



Briefing April 2013

Smoking Cessation and the Workplace

Briefing 1—Profile of Tobacco Smokers in Canada

At a Glance

- ◆ Given the risks and costs of smoking, Canada could do more to help current smokers quit.
- ◆ Three-quarters of current smokers are employed, with many working in the construction, mining, and transportation industries.
- ◆ Employers have a role as part of an integrated approach to smoking cessation programs.
- ◆ Evidence-based cessation methods exist, but their uptake in the general population is low.

Smoking kills—stopping works.

—Sir Richard Peto

SMOKING CESSATION: OPPORTUNITIES FOR ACTION

In his October 2012 address to the Royal College of Physicians in the United Kingdom, epidemiologist and tobacco expert Sir Richard Peto warned that although progress has been made in reducing smoking, we cannot be complacent.¹ Smoking does kill—in Canada in 2002, just over 16 per cent of all deaths were attributed

¹ Royal College of Physicians, “Despite Falling Death Rates.”



to cigarette smoking.² Tobacco use is implicated in many of the leading chronic diseases in this country. These diseases are responsible for significant societal, business, and health care costs along with individual suffering and reduced quality of life. (See box “Smoking: A Sickening Risk.”) Although Canada is a global leader in tobacco control, 17.3 per cent of Canadians smoke tobacco. Given the risks and costs from tobacco use, there is still significant room to reduce smoking among Canadians.

Tobacco use is implicated in many of the leading chronic diseases, and these are responsible for significant societal, business, and health care costs, along with reduced quality of life.

The understanding of tobacco addiction, along with the ways to help people quit, have advanced significantly over recent decades. However, some tobacco researchers believe that the full benefit of this progress has not been realized and that a significant opportunity exists to increase smokers’ demand for and use of effective cessation programs and treatment, and in turn improve lives and reduce the economic burden of tobacco-related diseases.³ Many people want to quit smoking but experience considerable difficulty in doing so, especially over the long term.⁴ While there is no shortage of cessation strategies and treatments, tobacco researchers believe what is still missing are effective, integrated approaches that provide long-term support that help people successfully quit permanently.⁵ An integrated approach that draws on collaboration among health, government, research, and business stakeholders could help to ensure the most efficient and effective investment of smoking cessation dollars, including public, individual, and employer spending. This study explores the role of employers as part of an integrated approach to helping smokers quit.

The risks and costs from smoking have been detailed in previous Conference Board publications on the Canadian Heart Health Strategy,⁶ the National Lung Health Framework,⁷ and the costs of smoking in the workplace. The objectives of this current report series are to:

- ♦ understand the profile of smokers, and in particular employed smokers in Canada (including by industry/occupation);
- ♦ explore the cessation benefits, programs, and policies offered by employers;
- ♦ contrast these benefits against the recommended/ evidence-based approaches to smoking cessation generally and in the workplace;
- ♦ examine the potential for employer collaboration with other stakeholders (i.e., health professionals like pharmacists, nurses, and public health departments) to deliver cessation programs and benefits;
- ♦ estimate the potential impacts (health and economic) from greater uptake of effective cessation programs through the workplace.

The report series comprises three briefings:

1. *Profile of Tobacco Smokers in Canada*: This first briefing presents data on smoking prevalence and smoking cessation, with a focus on the employed population. We examine smoking data to identify at-risk populations and opportunities for targeted action.
2. *Access to and Effectiveness of Workplace Smoking Cessation Programs*: The second briefing explores cessation programs and in particular workplace programs. The results of the Conference Board’s survey of Canadian employers on smoking cessation benefits are presented.
3. *Current and Future Impact of Workplace Smoking Cessation Programs*: The third briefing builds on the Conference Board’s economic modelling expertise and past work on cardiovascular and respiratory diseases to estimate the potential impact (such as disease prevalence, and direct and indirect costs, including productivity) of improving abstinence through workplace smoking cessation programs.

