Addendum: Audit of the Contribution Agreements Under the Enforcement Program for Federal Tobacco Legislation

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Summary Assessment

An audit was completed of six Contribution Agreements pursuant to the Enforcement Program for Federal Tobacco Legislation. The audit work was carried out during February 1997. The objectives of the audit were to:

- assess and report on the management and disbursement of the resources provided to provinces under the contribution agreements for the enforcement of the federal tobacco legislation;
- assess and report on the management of the funded activities; and,
- recommend improvements should weaknesses be found.

The scope of the audit was the six provinces with Contribution Agreements with the federal government (Newfoundland and Labrador, PEI, New Brunswick, Nova Scotia, Ontario and British Columbia). Each of the provinces was visited during the audit.

The key issues of the audit were:

- roles and responsibilities;
- accountability structures and program management controls;
- appropriateness of activities funded under the Agreement by geography and population density;
- assurance that operational procedures and controls are satisfactory; and,
- fulfilment of terms and conditions of the Agreements.

The key findings and observations are described below.

Roles and Responsibilities

The audit team determined that roles and responsibilities are defined and well understood in each of the Contribution Agreement provinces.

The division of roles and responsibilities between the Ministries of Health and the health units/departments in British Columbia and Ontario are defined through correspondence and memoranda. There is no overall MOU in place between each provincial MoH and the health units. The current arrangements have created a situation where no one in British Columbia or Ontario can be held completely accountable for the enforcement program. The MoH is a funding agency, but they have limited powers over the provincial health units in terms of assuring that they carry out the enforcement program. This has led to variations in the activity levels for the enforcement program by health units.

Adequacy of Training

With the exception of Newfoundland and Labrador, all of the Contribution Provinces have provided some training to enforcement officers. There are no national standards for training, so it was not possible to determine whether the training received is adequate in all cases. Weaknesses noted relate to insufficient training on surveillance techniques in Ontario, and insufficient training in court and prosecution techniques in some provinces. In provinces that utilize health inspectors, incumbents have a basic training received from their university programs. In other provinces the inspectors' background generally is law enforcement, which provides good background knowledge. Weaknesses overall are in keeping inspectors updated on emerging issues in the Tobacco Enforcement program, and keeping abreast of new techniques required to ensure compliance.

Procedures in Place for Organizing Managing, Directing and Controlling

Although we found that procedures have been developed in each of the provinces, there are no standards for inspection coverage, or compliance checks, in terms of retailer coverage each year. This means that there is no real basis for coherent work planning. This is further complicated by the fact that the inventory of the retailer populations is not comprehensive or accurate in each jurisdiction, and management information systems used to compile information on the outcomes of compliance checks for the most part are not working properly in most of the provinces.

In most of the provinces, we observed that there are some procedures to guide the enforcement program. In British Columbia procedures are being revised currently. In New Brunswick, procedures for compliance checks have been developed, but approval for the implementation of compliance checks has not been granted.

There are no standards for inspection coverage and compliance coverage annually to guide workplanning. As a result workplanning tends to be based primarily on the resources available. We determined that workplanning varies as per the delivery program approach. We found that in some cases the workplanning process is informal and is based on short term considerations, such as complaints, availability of inspectors, etc. Informal workplanning is considered satisfactory provided the inspection organization maintains a good inventory of the retailer population, and the history of inspections and compliance checks and assures adequate coverage in its activities.

Information to Manage the Enforcement Program

Appropriate information is required to properly manage the enforcement program. First, there is a need to have an up-to-date inventory of retailers that can be used as a basis for enforcement activities. Second, there is a need to have a database of all retailers that incorporates information on the history of inspection activity, compliance check activity and ultimately decoy purchase activity. The information base together with inspection and compliance check standards are essential for effective workplanning of the enforcement program.

Compliance statistics can be derived from a number of sources:

- all inspection activity and compliance check activity is generally analyzed and the results of annual activity can be summarized to provide the percentage of retailers that are compliant. These statistics are representative only of retailers inspected or subjected to compliance checks in a particular year. As a result they may not be representative of the retailer population as a whole;

- the Nielsen surveys that are carried out annually provide estimates of provincial and national compliance rates. Because of the Nielsen methodology the results are not accurate to the county or health unit level. Furthermore, compliance survey results can vary depending on the minor carrying out the compliance check . Therefore, there have been noted variances between the Nielsen results and the results of local surveys; and,

- local compliance surveys have been done in some regions that are similar to the Nielsen survey but are representative at the health unit or county level.

Our review indicated that the most consistent method for measuring compliance is the Nielsen survey. Comprehensive compliance surveys at the health unit or country level are only being done in selected jurisdictions (e.g. Ontario did a survey of 12 health units). In general, all of the contribution provinces are compiling compliance statistics for inspections and compliance checks done each year. However, the compliance statistics can not be taken as representative of the entire population as the compliance checks are not designed to be a random survey of the retailer population.

The most important weaknesses noted are:

- the failure of most jurisdictions to compile a comprehensive and accurate database of retailers (although this is being remedied currently);

- the lack of a well designed management information system and database that can be used for tracking retailer performance on compliance checks, and as a basis for future planning. The systems in existence vary extensively and can range from well designed computer databases to written lists of retailers and results of inspections and compliance checks.

We concluded that there are a number of weaknesses with the information maintained on compliance in the contribution provinces:

- generally there is no assurance that each province has an up-to-date and comprehensive list of tobacco retailers. (This is being remedied currently by improvements in the list of retailers in most provinces). Nova Scotia and New Brunswick have comprehensive listings because tobacco retailers are licensed. Ontario and British Columbia are still developing a comprehensive listing of retailers. (Ontario is requiring manufacturers/distributors to provide a list of their customers.) Newfoundland and Labrador and Prince Edward Island have listings that have been developed (based on a database of food retailers), but there may be gaps;

- the review indicated that there are adequate systems for filing reports manually on retailers that are inspected and for maintaining records for those retailers that are not in compliance;

- in most cases tracking non-compliance is done on a manual basis. Although this may be satisfactory for operational purposes it is not adequate for analysis and work planning, etc, especially where there are large volumes of retailers; and,

- it is not possible to determine the level of coverage of compliance checks and inspections for the retailer populations. Therefore it is not possible to ascertain whether all retailers have been inspected or checked for compliance, nor is it possible to check the frequency at which checks are made.

Regional Health Canada Monitoring of the Agreement

The Health Canada regional offices are monitoring provincial compliance with the Contribution Agreement and associated conditions. The HC Regional Offices do not monitor the effectiveness of provincial program management.

Appropriateness of the Activities Funded Under the Agreement

Since each of the provinces has a different arrangement for implementing the enforcement program, it is difficult to generalize on the cost-effectiveness of the different approaches. Furthermore, it would be necessary to determine the results achieved in terms of stable compliance rates to assess cost effectiveness. In the opinion of the audit team, the provinces with centralized organizations are generally more cost-effective, given that one or two inspectors can usually handle the entire province. This negates the need to set up management regimes in each health unit and to develop procedures and software to manage the programs. Unfortunately in provinces such as Newfoundland and Labrador, British Columbia, and Ontario this is not possible due to geographic distances and the size of the population that must be covered. Therefore, the primary concern is the failure of Ontario and British Columbia to provide adequate information systems for managing the enforcement program.

The audit team believes that provinces employing compliance check procedures, and a two round versus a three round process have a more cost-effective program than the other provinces with different approaches.

Assurance That Activities are Adequately Targeted

We concluded that the Prince Edward Island, New Brunswick, Newfoundland and Labrador, and Nova Scotia have obtained good regional geographic coverage. Ontario and British Columbia have had a greater problem in assuring coverage due to the decentralized nature of the program. Virtually all jurisdictions are trying to do compliance checking of the entire retailer population in their jurisdiction with subsequent targeting to be based on the results of the first round compliance checks. Where priorities are set for first round checks they are based on retailers near schools or where there are large numbers of youthful clients.

