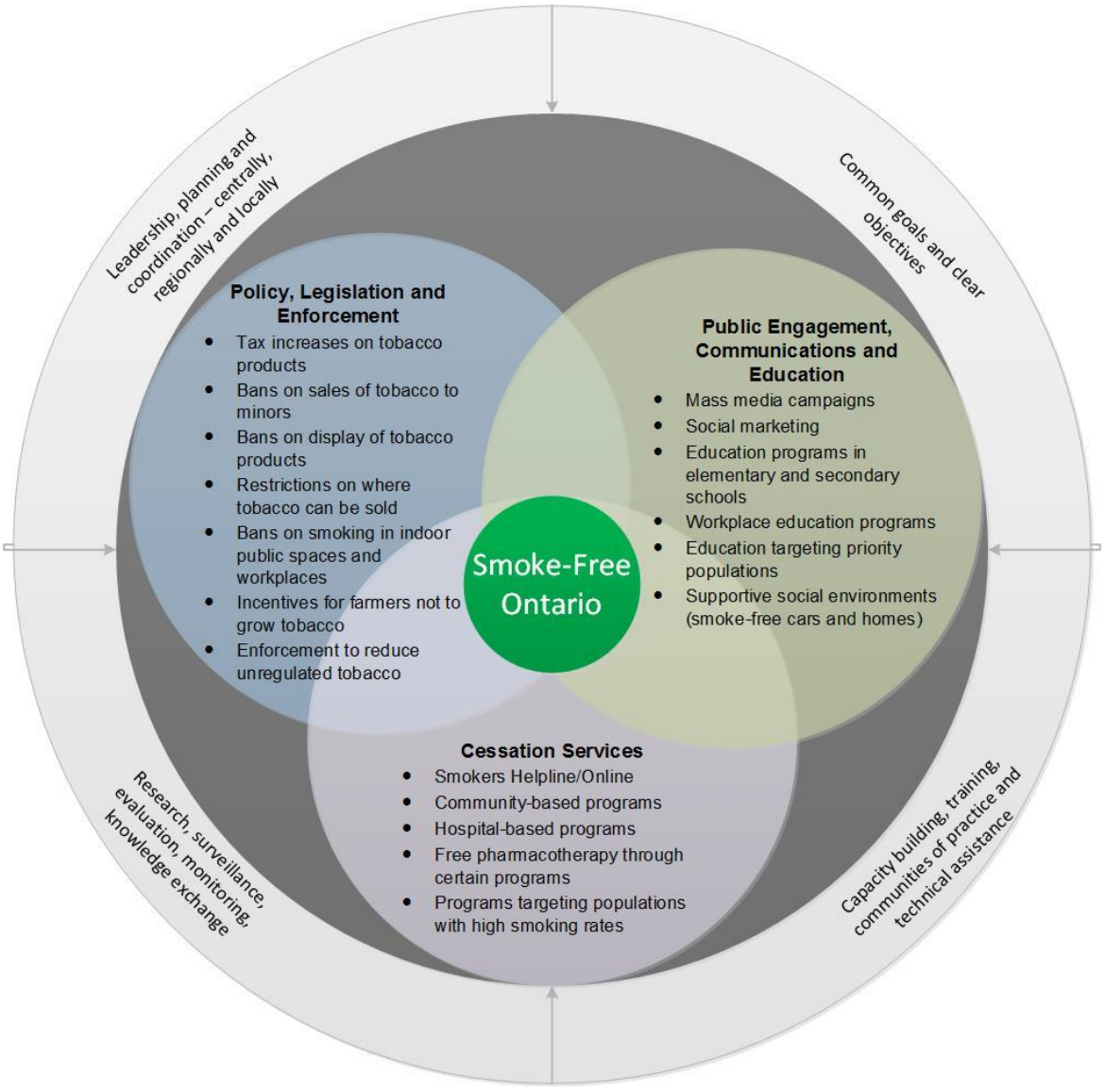
[4] Manuel DG, Perez R, Bennett C, Laporte A, Wilton AS, Gandhi S, Yates EA, Henry DA. A $4.9 Billion Decrease in Health Care Expenditure: The Ten-Year Impact of Changing Smoking, Alcohol, Diet and Physical Activity on Health Care Use in Ontario (2016). Toronto, ON: Institute for Clinical Evaluative Sciences.

LOOKING BACK AND LOOKING FORWARD

The tobacco epidemic started over a century ago. Efforts to prevent health problems related to tobacco began about 50 years ago, and substantial progress has been made in the last 30 years.

Over the past two decades, Ontario has been a national and international leader in tobacco control. With the ground-breaking Ontario Tobacco Strategy and Tobacco Control Act in the 1990s and the more recent Smoke-Free Ontario Strategy and Smoke-Free Ontario Act (2006), the province took a comprehensive approach to reducing tobacco use, funding programs and services to prevent and reduce smoking and exposure to secondhand smoke as well as key infrastructure, such as research and capacity building, to inform and support the network of programs and services.

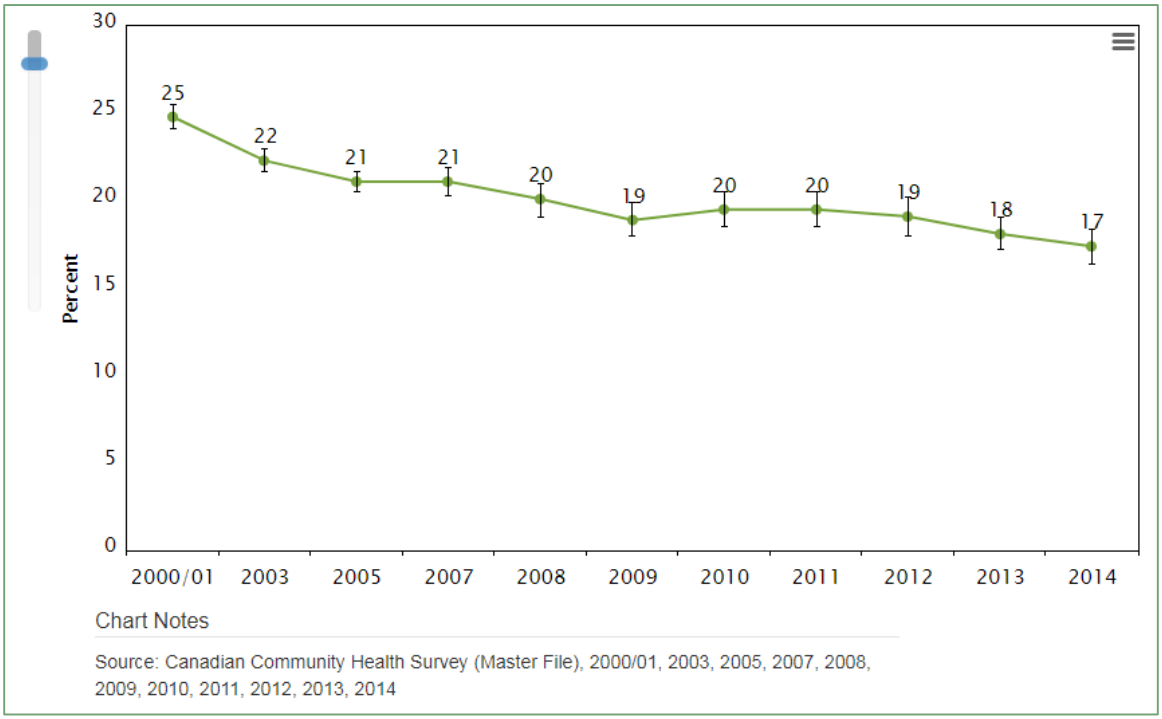
Figure 2: Smoke-Free Ontario's Comprehensive Approach to Tobacco Control



The Impact:

- Ontario has been able to significantly reduce smoking rates. In 2000, about 25% of the population – one in four Ontarians -- smoked. Today, about two million or 17.4% smoke.

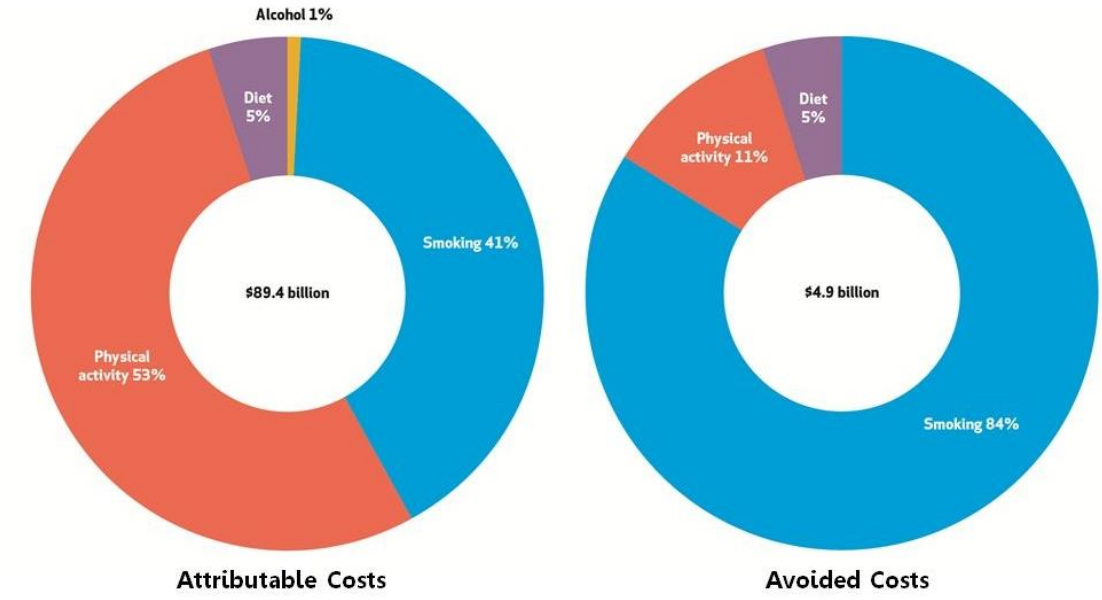
Figure 3: Drop in Smoking Rates in Adults (18+) in Ontario, 2000 to 2014



- Ontario has significantly reduced smoking in youth ages 12 to 18. In 2000, 11.2% of youth were current smokers; by 2014, only 2.7% smoked. At the same time, 17% of 20 to 24 year-olds still smoked in 2014 (down from 32% in 2000).
- About 45,000 Ontarians successfully quit smoking each year.
- Ontario has eliminated exposure to secondhand smoke in indoor public spaces and workplaces.
- According to the Canadian Community Health Survey, between 2000 and 2014, approximately $4.1 billion in health care costs were avoided because of the large number of Ontarians who quit smoking.

Figure 4: Impact of Quitting Smoking on Health Care Costs

According to the 2016 ICES report entitled, *A $4.9 Billion in Health Care Expenditure: The Ten-Year of Changing Smoking, Alcohol, Diet and Physical Activity on Health Care Use in Ontario*, Ontarians unhealthy behaviours cost $89.4 billion between 2004 and 2013. Improvements in health behaviours also led to an approximate $4.9 billion in avoided costs during this time. The largest proportion were as a result of Ontarians quitting smoking.



Manuel DG, Perez R, Bennett C, Laporte A, Wilton AS, Gandhi S, Yates EA, Henry DA. A $4.9 Billion in Health Care Expenditure: The Ten-Year of Changing Smoking, Alcohol, Diet and Physical Activity on Health Care Use in Ontario, Toronto, ON: Institute for Clinical Evaluative Sciences; 2016

Ontario has made real progress. But it is not enough.

Almost one in five Ontarians still smokes. Our smoking rates have not declined significantly over the past few years.

Unless we act boldly, over the next two decades:

- at least 260,000 Ontarians – over a quarter of a million people – will die of smoking-related illnesses;
- the health and social costs of smoking will continue to increase;
- the environmental damage (e.g., littering, toxins in air, water and soil) will grow; and
- Ontario will miss a unique opportunity to end the tobacco epidemic and create a healthier smoke-free society for our children and grandchildren.

The status quo is not an option.

THE CHALLENGE: CAN WE END THE TOBACCO EPIDEMIC IN 20 YEARS?

Ontario is part of national and global efforts to stop the harms caused by smoking. Jurisdictions around the world are trying to loosen the addictive grip tobacco products have on their citizens. In 2003, Canada became a signatory to the World Health Organization (WHO) Framework Convention on Tobacco Control (FCTC), binding Ontario and all other provinces and territories to implement the framework interventions.

The FCTC sets out a comprehensive tobacco control strategy[5]. In addition, the WHO identified a minimum subset of interventions, called MPOWER, (**M**onitor-**P**rotect-**O**ffer-**W**arn-**E**nforce-**R**aise) that all jurisdictions should strive to implement.

Despite more than 50 years of tobacco control efforts, smoking continues to kill in astonishing numbers. As a result, more jurisdictions are now asking: what would it take to end the tobacco epidemic?

According to the Tobacco Atlas: "Policymakers must utilize existing strategies that have been proven effective in reducing tobacco prevalence, and they must explore bold, innovative tactics to achieve the endgame for tobacco use[6]."

FCTC INTERVENTIONS

Price and tax measures to reduce the demand for tobacco.

Non-price measures to reduce the demand for tobacco, including:

- protection from exposure to tobacco smoke;
- regulation of the contents to tobacco products;
- regulation of tobacco product disclosures;
- packaging and labeling of tobacco products;
- education, communication, training and public awareness;
- tobacco advertising, promotion and sponsorship; and
- evidence-based cessation services.

Measures to reduce tobacco supply, including:

- efforts to stop illicit trade in tobacco products;
- efforts to prevent sales to and by minors; and
- support for economically viable alternative activities.

[5] World Health Organization. WHO Framework Convention on Tobacco Control. 2003 (updated 2004, 2005). Geneva: Switzerland.

[6] The endgame is the final stage of some action or process: in this case, the final stage of the process of ending the tobacco epidemic and the harms associated with smoking.

Some countries, such as Ireland, Scotland, Finland and New Zealand, have set tobacco endgame targets of less than 5% prevalence of smoking by 2035.