2 Baliunas and others, “Smoking-Attributable Mortality,” 154.

3 Orleans, “Increasing the Demand.”

4 The Lung Association, *Making Quit Happen*, 9.

5 Lansdell, “The Art of Quitting.”

6 See Browarski, Stonebridge, and Thériault, *The Canadian Heart Health Strategy*.

7 See Thériault and others, *Cost Risk Analysis*.

Smoking: A Sickening Risk

Tobacco smoking is related to poor health and early death in many ways. Lung cancer is the leading cause of death from smoking.¹ Furthermore, the most recent United States Surgeon General report on smoking and disease reaffirms that inhaling tobacco smoke "... causes adverse health outcomes, particularly cancer and cardiovascular and pulmonary diseases" and that there is no "risk-free level of exposure to tobacco smoke."² An estimated one-half of all long-term smokers, and especially those who started smoking in their teens, will eventually die from tobacco use.³ In Canada, smoking is the leading cause of premature death.⁴ Furthermore, smoking during pregnancy carries risks for both the mother and fetus, such as low birth weight, still birth, and placental complications.⁵ In addition, exposure to second-hand smoke (SHS) is harmful to health, including "immediate adverse effects on the cardiovascular system and causes coronary heart disease and lung cancer."⁶

Smoking is costly to individuals, health care systems, businesses, and society. For example, the Conference Board's 2006 publication *Smoking and the Bottom Line* estimated that businesses incur costs of \$3,396 per employee who smokes from absenteeism, decreased productivity, and smoking area costs.⁷ Rehm and others estimated that, in 2002, cigarette smoking cost Canadian society about \$17 billion.⁸ Of this, \$12.5 billion was for lost productivity due to illness and premature death and \$4.4 billion was for direct health care costs, including hospitalizations, treatment, drugs, and physician visits.

Canadians seem to be well aware of the risks that smoking brings. A recent survey found that an overwhelming majority—82 per cent of Canadians—believe that refraining from smoking is very important in helping to maintain health and prevent or delay illness, while a further 12 per cent thought it was somewhat important.⁹

1 Public Health Agency of Canada, *Life and Breath*, 12.

2 U.S. Department of Health and Human Services, *How Tobacco Smoking Causes Disease*, 9.

3 *Ibid.*, 1.

4 Janz, "Current Smoking Trends."

5 Health Canada, *Smoking and Your Body*.

6 U.S. Department of Health and Human Services, *The Health Consequences of Involuntary Exposure*, 11.

7 Hallamore, *Smoking and the Bottom Line*.

8 Rehm and others, *The Costs of Substance Abuse in Canada*, 1.

9 The Conference Board of Canada. *Canadians See Their Own Behaviour and Lifestyle as Key to Their Health*.

Source: The Conference Board of Canada.

This first briefing begins by exploring smoking prevalence in Canada and then probes smoking from the perspective of the employed population. A better understanding of the profile of smokers in this population group will help inform strategies that employers can adopt to reduce smoking among their workforce. The importance of smoking cessation is discussed along with the impact of the workplace in helping smokers quit.

HISTORICAL TRENDS

Canadians today smoke far less than they did in the mid-1960s, when smoking in Canada was at an all-time high.⁸ Mounting evidence linking smoking to lung cancer and various other diseases emerged in the 1950s, leading to

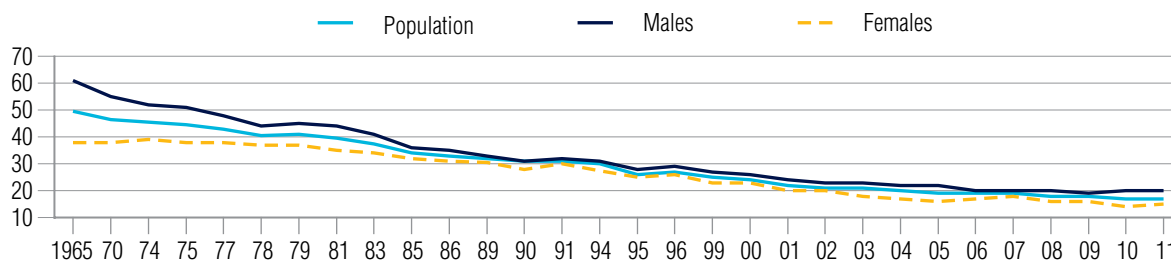
a cancer scare that set the stage for a precipitous decline in tobacco smoking in Canada. In 2011, 17.3 per cent of Canadians smoked cigarettes on a daily or occasional⁹ basis, down from nearly 50 per cent in 1965. (See box "Tobacco Use Data Sources.") Over the last few years, the prevalence of smoking has continued to decrease, but the rate of decline has gradually slowed. (See Chart 1.) As the saying goes, the low-hanging fruit has already been picked and more targeted efforts are now required to make further inroads into reducing smoking in Canada.