Assurance that Operational Procedures and Controls are Satisfactory

Five of the six provinces have procedures that have been disseminated to inspectors. The procedures in use vary, and each province has adapted the procedures to suit its needs. It appears that in Ontario and British Columbia, procedures at the Health Unit level may not be adequate given the fact that there is a lot of turnover of inspections, and given that there is often limited capacity to enforce the tobacco legislation. The only negative consequences have occurred in Ontario, where health units have had some difficulty interpreting how to conduct surveillance and in provinces that are currently undertaking prosecutions.. Generally, there are well defined procedures available for complaint checks (from Health Canada or the provincial governments.)

Dissemination of Materials to Retailers

We found that in all of the Contribution provinces materials have been distributed to the retailers, and follow-up visits have been made by inspectors for educational purposes. Generally, information packages have been distributed to all retailers. There was an initial federal mailout. In addition, some provinces with Agreements have developed and distributed their own materials.

Documentation of Inspection Visits

All of the provinces have some procedures in place for documenting inspection visits. Procedures range from documenting the visits on individual reporting forms such as TARF, to computerized record of visits. In our view, the computerized database facilitates tracking of the inspection history for retailers and the history of infractions for individual retailers. At present there are no national standards. Each unit reviewed appears to have satisfactory minimum documentation.

Supervisory Control Procedures

Supervisory procedures are somewhat informal in each of the provinces reviewed. In Ontario and British Columbia the decentralization has resulted in a situation where the MoH in each province has limited say over what individual health units do in managing the enforcement programs. As a result application of the enforcement program in the health units in British Columbia and Ontario can vary significantly in quality.

Recording and Reporting Inspection Activities

Each province has a system for logging inspection and compliance activity. The systems used vary, and are generally manual. The Ontario CISS system is used to record activity counts. A few British Columbia health units have developed database systems to track retailers and to be able to generate reports and analyses of non-compliance. In most cases, systems for tracking retailer compliance are inadequate.

Handling of Complaints

All of the provinces have systems for following up on complaints. However, there is often no formal tracking done of all complaints received.

Procedures for Following Up on Non-compliance

We found that the procedure for following up on non-compliance varies by province. In most of the Contribution provinces, non-compliant retailers are either subjected to one or two additional checks for non-compliance. Where one additional check is performed, ticketing usually ensues if there is non-compliance. Where prosecution is required, two additional checks for non-compliance may occur (as per the federal guidelines). In Ontario, surveillance has been used as well as compliance checking for enforcement purposes. Where surveillance is used, ticketing usually occurs immediately.

We concluded that there is no consistent approach to following up on non-compliance by the provinces with Contribution Agreement. While the Health Canada procedures recommend 2 rounds of compliance checks followed up by decoy purchases, the provinces (and in some cases health units) have followed a number of approaches:

- inspection activity and addressing complaints only;
- use of surveillance techniques to respond to non-compliance;
- the 2 round compliance checks followed by a decoy purchase (recommended); and,
- a single round compliance check, followed by a decoy purchase attempt.

Extent to Which the Terms of the Agreement Have Been Fulfilled

Our overall conclusion is that each of the provinces has met its obligations under the Contribution Agreement. In the case of Prince Edward Island, Nova Scotia, New Brunswick and Newfoundland and Labrador, the work units claimed were transparent and traceable. In British Columbia and Ontario, the claimed work units are credible, however, because each province has had difficulty collecting appropriate data on enforcement activity, we could not verify whether the activities claimed as done are accurate. An examination of overall activity reports does indicate that most provinces have actually exceeded the Contribution Agreement targets.

We also noted that in British Columbia and Ontario, the work units claimed have been clustered in a small number of health units. This means that some of the Health Unit/Health departments in British Columbia have been overachieving and others underachieving. The Agreement does not specify that the provinces have to meet an appropriate distribution of funding. However, it was noted that the Contribution Agreements for both provinces specify that the enforcement program pay particular attention to *"balanced enforcement activity across all health regions in the province".*

In conclusion, we found that all of the provinces with Contribution Agreements were in compliance with the respective federal-provincial Agreements. Invoicing of Health Canada, is generally based on activity counts which are converted to work units as required in the Agreements. We found that in Prince Edward Island, Newfoundland and Labrador, Nova Scotia, and New Brunswick, the work units are transparent and the activities completed are visible. In British Columbia and Ontario, activities are completed at the health unit/health department level, and reports are sent to a Tobacco program enforcement coordinator in the respective Ministries of Health. The available reports and documentation in the MoH office was insufficient to verify the validity of the activities and work units reported. We must note that it appears that both provinces actually exceeded their commitments under the Agreement, however, it is not possible to verify the exact numbers.

Deficiencies Noted in the Agreements

We noted a number of deficiencies in the Agreements which we think could be addressed in the future.

1. We noted that the Contribution Agreements are based on activity measures rather than performance measures related to effectiveness of enforcement (e.g., coverage, compliance rates achieved, etc.) Without indicators of coverage, there is no way of correlating the provincial activities with coverage standards.

2. We noted that the Agreements do not include standards of coverage for the key activities in the enforcement program. In our view, funding of activities should be based on frequency of occurrence per retailer per year. The precise standard could be negotiated with each province, but we recommend that a national coverage standard be imposed, based on the fact that there is federal legislation which must be upheld and enforced by the provinces under the Agreements.

3. Contribution Agreements do not require sustainability of the program by either the federal or the provincial government, although it appears to be a widely held opinion that if enforcement activities decline, compliance rates will decline fairly quickly. We would recommend that future Agreements have provision for sustainability by the province if federal funding ceases.

4. The Contribution Agreements do not require monitoring/evaluation of effectiveness vis-a-vis youth procurement of tobacco products and smoking rates by the provinces. This means that reliance is being placed on the enforcement activity alone for reduction (presumably) of youth procurement of tobacco products and smoking without provision for evaluation of the desired outcome, i.e., reduction in access to tobacco products and reduction in youth smoking rates. A future Agreement should require ongoing monitoring of longer term impact indicators such as access of tobacco products by youth and youth smoking rates. This will permit an adjustment in the enforcement program, if the desired results are not forthcoming.

5. It is recognized in the literature that reducing youth access to tobacco and smoking rates requires: enforcement, information and education, community awareness and support. The Contribution Agreements only cover compliance and do not require a holistic approach on the part of the province. Future Agreements should be co-ordinated with other TDRS activities to assure maximum impact.

6. There is no assurance in British Columbia and Ontario that reported activities are completely accurate.

- although reports are being received from each of the health units/health departments, the accuracy of these reports is variable and difficult or impossible to verify precisely; however, the activity levels look reasonable and it is obvious that activity is taking place ;

- reporting has taken place as per the Agreement; and,

- recording and billing of expenditures are as per the Agreement.

Future Agreements should require that provincial health authorities ensure that satisfactory systems are in place to track enforcement activities under the Agreements.

1.0 Introduction

1.1 Introduction

The objectives of the audit component of this study were:

- To assess and report on the management and disbursement of the resources provided to the provinces under the contribution agreements for the enforcement of the federal tobacco legislation;
- To assess and report on the management of the funded activities; and,
- To recommend improvements should weaknesses be found.

1.2 Scope

The scope of the audit is limited to an assessment of the implementation of the federal-provincial Agreements in the six provinces that have already signed Agreements.

Specifically the focus of the audit component of the study was to:

- Determine whether:
  - there is a clear understanding on the part of Regional Health Canada and Provincial Ministry Staff of the provincial roles, and responsibilities and the tasks to be performed for the resources allocated to them; and,
  - whether an effective working relationship has been established between the parties involved in the delivery of the Agreement.
- To determine the extent to which the terms of the six Agreements have been fulfilled;
- To determine whether deficiencies exist in the implementation of these Agreements, and whether mechanisms have been put in place to address these deficiencies;
- To ascertain the appropriateness of the activities funded within each Provincial territory in terms of geography and population density;
- To identify the resources allocated under the Federal Provincial Agreement and to determine how the money was actually spent;
- To verify that accountability structures and program management controls have been put in place by the provinces to evaluate the effectiveness of the various enforcement activities and to redirect efforts accordingly and the impact of these controls; and,
- To verify that accountability structures and financial controls have been put in place by the provinces to monitor the expenditures under the Agreements and to ensure that they have been spent on legitimate activities.