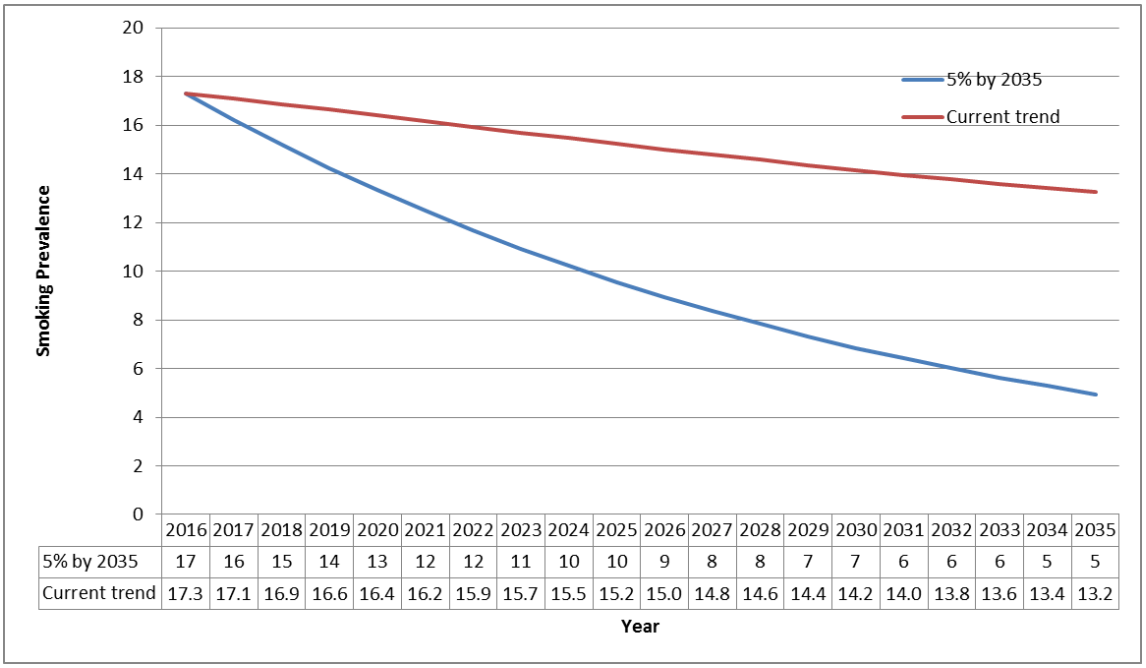
Tobacco control is a joint federal-provincial responsibility. In the fall of 2016, Canadian experts in tobacco control held a Summit to discuss a Tobacco Endgame for Canada.[7] In February 2017, as part of the Government of Canada's renewal of the Federal Tobacco Control Strategy, the federal Minister of Health issued a consultation paper that proposes a target, identified at the Summit, of <5% prevalence of tobacco use in Canada by 2035.[8]

ARE THE ENDGAME TARGETS WITHIN REACH?

Currently, about two million Ontarians smoke (17.4% of the population). Each year, about 45,000 quit successfully.

To reach the <5% target by 2035, Ontario would have to steadily reduce the proportion of Ontarians who smoke from 17.4% in 2017 to 11% by 2023 and to 8% by 2028.

Figure 5: Status Quo compared to Meeting Tobacco Endgame Targets



	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035
5% by 2035	17	16	15	14	13	12	12	11	10	10	9	8	8	7	7	6	6	6	5	5
Current trend	17.3	17.1	16.9	16.6	16.4	16.2	15.9	15.7	15.5	15.2	15.0	14.8	14.6	14.4	14.2	14.0	13.8	13.6	13.4	13.2

[7] A Tobacco Endgame for Canada Summit. Background Paper. August 2016.

[8] Health Canada. Seizing the Opportunity: The Future of Tobacco Control in Canada. 2017. Ottawa, ON: Government of Canada.

To take that steady path to <5% by 2035:

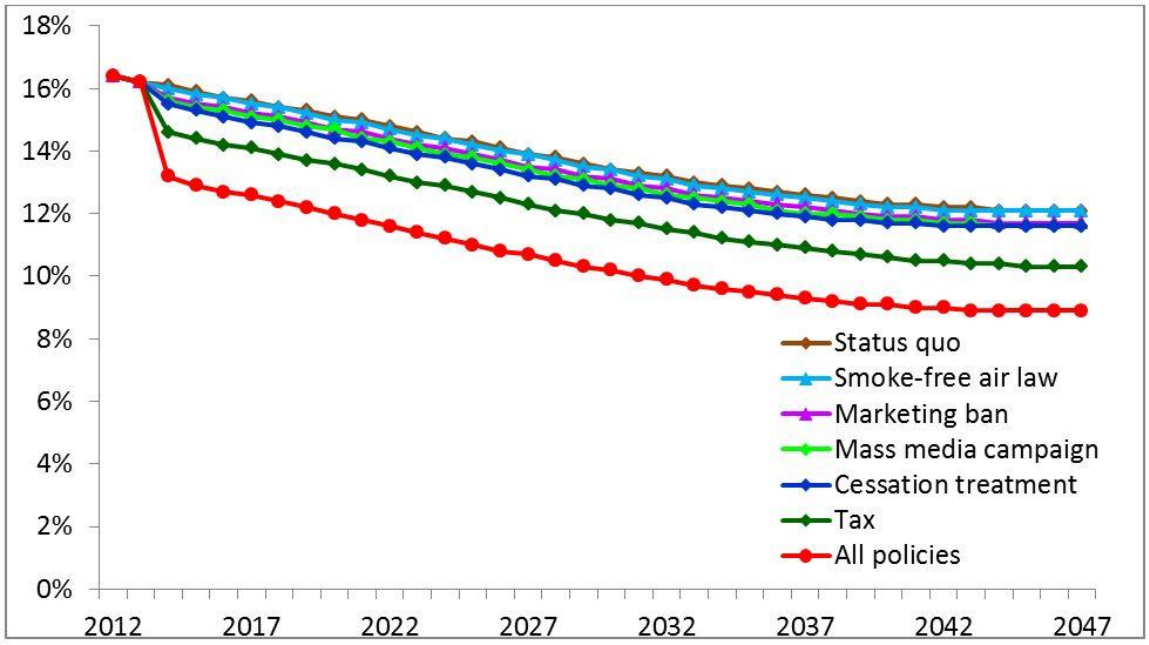
- More than 80,000 Ontarians who smoke would have to quit each year for 17 years. That is 220 people successfully quitting each and every day – almost twice as many as quit now.
- No more than 10,000 people would start smoking each year.

Is that doable? Absolutely – with the right mix and intensity of interventions and an unshakeable, sustained level of commitment. Societies have successfully stopped the use of other much less toxic products over much shorter periods of time.

What bold innovative steps would Ontario have to take to drive down tobacco use to <5% by 2035?

As the following graph illustrates, it will take much more than what Ontario is doing now. Without decisive government leadership and action, the plateauing of smoking rates in Ontario will leave the province far short of the endgame goal.

Figure 6: Status Quo vs Fully Implementing WHO MPOWER Recommendations



* Source: Zhang, B. & Schwartz, R. Technical Report of the Ontario SimSmoke: The Effect of Tobacco Control Strategies and Interventions on Smoking Prevalence and Tobacco Attributable Deaths in Ontario, Canada. 2013. Toronto, ON: Ontario Tobacco Research Unit.

The tobacco endgame is strongly supported by the public – including Ontarians who smoke:

- 66% of Ontarians agree that the number of retail tobacco outlets should be decreased;
- 51% support the notion that tobacco not be sold at all or should only be sold in government-owned stores;
- 53% agree that the sale of cigarettes should stop as soon as possible or be phased out over 5 to 10 years; and
- over 80% of Canadian smokers support raising the legal age for purchasing tobacco to 21.

Even if Ontario were to successfully implement all the FCTC-derived MPOWER interventions, the province would only be able to reduce smoking rates to about 11% by 2035 – less than half way to the <5% target.

To meet that target – which is essential to protect Ontarians' health – the province will need bold leadership and a much more aggressive smoke-free strategy.

That strategy must take into account not just the impact of traditional tobacco products, but the rapidly shifting market for harmful inhaled substances, such as shisha and cannabis, as well as potentially harmful emerging vaped and heat-not-burn products. While vaped and heat-not-burn products may help reduce the harm for people who smoke, the full impact of these products is not yet known. At this stage – early in their entry to the market – Ontario has a unique opportunity to develop coherent policy that can reduce harms caused by all inhaled products.

There is a moral and economic imperative to phase out the use of this deadly substance.

This report focuses mainly on cigarette smoking because it is, by far, the most prevalent form of tobacco use, but Ontario must be vigilant to avoid a shift from cigarettes to other harmful forms of tobacco and to minimize the risk from other harmful inhaled substances, such as shisha and cannabis.

A PRESCRIPTION FOR BOLD ACTION

At this stage in Ontario's smoke-free efforts, the challenge is to augment and strengthen the effective initiatives already in place while implementing a series of innovative, high-impact, multi-faceted interventions that will:

- build on what we know works and scale up proven strategies;
- challenge the status quo; and
- disrupt the systems that distribute and market tobacco and other harmful inhaled substances and products.

In the ESC's view, Smoke-Free Ontario has made great strides in prevention (particularly in preventing youth under age 19 from starting to smoke) and in protection (creating more smoke-free spaces and reducing harmful exposure to secondhand smoke). Going forward, however, Smoke-Free Ontario initiatives must protect and build on those gains while focusing much more on: challenging industry practices that undermine tobacco control efforts; and helping people who smoke quit and stay quit.

A number of jurisdictions have adopted the <5% by 2035 target, but no one has yet set out a detailed strategy to reach that target. As a national and international leader in tobacco control, Ontario should be the first to adopt and implement an ambitious comprehensive, integrated, multi-level "endgame" strategy -- consistent with international best practices for tobacco control.

To protect Ontarians from the harms associated with tobacco and other inhaled substances, the ESC proposes the following framework and a comprehensive 10-year strategy. The ESC has also highlighted a suite of high priority strategic interventions for the first five years of the strategy (i.e., short term priorities). The ESC recommendations build on the comprehensive appraisal of evidence for tobacco control interventions by the Smoke-Free Ontario Scientific Advisory Committee[9].

[9] Smoke-Free Ontario Scientific Advisory Committee, Ontario Agency for Health Protection and Promotion (Public Health Ontario). Evidence to Guide Action: Comprehensive Tobacco Control in Ontario (2016). Toronto, ON: Queen's Printer for Ontario.

THE FRAMEWORK

VISION

Within one generation, Ontario will be free of the epidemic of disease, death and other harms caused by tobacco and other harmful inhaled substances and products.

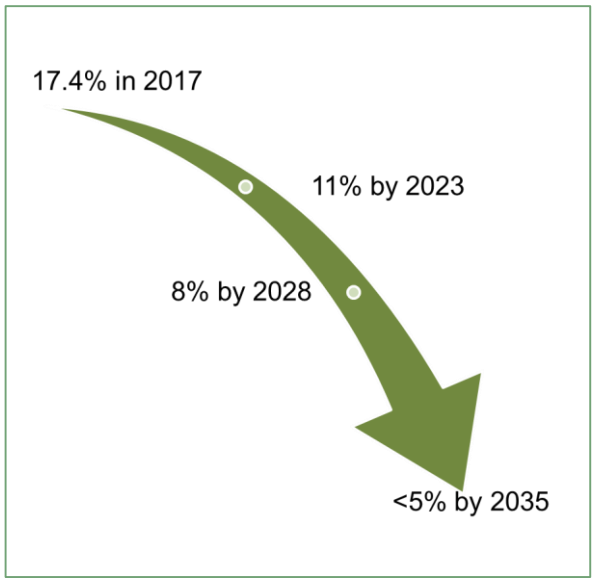
GOALS

- To substantially reduce tobacco use in Ontario.
- To regulate and limit access to the supply of tobacco and other harmful inhaled substances and products.
- To reduce exposure to the harmful effects of tobacco and other harmful inhaled substances and products.

TARGETS

To reduce regular (daily and occasional) smoking prevalence in Ontario from 17.4% in 2017 to:

- 11% by 2023
- 8% by 2028
- <5% by 2035



To increase the number of Ontarians who quit smoking successfully from 45,000 to more than 80,000 a year.

To decrease the number of Ontarians who start smoking to 10,000 a year.

To reduce the number of smoking-related deaths by 4,900 a year or 98,000 by 2035.

To reduce smoking-related health costs by $4.1 billion by 2023.

To reduce the social and economic costs of smoking by $8.1 billion by 2023.

Smoke-Free Ontario: A Ten-Year Strategy

A Framework for an Integrated Strategy to Address Tobacco, Other Inhaled Substances and Emerging Products

Principles	Evidence-Informed	Focused and Results Based	Comprehensive and Integrated	Effective	Person-Centred	Equitable	Trans-parency	Public Engagement
Vision	Within one generation, Ontario will be free of the epidemic of disease, death and other harms caused by tobacco, and the harms caused by smoking and vaping of other substances							
Over-Arching Goals	• To reduce tobacco use in Ontario to less than 5% prevalence by 2035 • To regulate and reduce access to the supply of tobacco and other harmful inhaled products and substances • To reduce exposure to the harmful effects of tobacco and other combustible substances							
Population Health Outcomes	Reduce the proportion of Ontarians who smoke from 17.4% to 11% by 2023 and 8% by 2028 Reduce the number of smoking related deaths by 4,900 each year (24,500 by 2023 and 49,000 by 2028) Reduce smoking-related health, social and economic costs by $12.2 billion by 2023							
Pillar	**Challenge and Contain the Industry**							
Objectives	• Undertake actions or interventions to decrease the sale of tobacco products • Protect the development of healthy public policies from the influence of the tobacco industry • Develop a 10-year plan to phase out the growing of commercial tobacco on non-Indigenous lands in Ontario							
Goals	Stop industry practices that threaten health							
Targets	Increase price of tobacco to consumers, reduce availability in retail settings and reduce the supply of tobacco products							
Pillar	**Cessation**		**Prevention**			**Protection**		
Objectives	Substantially increase the number of people who successfully quit tobacco use		Prevent the initiation and escalation of the use of tobacco, and other harmful inhaled substances and products			Reduce exposure to secondhand smoke and harmful aerosol from vaped products		
Goals	Substantially increase cessation		Substantially decrease initiation			Reduce exposure to secondhand smoke at home, in public places and in workplaces		
Targets	80,000 smokers quit each year		No more than 10,000 Ontarians start smoking each year			A 50% reduction in exposure to secondhand smoke in public places, workplaces, homes and vehicles		
Enablers	Research	Evaluation	Surveillance and Monitoring	Public and Stakeholder Engagement	Training and Capacity Building	Leadership & Coordination	Public Reporting and Accountability	Learning System
	Ensure up-to-date research knowledge is readily available to inform policy and practice	Evaluate strategy initiatives, activities and enablers	Develop and implement a coordinated data backbone to support a compre-hensive surveillance and monitoring strategy	Create an intense, compelling multi-year mass media based public education and social marketing campaign	Build capacity to implement the strategy	Ensure strong leadership, coordination and accountability	Ensure accountability, including regular reporting to the public on progress	Establish a compre-hensive learning system

PRINCIPLES GUIDING OUR WORK

The ESC's recommended strategies are driven by the following principles:

Evidence-informed. The recommended strategies are supported by rigorous scientific evidence, the lion's share of which is drawn from the 2017 Smoke-Free Ontario Scientific Advisory Committee report, as well as knowledge of provincial and local contexts, resources and political and community preferences.