Despite a significant decline in smoking, the number of Canadians who continue to smoke is hardly negligible. The remaining tobacco smokers include over

8 See Collishaw, *History of Tobacco Control in Canada*.

9 Based on Statistics Canada's CTUMS question: "At the present time do you smoke cigarettes every day, occasionally or not at all?"

Chart 1
Smoking Prevalence in Canada
(per cent)



Note: Canadians aged 15 and over who smoke on a daily or occasional basis
Source: Physicians for a Smoke-Free Canada.

4.9 million¹⁰ Canadians, and are present in all segments of Canadian society. Moreover, the health risks associated with smoking extend beyond this population. Among non-smokers, a further 8.6 million Canadians report being exposed to second-hand smoke at least once a week, 900,000 of whom report being exposed to second-hand smoke on a daily basis.

In the past, raising awareness of the negative effects of smoking was instrumental in reducing smoking prevalence in Canada. Since December 2000, the Canadian government has required explicit and graphic health warnings on all imported and domestically manufactured cigarette packages. As of March 2012, the federal government's new Tobacco Products Labelling Regulations require larger and more graphic warning messages.¹¹

These warnings, combined with tobacco denormalization advertisements and other public health campaigns, have been proven to significantly improve awareness of the health risks of smoking.¹² Yet, many Canadians

Tobacco Use Data Sources

Two Statistics Canada surveys provide a wealth of information on smoking in Canada. The Canadian Tobacco Use Monitoring Survey (CTUMS) is an annual survey conducted by Statistics Canada on behalf of Health Canada. It collects information on the smoking habits of Canadians aged 15 and over, with a special focus on youth smoking. Its sample size of about 20,000 Canadians excludes residents of the Northwest Territories and Nunavut. The second source, the Canadian Community Health Survey (CCHS), collects information from Canadians aged 12 and over on a large number of health topics, including smoking. Its sample size of about 65,000 excludes residents of Native reserves.

Due to different sampling designs and data collection methods, the results of the two surveys differ in some respects. Most notably, CCHS reports significantly higher smoking rates across all demographics. However, the trends observed in the two surveys are consistent. Given its focus on smoking, CTUMS will be relied on as the primary source in this analysis, while CCHS will be used to cover topics that are not included in CTUMS, as indicated.

Source: The Conference Board of Canada.

10 This figure is based on CTUMS (please note that all computations, use, and interpretation of CTUMS data are entirely those of the authors). Data from the CCHS put the figure at a significantly higher 5.8 million.

11 Health Canada, *New Health Warnings Appearing Soon*.

12 See Hammond and others, "The Effectiveness of Cigarette Warning Labels."

continue to smoke, despite being aware of the risks. More targeted programs may be necessary to help them quit. With this in mind, the following analysis will shed some light on the segments of society that are most vulnerable to smoking in Canada.

Table 1
Smoking Status in Canada, 2011
(per cent)

| | Men | Women | Total |
|---------------------------|------|-------|-------|
| Current daily smoker | 15.4 | 12.1 | 13.7 |
| Current occasional smoker | 4.2 | 3.0 | 3.6 |
| Former daily smoker | 24.0 | 21.4 | 22.7 |
| Former occasional smoker | 2.9 | 2.4 | 2.7 |
| Experimental smoker | 16.3 | 13.3 | 14.8 |
| Lifetime abstainer | 37.0 | 47.8 | 42.5 |

Note: Canadians aged 15 and over
Source: Statistics Canada, CTUMS.

PROFILE OF CANADIAN SMOKERS

In 2011, 13.7 per cent of Canadians smoked on a daily basis and a further 3.6 per cent were occasional smokers. Meanwhile, 42.5 per cent of Canadians indicated they had never smoked a cigarette in their lives. (See Table 1.) While smoking is a public health risk that is prevalent in all sectors of Canadian society, certain groups may be more susceptible to developing this habit than others.