2.0 Audit Approach and Issues

The Audit was conducted in the provinces that fall under a Contribution Agreement.

A review was completed of the systems in place for the management, control and reporting of program delivery for provinces with a contribution agreement. This included inter alia:

- the planning and management of enforcement activities in each contribution agreement province; and,
- the planning, management and control over all financial resource expenditures for Tobacco Legislation Control Activities. This included the documentation supporting expenditures under the Agreement.

A review was completed of the clarity of the roles and functions of each of the players that are party to the Agreement.

The audit program required visits to each of the 6 provinces (Newfoundland and Labrador, Prince Edward Island, Nova Scotia, New Brunswick, Ontario and British Columbia) in which there is a Contribution Agreement.

The actual audit work program varied by province visited (depending on the organizational structure for the tobacco control and enforcement area). In British Columbia and Ontario, a sample of 3 health units was visited in each province as the compliance and enforcement activity takes place at the Health Unit level. In Newfoundland and Labrador, there was a need to visit 3 of the Provincial Government Service Centres.

The audit was carried out at the provincial level, generally using an audit work package and checklist.

Audit Issue: Roles and Responsibilities

Lines of Inquiry

I. Are the roles, responsibilities and accountabilities of the provincial government and the federal government clearly specified in the Contribution Agreements and/or associated documentation?

a. Are they understood?

2. Are the roles, responsibilities and accountabilities of the program delivery agencies and agents clearly documented?

a. Are they understood?

3. *Have all inspectors received appropriate training in the enforcement of tobacco legislation?*

Audit Issue: Accountability Structures and Program Management Controls

Lines of Inquiry

1. Are satisfactory procedures in place for organizing, directing and managing enforcement activities at the field level?

a. Is appropriate work planning done?

b. Is the work planning process linked to resourcing and budgeting?

2. Is appropriate information being collected and analysed on compliance trends and enforcement, and on the allocation of resources to ensure that the provincial program is being effectively managed?

3. Is the regional Health Canada office monitoring the federal-provincial contribution agreement implementation to ensure that:

- *all of the conditions of the agreement are being met;*
- *the agreement is being managed in an effective manner;*
- *all the goals and targets specified in the agreement are being adhered to; and,*
- *the program is being monitored and evaluated by the province.*

Audit Issue: Appropriateness of Activities funded under the Agreement by Geography and Population Density

Lines of Inquiry

1. Are the field delivery organizations (provincial and federal) using cost-effective procedures? (Selection of enforcement targets.)

a. Are resources being used efficiently?

b. Are resources redirected to achieve maximum results?

***c.** Is enforcement activity ensuring geographic coverage?*

2. Is there a mechanism in place to ensure that activities are allocated according to the target populations (geography, target groups)?

***3.** Is the enforcement activity appropriately targeted geographically and towards the high risk retailers?*

Audit Issue: Assurance that Operational Procedures and Controls are Satisfactory

Lines of Inquiry

1. Are all inspection procedures appropriately documented and disseminated to inspectors?

2. Have information and materials been produced and distributed to retailers to inform them of their obligations under federal tobacco legislation?

3. Are there procedures in place to ensure documentation of inspection visits?

4. Are there established supervisory and control procedures to ensure the quality of inspection activity carried out?

5. Is there a system in place for logging all inspection visits, ticketing, compliance checking, etc. and reporting this activity on a regular basis?

6. Are there procedures for handling, documenting, and following up on complaints from the public?

a. Are these procedures followed?

7. Are there procedures for following up on non-compliance?

a. *Are these procedures followed?*

Audit Issue: Fulfilment of the Terms and Conditions of the Agreements

Lines of Inquiry

The following lines of inquiry form the basis for investigating this issue:

1. To what extent have the terms of the Agreement been fulfilled?

a. *Have agreed upon activities been completed?*

b. *Was appropriate reporting of activity (as stipulated in the Agreement) carried out?*

c. *Did appropriate recording and billing of expenditures take place?*

2. *What deficiencies are evident?*

The following methodologies were employed:

Interviews with Managers of Tobacco Legislation Enforcement

Interviews were conducted with the various levels involved in enforcement: NHQ, HC Regional Offices, provincial ministry officials and, where appropriate, inspection units. These interviews addressed the following audit issues:

Review of Planning and Reporting Systems

This required a review of planning methodologies and all detailed operational plans for enforcement activity at the provincial level. The purpose of this review was to determine the adequacy of the planning process, the targeting of compliance activity and the adequacy of geographic coverage.

The audit steps included:

- a review of the planning procedures at each level;
- a review of the documented plans to ensure that they provide an adequate basis for controlling the program; and,
- a review of the reports provided at each level to determine whether there is adequate monitoring and control for the management of the program.

Review of Operational Control Systems for the Program

The purpose of this part of the review was to ensure that appropriate operational procedures have been put in place for the operational management of the program. The review was completed at the provincial and inspection unit level. The key audit steps were:

- to review the adequacy of inspection procedures and reports for each province;
- to assess whether the procedures are actually being used;
- to ensure adequate supervision and control of inspection activities; and,
- to ensure whether an adequate inspection reporting system exists.

Assurance of Compliance with the Agreement

This required a review of the Terms and Conditions of each of the federal-provincial Contribution Agreements and assurance of compliance, both operational and financial. As part of the financial compliance, the audit team verified the financial basis of expenditures under each Agreement. The purpose was to ensure that all expenditures have adequate supporting documentation. This audit work was done for each of the six Contribution Agreements.

The audit steps required were as follows:

- to review the Terms and Conditions of each Agreement;

- to verify that all conditions are being met including implementation of inspections and reporting requirements; and,
- to verify that financial expenditure documentation exists where this is required.

3.0 Audit Findings

3.1 Audit Issue 1: Roles and Responsibilities

Lines of Inquiry

1. Are the roles, responsibilities and accountabilities of the provincial government and the federal government clearly specified in the Contribution Agreements and/or associated documentation?

- *Are they understood*

2. Are the roles, responsibilities and accountabilities of the program delivery agencies and agents clearly documented?

- *Are they understood?*

Finding:

In general the audit team found that the roles and responsibilities are clear and understood for each of the Contribution Agreements. The Contribution Agreements do not articulate the responsibilities for each party involved in the Agreements. Informally, however, there appears to be adequate understanding of roles and responsibilities.

In the case of Ontario and British Columbia, in which implementation is actually carried out by local health units (and health departments in British Columbia), the lack of an MOU between the Ministries and the health units results in a lack of clear responsibility for the overall British Columbia and Ontario programs. The respective Ministries of Health are responsible for funding and setting standards, however they have no responsibility for service delivery, and because of the mandate of the health units, they cannot be held accountable for success of the program overall.

In Newfoundland and Labrador, where service delivery is actually the responsibility of the Government Service Centre in St John's and the Regional Government Service Centers for delivery, a Memorandum of Understanding has been documented which defines the roles of the Department of Health, Community Health Boards and the Government Service Center.

An analysis of the clarity of provincial roles and responsibilities follow:

In Ontario the roles are clear in terms of the Ontario Government Ministry of Health and the health units responsible for program delivery. The provincial roles are coordination, monitoring, funding, and reporting. The health units do all of the implementation. We are not aware of any formal MOU between the MoH and the health units, however, roles appear to have been clarified through provincial directives and through correspondence. The implications of the lack of MOUs between the MoH and health units is unclear responsibility and accountability for the overall success of the program;

- We found that the roles and responsibilities are clear in British Columbia as well. The health units or health departments are responsible for the program implementation and reporting of results. MoH has a funding role, quality control role, and sets policies, procedures and standards, and compiles statistics. The Tobacco program enforcement coordinator acts as the coordinator of the program. He is dependent on receiving information from the health units/health departments. The Coordinator also handles all legal issues. As in Ontario, there did not appear to be any MOUs between the Ministry and the health units,

rather, roles appear to be defined in directives and correspondence. The implications of this are unclear accountability and responsibility for the overall success of the program;

- We found that in Prince Edward Island, the roles, responsibilities and accountabilities of the respective governments are well understood. There is no single source document that describes the respective roles and responsibilities of the parties involved: OTC, Health Canada Regional Office, Department of Health and Community Services.
- In Nova Scotia, a TCU has been established to implement the Nova Scotia Tobacco Act and the federal Agreement. Internal working documentation clearly describes the TCU role, mission, and goals.
- The provincial responsibilities in New Brunswick are divided between the Departments of Health and the Department of Finance. The Department of Health is responsible for setting overall tobacco related policies and is involved in education and prevention activities. The Department of Finance is responsible for enforcement of the tobacco legislation. The Department of Finance's roles and responsibilities are outlined in the Contribution Agreement and the Tobacco Sales Act.
- Newfoundland and Labrador has split responsibilities between Ministry of Health, the Government Service Center in St John's, and the Regional Government Service Centers. Responsibilities appear to be clearly defined.