Focused and Results-based. In identifying its priorities, the ESC focused specifically on the types of activities and interventions that could have the greatest impact if executed effectively.

Comprehensive and Integrated. The ESC recognizes that, to be optimally effective, strategies to control tobacco must be comprehensive – multifaceted, multi-component, multi-level – and integrated. These strategies must influence all aspects of supply (production and distribution) and demand (marketing and consumption). In addition, these strategies should operate at all levels (municipal, provincial, federal) and in all settings (schools, workplaces, health care, community, and retail environments) and use all available tools (policy and programs, legislation and regulations, enforcement, education, mass media, treatment services, research, monitoring and evaluation, surveillance and capacity building).

Effective. The effectiveness of tobacco control interventions depends on their intensity. These interventions have to be delivered at a sufficient dose (frequency, duration) to affect the underlying causes of the epidemic, including the influence of the well-resourced tobacco industry. Strategy investments have to be large enough, well spent and sustained over time to ensure intensity and impact.

Person-centred. Smokers are family members, friends, colleagues, and members of our communities – and should be supported in their efforts to address their health challenges. All Ontarians should have easy access to high quality, culturally appropriate cessation services that meet their individual needs, and be actively engaged in their health and care.

Equitable. Smoking has a disproportionately negative effect on some Ontarians. Different people/populations need different levels and types of support to help individuals stay smoke-free or to quit. Consistent with Patients First, interventions should be tailored to meet Ontarians' diverse needs and have an equitable impact on their health.

Transparency. Individuals responsible for implementing the strategies should report publicly and at regular intervals their implementation, progress and impact.

Public engagement. The public has played a critical role in Ontario's tobacco control programs. Changing public attitudes towards smoking made it possible for Ontario to introduce and enforce a wide range of smoke-free policies. The public – including people who smoke – continue to be highly supportive of tobacco control initiatives. The public should be actively engaged in achieving Ontario's smoke-free targets, goals and vision.

STRATEGIC DIRECTIONS

The ESC recommends that Ontario focus on five key strategic directions:

I. CHALLENGE AND CONTAIN THE TOBACCO INDUSTRY

The powerful, well-resourced tobacco industry has a history of deceptive and fraudulent practices designed to keep people smoking. Healthy public policy should challenge and contain the industry's influence and practices.

II. MOTIVATE AND SUPPORT MANY MORE ONTARIANS WHO SMOKE TO QUIT AND STAY QUIT

Most Ontarians who smoke want to quit, but the easy availability of inexpensive tobacco at just about every corner coupled with the lack of routine, ongoing support and treatment prevent them from overcoming this powerful addiction and quitting successfully.

III. KEEP MORE ONTARIANS FROM STARTING TO SMOKE

It is essential to keep people from starting to use tobacco and other harmful inhaled substances and products.

IV. EXPAND POLICIES THAT PREVENT EXPOSURE TO SECONDHAND SMOKE AND HARMFUL AEROSOL FROM VAPED PRODUCTS

Exposure to secondhand smoke from tobacco, shisha and cannabis and harmful aerosol from vaped products causes serious health problems. Smoke-free spaces reduce harm, protect population health, limit social exposure to smoking and help de-normalize smoking.

V. CREATE A STRONG ENABLING SYSTEM TO EXECUTE THE STRATEGY

To be effective, the strategy and its interventions must be based on evidence, integrated into a forward-looking campaign, delivered by skilled people and supported by key leaders and an engaged public. All aspects of the strategy should be implemented through shared leadership and execution, strategic partnerships, capacity building, and learning through research and evaluation.

PRIORITY ACTIONS: THE FIRST FIVE YEARS

The following pages set out a comprehensive 10-year strategy for Ontario – with rationales for all activities and interventions.

In the first five years, the ESC recommends that Ontario focus on the following priority actions to have the greatest possible impact:

I. CHALLENGE AND CONTAIN THE TOBACCO INDUSTRY

1. **Use tax and other pricing policies** to increase the cost of tobacco products by:
    - immediately raising provincial taxes on all tobacco products to at least the highest level of all other provinces and territories and investing the increased revenue in tobacco control, and then continue to regularly increase taxes to at least double the price of tobacco products;
    - preventing the industry from circumventing tax-related price increases by reducing the price differential between different types and brands of cigarettes and prohibiting volume discounts;
    - banning all industry incentives offered to retailers; and
    - eliminating any provincial tax deductions or fiscal advantages available to tobacco companies.
2. **Reduce the availability of tobacco in retail settings** by:
    - using provincial legislation and local bylaws, zoning and licensing fees to reduce the number and density of retail tobacco vendors; and
    - expanding the ban on cigarette displays to include all smoking, tobacco-related and vaping paraphernalia.
3. **Reduce the supply of tobacco products** in Ontario by:
    - reducing the amount of tobacco released to the market for sale; and
    - enhancing enforcement efforts to combat unregulated tobacco.
4. **Make industry practices more transparent** by:
    - prohibiting its involvement in any activities that could influence health policy;
    - ensuring all government-industry contacts are documented and made public; and
    - requiring the industry to disclose information on its practices.

II. MOTIVATE AND SUPPORT MORE ONTARIANS WHO SMOKE TO QUIT AND STAY QUIT

In addition to the recommendations above, related to price and availability, which will support people who smoke to quit:

5. Create **environments that encourage and support quitting** by:
    - making quitting the easy and obvious choice;
    - expanding smoke-free policies;
    - building on existing partnerships and proven strategies; and
    - promoting cessation services through sustained mass media-based and social media-based public education over the life of the strategy.
6. Implement a highly visible **network of high quality, person-centred cessation services** by:
    - coordinating health care, community and population-based services and providing systematic referrals to ensure seamless nonjudgmental services, supports and follow up for Ontarians who want to quit;
    - expanding the cessation services available and ensuring people are aware of services;
    - embedding best practice smoking cessation services in all health care settings;
    - shifting to an opt-out approach to smoking cessation;
    - maintaining and enhancing robust clinical standards;
    - ensuring health care providers have the core knowledge, skills and competencies to provide evidence-based cessation services; and
    - exploring the potential of non-combustible nicotine delivery systems to reduce harm for people who are unable or unwilling to quit smoking.
7. Ensure **equitable access to smoking cessation services** by:
    - providing cost-free cessation pharmacotherapies in accordance with clinical standards and individual needs;
    - targeting smoking cessation services to those with high rates of smoking; and
    - making more effective use of behavioural technologies (e.g., text messaging, online and phone counseling) to reach more people who smoke.

III. KEEP MORE ONTARIANS FROM STARTING TO SMOKE

8. Implement **comprehensive policies to prevent youth and young adults from starting to smoke** by:
    - raising the minimum age to buy tobacco products to 21;

- reducing youth exposure to on-screen smoking by requiring movies that contains tobacco imagery to be assigned an adult rating (18A), requiring movie theatres to show strong anti-tobacco ads before movies that contain smoking or tobacco use, and making media productions that include smoking ineligible for public subsidies; and
- making all Ontario post-secondary campuses smoke-free, tobacco-free and free of tobacco industry influence.

IV. EXPAND POLICIES THAT PREVENT EXPOSURE TO ALL SECONDHAND SMOKE AND HARMFUL AEROSOL FROM VAPED PRODUCTS

9. Continue to **reduce exposure to all secondhand smoke at home** by:
    - increasing the number of smoke-free multi-unit housing buildings in Ontario;
    - including an optional smoke-free housing clause in the new standard lease; and
    - amending the Ministry of Housing Residential Tenancies Act to allow landlords to evict a tenant who violates a no-smoking provision in a lease.
10. **Amend the Smoke-Free Ontario Act** to:
    - prohibit smoking of shisha and cannabis and vaping in all indoor and outdoor places where tobacco is banned; and
    - prohibit smoking of tobacco, shisha and cannabis within a 9 meter buffer zone around public buildings and in outdoor workplaces.

V. CREATE A STRONG ENABLING SYSTEM TO EXECUTE THE STRATEGY

11. Establish a system that provides the leadership, coordination, accountability, knowledge, research and engagement to execute the strategy by:
    - creating a mass media/social marketing campaign that will engage the public, build public support for strategy initiatives and support/promote the network of cessation services;
    - establishing a learning system that creates and uses the latest research knowledge, surveillance information, ongoing monitoring and evaluation data and practice-based knowledge to routinely inform policy and practice;
    - providing technical assistance and education to enhance the capacity of all those involved in the Smoke-Free Ontario strategy; and
    - identifying the most effective mechanism(s) to lead and coordinate the strategy and ensure accountability, including regular reporting to the public on the progress being made.

Each of these priority actions is described in more depth – along with other recommended initiatives – in the following pages.

PROPOSED 10-YEAR SMOKE-FREE ONTARIO STRATEGY

1. CHALLENGE AND CONTAIN THE INDUSTRY

Effective disease control efforts work by targeting the causal agent (e.g., virus, bacteria, product), the disease vector (the means by which the disease spreads), and the environment that allows the disease to thrive.

In the case of smoking-related illnesses, the cause is a highly addictive, toxic product (tobacco), the disease vector is a powerful and highly adaptable industry and the environment is a society that tolerates businesses that market lethal products. Until now, social and fiscal policies have not directly challenged the impact of the tobacco industry and its practices on the tobacco epidemic. That must change.

> *There is a fundamental and irreconcilable conflict between the tobacco industry's interests and public health policy interests.*
>
> *World Health Organization Framework Convention on Tobacco Control*

The tobacco industry – one of the most profitable in the world today – has a long history of denying the negative health effects and addictive nature of its products, targeting marketing at youth and young adults, manipulating and undermining scientific research, and trying to influence health policy and tobacco control policies. Unlike most other businesses, it has been deceptive and fraudulent in the way it designs and represents its products. With its current aggressive promotion of "reduced risk products" and "next generation products", the industry has also demonstrated its adaptability: it will continue to develop potentially harmful products under the auspices of "harm reduction" while marketing them only in jurisdictions that have seen a dramatic drop in smoking of their highly profitable traditional tobacco products.

The WHO Framework Convention on Tobacco Control focuses squarely on the role of the tobacco industry. Article 5.3 calls on all signatories to protect their tobacco control and public health policies from commercial and other vested interests of the tobacco industry. Policies such as taxing cigarettes to increase their price, restricting advertising and requiring health warning labels on cigarette packages have helped protect consumers from some predatory industry marketing practices. However, given the speed with which the industry adapts and its ability to circumvent regulatory efforts, more must be done to challenge and contain the industry's influence. Lessons learned from tobacco control should also be used to prevent the same harms arising from the legalization of cannabis and industry marketing of other harmful inhaled substances and products.

The ESC recommends the following strategies to stop industry practices that threaten health:

This combination of innovative initiatives will not only help challenge and contain the industry, they will help people who smoke quit and stay quit, prevent young people from starting to smoke, and protect society as a whole from the harms of tobacco and other harmful inhaled substances and products.

1.1 USE TAX AND OTHER PRICING POLICIES TO INCREASE THE COST OF TOBACCO PRODUCTS

Tax policies that increase the price of tobacco are effective in reducing smoking particularly among groups who are more price-sensitive, such as youth, young adults, people with low incomes and people with mental illness. Higher tobacco prices also motivate people who are heavy and long-term smokers to try quitting.

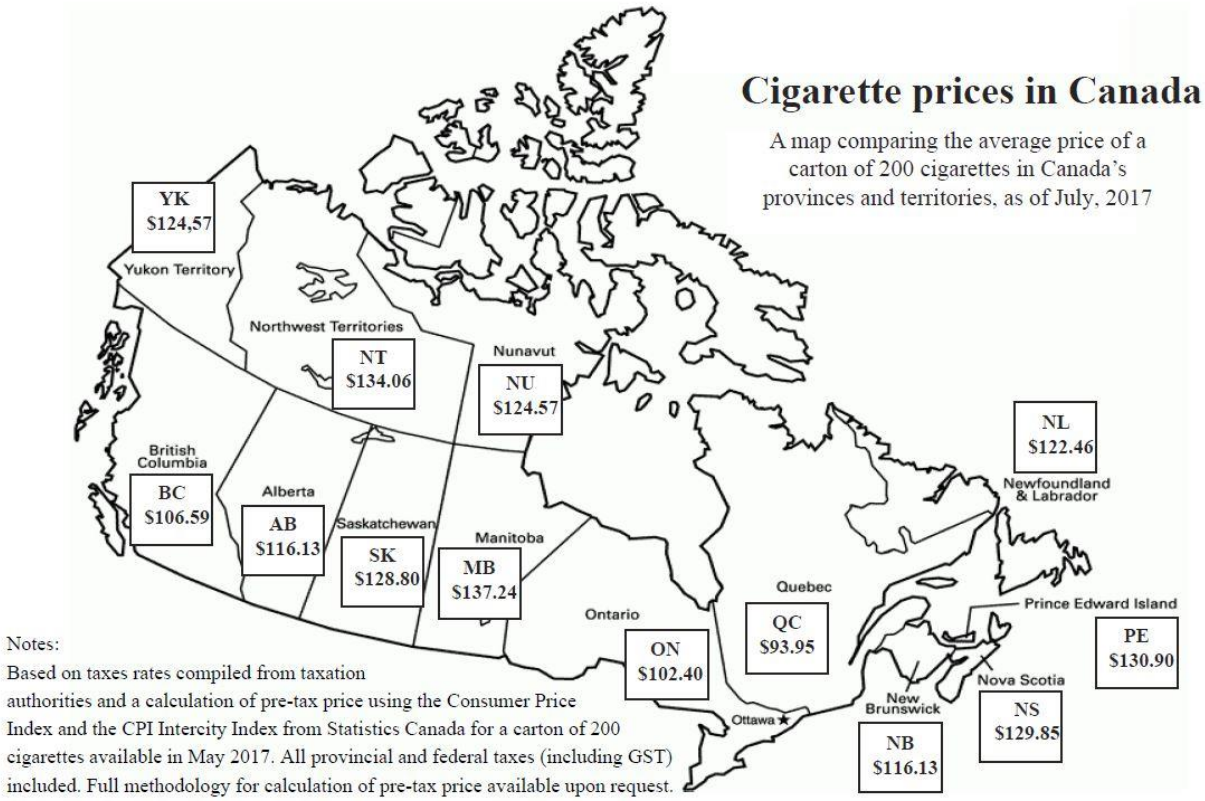
A 10% increase in the price of cigarettes leads to a 3 to 4% decrease in consumption. Among adolescents and children, the impact of price increases is even greater: it can lead to a 6 to 8% decrease in consumption.