Men, for example, are significantly more likely to smoke than women. In 2011, 19.6 per cent of men over 15 years of age smoked on a daily or occasional basis, compared to 15.1 per cent of women. The gap between the two sexes has narrowed since the 1960s, but men continue to be more likely to smoke.

The provincial variations in smoking are highlighted in Table 2. A regional breakdown reveals that British Columbia and Ontario have the lowest prevalence of smoking in Canada. In 2011, 14.2 per cent of British Columbians and 16.3 per cent of Ontarians smoked cigarettes. The prevalence of smoking was highest in Quebec (19.8 per cent) and Saskatchewan (19.2 per cent) and was also generally higher in the Atlantic provinces.

Many smokers start smoking at an early age. In fact, current smokers report having their first cigarette at the average age of 16, confirming that smoking is often initiated before adulthood. In 2011, as many as 7.7 per cent

Table 2
Smoking Prevalence by Province, 2011
(share of Canadians, per cent)

| | |
|---------------------------|------|
| Quebec | 19.8 |
| Saskatchewan | 19.2 |
| Prince Edward Island | 19.1 |
| Newfoundland and Labrador | 18.9 |
| New Brunswick | 18.8 |
| Manitoba | 18.7 |
| Nova Scotia | 18.1 |
| Alberta | 17.7 |
| Ontario | 16.3 |
| British Columbia | 14.2 |

Note: Canadians aged 15 and over who smoke on a daily or occasional basis
Source: Statistics Canada, CTUMS.

of Canadians aged 15 to 17 reported smoking on a daily or occasional basis. Smoking rates were highest among those aged 20 to 44, peaking at 22.3 per cent among 23- and 24-year-olds. Starting smoking at an early age increases the likelihood of becoming a lifetime smoker.

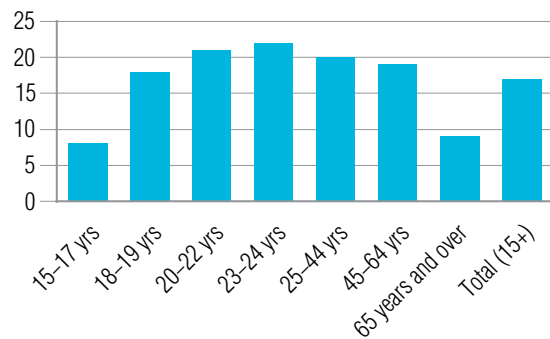
In the U.S., research has shown that among adult smokers, about 88 per cent of first use of tobacco occurred before the age of 18.¹³ It is therefore important to target younger age groups to prevent them from developing the habit.

Certain groups may be more susceptible to smoking than others. For example, men are more likely to smoke than women. Smoking is also highest in Quebec, Saskatchewan, and the Atlantic provinces.

The prevalence of smoking drops sharply among the older population. In particular, only 9.5 per cent of Canadians aged 65 and older smoked in 2011. (See Chart 2.) Among this demographic, a striking 43.6 per cent were former smokers, a rate consistent with the high smoking prevalence observed until the 1980s.

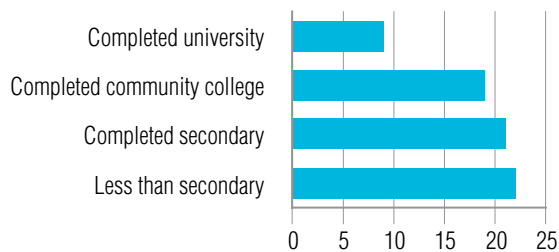
13 U.S. Department of Health and Human Services, *Preventing Tobacco Use Among Youth*, 3.

Chart 2
Smoking Rate by Age Group, 2011
(per cent)



Source: Statistics Canada, CTUMS.

Chart 3
Smoking Prevalence by Level of Education, 2011
(per cent)



Note: Canadians aged 15 and over who smoke on a daily or occasional basis

Source: Statistics Canada, CTUMS.

Smoking also varies with a person's marital status. Among Canadians aged 25 to 44, for instance, 37 per cent of divorced, widowed, and separated persons smoked cigarettes, while the share of smokers falls to 28 per cent among singles, and drops further to just 16 per cent among Canadians who were married or living in a common-law relationship.