Observation:

The audit team determined that roles and responsibilities are defined and well understood in each of the Contribution provinces. The roles and responsibilities between the Ministries of Health and the health units/departments in British Columbia and Ontario are defined through correspondence and memoranda. There is no overall MOU in place between each provincial MoH and the health units. The current arrangements have created a situation where no one in British Columbia or Ontario can be held completely accountable for the enforcement program. The MoH is a funding agency, but it has limited powers over the provincial health units in terms of assuring that they carry out the enforcement program. This has led to variations in the activity levels for the enforcement program by health Units.

Line of Inquiry

3. Have all inspectors received appropriate training in the enforcement of tobacco legislation?

Finding:

We found training to be adequate in most of the Contribution Agreement Provinces. British Columbia and Ontario have organized internal training programs, which appear to be adequate for the enforcement program. In both British Columbia and Ontario, there is an issue of whom to train. For example, Ontario is cross training all of their health inspectors in the Tobacco Enforcement legislation. There were concerns raised in Ontario of the need for training in surveillance techniques because of Ontario's reliance on surveillance to enforce the legislation. About 300 of 600 inspectors in the province have been trained. British Columbia has also trained all of the inspectors involved in the tobacco enforcement program.

The provinces of Newfoundland and Labrador and Prince Edward Island have encountered more difficulty with training. In Newfoundland and Labrador only 5 of 31 inspectors involved in tobacco enforcement have received training, and three of the five are no longer involved in the Tobacco Enforcement Program. An additional three inspectors participated in the Dartmouth orientation session sponsored by Health Canada. There appears to be a

need in Newfoundland and Labrador for general awareness/context of tobacco legislation and prosecution techniques and court proceedings.

New Brunswick inspectors all received training, however, they felt that there has not been adequate follow-up or workshops to share lessons learned.

Prince Edward Island inspectors have relied on their own training as public health inspectors, but have not received the Cornwall training on the Tobacco Enforcement Program.

Finally Nova Scotia inspectors did not attend the Cornwall training but did attend the training in Halifax provided by the HC Regional Office.

Observation:

In summary, with the exception of Newfoundland and Labrador and Prince Edward Island, all of the Contribution Provinces have provided some training. There are no national standards for training, so it was not possible to determine whether the training received is adequate in all cases. Weaknesses noted relate to insufficient training on surveillance techniques in Ontario, and insufficient training in court and prosecution techniques in some provinces. In provinces that utilize health inspectors, incumbents have received basic training from their university programs. In other provinces the inspectors background usually is law enforcement. This usually provides a good background for enforcement of the TSYPA. Weaknesses overall are in keeping inspectors updated on emerging issues in the Tobacco Enforcement program, and keeping abreast of new techniques required to ensure compliance.

3.2 Audit Issue 2: Accountability Structures and Management Controls

Audit Issue: Accountability Structures and Program Management Controls

Line of Inquiry

4. Are satisfactory procedures in place for organizing, directing and managing enforcement activities at the field level?

- *Is appropriate work planning done?*
- *Is the work planning process linked to resourcing and budgeting?*

Finding:

We found that the procedures for managing the enforcement programs differ for each of the provinces with Contribution Agreements.

We found that in ***Nova Scotia***:

- The inspection staff have a set procedure for organizing and managing inspection activities. This includes the preparation of weekly schedules for inspection activities. Factors which cannot be planned include responding to complaints and court dates.

In ***Prince Edward Island***:

- There are annual and quarterly workplans for the unit as a whole, covering the broad mandate of the unit (food poisoning inspections, food protection, environmental health, indoor air quality, etc). Given that this is a centralized unit, with inspectors having office space in close proximity, the process of workplanning is on the level of the unit as a whole.

- Workplanning, resourcing and budgeting are done manually, as the unit does not have access to computer and information systems. Given the relatively small number of retailers, this does not appear to cause problems. Planning of compliance check blitzes and selection of retailers to visit, are done manually.

We found that in ***Newfoundland and Labrador:***

- Overall, procedures for managing and planning enforcement activities are adequate and appropriate.

- At the field level, work planning for tobacco inspections is linked with license renewal activities related to food premises, and is the responsibility of individual inspectors. Inspectors perform these renewals between the beginning of December and the end of March. Inspectors identify locations (and generate targets) requiring license renewals one month in advance. The number of establishments assigned per inspector varies by geographical location.

- Tobacco enforcement activities involve education/consultation with the retailer and inspection of signage. These activities are integrated into the overall food inspection routine, and typically involve:

  - observation of tobacco purchases by minors;

  - consulting with retailers on their knowledge of the regulations and legislative requirements; and,

  - checking for appropriate signage.

- The Tobacco Activity Report Form (TARF) includes an inspection checklist identifying provincial and federal requirements to be assessed. Provincial requirements include violations under the Smoke Free Environment Act. The TARFs are considered to be a control mechanism that ensures that all inspectors are checking for the same issues.

- In terms of operating procedures, each Regional Office has a copy of the training manual from the Cornwall session for reference purposes. Flexibility in terms of scheduling and performing assigned duties exists to allow inspectors to respond to demand-related activities (e.g., complaints/information requests).

- Compliance checks are not linked with routine inspections and are undertaken as a separate activity. Procedures for undertaking compliance checks have been prepared by the province. Health Canada's procedures for compliance checks and those of the Canadian Cancer Society are also available to the Regional Offices.

- Regional tobacco program enforcement coordinators track individual and aggregate inspection activities (including tobacco) on a monthly basis. Regional Directors may hold monthly planning meetings with managers for all inspection programs, including tobacco.
- GSC Support Services (St. John's) has indicated its intention to develop a risk framework for identifying higher risk retailers to assist Regional Offices in terms of targeting compliance checks.

In ***New Brunswick*** we found that:

- While operational procedures exist for compliance checks, these have not been put into effect because compliance checks have not been undertaken. Otherwise, no official written procedures exist.
- A monthly planning/strategy meeting takes place to identify goals and activities of enforcement. It was noted that more formal planning should take place.
- There is no formal day-to-day work planning. Enforcement officers know the problem areas and will target higher risk areas (e.g., locations near schools).
- Activities will also be in response to information obtained from other inspectors and/or through complaints. The AC Nielsen studies are also used for targeting purposes.
- The identification of inspection targets (for planning and scheduling purposes) is based on the licensing database, which indicates licensed establishments by geographical location. Complaints are also used for targeting purposes.
- There was a limited knowledge of the number of tobacco vendors in the province. Actual figures had to be checked with the vendor licensing group. The original number of vendors was estimated at 16,000, when in fact it is approximately 2,000.

British Columbia and Ontario (Decentralized)

British Columbia and Ontario (which are decentralized) must rely on the individual health units to manage the enforcement program delivery. In both British Columbia and Ontario, the MoH has distributed a copy of recommended procedures and protocols for implementing enforcement activities. In our opinion the procedures and protocols in British Columbia are comprehensive, especially the draft revised procedure developed by the MoH. We found the procedures developed in Ontario to deal mainly with court process and prosecutions.