While increasing tobacco prices is effective, it is not enough on its own to have the desired impact because the industry is able to find work-arounds that keep the cost of some cigarettes low. To offset the current industry practice of pricing some of its products at discount levels:

1.1.1 Immediately raise provincial taxes on all tobacco products, including roll-your-own tobacco, to at least the highest rate of all other provinces and territories. Continue to regularly increase taxes to at least double the price of tobacco products. Reinvest all new revenue generated from these taxes into tobacco control

Ontario taxes tobacco products now but its provincial excise tax and retail price for cigarettes are the second lowest in Canada. With the tax increases already approved for the next two years, the price of cigarettes in Ontario will still be below the national average ($55.93 per carton as of May 1st, 2017).

Figure 7: The Cost of a Carton of Cigarettes Varies Significantly Across Canada



Source: Smoking and Health Action Foundation, www.nsra-adnf.ca

Even with the ESC's recommended tax increases, which will bring Ontario in line with other Canadian jurisdictions, the province will still lag behind other leading jurisdictions in its tobacco pricing policies.

Any increase in the cost of cigarettes may push some people to switch (at least temporarily) to roll-your-own tobacco; therefore, to have the desired impact, it is essential to apply any tax increase to all tobacco products.

To be an effective deterrent, tax increases should be substantial initially and then be automatically adjusted to keep pace with inflation and any increases in real income.

Australia recently announced a 12.5% annual increase in tobacco taxes from 2017 to 2020: cigarettes are $30 a pack now and will be $45 a pack by 2020.

1.1.2 Prevent the industry from circumventing tax-related price increases by:

- **eliminating the price differential among different types and brands of cigarettes; and**
- **prohibiting manufacturers and retailers from offering volume discounts (i.e., lower per-pack price for buying more than one pack of cigarettes).**

The tobacco industry currently uses a number of different pricing strategies to reduce the impact of tax-related price increases and keep cigarettes affordable. For example:

- There is a three-tier pricing system for cigarette packs in Ontario, with cigarettes available in three different price bands and some brands available at deep discount prices. This pricing system allows companies to undermine the impact of any tax increase by shifting the costs of any tax increase to premium brands and consumers who are less price sensitive. At the same time, they can keep the price of cheaper brands low, which allows them to keep people who are more price-sensitive smoking and to offer youth more affordable options.

At the current time, discount cigarettes account for 60 to 65% of cigarettes sales in Ontario.

- Manufacturers and retailers often use volume discounts and other price promotions, such as a free lighter or other accessory, to minimize the impact of tax increases on cigarette prices.

These types of predatory practices should be prohibited. To be able to counter industry pricing practices, Ontario first needs to understand industry pricing systems and practices: information that industry should be required to make public (see recommendation 1.4). This information will make it more obvious to both policy makers and the public how the industry manipulates prices in order to continue to market harmful tobacco products to certain populations (e.g., people with low incomes, youth).

Ontario will also need to assess the impact of different options to counter these practices. For example, the options to end tiered pricing include establishing a minimum, maximum and/or government-regulated price (e.g., setting a high uniform price for all brands of cigarettes and equivalent quantities of roll-your-own tobacco). Each of these options will have different impacts, and they should be adopted based on detailed research to determine which will be most effective in the Ontario context. Empirical experience should factor into future pricing policies.

1.1.3 Ban price signs in retail settings

Under the Smoke-Free Ontario Act, retail establishments are not permitted to have signs or displays that promote tobacco products; however, they are allowed to post signs that list cigarette prices and availability. These signs are used to actively promote volume discounts and discount cigarettes and should be banned. Retail outlets can rely on other means to provide price information for consumers, such as the binders (approved under current Ontario law and available in every retail outlet) that list different brands and prices.

1.1.4 Ban all industry incentives offered to retailers

Tobacco companies offer a range of direct and indirect incentives to retailers to increase sales of their products. For example, manufacturers offer rebates to retailers for selling a particular brand below the maximum retail price. Retailers who meet their sales targets receive bonuses and perks, such as vacations. Tobacco companies often pressure retailers to sign performance-based contracts. To avoid losing their contracts and perks, retailers will often sell cigarettes at deeply discounted prices.

According to consumer surveys, even people who smoke agree that we need to end the cycle of addiction: the industry should be stopped.

A growing number of tobacco companies are part of large international conglomerates that sell many other products besides tobacco. In some cases, the incentives appear to be related to selling these other products but are, in fact, based on the retailer meeting tobacco sales targets.

Quebec has already successfully introduced legislation to stop these practices, and Ontario could learn from its experience to implement and enforce this type of ban. This strategy would have the added benefit of making the public more aware of industry practices and establishing a higher bar for ethical business behaviour.

1.1.5 Work with the federal government to identify and eliminate tax deductions and any other fiscal advantages available to tobacco companies

Tobacco companies make a highly addictive and toxic product that costs Ontario thousands of lives and billions of dollars in health care and other costs each year. Yet they enjoy the same corporate and other tax advantages as manufacturers of safe consumer products. Tobacco companies often argue that they are only meeting a demand – selling a legal product that consumers want – however, they do not acknowledge that the demand exists because their product is addictive.

Because tobacco is a uniquely dangerous product with no safe level of use (unlike any other consumer product) – one that kills half of its long-term users prematurely – the industry should not receive any government support or incentives.

1.2 REDUCE THE AVAILABILITY OF TOBACCO IN RETAIL SETTINGS

Although tobacco is more deadly than alcohol and there is no safe level of use as there is with alcohol (i.e., low risk alcohol drinking guidelines[10]), tobacco products are available 24/7 in over 10,000 retails settings across Ontario. The fact that tobacco is so available belies the risk and may give consumers a false sense that the product is less dangerous than it actually is.

When tobacco is less available, fewer people – particularly young people – start smoking and people who are smokers smoke less and are more likely to successfully quit. There is a correlation between distance to the nearest tobacco retailer and the amount a person smokes: people who smoke who live less than 500 metres from a tobacco retailer are less likely to stay quit.

If tobacco were a new consumer product coming to market today, it would not pass even the early stages of product testing and approval.

The ESC recommends that Ontario take three key steps to reduce the availability of tobacco and other harmful inhaled substances and products in retail settings.

1.2.1 Use provincial and municipal legislation, zoning restrictions and licensing fees to reduce the number and density of retail tobacco vendors

Ontario currently bans tobacco sales in nine locations compared to 15 in Quebec and 17 in Nova Scotia. Cigarettes are no longer sold in pharmacies, hospitals, stores on post-secondary campuses and vending machines in Ontario, but they are still available in theatres, bars, casinos, convenience stores, grocery stores and gas stations.

While it may not be possible at this time to ban cigarette sales in all these settings, there are opportunities to reduce the number and density of retail outlets that sell tobacco – particularly in areas where there are highly vulnerable populations (e.g., youth). Zoning restrictions that prohibit the sale of cigarettes near schools, campuses and recreation centres and limit the number of retailers who can sell cigarettes within a given area or neighbourhood can reduce social exposure to smoking and make it harder to buy tobacco products.

[10] http://www.ccsa.ca/Resource%20Library/2012-Canada-Low-Risk-Alcohol-Drinking-Guidelines-Brochure-en.pdf

Table 1: Locations Where Tobacco Sales are Banned in Canada

Places Where Tobacco Sales Are Prohibited by Law													
Location	**Province/Territory**												
	AB[i]	**BC**[ii]	**MN**[iii]	**NB**[iv]	**NL**[v]	**NS**[vi]	**NT**[vii]	**NWT**[viii]	**ON**[ix]	**PEI**[x]	**QC**[xi]	**SK**[xii]	**YK**[xiii]
Provincial gov't buildings		X			X	X			X	X		X	
Municipal gov't buildings		X			X	X				X		X	
Vending machines				a	X	X	X	X	X	X	X	b	
Pharmacies	X			X	X	X	X	X	X	X	X	X	X
Hospitals	X	X			X	X	X		X	c	X	X	
Health care facilities	X	X			X	X	X		X	X	X	X	
Residential care facilities	X	X			X	X	X		X	X	X	X	
Schools	X				X	X			X	X	X	X	
Post-secondary schools	X	X			X	X		d	X	X	X		
Child care facilities					X		X		X		X		
Indoor sport/recreation		X			X	X		X		X	X	e	
Community centres						X					X		
Theatres/cinemas					X	X				X	X	X	
Libraries/Galleries					X	X					X		
Outdoor recreational facilities, e.g. amusement parks												X	
Temporary outdoor locations					X	X					X		
Restaurants						X					X		
Bars						X					X		
Gaming facilities						X							

[a] No vending machine sales in retail stores
[b] Vending machine sales permitted only in places off-limits to minors
[c] Except psychiatric hospitals
[d] NWT has only one post-secondary institution which has a policy not to sell tobacco products
[e] Sales prohibited in recreation facilities only.

* Source: Non-Smokers' Rights Association / Smoking and Health Action Foundation

Currently, the provincial government requires all retailers/vendors of tobacco products to be registered under the Tobacco Tax Act. Retailers are required to have a Tobacco Retail Dealer's Permit. However, there is no fee for that permit. One strategy that could reduce the number of retail outlets for tobacco is the requirement that all registered tobacco retailers be required to pay an annual municipal licensing fee and meet certain conditions to be able sell tobacco (e.g., know the risks of smoking, not actively promote tobacco sales, abide by age restrictions on the sale of tobacco products, and accept no remuneration from tobacco companies). At the current time, only 20 Ontario municipalities charge a vendor licensing fee and the amount of that fee varies widely. To have the desired impact, municipal vendor licensing fees should be high enough to be a barrier to selling tobacco and not simply an acceptable cost of doing business. Income from licensing fees should remain with municipal governments with the requirement that they be used to defray the costs associated with the licensing system, including enforcement and public education.

Having all tobacco retailers registered under the Tobacco Tax Act also allows municipalities to map the number and location of vendors, and then develop zoning restrictions that can limit the number of vendors in certain areas.

1.2.2 Expand the ban on the display of cigarettes to include all smoking, tobacco-related and vaping paraphernalia

Banning point-of-sale displays reduces environmental cues to smoke and helps de-normalize tobacco use. The Smoke-Free Ontario Act prohibits retailers from displaying cigarette packages or promotional displays. However, unlike legislation in many other provinces and territories (i.e., New Brunswick, Newfoundland, Nova Scotia, Prince Edward Island, Quebec, Manitoba, Saskatchewan, Northwest Territories), it does not prohibit displays of smoking paraphernalia, including but not limited to branded lighters, lighter fluid, matches, e-cigarettes, e-liquid, cartridges, pipes, water pipes, rolling papers and other smoking-related products. Banning these other displays – focusing first on settings where minors are permitted – would further eliminate promotional cues to smoke.

Ontario should also strongly support federal government efforts to require the industry to use plain and standardized packaging for all its products.

1.3 REDUCE THE SUPPLY OF TOBACCO PRODUCTS IN ONTARIO

1.3.1 Reduce the annual quota of tobacco products in Ontario by implementing a "sinking lid" system that gradually reduces the amount of tobacco released to the market for sale

A "sinking lid" system involves regularly reducing the amount of tobacco released to the retail market for sale in order to reach a certain target. Tobacco companies would bid through a provincial auction system for their share of that shrinking quota each year. As the overall supply of tobacco products drops, prices will increase. To be effective, this strategy must be accompanied by other interventions to reduce demand and provide comprehensive cessation services, as well as stronger regulation of tobacco supply and retailing.

1.3.2 Significantly enhance enforcement efforts to combat unregulated tobacco

While the black market in tobacco is not as well developed as, for example, the black market for cannabis, it is estimated that unregulated, untaxed tobacco may account for a substantial proportion of the tobacco market in the province. The availability of unregulated, untaxed tobacco products undermines the impact of tax and pricing policies designed to increase cost and reduce consumption. It also reduces tax income to the government – although revenue from tobacco excise taxes does not come close to offsetting tobacco-related health care costs.

The Ministry of Finance has implemented enforcement initiatives, such as the Ontario Provincial Police's dedicated Contraband Tobacco Enforcement Team (CTET), to investigate tobacco smuggling and trafficking by organized crime.

Quebec has had a similar initiative, the ACCES TABAC program, for a number of years. That program has been able to help drive unregulated tobacco down to 15% of that province's tobacco market. To achieve that level of success, Quebec had to more than triple its investment in the program (from $5 to $18 million a year). If Ontario wants to have a similar impact, it must significantly increase CTET resources.

1.4 MAKE INDUSTRY PRACTICES MORE TRANSPARENT

Because the tobacco industry is large, well-resourced and politically well connected, it often has undue influence on policy decisions. It has successfully lobbied governments to lower tobacco taxes and reduce other measures to control tobacco use. To fulfill the spirit of Article 5.3 of the Framework Convention on Tobacco Control, Ontario must take concrete steps to "protect their tobacco control and public health policies from commercial and other vested interests of the tobacco industry."

It is essential that the province hold the tobacco industry and those who have contact with industry representatives to the same standard for transparency that it has established, for example, for pharmaceutical companies and the prescribers, hospitals and others who have contact with those companies.

1.4.1 Prohibit industry involvement in any activities that could impact health policies

Industry should have no role or influence in any tobacco control or public health policies, including drafting, monitoring or enforcing policies.

Tobacco industry representatives who want to lobby government should go through the same process as other lobbyists. Sanctions for illegal lobbying activities should be severe and costly enough to deter the activity.

1.4.2 Make all government-industry contacts transparent

There will, of course, be times when public servants and elected representatives must meet with tobacco industry representatives to discuss, for example, technical issues, licensing, compliance inspections, pro-active or defensive litigation, mandated industry reporting, and constitutionally required consultations on new policy or law. However, there should be clear conflict-of-interest guidelines that define:

- the circumstances when those meetings and contacts can occur;
- the requirement to document those discussions and make that information publicly available; and
- the requirement for a cooling off period (e.g., 12 to 24 months) before a former government employee can accept an industry position involving tobacco-related policy.