The level of education emerges as one of the most important predictors of smoking behaviour. Among Canadians who have completed only secondary education, 20.8 per cent were smokers in 2011. Meanwhile, this share drops to 8.9 per cent among those with a university degree. (See Chart 3.)

SMOKING AND EMPLOYMENT

On the whole, over three-quarters (77 per cent) of smokers in 2011 had worked at one point in the past 12 months.¹⁴ This makes the workplace a potentially important platform through which to implement smoking cessation programs.

Among the working population in 2011, 19 per cent were smokers, which is higher than the percentage of smokers in the non-working population.¹⁵ In addition, 23 per cent of non-smoking workers were still exposed to second-hand smoke at their workplace.

Given that the percentage of smokers is higher in the working population than in the non-working population—and exposure to second-hand smoke is high—the workplace is a potentially important platform through which to implement smoking cessation programs.

The prevalence of smoking was significantly higher among blue-collar occupations. In particular, smoking was highest in occupations related to trades, transport, and equipment operators (28 per cent), followed by processing, manufacturing, and utilities (24 per cent). Not only are they more likely to smoke, the data show that blue-collar workers also experience a significantly higher level of exposure to second-hand smoke at work.¹⁶ In contrast, smoking was generally lower in more white-collar occupations related to social science, education, government, and religious occupations (9 per cent) and health (12 per cent). (See Table 3.)

In a breakdown by industry, the data reveal that the prevalence of smoking was highest in the construction, mining and oil and gas extraction, and transportation and warehousing industries. This is consistent with the

14 Statistics Canada, CTUMS.

15 This is mainly because those who are not currently working include many women who left the labour force while on maternity leave or to raise their children, and are generally less likely to smoke.

16 Statistics Canada, CTUMS.

Table 3

Smoking by Occupation, 2011
(share of workers who smoke, per cent)

| | |
|---|----|
| Trades, transport, and equipment operators | 28 |
| Processing, manufacturing, and utilities | 24 |
| Management | 23 |
| Primary industry | 22 |
| Sales and service | 20 |
| Business, finance, and administration | 16 |
| Health | 12 |
| Natural and applied sciences, and related | 12 |
| Social science, education, government, and religion | 9 |
| Art, culture, recreation, and sport | 9 |

Source: Statistics Canada, CTUMS.

occupational breakdown, as most of these industries have a predominantly blue-collar workforce. In contrast, the white-collar-dominated education services and finance and insurance industries had the lowest smoking prevalence. (See Table 4.)

Low personal income is strongly associated with a higher prevalence of smoking, which is consistent with the relationship between smoking and education levels. Canada's highest earners are far less likely to smoke than its lowest earners. The prevalence of smoking among Canadians earning less than \$20,000 was 33.1 per cent in 2010, more than double that of those earning over \$80,000, which was only 16.2 per cent.¹⁷ (See Chart 4.)

Finally, male part-time workers were generally more likely to smoke than male full-time workers. In 2010, among men aged 25 to 59 who were employed part time, 32 per cent smoked, compared to only 26 per cent among male full-time workers.¹⁸ However, the opposite was true among women. This may be explained by the fact that many women choose to work part time to raise their children. Knowing that pregnancy and having a baby

Table 4

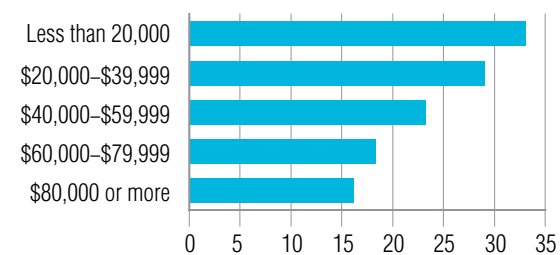
Smoking Prevalence by Industry, 2011
(share of workers who smoke, per cent)

| | |
|--|----|
| Construction | 34 |
| Mining and oil and gas extraction | 29 |
| Transportation and warehousing | 29 |
| Administrative support, waste management, and remediation services | 27 |
| Accommodation and food services | 27 |
| Wholesale trade | 26 |
| Manufacturing | 24 |
| Retail trade | 23 |
| Real estate and rental leasing | 23 |
| Agriculture, forestry, fishing, and hunting | 22 |
| Other services (except public administration) | 22 |
| Health care and social assistance | 18 |
| Arts, entertainment, and recreation | 18 |
| Utilities | 17 |
| Information and cultural industries | 17 |
| Professional, scientific, and technical services | 16 |
| Public administration | 16 |
| Finance and insurance | 15 |
| Educational services | 10 |

Source: Statistics Canada, CCHS.