In each province detailed procedures may be further developed by the individual health units, however, we found that in British Columbia and Ontario, the health units are using the provincial procedures, and in Ontario the provincial procedures have been adjusted to individual health unit needs in some cases.

The important point is that workplanning for British Columbia and Ontario varies by health unit. The following factors influence the workplanning and hence work program:

the health unit's commitment to the enforcement program;

whether the health unit has a dedicated enforcement officer;

urban vs rural issues;

whether the health unit is doing inspections, compliance checks or decoy purchases;

whether the health unit is doing compliance "sweeps" or is focused on a continuous effort.

In most cases, the health units first completed a round of retailer inspections in which retailers were inventoried and compliance with the law was monitored. During the first round of inspections information packages were disseminated. After the first round inspections, most health units concentrated on compliance checks. Normally these are done through periodic short sweeps that concentrate on a specific geographical area. Once the area is done the results are documented, non-compliant retailers are normally warned and a list is prepared for follow-up decoy purchase checks.

In British Columbia and Ontario there is great variability in the work programs, with some health units/health departments doing a very comprehensive job and some only doing retailer inspections. The work planning is generally informal and is based on what the health unit has resources to accomplish and how dedicated it is to the task.

Observation:

Although we found that procedures have been developed in each of the provinces, there are no standards for inspection coverage, or compliance checks, in terms of retailer coverage each year. This means that there is no real basis for coherent work planning. This is further complicated by the fact that the inventory of the retailer populations is not comprehensive or accurate in each jurisdiction, and management information systems used to compile information on the outcomes of compliance checks are for the most part not working properly in most of the provinces.

In most of the provinces, we observed that there are some procedures to guide the enforcement program. In British Columbia procedures are being revised currently. In New Brunswick procedures for compliance checks have been developed, but approval for the implementation of compliance checks has not been granted.

As described above, our major finding is a lack of standards for inspection coverage and compliance coverage annually to guide workplanning. Workplanning, as a result, tends to adjust to the resources available. We determined that workplanning varies as per the delivery program approach. We found in some cases the work planning process is informal and is based on short term considerations, such as complaints, availability of inspectors, etc. Informal workplanning is considered satisfactory provided the inspection organization maintains a good inventory of the retailer population, and the history of inspections and compliance checks and assures adequate coverage in its activities.

Line of Inquiry

5. Is appropriate information being collected and analysed on compliance trends and enforcement, and on the allocation of resources to ensure that the provincial program is being effectively managed?

Finding:

Appropriate information is required to properly manage the enforcement program. First, there is a need to have an up-to-date inventory of retailers that can be used as a basis for enforcement activities. Second, there is a need to have a database of all retailers that incorporates information on the history of inspection activity, compliance check activity and ultimately decoy purchase activity. As was indicated previously, the above together with inspection and compliance check standards are essential for effective workplanning of the enforcement program.

Compliance statistics can be derived from a number of sources:

- all inspection activity and compliance check activity is generally analyzed and the results of annual activity can be summarized to provide the percentage of retailers that are compliant. These statistics are

representative only of retailers inspected or subjected to compliance checks in a particular year. They may not be representative of the retailer population as a whole;

- the Nielsen surveys that are carried out annually provide estimates of provincial and national compliance rates. Because of the Nielsen methodology the results are not accurate to the county or health unit level. Furthermore, compliance survey results can vary depending on the minor carrying out the compliance check. Therefore, there have been noted variances between the Nielsen results and the results of local surveys; and,
- local compliance surveys have been done in some regions that are similar to the Nielsen survey but are representative at the health unit or county level.

Our review indicated that the most consistent method for measuring compliance is the Nielsen survey. Comprehensive compliance surveys at the health unit or county level are only being done in selected jurisdictions (e.g., Ontario did a survey of 12 health units). In general, all of the Contribution Agreement provinces are compiling compliance statistics for inspections and compliance checks done each year. However, the compliance statistics can not be taken as representative of the entire population as the compliance checks are not designed to be a random survey of the retailer population.

The most important weaknesses noted are:

- the failure of most jurisdictions to compile a comprehensive and accurate database of retailers (although this is being remedied currently);
- the lack of a well designed management information system and database that can be used for tracking retailer performance on compliance checks, and as a basis for future planning. The systems in existence vary extensively and can range from well designed computer databases to written lists of retailers and results of inspections and compliance checks.

Following are more specific observations by province:

British Columbia

- Each health unit or health department has been responsible for developing its own list of retailers. Most of the health units/health departments have developed reasonably accurate lists of the tobacco retailers.
- no software package was provided to the health units to track inspection and compliance activity, although one version was provided at an early stage in the program but found to be inappropriate. The health units/health departments have been left to develop tracking systems on their own.
- Some of the health units/health departments have conducted compliance sweep surveys which have provided statistics on the progress towards compliance in their catchment areas;

Ontario

- Ontario has no centralized system for collecting information on retailer history or retailer compliance. Ontario provides a software package called CISS to the health units for tracking overall inspection activities. This system has been utilized in a few health units to track retailer compliance. Some health units have developed their own systems, and others use a manual listing. There is no consistent approach.

New Brunswick

- No compliance surveys have been conducted by the province. They have relied on the AC Nielsen studies to indicate compliance rates/benchmark information.

- Enforcement activities and the allocation of resources are captured on the Department's computer tracking system. The list of retailers is obtained from the tobacco licensing database. The list of retailers which comes from the tobacco licensing bureau, is not completely accurate (e.g., many of the retailers listed have closed).

Prince Edward Island

- In Prince Edward Island, the Queens Region Environmental Health Authority (responsible for tobacco enforcement in Prince Edward Island) is gathering extensive information on vendors. This information is being manually filed by vendor. There are plans to move toward a computerized system.

After each compliance check, performance indicators are prepared, indicating the rate of compliance to first round, second round and third round compliance checks.

Nova Scotia

- Nova Scotia tracks retailers manually, and creates a file and a listing of non-compliant retailers. The listing is based on the tobacco licensing database. Compliance rates in terms of signage and results from compliance checks are tracked on a weekly or bi-monthly, monthly and quarterly basis. Results are reported by region.

Newfoundland and Labrador

- Newfoundland and Labrador has a good database of food retailers, which includes most of the tobacco retailers in the province. Officials believe that a small percentage of tobacco retailers are not included in the database.

- Compliance, in terms of signage and sales to minors, are reported by each regional office and aggregated by a provincial coordinator in the St. John’s Regional Office. Completed activities are also reported on by the Regional Offices and by the GSC Support Services.

- Follow-up on compliance checks is done manually based on the TARF forms used for inspection. Since Nfld is only checking for compliance with signage requirements, non-compliant retailers are advised of the need for signs. There is no other follow-up mechanism.

- Newfoundland and Labrador maintains a list of the results of compliance checks and follows up with a warning letter. There is no permanent database of non-compliant retailers.

Observation:

We concluded that there are a number of weaknesses with the information maintained on compliance in the Contribution Agreement provinces:

- generally there is no assurance that each province has an up-to-date and comprehensive list of tobacco retailers. Nova Scotia and New Brunswick have comprehensive listings because tobacco retailers are licensed. Ontario and British Columbia are still developing a comprehensive listing of retailers. Ontario is requiring manufacturers/distributors to provide a list of their customers. Newfoundland and Labrador and Prince Edward Island have listings that have been developed based on a database of food retailers, but there may be gaps. (This is being remedied currently by improvements in the list of retailers in most provinces.);

- the review indicated that there are adequate systems for filing reports manually on retailers that are inspected and for maintaining records for those retailers that are not in compliance;
- in most cases tracking non-compliance is done on a manual basis. Although this may be satisfactory for operational purposes it is not adequate for analysis and work planning, especially where there are large volumes of retailers; and,
- it is not possible to determine the level of coverage of compliance checks and inspections for the retailer populations. Therefore it is not possible to ascertain whether all retailers have been inspected or checked for compliance, nor is it possible to check the frequency at which checks are made.