1.4.3 Require the tobacco industry to disclose information on its practices

Transparency is not possible without greater knowledge of the practices the tobacco industry uses to circumvent health policy. Tobacco companies should be required to provide detailed information on their pricing practices, product content and manufacturing, brands and brand variants, all lobbying and advocacy activities, including industry funding of retailers, think tanks, policy analysts, research projects and other allied/front groups, and any tax deductions or fiscal incentives they receive from governments.

This information will help government understand industry tactics and their impact and develop effective policies to contain them. It should also be used to make the public more aware of industry practices and manipulation.

1.4.4 Vigorously pursue the health care cost recovery litigation against the industry launched in 2009

The 2009 case[11], which was launched to recover health care costs for past tobacco-related illnesses and deaths, has been in process for many years. While it may be tempting to settle (as was done with tobacco litigation in 1990s), the ESC recommends that, instead of settling for pennies on the dollar and no convictions (as in the past), the case go through the full judicial process including a court process and a verdict that would impose mandatory conditions on the industry to promote public health.

Similar trials in other jurisdictions, such as the recent Quebec class action trial, have had significant positive impacts. Media coverage of the trials made the public aware of questionable industry practices, government plaintiffs received much larger awards and criminal charges were laid. High costs to the industry from defending against litigation may also drive up tobacco prices, which could help reduce smoking. Depending on the size of the cost recovery and future required practices, some tobacco companies may be forced to leave the market.

1.4.5 Calculate and publish the full annual cost of tobacco use, including personal costs (deaths, loss of quality life years), health care costs, productivity costs, other social costs and environmental costs (littering, toxins from smoke and cigarette butts leaching into soil and water)

Past efforts to calculate the costs of tobacco use have focused mainly on health care costs; however, the tobacco industry also creates other significant social and environmental costs. More comprehensive and regular reporting of the impact and cost of tobacco use will make it even more apparent that the actual costs (i.e., disease burden, lost wages) dramatically outweigh the economic benefits of the industry (i.e., employment, tax revenue). This information would be a strong

[11] See https://www.attorneygeneral.jus.gov.on.ca/english/tobacco_litigation.php.

incentive for government to intensify efforts to make Ontario tobacco-free and smoke-free.

1.4.6 Impose an annual levy on tobacco companies to defray the health, social and environmental costs of their products not covered by tobacco excise taxes

At the current time, most of the costs of the tobacco industry are borne by Ontarians – including the 83% of Ontarians who do not smoke. Excise taxes charged on tobacco products cover only about an eighth of what smoking costs society and, even with planned price increases, will come nowhere close to covering all health care or other indirect costs, such as foregone income and lost productivity ($8.76 billion a year).

If the tobacco industry had to cover the full cost of the use of its products, it would no longer be financially viable.

The health care cost recovery litigation now in court will bring in some industry money to cover **past** health care costs; however, there is no ongoing mechanism to hold the industry responsible for current and future health, social and environmental costs of its products.

Ontario already has many precedents for ensuring that industry cover costs associated with its business activities, such as requiring mining companies to pay the cost of environmental damage.

1.4.7 Discourage all publicly funded organizations from investing in the tobacco industry

Because the tobacco industry is highly profitable, it is an attractive investment for many individuals and organizations, including governments, universities, hospitals and public pension plans. Ontario cannot in good conscience advocate for a tobacco-free province while continuing to invest in tobacco companies; that is an investment in death and disease for tens of thousands of Ontarians and millions more around the world.

Ontario has an opportunity to highlight the negative impact of investing in the tobacco industry and set an example for private sector organizations and individuals. To discourage investment in the industry and encourage divestment, the ESC recommends that Ontario:

- Establish a tobacco industry divestment policy for all provincially-funded organizations; and
- Require the tobacco industry to publicly disclose in a prescribed format (e.g., sorted separately by value of investment and region of the province) the names of provincially funded organizations that hold stock in their companies and the amount of their holdings.

1.5 REGULATE NEW INHALED SUBSTANCES AND DELIVERY DEVICES

As part of the tobacco industry's efforts to maintain a market for its products in the face of evidence of smoking-related harms, growing social disapproval of cigarettes and dropping smoking rates, companies are investing heavily in developing and promoting a growing number of smokeless products and devices to deliver nicotine, such as e-cigarettes and vaping products. Many vaping and heat-not-burn products are promoted as a form of harm reduction (i.e., less harmful than smoking tobacco) and a means to help people who smoke quit. However, these devices still produce harmful toxins and feed nicotine addiction. They may also be attractive to non-smokers as a "safer" and more socially acceptable way to smoke. Ontario should act now to regulate and limit their use as evidence is gathered on their health effects and potential efficacy in reducing harm for some users. In particular, measures should be put in place to ensure that non-smokers do not start using them.

1.5.1 Evaluate and regulate the marketing and use of all inhaled drug delivery devices and ultimately phase out the sale of all *combustible* delivery devices

Those devices that involve heating tobacco (e.g., the industry's new generation of heat-not-burn products) create many of the same toxins as smoking. Nevertheless, some are less toxic than combustible products. As a harm reduction measure, all devices that involve the burning of substances should be phased out completely over the long-term.

In the meantime, there is currently no process in Canada to assess/evaluate the new drug delivery devices for their safety or to regulate their sale or use. Products such as iQOS, a new heat-not-burn smokeless cigarette, have been introduced to the market with no health or safety assessment.

As part of the regulatory process, the industry should be required to provide information related to product testing, toxicity and marketing plans before a product appears on the market.

To protect public health, the display, promotion and sale of all these devices should be closely regulated. They should be subject to the same restrictions as tobacco products under the Smoke-Free Ontario Act, including:

- banning display and promotion of these devices;
- banning their use in workplaces and public spaces (to protect Ontarians from secondhand exposure to vaping emissions); and
- including all heat-not-burn products and devices, such as the iQOS charger, under the paraphernalia display ban(Some retailers are getting around the display ban by displaying the heating device but not the tobacco sticks).

The regulation of products is a joint federal-provincial responsibility and the province could play a larger role by contributing to product regulation.

1.5.2 Restrict the sale of e-cigarettes and vaping products to people who smoke

E-cigarettes and vaping products are less toxic than cigarettes, but they are still harmful. Given the industry's own claims that these products were developed to help people who smoke quit, their use should be limited to people who smoke and who might benefit from them. They should not be sold to non-smokers.

The ESC recognizes that this could be a difficult recommendation to police and enforce. However, the ministry could explore options such as a card system for people who smoke or making these products available only by prescription. This recommendation should be implemented with a public education campaign about the danger of e-cigarettes and vaping devices for non-smokers and about their potential for reducing harm for people who already smoke.

1.6 ELIMINATE ALL TOBACCO PRODUCTION IN ONTARIO

The ESC recognizes the unique challenge that Ontario faces in countering the industry as it is the only province in Canada where tobacco is produced in significant quantities and where the industry creates employment for people and communities. However, the health and other social costs to the province associated with tobacco use far outweigh the economic benefits from the industry. There is also strong evidence that tobacco produced in Ontario provides at least some raw material for the province's unregulated tobacco market, thereby undermining Ontario's efforts to reduce smoking.

Ontario has tried in the past, with some success, to reduce tobacco production in the province. It provided incentives for producers to switch to other crops (mainly ginseng) and established quotas that, for a time, reduced crop size. However, when the quota system was eliminated, new producers came into the market. Over the past 10 years, the size of Ontario's tobacco crop has nearly tripled.

The ESC recommends a phased approach to eliminating tobacco production in Ontario that takes into account the needs of families and communities that depend on tobacco for their livelihood.

Ontario cannot in good conscience seek to protect its own citizens from the harms of smoking while, at the same time, producing tobacco that will harm people here and in other parts of the world.

1.6.1 Establish a mandatory timeline (5 to 10 years) to phase out tobacco production on non-Indigenous lands

It will take time and other supports to phase out tobacco production acreage. However, having a timeline with targets will help focus efforts and keep the process on track.

1.6.2 Work with tobacco producers to develop crop replacements

An effective crop replacement program should include appropriate incentives as well as training and assistance with costs related to changing crops. The full cost

of weaning tobacco producers from their economic addiction should be borne by the tobacco companies through taxation on tobacco products. The ESC assumes that the Ministry of Finance will continue to work with First Nations communities to find an alternative to commercial tobacco production.

2. MOTIVATE AND SUPPORT MORE ONTARIANS TO QUIT AND STAY QUIT

Most of the two million Ontarians who smoke want to quit, but nicotine is highly addictive. It may take multiple attempts before someone successfully stops smoking. Because quitting is so difficult, it is essential to create social environments that encourage and support quitting. It is also critically important that the cessation system be there to provide welcoming, compassionate, nonjudgmental cessation services for Ontarians who want to quit.

To reach our aggressive target of more than 80,000 Ontarians quitting each year for the next 17 years, Ontario has to bring cessation and cessation support services to whole new levels. Over the past 35 years, Ontario has learned a great deal about effective cessation interventions and Ontario must leverage that knowledge, expertise, infrastructure and assets to save lives and ensure all Ontarians have the same opportunity to enjoy good health.

The ESC recommends the following interventions to motivate and support more Ontarians to quit and stay quit:

To reach the aggressive target of at least 80,000 Ontario smokers quitting each year or 220 each day – at least 35,000 more than the number who quit now – Ontario needs cessation services that provide seamless support and keep people engaged throughout the quitting process and after to prevent relapse.

2.1 CREATE ENVIRONMENTS THAT ENCOURAGE AND SUPPORT QUITTING

Ontario should maintain and intensify all efforts to create environments that **make quitting the easy and obvious choice.** Many of the recommendations discussed in detail under other Strategic Priorities (Challenge and Contain the Industry, Keep More Ontarians from Starting to Smoke, Expand Policies to Prevent Exposure to Secondhand Smoke) help create supportive environments, including:

- health promotion policies and programs that promote healthy active living (e.g., tobacco taxes, clean air policies);
- information about the harms related to smoking and manipulative industry practices;
- ongoing multi-year mass media and social marketing campaigns that motivate people to quit and guide them to services that are easy-to-access;

- the telephone quitline;
- the use of evidence-based incentives to help people quit;
- bans on displays of all smoking products that reduce the social cues to smoke; and
- easy access to person-centred smoking cessation programs.

2.2 IMPLEMENT A VISIBLE NETWORK OF HIGH QUALITY, PERSON-CENTRED CESSATION SERVICES

Ontario's cessation services should see people who smoke as colleagues, friends, family members and neighbours who want to regain control over their addiction – and who likely need support to quit and stay quit.

People who smoke may benefit from a range of counseling, pharmacotherapy and support services during the quitting process. To be effective, these services should be person-centred and accessible and able to adapt to meet each person's individual needs. They should engage people, building on their strengths and resiliency.

Cessation services in Ontario are currently provided by a range of different providers, including physicians, nurses, pharmacists, social workers, health promoters and radiation technicians, and a range of organizations, including hospitals, public health units, family health teams and other primary care settings, cancer centres and non-governmental organizations.

People who smoke will seek to be part of a support system that provides access to new and innovative approaches and helps them cope with the challenge of quitting.

Tobacco interventions that include behavioural support with access to pharmacotherapy and support groups need to be embedded within Ontario's health system. This includes effective programs provided in community settings – in primary care practices, community health centres, outpatient clinics, dental offices, public health units and pharmacies – as well as hospital-based programs that systematically identify all inpatients who smoke and offer them evidence-based cessation services that include counseling, pharmacotherapy and clinically appropriate services following discharge. Patients who participate in hospital-based programs are more likely to quit and be smoke-free at six months and less likely to be readmitted to hospital, visit an emergency department or to die in the two years after discharge. Systematic approaches to the identification and treatment of smokers in clinical settings

have been developed and applied in Ontario; they are now emulated in other jurisdictions. Expanding these programs should be a priority.[12]

2.2.1 Organize all cessation services into a network that people who smoke can access easily

By organizing all population-based, community-based and health care-based cessation services into a network, it will be possible to differentiate and target services to meet diverse needs and make effective use of all cessation resources. A coordinated system will ensure that individuals get the supports to meet their individual needs and, when one support or service ends (e.g., hospital-based intervention), another support (e.g., community support group) is in place if required (i.e., continuity of care and follow up).

> Integrated delivery of smoking cessation supports for smokers trying to quit should be the modus operandi for all health care providers: Patients First. The ministry recently convened a Cessation System Advisory Group, which provided advice on the design and elements of an integrated system and the process to develop one in Ontario, including regional planning processes.

For example, some empowered and self-motivated Ontarians may be able to quit successfully with technology-enabled cessation information and tools (e.g., online program support, text messaging). Some individuals may need behavioural counseling, while others may find it helpful to be part of a support group. Many individuals may require a mix of behavioural counseling, pharmacotherapy and technology-enabled supports. Some individual may require support for a short period of time while others may need more intense pharmacotherapy services for a longer period of time.

Features of the network should include:

- programs that provide evidence-based, consistent nonjudgmental compassionate support for people who want to quit;
- a common “brand” and visual identity so Ontarians know where to go to receive high quality services;
- one website where people can go for population-based services and for information about other available services;

[12] Mullen KA, Manuel D, Hawken S, Pipe AL, Coyle D, Hobler LA, Younger J, Wells GA, Reid RD. Effectiveness of a hospital-initiated smoking cessation program: two-year health and healthcare outcomes. Tob Control. Online First: May 25 2016 doi:10.1136/tobaccocontrol-2015-052728

- one phone number to call to access the Quitline and other cessation services within a region;
- a streamlined intake and referral process that guides people to the right services to meet their needs; and
- support networks that can be joined by people who want to quit.

2.2.2 Require all health care settings to embed smoking cessation best practices

Every interaction between someone who smokes and a health care provider is an opportunity to help that person quit – and hundreds of thousands of those opportunities are missed every year in Ontario.

Regardless of where people have contact with the health care system – their primary care provider, a hospital, a workplace cessation program, the pharmacist, a cancer centre – they should be able to access cessation services. Every door should be the right door to help people quit.

Advice and support from health providers can help people decide to quit and stay the course

If Ontario is to truly end the epidemic of tobacco-related disease and death, all health care settings must be required to either provide high quality cessation services directly or link their patients or clients with a setting that does (e.g., the Quitline, public health group-based cessation interventions and support groups, specialists in cessation pharmacotherapy, tobacco intervention implementation specialists, addiction workers). That requirement should become part of all accountability agreements, standards, indicators and performance measures for all health care settings – as it is now, for example, for hospitals within the Champlain LHIN and for all family health teams in the province.