Chart 4

Smoking Prevalence by Income, 2010
(per cent)



Note: Canadians aged 25 to 59
Source: Statistics Canada, CCHS.

17 Based on CCHS data. CTUMS does not provide information on personal income.

18 Based on CCHS data. CTUMS does not specifically provide information on part-time workers.

in the household is cited as one of the main reasons to quit smoking among women,¹⁹ it is not surprising that female part-time workers were less likely to smoke than those working full time.

THE IMPORTANCE OF SMOKING CESSATION

The case for helping smokers quit is very compelling, as most current smokers want to quit. Results from Canada's 2011 CTUMS showed that for Canada's 4.9 million smokers, 3.1 million were considering quitting in the next 6 months and of these, 1.4 million were considering quitting in the next 30 days.²⁰

The returns of quitting smoking are great and extend far beyond lowering the risk of lung cancer. For example, research by Pipe and others suggests "smoking cessation may have a greater effect on reducing mortality among smoking patients with coronary artery disease than any other intervention or treatment."²¹ The risk of myocardial infarction has been found to decrease by 50 per cent within two years of smoking cessation.²² The earlier in life a smoker quits the better. Taylor and others used U.S. data to examine the impact of the timing of quitting smoking on life expectancy and found that quitting at an early age is important, but even quitting later in life can bring benefits.²³ A 2013 study of U.S. smokers reinforces this finding by demonstrating that "... adults who had quit smoking at 25 to 34, 35 to 44, or 45 to 54 years of age gained about 10, 9, and 6 years of life, respectively, as compared with those who continued to smoke."²⁴ And new research from the U.K. on smoking and women shows that stopping smoking before age 30 prevents more than 97 per cent of the excess mortality caused by smoking.²⁵

19 Statistics Canada, CTUMS.

20 Ibid.

21 Pipe, Papadatus, and Reid, "The Role of Smoking Cessation," 146.

22 Ibid., 148.

23 Taylor and others, "Benefits of Smoking Cessation."

24 Jha and others, "21st-Century Hazards of Smoking and Benefits of Cessation."

25 Pirie and others, "The 21st Century Hazards of Smoking."

Despite a desire to quit smoking and the benefits from doing so, the highly addictive nature of tobacco is why it is difficult for people to quit. Canadians who successfully quit smoking required an average of 3.2 attempts before succeeding.²⁶ Fortunately, several forms of smoking cessation aids are available today. But are cessation aids getting to those who are interested in quitting, and what kind of help are people currently accessing?

EVIDENCE-BASED TOBACCO CESSATION STRATEGIES

What works to help people quit? The evidence for a range of smoking cessation treatments and programs is strong and includes interventions that address both the physical and psychological nature of a smoking addiction. This evidence is typically reviewed and incorporated into guidelines for evidence-based approaches to smoking cessation. For example, systematic reviews and meta-analyses produced by the Cochrane Tobacco Addiction Group, part of the international consortium The Cochrane Collaboration, provides insights into the evidence on effective practices and treatments. The Canadian Agency for Drugs and Technologies in Health (CADTH) also provides evidence-based reviews to inform Canadian policy- and decision-making. For example, researchers at CADTH reviewed the evidence on pharmacologic-based strategies and found that smoking cessation medications (nicotine replacement therapy [NRT], varenicline [Champix], bupropion [Wellbutin, Zyban]) "... are all effective in helping the general population quit smoking and remain smoke-free one year later."²⁷ NRT and bupropion can double the odds of a smoker quitting, with varenicline increasing the odds from between two- and threefold, compared with those not using medications.²⁸ New research from the International Tobacco Control (ITC) four-country survey (U.K., Canada, U.S., and Australia) supports this finding by determining that