Line of Inquiry

6. Is the regional Health Canada office monitoring the federal-provincial contribution agreement implementation to ensure that:

- *all of the conditions of the agreement are being met;*
- *the agreement is being managed in an effective manner;*
- *all the goals and targets specified in the agreement are being adhered to; and,*
- *the program is being monitored and evaluated by the province.*

Finding:

We found that the Health Canada regional offices are monitoring the provincial Contribution Agreements, and are ensuring that the conditions in the Agreements are adhered to. The offices do not monitor whether the Agreements are managed in an effective manner. To do that would require that the HC regional office retain inspectors to monitor the provincial program operations. The Ontario Regional office has four inspectors available to assist the provincial health units carry out their enforcement program. In most cases, they work in cooperation with the health units. They do not operate in a monitoring role.

Each of the regional offices receives all activity reports from the provinces as per the Agreements. The activity reports are the mechanism for monitoring the provincial Agreements. There is no requirement for the provinces to evaluate the enforcement activity effectiveness, although some are carrying out compliance and smoking surveys.

Observation:

The Health Canada regional offices are monitoring provincial compliance with the Contribution Agreement and associated conditions. The HC Regional Offices do not monitor the effectiveness of provincial program management.

3.3 Audit Issue 3: Appropriateness of the Activities Funded Under the Agreement

Line of Inquiry

7. Are the field delivery organizations (provincial and federal) using cost-effective procedures? (Selection of enforcement targets.)

- *Are resources being used efficiently?*
- *Are resources redirected to achieve maximum results?*
- *Is enforcement activity ensuring geographic coverage?*

Findings*:*

We found that each province uses a different approach to enforcement. In addition, the organizational structures are quite different. There are a number of factors that will determine the cost-effectiveness of enforcement procedures:

- whether the enforcement program is centralized or decentralized;
- whether enforcement is currently focused on inspections, compliance checks or on surveillance; and,
- whether enforcement sanctions include fines or require prosecutions.

It is generally recognized that inspections of retailers can be done in less than an hour, therefore, provinces that have focused on inspections only would be running a lower cost program. There is some indication, however, that use of inspections alone is not effective. While inspections create a presence in the community, once the retailers realize that inspections will only turn up non-compliance with sign laws, and displays, etc, compliance regarding sales to minors may drop.

Compliance checks also take only minutes to complete. Some provinces estimate that compliance checks can be performed at a rate of 4-6 per hour, with follow-up requirements for reporting and the issuance of warning letters.

Decoy purchases take longer, because of the dispersion of retailers that have to be subjected to decoy purchases. These can be done at a rate of 5-6 per day. These also require more time to document evidence for possible court action.

Finally, prosecutions are the most time consuming of the procedures. There are estimates that prosecutions can take up to 20 hours to complete.

An analysis of the cost of each program is included in the evaluation report, this report contains observations on areas which appear to be less efficient than alternatives.

Ontario

Ontario is very decentralized and, therefore, the cost-effectiveness of the program may vary by health unit. There is no overall strategy for enforcing compliance. It is up to each health unit to devise its own strategy. For checking compliance all health units follow a basic approach developed by the Cancer Society. The province has focussed on surveillance, however, individual health units are starting to use compliance surveys as they are more effective. In small communities, the existence of one enforcement officer makes it impossible for him/her to do compliance or surveillance sweeps once he/she is known and recognized. The decentralized model in which each

health unit has to develop its own procedures, train personnel, and develop its own systems, would appear to be less cost-effective than the centralized model used in other jurisdictions. Furthermore, the heavy utilization of surveillance techniques, which are time intensive, is not considered cost effective. Finally, there is no guarantee that, in such a decentralized system, enforcement activity will be done in some Health Units.

British Columbia

British Columbia has some of the same problems as Ontario, however, the use of compliance checks and extensive ticketing make the program potentially more cost-effective than Ontario's. Some of the health units have tried to cost out the compliance checks and have arrived at costs varying from $6[1] to $50. Finally, as for Ontario, there is no guarantee that, in such a decentralized system, enforcement activity will be done in some Health Units.

Prince Edward Island

The Department of Health and Community Services bases its coverage strategies on systematic, 100 per cent geographic coverage of the island over time. Until the third and fourth quarters of 1996/97, the Department of Health and Community Services inspected each establishment virtually once per quarter for signage. By the end of 1996/97, the Department will have completed a minimum of first round compliance checks on half the vendors of the province, and a significant number of second and third round compliance checks for those retailers who have not been compliant.

The costs per compliance check are estimated to be under the $50 proposed under the Contribution Agreement. Calculated in a "back of the envelope manner", direct costs alone are of the range of $14 to $15 per compliance check. Related and indirect costs are potentially at least equal to this amount: selection and training of youths; workplanning time; data collection, reporting and analysis time, etc.

We noted that Prince Edward Island has done an excessive number of inspections, prior to shifting to compliance checks which are generally felt to be more effective.

New Brunswick

There are two dedicated tobacco enforcement inspectors. All tobacco retailers are covered by enforcement activity. With approximately 2,500 tobacco retailers in the province - this means about 1,250 per inspector. To date, the only activities undertaken have been inspections, surveillance, minor investigations, major investigations, and liaison. No compliance checks or decoy purchases have taken place due to resistance from the political level. As such, focus has been on administrative actions such as warnings, fines, restriction/suspension of sales and not on prosecutions. Lack of local compliance surveys does not allow assessment of the impacts resulting from activities to date. Program costs are low because of the centralized, dedicated organization.

Nova Scotia

With two inspectors, the province was divided into two coverage areas: North and South. This enabled each inspector to focus on one region. Since the departure of one inspector, there has been only one inspector for the entire province.

With respect to the first round of compliance checks (which occurred during the summer of 1996) , the TCU used Nielsen to cover the Halifax urban area, while the inspectors focused on the rural areas of Nova Scotia (i.e., non-Halifax). In the fall and winter of 1996/97, the inspector(s) focused on Halifax, as travel was less convenient

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[1] *New Westminister Compliance Survey: Youth Access to Cigarettes* , S. Bodani, Public Health Inspector

during these months. This approach allowed the TCU to effectively and efficiently cover both urban and rural areas of the province, and we noted that the program is efficiently run.

Newfoundland and Labrador

Originally, the tobacco enforcement program in Newfoundland and Labrador focused solely on routine (seasonal) inspections. The value of retailer inspections was questioned by Health Canada, and through the Department of Health, reduced the applicable GMUs from 1.5 to 1.0, and emphasized the use of a more diverse set of enforcement activities, particularly administrative compliance checks and liaison with educational institutions. As a result, compliance checks for administrative purposes and educational liaison have increased and/or have been put in place.

Province-wide coverage is now in place for inspections. Inspection activities are the responsibility of inspectors in all five regional offices.

The current arrangement appears cost-effective in terms of obtaining province-wide coverage for the resources available from the program.

Observations:

Since each of the provinces has a different arrangement for implementing the enforcement program, it is difficult to generalize on the cost-effectiveness of the different approaches. Furthermore, it would be necessary to determine the results achieved in terms of stable compliance rates to assess cost-effectiveness. In the opinion of the audit team, the provinces with centralized organizations are generally more cost-effective, especially since the staffing can be adjusted to meet the required workload quite closely. This is more difficult in a decentralized situation. This negates the need to set up management regimes in each health unit and to develop procedures and software to manage the programs. Unfortunately in provinces such as Newfoundland and Labrador, British Columbia, and Ontario this is not possible due to geographic distances and the size of the population that must be covered.

We also observed that provinces employing compliance check procedures, and a two round versus a three round process appear to be more cost effective.

Lines of Inquiry

8. Is there a mechanism in place to ensure that activities are allocated according to the target populations (geography, target groups)?

9. Is the enforcement activity appropriately targeted geographically and towards the high risk retailers?

Findings:

Our review indicated that in the three provinces in which enforcement activities are centrally managed, geographic coverage is easier to assure. In Newfoundland and Labrador, the arrangement with Government Services has actually been a positive development in that it has ensured good geographic coverage through the utilization of the Regional Service centers. This has extended the leverage available from federal funds as the inspectors are multi-tasked.