> *The [cessation] program is exactly what I needed to succeed. The combination of nicotine replacement therapy and the encouragement from my [practitioner] made all the difference.*
>
> Participant in CAMH survey
> June 2016

The health system must ensure appropriate investments and funding mechanisms – as well as accountability mechanisms – to ensure all health care settings and providers provide high quality evidence-based smoking cessation services.

2.2.3 Shift to an opt-out approach to smoking cessation in health care settings

Historically, health providers have used an opt-in approach to smoking cessation: they counsel people who smoke about the harms and risks, tell them about available services and ask them to come back if and when they are ready to try quitting. Based on recent evidence, the ESC is recommending a shift to a universal opt-out approach to smoking cessation: health providers immediately

provide initial cessation or treatment services (as they would for any other illness) – unless the person "opts out". This approach is effective in engaging people and in helping them quit successfully.

2.2.4 Maintain and enhance robust clinical standards for smoking cessation services

All Ontarians who smoke should have access to the highest quality smoking cessation interventions.

Best practice smoking cessation today involves pharmacotherapy with or without behavioral support, for as long as the person needs it.

Although there are best practice guidelines for cessation services (e.g., CAN-ADAPTT guidelines for smoking cessation, RNAO best practice guidelines), these guidelines and standards are not applied consistently by all health providers or in all health care settings or cessation programs. More effective implementation of evidence-based guidelines to meet clinical standards would significantly enhance the quality and consistency of cessation services as well as their impact and effectiveness. Standards would also help reinforce the critical role that all health care providers should be playing in addressing nicotine addiction and ending the tobacco epidemic in Ontario.

Every health care provider in Ontario should know how to respond to Ontario's leading cause of preventable disease and death.

To improve the quality, consistency and efficacy of cessation services, the health system should require that all services implement evidence-based guidelines and meet clinical standards. The guidelines and standards should be reviewed regularly to ensure they reflect the latest scientific consensus and evidence, and used to inform decision-making about effective interventions, including the recommended shift to opt-out cessation services.

2.2.5 Ensure health providers have the core skills and competencies to provide high quality evidence-based cessation services

Cessation services are most effective when the providers delivering them have the right knowledge, skills, attitudes (core competencies) and resources (tools).To ensure that both regulated and unregulated providers have the core competencies required to provide cessation services that integrate best practices and meet

clinical standards, educational institutions should develop curricula for entry-to-practice preparation as well as continuing education for practicing clinicians that are based on the clinical standards and guidelines and take advantage of existing supports (e.g., nationally recognized guidelines for smoking cessation, Ontario's smoking cessation provider certificate programs, clinical services already established in Ontario hospitals and family health teams, the RNAO Nursing Faculty Education Guide).

> *This presentation addressed many of my misconceptions about smoking, helped me more effectively assist smokers, and make better use of pharmacotherapy. It will change my practice.*
>
> Physician attending Ottawa Model for Smoking Cessation workshop

2.2.6 Explore the potential of non-combustible nicotine delivery systems to reduce harm for people who are unable or unwilling to quit smoking

All tobacco control efforts are based on the principles of reducing harm for people who smoke as well as people exposed to smoke. Among Ontarians who smoke, there will be a small proportion that is unable or unwilling to quit smoking. However, it is still possible to take a harm reduction approach by exploring the potential to help them substitute a non-combustible form of nicotine delivery, such as e-cigarettes in place of deadly smoked tobacco. Taking the smoke out of tobacco use – as well as cannabis and shisha use – will significantly reduce harm: it is the by-products of incomplete combustion and the resulting smoke that cause much of the tobacco-related cancers and lung, vascular and heart disease.

Although the full impact of these emerging technologies and products is not yet known, early research indicates that some (e.g., newer generation vaping devices) likely deliver appropriate levels of nicotine and are much less harmful than heat-not-burn or oral forms of tobacco. They may also help some people quit. An effective program would identify those who would benefit from this harm reduction approach and help them use these new products and devices in the safest possible ways. Appropriate policies that nudge use of safer products versus more harmful cigarettes will lead to greater adoption of these products without reducing the number of people who become nicotine-free in the long run.

2.3 ENSURE EQUITY AND IMPROVE THE PATIENT EXPERIENCE

Even when people who smoke are ready to try quitting, they often face barriers, such as problems finding high quality services, the cost of pharmacotherapy (e.g., nicotine replacement therapy and other cessation pharmacotherapies), and lack of access (particularly for those who live in rural and remote areas).

The proposed cessation network, “branded” provincial cessation services and the recommendation that all health care settings offer cessation services should make it easier for Ontarians to find high quality cessation services.

To remove other barriers, improve the patient experience and provide equitable opportunities to engage in cessation services, the ESC recommends three steps:

2.3.1 Provide cost-free pharmacotherapy based on clinical standards and individual needs

One of the greatest barriers to people participating in smoking cessation programs is the cost of cessation pharmacotherapies. Right now, people who receive treatment in hospital or through community-based programs can receive free pharmacotherapies for a certain period of time. People who smoke who are eligible for the Ontario Drug Benefit program (i.e., seniors, people on social assistance, residents of long-term care homes and homes for special care, people receiving home care services) can receive one 12-week course of certain treatments once per year. Unless they are fortunate enough to have a supplementary insurance program that adequately covers nicotine replacement therapy, people who do not qualify for these programs or who need more than 12 weeks of treatment must cover their own costs, which can range from $413 (8 weeks) to $1,341 (26 weeks) per quit attempt (taxes not included).

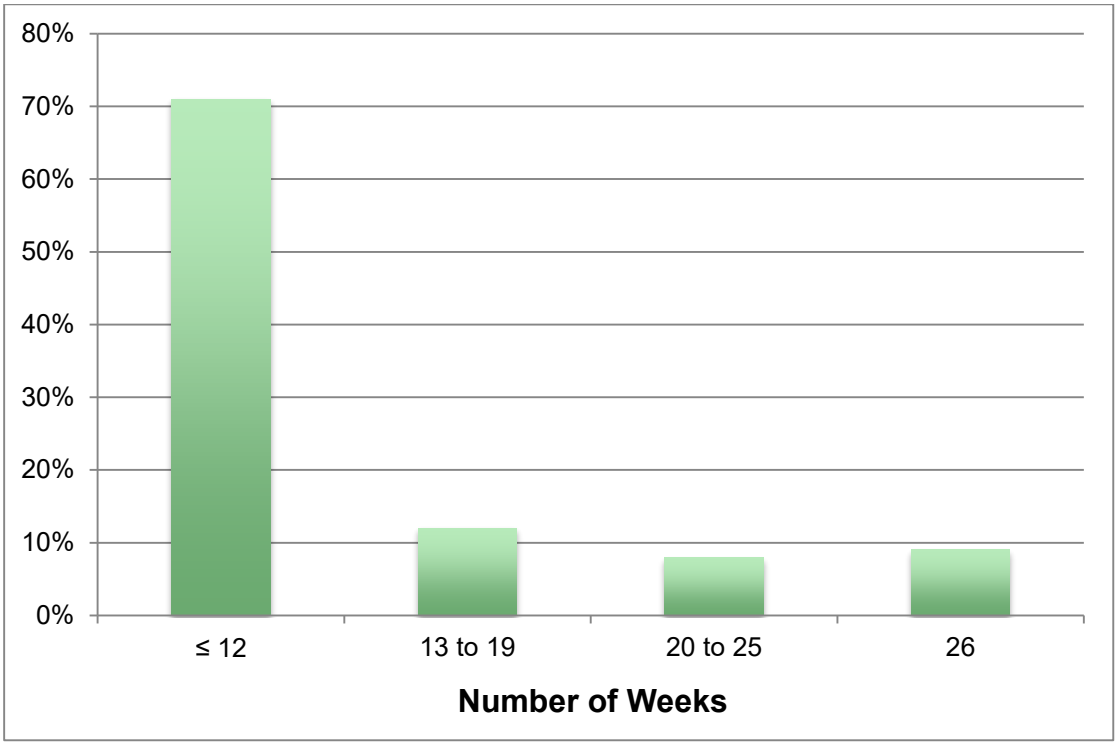
> The use of pharmacotherapy doubles the success of cessation approaches such as behavioural counselling and brief advice.

To increase the likelihood that people who smoke will quit and stay quit, the system should provide equitable access to free cessation pharmacotherapies for the length of time each person requires based on individual needs. Like other chronic diseases, addictions often require long-term treatment. For example, some people may require cessation pharmacotherapy for longer periods of time (i.e., several months) to quit successfully.

The following graph shows the proportion of people who participated in the STOP on the Road program (delivered in primary and community settings) who needed pharmacotherapy for different lengths of time.

> *I quit in March, 2016 … and haven't smoked since. I doubt I could have stopped without the patch (I tried many times and failed). You gave me the tools I needed; an education, a plan of action and a supply of patches (which I could hardly afford). I'm very grateful for your program … and also for the help I got from the Smokers Helpline because they helped me stay focused and remain confident.*
>
> Participant in CAMH survey, July 2017

Figure 8: Length of Time on Cessation Pharmacotherapy, Participants, STOP on the Road Program



* Source: Centre for Addiction and Mental Health (CAMH)

The STOP program reports that the almost 1 in 10 people who received 26 weeks of pharmacotherapy (the longest provided) had the highest number of co-morbidities including mental and chronic physical illnesses, and the majority (70%) had an annual income of less than $40,000, which means they are also coping with poverty and other social determinants of health.[13] Providing a set or limited duration of treatment for all people who smoke will lead to inequities in their response, which will mean the intervention will have less impact. As part of commitment to health equity, cessation services should try to address the impact of social determinants of health on tobacco use and on people's ability to quit successfully.

Treatment should be as easy to access as cigarettes currently are – particularly for people in rural and remote areas who have trouble accessing pharmacies. Ontario has already demonstrated the effective use of mail-out nicotine replacement therapy combined with telephone and internet-based quit supports to overcome this barrier.

[13] Personal Communication. Peter Selby, Centre for Addiction and Mental Health. August 7, 2016.

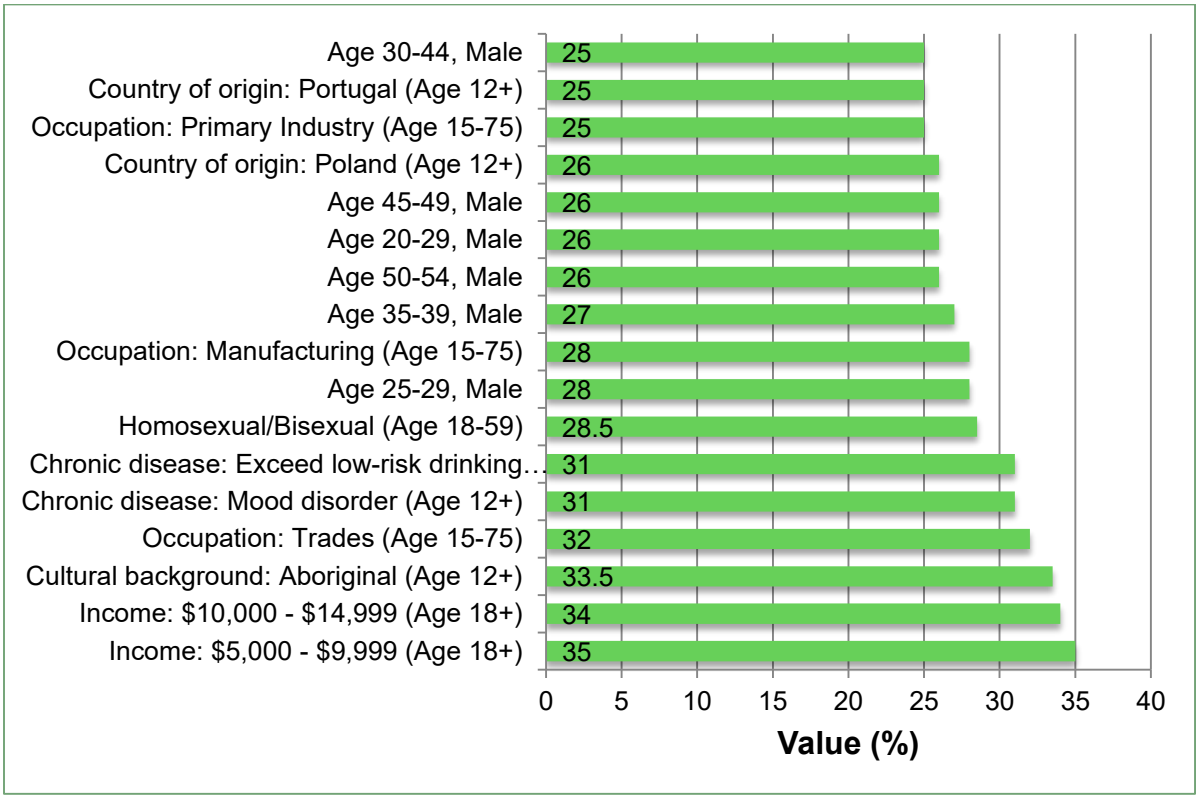
2.3.2 Provide targeted population-based cessation services

While most Ontarians who smoke do not belong to a high-risk population, certain groups have higher rates of smoking such as:

- Ontarians with low income;
- Ontarians with less formal education;
- Indigenous people;
- people working in certain occupations (e.g., trades);
- young men;
- people with mental health needs; and
- members of the LGBTQ community.

The cessation network should develop targeted programs and services that actively engage populations with high rates of smoking. The programs should identify effective motivational techniques and messages, supports and interventions for each group, and deliver services where these groups are (e.g., in workplaces to reach those working in industries with high rates of smoking as well as young adults with lower incomes).

Figure 9: Populations with High Rates of Smoking (25% or More), Ontario 2013/14



* Source: Ontario Tobacco Research Unit, Smoke-Free Ontario Strategy Monitoring Report, March 2017

2.3.3 Use population-based behavioural technologies to reach more tobacco users

There is evidence that behavioural technologies – telephone helplines, interactive Internet and computer and text messaging interventions – are effective ways to reach more people who smoke and help them quit. The cessation network should leverage and expand all these services and technologies, including a more coordinated and pro-active Smokers Helpline, to reach more Ontarians of all ages, triage people to the right services, improve access to pharmacotherapy and engage them throughout the quitting process and for some time after to prevent relapse.