26 Statistics Canada, CTUMS.

27 Canadian Agency for Drugs and Technologies in Health, *Smoking Cessation Pharmacotherapy*, 2.

28 Ibid., 2.

those smokers who used medication (varenicline, bupropion, or nicotine patch) were more likely to succeed in their quit attempts.²⁹

The findings from these reviews, along with other research, have been considered by those developing guidelines or adopting policies for smoking cessation. One example of such guidelines is the *Treating Tobacco Use and Dependence: 2008 Update*, produced by the U.S. Tobacco Use and Dependence Guideline panel, “contains strategies and recommendations designed to assist clinicians; tobacco dependence treatment specialists; and health care administrators, insurers, and purchasers in delivering effective treatments for tobacco use and dependence.”³⁰ A key feature of the guidelines is the recommendation that clinicians intervene with all tobacco users based on a system referred to as the 5As:

- ♦ A1: Ask about tobacco use at every visit.
- ♦ A2: Advise to quit.
- ♦ A3: Assess willingness to make a quit attempt.
- ♦ A4: Assist with counselling and pharmacotherapy.
- ♦ A5: Arrange follow-up support and assistance.

The Canadian Action Network for the Advancement, Dissemination and Adoption of Practice-Informed Tobacco Treatment (CAN-ADAPTT) has similarly developed evidence-based guidelines for smoking cessation that clinicians can use to help people to quit.³¹ The recommendations are based on the 5As for counselling and psychological approaches. The guidelines suggest a number of things, such as:

- ♦ Brief interventions can be effective (1 to 3 minutes), but more intensive interventions should be used when possible.
- ♦ Four or more counselling sessions are recommended.
- ♦ Combining counselling and medication together is more effective than each on its own, so both should be provided together.

29 Kasza and others, “Effectiveness of Stop-Smoking Medications.”

30 Fiore and others, *Treating Tobacco Use and Dependence*, v.

31 CAN-ADAPTT, *Canadian Smoking Cessation Clinical Practice Guideline*.

A new review by researchers with the Cochrane Tobacco Addiction Group found that the combination of treatment with cessation medications and behavioural support (such as brief advice and counselling) may increase smoking cessation success (abstinence after at least six months follow-up) when compared with usual care or a minimal intervention.³² The combination of behavioural support and medication could increase the chance of someone successfully quitting by 70 to 100 per cent than if the person just receives brief support or advice. Participants in the review studies were drawn from both health care settings and community-based settings.

A range of treatments and programs, including those that address both the physical and psychological nature of a smoking addiction, appear to be the most successful.

One example where the evidence has been put into an effective practice model is the University of Ottawa Heart Institute’s Ottawa Model for Smoking Cessation (OMSC). OMSC is one of the leading Canadian clinical-based programs for helping smokers quit. It is based on a systematic method of identifying and providing treatment and follow-up to all smokers seen in a given clinical setting.³³ Results show that the model has led to an 11.1 per cent improvement in long-term cessation rates among hospitalized patients. Over 144 sites are part of the network that has adopted the model, including inpatient, outpatient, and primary care settings.

CESSATION AIDS AND PROGRAMS

The main forms of available cessation aids include pharmaceutical products, counselling, and workplace cessation programs. However, while research has shown that the use of formal cessation methods significantly

32 Stead and Lancaster, “Combined Pharmacotherapy and Behavioural Interventions.”

33 University of Ottawa Heart Institute, *About OMSC*.

reduces relapse rates among quitters,³⁴ data from CTUMS reveal that the majority of smokers are either reluctant to use these methods or simply do not have access to them.

Pharmaceutical products such as NRT and medication were the most commonly used form of cessation aids in 2011. Yet, less than half of Canadians who tried to quit smoking in the past two years had used them. Cost is an important obstacle for many. When asked why they did not use these products, about one-fifth of quitters cited their high cost. Furthermore, even if employees have access to a group benefits plan through their employer, many do not include NRT or medications (e.g., Zyban, Champix) in their prescription drug coverage or they include a lifetime reimbursement or dosage limit. The Conference Board's *Benefits Benchmarking 2012* report shows that 43 per cent of organizations exclude smoking cessation aids from their prescription drug plan.³⁵

Many workers are either reluctant to use cessation aids such as pharmaceutical products, counselling, and workplace cessation programs or do not have access to them.