In the decentralized provinces, it is up to individual health units or health departments to ensure that enforcement activities occur. The provincial Ministries of Health can influence the health units to some degree, but ultimately the health units and their governing boards exercise control over their programs. From this perspective, ensuring geographic coverage is more difficult in the de-centralized provinces.

We also noted that most of the provincial enforcement organizations are undertaking compliance checks with the entire retail population in their jurisdiction. The results of the first round compliance checks then provides a basis for second round checks and decoy purchases. As a history of compliance or non-compliance is built up, it will be possible to identify priorities for future compliance sweeps. This underlines the need for an appropriate database on retailer performance that will permit tracking of non-compliance trends.

Observation:

We concluded that the Prince Edward Island, New Brunswick, Newfoundland and Labrador and Nova Scotia have obtained good regional geographic coverage. Ontario and British Columbia have had a greater problem in assuring coverage due to the decentralized nature of the program. Where compliance checking is done, it is usually targeted at the entire retailer population in the jurisdiction with subsequent targeting based on the results of the first round compliance checks. Where priorities are set for initial first round checks they are based on retailers near schools or where there are large numbers of youthful clients.

3.4 Audit Issue 4: Assurance that Operational Procedures and Controls are Satisfactory

Line of Inquiry

10. Are all inspection procedures appropriately documented and disseminated to inspectors?

Finding:

Each province has different requirements with respect to the documentation and dissemination of inspection procedures. We found that all of the provinces have some written procedures or protocols available for dissemination to inspectors. The provinces with centralized inspection units have generally used the operational procedures developed by Health Canada, which may be adapted to local needs. Ontario and British Columbia have developed their own procedures, which were disseminated to the health units/health departments in each respective province.

More specific comments follow:

In **Prince Edward Island** inspectors have been issued an Enforcement Protocol for the Tobacco Sales to Minors Act. The Environmental Health Division and its inspectors also use the document entitle "Procedures for Compliance Checks" prepared by the Office of Tobacco Control. Both these documents provide extensive guidance to inspectors.

In **New Brunswick** formal written procedures are not currently in place. Day-to-day management issues are the responsibility of the regional office managers and the inspectors themselves. Experience in law enforcement and training through federal government courses is deemed important in terms of understanding inspection procedures.

The **Nova Scotia** TCU has prepared operational procedures which appear complete. The procedures include examples of:

- summary offence information/ticket (SOT);
- TARF;
- information to obtain a search warrant, search warrant, and return to justice;
- exhibit form;
- caution card;

- Nova Scotia legal aid addresses and phone numbers;
- caution statement;
- information form;
- retailer information letter; and,
- parent/guardian consent form for minors.

The **Newfoundland and Labrador** tobacco enforcement activities involve education/consultation with the retailer and inspection of signage. These activities are integrated into the overall food inspection routine, and typically involve procedures for:

- observation of the sale of tobacco to minors;
- consulting with retailer on their knowledge of the regulations and legislative requirements; and,
- checking for appropriate signage.

In terms of written procedures, the Tobacco Activity Report Form (TARF) includes an inspection checklist identifying provincial and federal requirements to be assessed. Provincial requirements include violations under the Smoke Free Environment Act.

Each Regional Office has a copy of the training manual from the Cornwall session for reference purposes.

Compliance checks are not linked with routine inspections and are undertaken as a separate activity. Procedures for undertaking compliance checks have been prepared by the province. Health Canada's procedures for compliance checks and those of the Canadian Cancer Society are also available to the Regional Offices.

The **British Columbia** Ministry of Health has developed a detailed set of procedures (currently under revision), which have been disseminated to the health units and health departments. The standardized enforcement protocol developed by the province is used by most of the health units and health departments. There is evidence that some may not be using it - particularly if enforcement is only part of normal routine inspection activity and is complaint-base.

In **Ontario**, the MoH has developed a model set of procedures, mostly concerned with ticketing and prosecutions. The health unit procedures in use are all local. Health units use the MoH guidelines on tickets, prosecutions, court procedures, etc. Surveillance, compliance checks, and enforcement priorities and targeting are decided on locally.

Observation:

Five of the six provinces have procedures that have been disseminated to inspectors. The procedures in use vary, and each province has adapted the procedures to suit its needs. It appears that in Ontario and British Columbia, procedures at the health unit level may not be adequate given the fact that there is a lot of turnover of inspectors, and given that there is often limited capacity to enforce the tobacco legislation. Deficiencies in the procedures were noted in Ontario, where health units have had some difficulty interpreting how to conduct surveillance and in those provinces that are currently undertaking prosecutions. Generally, there are well defined procedures available for compliance checks (from Health Canada or the provincial governments.)

Line of Inquiry

11. Have information and materials been produced and distributed to retailers to inform them of their obligations under federal tobacco legislation?

Finding:

We found that in all of the Contribution Agreement provinces, materials have been distributed to the retailers, and follow-up visits have been made by inspectors for educational purposes. Generally, information packages have been distributed to all retailers. There was an initial federal mailout, in addition, some provinces with Contribution Agreements have developed and distributed their own materials.

Prince Edward Island has sent all retailers information packages informing them of the requirements of the Act, of the existence of the enforcement program, and of the consequences of non-compliance with the legislation. In addition, the province has provided retailers with a variety of signs, with the message, "It is illegal to sell tobacco to, or to purchase for, any person under the age of 19". In addition, the province has prepared letters that are sent to retailers subjected to compliance checks and that are either compliant, or non-compliant with the legislation. A 1-800 number is also made available, mainly for registering complaints.

Nova Scotia retailers have received an information letter on the Act; information on signage; information on regulations.

New Brunswick has also developed and disseminated provincial materials on the tobacco legislation. Packages are also disseminated to new retailers when required.

Newfoundland and Labrador tobacco enforcement activities involve education/consultation with the retailer and inspection of signage. These activities are integrated into the overall food inspection routine. An information package was prepared by the province for retailers outlining the provincial legislation.

An advisory letter on the responsibility of retailers with respect to the sale of tobacco to underage persons has also been prepared for dissemination to retailers.

A 1-800# was established (the "nicotine line"). While it initially had a lot of use, it became increasingly used for issues such as complaints under the Smoke Free Environment Act.

Newspaper ads were published with contact numbers for each regional office included.

In **Ontario**, a provincial information package was developed. This package has been disseminated to all retailers in the province. Each health unit has copies of the package, and has continued to distribute it to retailers as they do their routine inspections. Some health units have also provided additional information to retailers. Retailers all received the provincial education package (some areas have received a package from the Retail Council) and there have been media campaigns. Materials are continually distributed on an as needed basis. Ongoing education of retailers is considered to be very important.

British Columbia has followed the same procedure as Ontario. All retailers have received the provincial information package. New retailers/owners get the package during routine inspections on an ongoing basis. This package has been translated into a number of languages.

Observation:

We confirmed that information materials have been disseminated to retailers in each of the Contribution provinces.

Line of Inquiry

12. Are there procedures in place to ensure documentation of inspection visits?

Finding:

We found that all of the provinces have put in place some procedures to document inspection visits. The following describes the range of approaches used.

In **Prince Edward Island**, inspectors document every visit to a retailer. There are daily, weekly and monthly activity reporting requirements

In **New Brunswick** each inspector is responsible for documenting his/her own inspections. Inspection activity forms reflect the data input screen for the Department of Finance's computer tracking system. The Department is planning to implement a new reporting form/screen solely for tobacco sales purposes.

In **Nova Scotia** Tobacco Activity Report Forms (TARFs) are used to document visits. Compliance data collection forms are used to document compliance checks.

Newfoundland and Labrador inspectors also use the TARFs for documenting inspections and violations. Compliance check report forms are used to document compliance checks. No ticketing or prosecutions have taken place, and as such are not reported on.

Given that regional offices are not electronically linked with GSC Support Services at the St. John’s Regional Office, no electronic reporting of activities is undertaken. An initiative may be pursued in the 1997/98 fiscal year by GSC Support Services which would allow for the electronic tracking of license applications, inspection scheduling, and inspections. This would allow GSC Support Services to develop a profile of each inspector’s activities, and more importantly, a profile of each establishment in terms of legislative requirements/licensing.