Note: In the cessation section of this report, the ESC has focused mainly on strategies required to support Ontarians who smoke tobacco. Its recommendations do not address the need for cessation services for people who smoke cannabis: a need that will increase once cannabis use is legalized. However, the same principles and elements of tobacco cessation could form the basis for developing effective cannabis cessation services.

3. KEEP MORE ONTARIANS FROM STARTING TO SMOKE

Right now, we estimate that about 30,000 Ontarians start smoking each year. To reach the target of <5% of Ontarians using tobacco by 2035, we have to push that down to 10,000 a year.

Nicotine dependence can begin to develop within two to five months of starting to smoke.

Virtually no one starts using tobacco after age 24 so the focus of tobacco prevention efforts must be youth and young adults, who are particularly susceptible to starting to smoke and, once they do, at high risk of becoming regular smokers.

While youth and young adults can be highly vulnerable to the marketing efforts of the tobacco industry, they are also powerful and effective advocates for healthy public policy. They have played an active role in developing hard hitting social media campaigns that make their peers more aware of manipulative industry practices. Youth and young adults should not be seen simply as a target of prevention efforts but as partners in a civil society strategy to engage young people to address the tobacco epidemic.

Many of the recommendations in the industry section – such as increasing the price of tobacco products, banning displays and reducing the number of retail outlets where it is sold – will help keep Ontarians from starting to smoke. In addition, to prevent both initiation and escalation of use of tobacco and other harmful inhaled substances, the ESC recommends the following actions.

3.1 IMPLEMENT COMPREHENSIVE POLICIES AND PROGRAMS TO KEEP YOUTH AND YOUNG ADULTS FROM STARTING TO SMOKE

Because of their stage of brain development, youth (under 18 years of age) and young adults (18 to 24 years of age) are particularly vulnerable to starting to smoke and to becoming addicted to nicotine. Policies and programs to prevent youth and young adults from starting to smoke are more effective when they are comprehensive, consistent and enforced. Smoking prevention programs are also more effective when they reach youth early (i.e., before peak use of cigarettes which occurs in later adolescence and early adulthood).

3.1.1 Raise the minimum age to buy tobacco products to 21

Establishing a minimum age to buy tobacco products and enforcing that restriction reduces smoking among youth and young adults. Ontario has already had great success in reducing adolescent smoking by raising the minimum age to buy tobacco to 19, and enforcing that law.

In an ideal world, there would be one consistent age when youth are considered mature and informed enough to make decisions about harmful consumer products such as tobacco, alcohol and cannabis – and that age would take into account the impact of these products on brain development.

Because tobacco is a lethal product with no safe level of use, the ESC argues that the minimum age to buy it should be raised to 21. Raising the age of purchase for tobacco to age 21 based on the safety and potential harm of the product would also help justify a higher age for the legal purchase of cannabis products, which pose threats to young brains.

3.1.2 Intensify tobacco prevention policies and education in elementary, secondary and post-secondary schools, with particular emphasis on trade schools

Ontario has long had smoke-free policies and education programs in elementary and secondary schools as well as on post-secondary campuses (e.g. Leave the Pack Behind, the RNAO Tobacco Intervention [TI] initiative). Smoking (e.g., lighted cigarettes, not including smokeless tobacco or e-cigarettes) is prohibited in both public and private elementary and secondary schools. It is also prohibited anywhere on both public and private elementary and secondary school property (e.g., school yards). School officials are responsible for ensuring that staff, students and visitors know about the smoking prohibitions and do not smoke on school property. Local public health units conduct inspections in schools, investigate any complaints and enforce the requirements of the Smoke-Free Ontario Act.

It is difficult to tease out the specific impact of these policies and programs; however, the province has seen a marked decrease in the number of younger students smoking. School-based education programs are more effective when

they include multiple sessions, are delivered by trained facilitators, address social influences, build social and problem-solving skills, involve peer educators and parents, and are age appropriate.

Smoking is currently prohibited indoors on post-secondary school campuses. That ban should be extended to all areas (indoors and out) of all Ontario university, college and trade school campuses (see recommendation 3.2.2 below). Trade schools are a particularly important target because there are high rates of smoking in a number of trade occupations and youth should be prepared with the skills to avoid smoking once they start working in those settings.

3.1.3 Implement prevention interventions (policies and programs) in a variety of youth-centred settings

Interventions delivered in non-school settings, such as primary care practices, workplaces and homes, can also help keep youth and young adults from starting to smoke or becoming regular smokers. Primary care providers can play a key role by engaging youth and young adults in conversations about smoking and its health hazards. Workplaces can help reach youth and young adults. High intensity interventions that target families and parents can help improve parenting and communication skills which, in turn, can lead to changes in family relationships and reduce the risk that youth will start smoking.

When developing these interventions, the ministry should consider targeting harder-to-reach youth who may be at higher risk of smoking, such as LGBTQ youth.

Rather than targeting youth and young adults through advertising, Ontario should use a consumer and civil society based approach to social marketing, engaging youth in its design and execution. This approach, combined with youth civic action – such as the Truth Campaign in Florida and several Ontario campaigns, including Party Without the Smoke, #91 Reasons, Bad Ways to Be Nice and Freeze the Industry – has proven effective in reaching youth, shaping their attitudes towards smoking and reducing youth smoking.

3.2 REDUCE YOUTH AND YOUNG ADULT SOCIAL EXPOSURE TO TOBACCO USE

Although the Smoke-Free Ontario Act prohibits smoking in many public places, youth are still exposed to tobacco use in a variety of settings, including movies, video games and other on-screen settings and on Ontario post-secondary campuses.

3.2.1 Reduce youth and young adults exposure to on-screen smoking by:

- **requiring any movie that contains tobacco imagery to be assigned an adult rating (18A);**

- **requiring movie theatres to show strong anti-tobacco ads (PSAs) before movies that contain smoking or tobacco use and trailers that discount any credibility of association with tobacco; and**
- **making media productions that include smoking ineligible for public subsidies.**

Youth and young adults exposed to tobacco use and product placement in movies are more likely to experiment with or take up smoking and to have a more positive view of smoking. On the other hand, those who saw an anti-smoking ad before the movie were more likely to disapprove of characters in the movie who smoke and to not intend to smoke. Innovative strategies to limit youth exposure to smoking in movies and video games are in the early stages of development but may have potential to keep some youth and young adults from starting to smoke.

Article 13 of the WHO Framework Convention on Tobacco Control recommends measures to ban tobacco brands (i.e., product placement), imagery and use in youth-rated films. Rating movies with smoking as adult will put pressure on producers who are targeting the highly lucrative youth and young adults market for films. Withdrawing public subsidies for productions that include smoking is also consistent with the intent of the FCTC and is likely to have a significant impact on on-screen exposure to tobacco use.

3.2.2 Make Ontario post-secondary campuses smoke-free, tobacco-free and free from tobacco industry influence

While the Smoke-Free Ontario Act prohibits the sale of tobacco products on post-secondary campuses, it does not prohibit outdoor smoking or other tobacco use on those sites. When this report was written, no Ontario post-secondary institution had implemented its own campus-wide ban on smoking and/or tobacco use – although these policies are in place in other parts of the country (e.g., Memorial University of Newfoundland, Dalhousie University, University of Alberta) and internationally (e.g., Australia, Denmark, Finland, Hong Kong, the United Kingdom and hundreds of campuses in the United States). This is one area where Ontario lags behind many other jurisdictions.

Many universities also hold stock in tobacco companies which, in addition to delivering a mixed message to students about the legitimacy of the industry, may make it more difficult for administrations to introduce more extensive smoke-free policies.

Tobacco-free campus policies have high potential to prevent tobacco use among the large number of young adults who attend universities, colleges and trade schools. Students on smoke-free and tobacco-free campuses are less likely to smoke or intend to smoke and have less social exposure to smoking. These policies are more effective when they also ban tobacco advertising, tobacco industry funding for any campus events, programs and courses, tobacco industry

attendance at campus job recruitment fairs, and investment in the tobacco industry.

4. EXPAND POLICIES THAT PREVENT EXPOSURE TO SECONDHAND SMOKE AND HARMFUL AEROSOL FROM VAPED PRODUCTS

Tobacco and other inhaled burned substances and products do not just harm the people who use them directly, they threaten the health of the people around them. They expose bystanders to toxins and pollutants that can react with oxidants and other compounds in the environment to create new compounds, many of which are carcinogenic and difficult to eliminate[14].

There is no level of exposure to secondhand smoke that is considered safe by medical authorities.

Exposure to secondhand tobacco smoke has an adverse effect on health, including respiratory illness (asthma and decreased lung growth in children, chronic obstructive pulmonary disease in adults), reproductive and developmental effects (low birth weight, pre-term delivery, sudden infant death syndrome and childhood cancers), cancer among adults and cardiovascular diseases.

Tobacco is not the only combustible substance that poses a health risk:

- **Shisha** (i.e., usually tobacco sweetened with fruit or molasses sugar, heated using coal or charcoal and smoked using a water pipe) generally contains nicotine, tar, carbon monoxide and other toxins, such as arsenic and lead. When someone smokes shisha, the person as well as anyone around them breathes in those toxins. The risks from exposure to secondhand shisha smoke is higher than tobacco smoke because people often smoke shisha for longer periods (i.e., the average smoking session lasts an hour) and can inhale the same amount of smoke as more than 100 cigarettes. While some forms of herbal shisha do not contain tobacco, they still put people at risk from secondhand exposure to carbon monoxide and toxins related to burning.
- **Cannabis** also produces toxins and carcinogens that can damage the lungs, blood vessels and heart. The smoke produced when smoking cannabis is considered as harmful to non-smokers as cigarette smoke. Cannabis smoking also poses another health risk because a significant proportion of Ontarians who smoke cannabis will mix tobacco and cannabis when they smoke.

[14] Smoke-Free Ontario Scientific Advisory Committee, Ontario Agency for Health Protection and Promotion (Public Health Ontario). Evidence to Guide Action: Comprehensive Tobacco Control in Ontario (2016). Toronto, ON: Queen's Printer for Ontario.

Every effort should be made to protect people from both direct and secondhand exposure to smoke from all combustible substances and products.

Ontario has been a leader in efforts to protect people from exposure to secondhand smoke. Provincial legislation prohibits tobacco smoking in workplaces and indoor public spaces, such as government buildings, restaurants, stores, malls and concert venues. Ontario also prohibits exposure to tobacco smoke in some outdoor spaces, such as bar patios, areas within 20 metres of public sporting areas and children's playgrounds, as well as on the outdoor grounds of hospitals. Tobacco waterpipe use is prohibited wherever smoking cigarettes and other conventional tobacco products are banned.

Some Ontario municipalities have gone further, enacting local by-laws that:

- prohibit smoking in outdoor buffer zones around doorways and windows of buildings, in outdoors parks, beaches and recreational facilities, bed and breakfasts, and in transit shelters;
- prohibit the use of e-cigarettes in city workplaces;
- make community housing smoke-free; and
- prohibit water pipe use in indoor (and, in some cases, outdoor) public and work spaces.

The same types of policies should be applied to all combustible substances. More can and should be done to protect Ontarians from exposure to secondhand smoke and harmful aerosol from vaped products. The ESC recommends three key actions:

4.1 CONTINUE TO REDUCE EXPOSURE TO SECONDHAND SMOKE AT HOME

Smoke-free policies have been able to reduce exposure to secondhand smoke at work and in many public settings; however, Ontarians remain at high risk if they live with or near someone who smokes. To protect their family members, many people who smoke avoid smoking in the house. There is strong evidence that, in addition to reducing exposure to secondhand smoke, smoke-free home policies help people who smoke quit by eliminating cues for smoking, reducing the amount they smoke and increasing their attempts to quit.

4.1.1 Raise awareness through a public engagement campaign about the importance of smoke-free homes

As part of a coordinated provincial public engagement campaign, Ontario should raise awareness of the risks of exposure to secondhand smoke at home as well as the need for smoke-free policies that protect people in congregate living situations and how those policies will be implemented and enforced. An effective "take it outside" awareness campaign may encourage more people who smoke tobacco, shisha or cannabis to voluntarily decide to smoke outside the home to avoid exposing their families and friends to secondhand smoke.

4.1.2 Increase the number of smoke-free multi-unit housing buildings in Ontario

The risk of exposure to secondhand smoke at home is high for people who live in multi-unit housing developments where 20 to 30% of residents are exposed to secondhand smoke. Based on experience in other jurisdictions, preventing smoking in multi-unit housing has a substantial positive impact on the health of people who are particularly vulnerable to the harms of smoke, such as seniors and children with pre-existing health conditions. A number of Ontario municipalities have already taken steps to protect people who live in these multi-unit settings – particularly those in municipally owned community housing.

4.1.3 Amend the Ministry of Housing Residential Tenancies Act to allow landlords to evict a tenant who violates the no-smoking provision in a tenancy agreement and include an optional smoke-free housing clause in the new standard lease

Approximately 95 Ontario municipalities already have at least one multi-unit housing provider that has implemented smoke-free policies. As of December 2016, more than 200 multi-unit housing and non-profit housing corporations across 89 municipalities had adopted or were in the process of adopting smoke-free policies in all their sites.

Provincial legislation and tools (such as a clause in the standard lease) will support municipalities and other landlords in implementing smoke-free policies. Many landlords are not aware that it is legal to put a smoke-free clause in a lease; they also worry that the clause may not be enforceable. Many tenants do not know that they can legally request a smoke-free environment. Government should work with housing providers and landlords to develop effective tools to help implement and enforce smoke-free policies in these home environments.

4.2 ESTABLISH MORE SMOKE-FREE SPACES

As a result of the success of smoke-free policies in workplaces, restaurants and other public indoor spaces, more people are now smoking outside, increasing the risk of exposure to secondhand smoke in areas around offices and other buildings, and in other outdoor spaces.

Given that physical exposure to secondhand smoke in outdoor settings can be just as harmful as exposure in indoor settings, and that social exposure to people smoking may cause some young people to start smoking, it is critical to reduce that exposure.

4.2.1 Amend the Smoke-Free Ontario Act to ban vaping and the smoking of non-tobacco products, including shisha and cannabis, in all the indoor and outdoor settings where tobacco is banned

Smoke is smoke: all types of smoke expose people to harmful toxins. To protect Ontarians from exposure to secondhand smoke, all inhaled substances and products that create smoke should be banned in the same places where the

Smoke-Free Ontario Act bans tobacco smoking, including workplaces and public spaces.