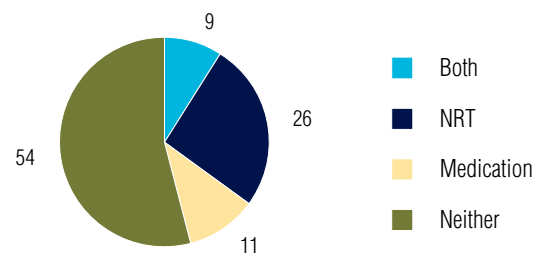
Meanwhile, others did not believe they would work (22 per cent), were concerned about their side effects (21 per cent), or simply did not have enough information about them (11 per cent). Among these cessation products, NRT was the most prevalent and was used by 35 per cent of those who attempted to quit (25 per cent exclusively and 9 per cent in conjunction with medication), while medication such as Zyban, Wellbutrin, and Champix was exclusively used by 11 per cent, and 9 per cent used both products in conjunction. (See Chart 5.)

In addition to pharmaceuticals, free counselling is available to quitters nationwide through toll-free “quitlines” in all provinces and territories. The counselling comes in the form of telephone support, with agents who help

34 Leatherdale and Shields, “Smoking Cessation,” 36.

35 Thorpe, Martin, and Lamontagne, *Benefits Benchmarking 2012*, 17.

Chart 5
Smoking Cessation Aids Used, 2011
(per cent)



NRT = nicotine replacement therapy

Note: Canadians who attempted to quit in past two years

Source: Statistics Canada, CTUMS.

smokers develop a quit plan. A Cochrane review of telephone counselling for smoking cessation found this method to be effective, especially with multiple sessions.³⁶ However, while 58 per cent of quitters were aware of the availability of this form of support, only 3 per cent chose to try it.³⁷

Finally, some workplaces offer special smoking cessation programs for their employees. Employer-sponsored programs may be stand-alone or offered as part of an overall health and wellness initiative. They vary widely in composition. In 2011, they were available to only about one-fifth of the workers who tried to quit in the past two years. Further, only a meagre 6 per cent of these workers took advantage of these programs while they were attempting to quit. There are calls for increasing consumer demand for proven cessation programs that in turn may help to generate policy changes that improve affordability, access, and ease of use of these programs.³⁸ The remainder of this briefing, and the subsequent two briefings that complete this research series, focus on the role of employers in extending the reach of effective cessation programs and helping smokers quit.

36 Stead, Perera, and Lancaster, “Telephone Counselling for Smoking Cessation.”

37 Statistics Canada, CTUMS.

38 Orleans, “Increasing the Demand,” S341.

IMPLICATIONS GOING FORWARD: THE ROLE OF THE WORKPLACE

The profile of smoking in Canada reveals that a sizable opportunity exists to address smoking cessation through the workplace. Three-quarters of current smokers are employed. Most want to quit. They are predominantly male, single, young, and middle-aged workers with relatively low income and education. Many hold blue-collar jobs in industries such as construction, mining, and transportation. Furthermore, evidence-based cessation methods exist but their uptake in the general population is low.

Organizational performance and success, and in turn Canada's prosperity, depend in large part on leveraging the value instilled through a healthy, productive workforce. Employers have a significant opportunity to improve employee health and productivity by addressing smoking cessation. Workplace interventions can be directed at individuals, such as providing access to evidence-based smoking cessation benefits and programs, and the workforce as a whole, such as workplace smoking bans. Employers can also provide education about the health impacts of smoking, the benefits of quitting, and the effectiveness of smoking cessation programs. Progressive workplaces may collaborate and/or develop partnerships with insurers, health professional groups, and public health agencies to offer new programs or improve the reach and effectiveness of existing programs. Indeed, tobacco control experts are calling for better integrated cessation services,³⁹ and employers should be part of this effort.

What is the status of employer-sponsored smoking cessation programs in Canada, and particularly in high-risk industries such as construction, mining, oil and gas, and transportation? Are effective programs being offered and used? Are there examples of collaboration among employers, insurers, and public health or health professionals to deliver better integrated services? These questions and others are the subject of the second briefing in this research series on smoking cessation in Canada.

39 Lansdell, "The Art of Quitting."

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