4.2.2 Amend the Smoke-Free Ontario Act to prohibit smoking of tobacco, shisha and cannabis:

- **within a 9-metre buffer zone around the entrances, exits, windows and air intakes of public buildings; and**
- **in outdoor spaces on post-secondary campuses (i.e., universities, colleges, vocational institutions, trade schools).**

Smoke-free policies that ban smoking in outdoor settings can be highly effective when they are enforced. These recommended legislative changes would bring Ontario into line with other provinces that have already created buffer zones. They would also protect youth and young adults – a group that is highly vulnerable to starting to smoke – from both exposure to secondhand smoke and social exposure to smoking. In addition, they would keep people who smoke from congregating outside of buildings which can create the false impression that a large proportion of the population still smokes. As with other smoke-free policies, making smoking more difficult or inconvenient helps people smoke less, consider quitting and stay quit (i.e., by reducing cues for smoking).

4.2.3 Protect workers in outdoor workplaces from exposure to secondhand smoke by:

- **expanding the Smoke-Free Ontario Act to prohibit smoking in outdoor workplaces;**
- **working with employers to develop effective smoke-free outdoor workplaces policies; and**
- **enforcing the law.**

Current smoke-free policies do a good job of protecting workers in indoor or enclosed settings from exposure to secondhand smoke. The same principles should be applied to protect those who work in outdoor settings that are not currently regulated under the Smoke-Free Ontario Act, such as construction, mining and forestry sites. As with other smoke-free initiatives, these policies will protect non-smokers and, at the same time, support people's efforts to quit.

5. CREATE A STRONG ENABLING SYSTEM TO EXECUTE THE STRATEGY

The ESC is proposing a comprehensive, multi-faceted integrated 10-year strategy that uses all available levers – policy, legislation, enforcement, transparency, awareness, education, capacity-building, research, evaluation, monitoring and surveillance – to drive down the use of tobacco and other harmful inhaled substances and products.

For provincial and municipal governments as well as other agencies (e.g., public health units, hospitals, other health care settings, law enforcement, non-governmental organizations), communities and individuals to act on the strategy recommendations, Ontario will need an enabling system that focuses on core functions, such as:

- public engagement;
- research, evaluation, surveillance and monitoring;
- capacity building; and
- leadership, coordination and accountability.

5.1 ENGAGE THE PUBLIC

The public has played a critical role in bringing down rates of smoking in Ontario. Changing public attitudes made smoking an urgent health and social issue, making it possible for Ontario to introduce and enforce smoke-free policies. Individuals – parents, teachers, health care providers, peers, friends, neighbours, workers, employers and business owners, and politicians – reinforce smoke-free messages every day and help create an environment that supports thousands of people who smoke to quit each year, keeps young people from starting to smoke, and protects all citizens by providing clean smoke-free spaces.

Because of the success of Smoke-Free Ontario, the use of tobacco and other harmful inhaled substances is no longer such a high profile issue. Many Ontarians think the problem has been solved. Nothing could be further from the truth. Most people are not aware that tobacco is still the number one cause of disease and death in the province. Another generation may become addicted to nicotine because we failed to act.

To reach the highly ambitious targets of <5% smoking prevalence by 2035, the new Smoke-Free Ontario Strategy must re-engage the public and leverage its energy and concern for public health to create more effective prevention and cessation services, and bring an end to the harm caused by tobacco and other harmful inhaled substances and products. People who smoke should be actively engaged to help shape cessation services and supports.

5.1.1 Create an intense, compelling, multi-faceted, multi-year mass media-based public education and social marketing campaign

It is not enough to ban tobacco displays and advertising. Ontario must also develop and deliver its own messages to reduce the use of tobacco and other

harmful inhaled substances. Complex, multi-layered smoke-free messages to expose tobacco industry practices, prevent smoking, motivate and support people who smoke to quit, and protect Ontarians from tobacco and other harmful inhaled substances must be persistent and inescapable.

The goal is to remind the public that smoking is still a devastating public health problem: one that, with concerted efforts, can be solved in our lifetime.

For the public and stakeholders to become engaged, they need to know more about:

- the harmful effects of tobacco – for people who smoke and for everyone around them – and the health, social and environmental cost of smoking to individuals, families, communities and society;
- industry practices and how the industry manipulates products, prices and people to maintain a market for a lethal product;
- the benefits of quitting tobacco use;
- cessation services and how to access them, and what non-smokers can do to help friends and family members quit and stay quit;
- the knowledge and skills that young people need to decide not to start smoking; and
- their rights as non-smokers and the changes that can be made in their homes and communities to protect people who are vulnerable to secondhand smoke.

There is strong evidence that mass media and social marketing efforts that are long and sufficiently intense (i.e., substantial investments, at least three years), target specific audiences, involve the target audiences in their development, are interactive (engage people in discussion, help people develop skills), coordinate province-wide with regional and local media and programs, connect people with services and include messages about tobacco industry manipulation are highly effective in: raising awareness, making smoking less socially acceptable, keeping young people from starting to smoke and motivating people who smoke to quit.

To develop mass media and social marketing campaigns, the ministry should work collaboratively with public health, the cessation network and non-governmental organizations that have credibility in tobacco control. The partners should develop:

- a common brand (visual identity) – that the public will recognize; and
- an intense, multi-year staged mass media and social marketing campaign that meets all the evidence-based requirements listed above and strategically communicates a range of different key messages and knowledge to different target groups over time.

The Government should have its own communication strategy, integrated with this public health and NGO-led effort, to convey messages about smoking cessation brand identity, government commitments, and Ministerial and Cabinet leadership in addressing Ontario's leading cause of avoidable, premature disease and death.

5.2 ENSURE THE BEST EVIDENCE IS USED TO GUIDE THE STRATEGY

The goal is to develop a comprehensive evidence-based learning system -- one that: keeps pace with new knowledge from research, evaluation and practice experience; monitors trends and the effectiveness of strategy initiatives; continuously learns from new evidence; and works with decision-makers to integrate knowledge into policy and practice.

5.2.1 Establish a comprehensive learning system

All those involved in delivering the strategy must be part of a comprehensive learning system: one that tracks and reports on progress of all activities, and continually uses evidence from research, practice, surveillance, monitoring and evaluation to adjust initiatives to increase their impact. The learning system should engage and be led by those, within and outside government, who have specific expertise in tobacco control and smoking cessation to ensure that Smoke Free Ontario remains a high priority.

5.2.2 Ensure up-to-date research findings are readily available to inform policy and practice

To provide evidence to guide policy and practice, Ontario must continue to have the capacity to:

- assess, appraise and synthesize research findings (from within and outside Ontario);
- conduct relevant Ontario research on tobacco and other harmful inhaled substances;
- document innovative practices;
- respond to time-sensitive requests for rapid research reviews;
- convene meetings to discuss the scientific evidence;
- share new knowledge in timely and useful ways (e.g., online learning modules); and
- support research trainees and investigators.

5.2.3 Evaluate strategy initiatives, activities and enablers

To demonstrate the impact and effectiveness of the proposed initiatives, key activities and interventions should be evaluated (i.e., developmental, formative and outcome evaluation) to assess their individual and collective impact on strategy goals. The enabling system should also be evaluated to determine how effective its activities are in supporting the development and implementation of interventions. To support evaluation, systems must be established to collect,

analyze and report data on key activities and indicators of progress (i.e., output and outcome). Evaluation findings should be used to adjust and adapt the strategy.

5.2.4 Conduct ongoing surveillance

To ensure the strategy is able to adapt quickly to new trends, Ontario should conduct ongoing, flexible, frequent and comprehensive surveillance of:

- industry trends – including tobacco production, distribution, marketing, promotion and sales;
- population trends (e.g., rates of smoking, populations at risk) – using recommended indicators (e.g., Centers for Disease Control [CDC], the National Advisory Group on Monitoring and Evaluation [NAGME]) and frequent, timely, flexible population/panel surveys;
- the health care system's success in reaching and treating people who smoke – using administrative data; and
- progress towards the attainment of goals, objectives and targets.

5.3 BUILD CAPACITY TO IMPLEMENT THE STRATEGY

Effective implementation of the strategy will require knowledgeable, skilled people and organizations, and a well-functioning system throughout the province with the right evidence, tools, resources and working relationships. The enabling or capacity building system must support all these activities, including communication within the strategy.

Clinical practice guidelines and the opportunity to apply them in an organized, evidence-based system will be instrumental in dramatically improving the quality of cessation services in clinical and community settings.

5.3.1 Enhance the knowledge and skills of all involved in implementing the strategy

In the section on cessation services, this report highlighted the critical need for pre-licensure and post-licensure education for all health care providers so they advocate for smoking cessation and deliver high quality cessation programs.

There should also be ongoing opportunities for knowledge and skills development for others involved in implementing aspects of the strategy. This education and capacity building could take the form of training programs, conferences, webinars and e-learning.

5.3.2 Provide technical assistance

Individuals and organizations would benefit from technical assistance, advice and guidance in planning, implementing and evaluating evidence-based interventions.

5.3.3. Facilitate learning through communities of practice

In specific areas of practice and regions of the province, people learn from each other. Much can be learned within networks focused on improving practice (e.g., cessation in particular settings or for particular clients, media relations and advocacy practice). The enabling system should support these types of communities of practice/social learning in order to foster innovation and learning from peers.

5.4 ENSURE STRONG LEADERSHIP, COORDINATION AND ACCOUNTABILITY

To achieve the desired outcome, the proposed strategy will require leadership, coordination and accountability.

5.4.1 Identify the most effective mechanism(s) to provide leadership, assign responsibility, ensure coordination, and hold people and organizations accountable for executing the strategy

Effective leadership and coordination will ensure that:

- a back-bone organization is identified (e.g., the public health lead agency model used in California, Massachusetts and Ontario);
- all stakeholders/partners are engaged and understand their role, and come together to build a coalition and work effectively together to meet the goals and targets;
- accountable leads are established for each component of the comprehensive strategy (e.g., industry initiatives, cessation, prevention, protection);
- standards are established for all programs and services;
- planning is done across all strategy activities; and prevention, cessation and protection activities are integrated into local, regional and provincial networks that work to improve service quality, accessibility and availability;
- progress in delivering on the strategy and meeting targets is reported regularly to the public;
- there is a strong learning system and an effective performance management system;
- a coordinated capacity building strategy supports implementation and execution of the strategy;
- resources are used effectively; and
- efforts are coordinated, and duplication is limited.

5.5 WORK WITH INDIGENOUS PARTNERS TO DEVELOP STRATEGIES SPECIFIC TO FIRST NATIONS, MÉTIS AND INUIT COMMUNITIES BUILDING ON EXISTING APPROACHES.

5.5.1 Establish mechanisms to engage First Nations, Métis and Inuit communities to have further dialogue on the recommendations in this document

5.5.2 Ensure that no part of this strategy impinges on the use of tobacco by Indigenous people and communities when used for traditional or ceremonial purposes.

5.5.3 Support development, implementation and further expansion of Indigenous-specific approaches within an integrated health promotion/chronic disease risk factor approach, in a sustainable way.

A FEW LAST WORDS

The tobacco endgame is within our grasp. Within 20 years – in just one generation – Ontario could stop the devastation caused by tobacco and other harmful inhaled substances.

The benefits would be immediate: a quarter of a million lives saved, a healthier population, a cleaner environment and more than $12.2 billion – $4.1 billion in health costs and $8.1 in social and economic costs – avoided.

To cement its role as a national and international leader in tobacco control, Ontario should commit to driving down tobacco use to 11% by 2023, 8% by 2028 and <5% by 2035.

To meet that target, Ontario must:

- aggressively challenge and contain the tobacco industry, which continues to sell a lethal product and exploit people's health to optimize shareholder returns;
- embed evidence-based cessation services in all clinical and community settings;
- create a network of evidence-based, person-centred, barrier-free cessation services that will engage more Ontarians who smoke to help reach the target of 80,000 quits each year;
- intensify its efforts to keep people from starting to smoke and to prevent exposure to secondhand smoke; and
- provide the right mix of resources, system enablers and commitment to execute the strategy – including an engaged public, evidence, surveillance information, monitoring and evaluation, skills and competencies, and strong leadership and coordination.

The province has what it needs to act decisively and to disrupt the status quo: a public that wants a smoke-free and tobacco-free province; willing federal, municipal and non-governmental partners; strong evidence about effective interventions; and a solid foundation of tobacco control and cessation programs that can be leveraged into a seamless network of accessible person-centred services and supports.

With bold provincial commitment and leadership, Ontario can be one of the first jurisdictions in the world to reach the tobacco endgame.

It is time to stop the devastating toll of disease and death caused by tobacco and to reduce the harm caused by other harmful inhaled substances, such as shisha and cannabis.

APPENDIX A - EXECUTIVE STEERING COMMITTEE MEMBER

Organization	Name/Position
Ministry of Health and Long-Term Care (MOHLTC)	**Roselle Martino** (co-chair) Assistant Deputy Minister Population and Public Health Division
University of Ottawa Heart Institute (UOHI)	**Dr. Andrew Pipe** (co-chair) Division Head of Prevention and Rehabilitation
Canadian Cancer Society (CCS), Ontario Division	**Joanne Di Nardo** Senior Manager, Ontario Division
Centre for Addiction and Mental Health (CAMH)	**Dr. Peter Selby** Director of Medical Education
Council of Ontario Medical Officers of Health (COMOH)	**Dr. Charles Gardner** Medical Officer of Health, Simcoe Muskoka District Health Unit
Heart and Stroke Foundation (HSF)	**Mary Lewis** Executive Director and VP Research, Advocacy and Knowledge Exchange Ontario Mission
Ontario Campaign for Action on Tobacco (OCAT)	**Michael Perley** Executive Director
Ontario College of Family Physicians	**Jessica Hill** Former Chief Executive Officer
Ontario Lung Association (OLA)	**Sarah Butson** Director, Health Promotion and Youth Engagement
Ontario Pharmacists Association (OPA)	**Allan Malek** Executive Vice President, Chief Pharmacy Officer
Ontario Tobacco Research Unit (OTRU)	**Dr. Robert Schwartz** Executive Director
Propel Centre for Population Health Impact, University of Waterloo	**Dr. John Garcia** Scientist, Propel Centre for Population Health Impact, University of Waterloo

Organization	Name/Position
Public Health Ontario (PHO)	**Dr. George Pasut** Vice President, Science and Population Health and Chief Information Officer
Registered Nurses' Association of Ontario (RNAO)	**Dr. Valerie Grdisa** Director, International Affairs and Best Practice Guidelines Centre
Smoking and Health Action Foundation (SHAF)	**Lorraine Fry** Executive Director
Special Advisor	**Joe Belfontaine**