As part of the Contribution Agreement, individual regional offices were equipped with a computer for use in tracking tobacco activities. However, communication modems and reporting software were never delivered, and if any reporting does take place electronically, it is with the use of Word Perfect and/or a spreadsheet program.

We found that Newfoundland and Labrador also uses the Tobacco Activity Report Forms to document visits. Compliance data collection forms are used to document compliance checks.

In **Ontario** the MoH provides guidelines on tickets, prosecutions, court procedures, etc. Surveillance, compliance checks, and enforcement priorities and targeting are decided on locally. All reporting and documentation procedures are also local. As indicated earlier, some of the health units use the CISS system for recording inspection visits. We found that in the health units visited and surveyed, inspectors keep a log book and document all visits (name of retailer, date, what was observed, infractions, etc.). A record is kept of the number of inspections conducted and the number of charges laid. This information also provides some indication of compliance trends. This information is usually input into a computerized database - a province-wide CISS system. In some areas, regular summary reports are provided to the Municipal Board of Health

The reporting of HU activity to the MoH is on individual monthly reports. Inspection reports are retained locally, and there is no MoH repository of inspection records. Prosecutions are monitored separately provincially.

In **British Columbia** documentation of inspection visits occurs at the health unit level, generally on a standardized form called a H-124. Generally all inspection visits are documented, and monthly statistical reports are provided to MOH . In some cases (when done as part of other inspection work), tobacco enforcement data is just a small part of a larger inspection form filled out by the officer.

Observation:

All of the provinces have some procedures in place for documenting inspection visits. Procedures range from documenting the visits on individual reporting forms such as TARF, to a computerized record of visits. In our view, the computerized database facilitates tracking of the inspection history for retailers and the retailers history of infractions. At present there are no national standards. Each unit reviewed appears to have satisfactory minimum documentation.

Line of Inquiry

13. Are there established supervisory and control procedures to ensure the quality of inspection activity carried out?

Finding:

The supervisory procedures vary by province, and by the size of the tobacco enforcement unit. In general, supervisory procedures have tended to be informal. In the decentralized provinces such as British Columbia and Ontario, the tobacco enforcement coordination units in the Ministry of Health visit to the health units, but they do not operate in a supervisory capacity.

The following describes the various approaches used.

In **Prince Edward Island** the enforcement unit measures the quality of inspection activity through formal and informal feedback. This includes telephone calls from retailers to the Director of the unit; a periodic review of worksheets by the Director; and feedback from the unit administrative secretary with respect to the quality of retailer files.

In **New Brunswick** the management structure is based on a level of trust between the Director and the inspectors, in part because the inspectors are not located in Fredericton (the location of the Director). However, the Director does have access to the computer data of the regional offices reporting on the inspection activities centrally from Fredericton.

In **Newfoundland and Labrador** TARFs are reviewed by the regional tobacco program enforcement coordinators for completeness prior to aggregation and submission to the provincial coordinator.

Managers don't actually go out in the field and assess whether a complete or good quality inspection is performed (same for all inspections, not just tobacco).

In **Nova Scotia** TCU management relies on the integrity and professional background of the inspector to ensure quality inspections are undertaken. Management does not actually visit with inspectors to assess quality of individual inspections.

In **British Columbia** supervision would be expected at two levels. The first level is the health unit or health department level. The supervision in the health unit or health department is usually by the Director/ Manager of Inspection, who generally is tasked with enforcement of food health requirements, and health by-law enforcement. In many units, the Director/Manager approves the work program and is provided reports on inspections made. All inspection visits are documented manually on standardized forms provided by the MoH (in some cases, on an internally developed form). Monthly statistical reports are sent to MoH along with copies of inspection reports. Inspectors also keep a daily log sheet of their visits.

The second level of supervision should be the tobacco program enforcement coordinator's office in the Ministry of Health. Monitoring by the province is done through the monthly reports provided. In addition, all health units have to provide copies of the inspection forms (H124s). These document activity (compliance, inspection, etc). The Tobacco Coordinator reviews all reports and builds up monthly statistics as a result. The provincial

monitoring is based on the receipt of inspection reports and tickets. Although the health units send in monthly reports, the numbers are re-worked by the Tobacco Coordinator to ensure consistency. A system was developed to track province-wide enforcement activity. It has never worked properly. There is no province-wide information system for tracking activity, and, as a result, the monitoring activity is based on a manual compilation of data.

The MoH has little ability to take corrective action except by personal visits and funding reductions, as the health units are very independent. The MoH Tobacco Coordinator reviews inspection reports and will follow up with the health units if there are any questions on the information contained therein.

Ontario has a similar structure to British Columbia. The immediate supervision occurs at the health unit level . The health unit does its own supervision. The MoH only interferes if it believes that the health unit is under performing. It is difficult to hold the health unit accountable as MoH has limited authority over the health units. Each of the health unit managers of inspection have their own management approach. Normally, there is a requirement for weekly or monthly reports from inspectors. Some units monitor inspections on the CISS system. Most retain inspection reports on file for future action. The supervision varies from almost no supervision, in which the inspector is responsible for carrying out inspections and filling in appropriate reporting forms, to quite detailed reporting on TCA activity sheets which track retailers inspected. Health unit inspectors also fill in daily inspection activity reports. In some health units activity is also entered into the CISS system.

The province has little supervisory control over the health unit inspection procedures except through visits and sanctions in extreme cases. Informally, the health units seek assistance from both the MoH and from Health Canada - Ontario. As indicated, the quality of enforcement at the health unit level is variable, and there is little that the MoH can do to change the local approach. A problem in Ontario is defining what is meant by surveillance versus compliance, as the health units rely on surveillance extensively for enforcement. As a result, the MoH is trying to provide better direction as to what is meant by surveillance and compliance, as the health units all interpret the activities differently.

Observation:

Supervisory procedures are somewhat informal in each of the provinces reviewed. In Ontario and British Columbia the decentralization has resulted in a situation where the MoH in each province has limited say over what individual health units do in managing the enforcement programs. As a result application of the enforcement program in the health units in British Columbia and Ontario can vary significantly in quality.

Line of Inquiry

14. Is there a system in place for logging all inspection visits, ticketing, compliance checking, etc. and reporting this activity on a regular basis?

Finding:

We found much variation in the recording and reporting of inspection activity as is described below.

In **Prince Edward Island** forms and procedures are in place, requiring that all activities of the unit be reported on. Documentation is provided for each vendor file. Inspectors fill out daily, weekly, and monthly reports.

In **New Brunswick** Each inspector is responsible for documenting their own inspections. Inspection activity forms reflect the data input screen for the Department of Finance's computer tracking system.

Nova Scotia TCU inspectors are responsible for rolling up activities on a weekly or bi-monthly, monthly and quarterly basis (copies of bi-monthly, monthly, and quarterly reports obtained). Reporting measures include the following (by region and aggregated total):

- retail inspections;
- minor investigations/follow-up;
- major investigations;
- total inspections (above activities combined);
- number of complaints;
- Tobacco Access Act violations;
- TSYPA violations;
- total violations;
- number of compliance checks; and,
- year to date summary.

Given its breakdown by region, the TCU reporting is the most comprehensive of all the Maritime provinces.

Newfoundland and Labrador uses the TARFs for documenting inspections and violations. Compliance check report forms are used to document compliance checks. No ticketing or prosecutions have taken place, and as such are not reported on.

In **British Columbia** inspection and compliance visits and decoy purchases are logged on the H-124 form distributed by the MoH. Copies of this form are sent to the MoH for statistical analysis. The MoH has a control copy of all inspections, and compliance and decoy purchase visits. Each health unit usually opens a file for retailers who are in violation of the provincial Tobacco Sales Act (TSA). Some of the health units/health departments have utilized provincially developed software or have developed their own software to log all visits, ticketing and compliance checks. The provincial software was found to be insufficient for the task, and hence some of the health units have developed their own packages. Although tracking compliance activity and violations is complex, the province has not adequately funded the procurement of software to do the tracking.

In **Ontario**, all inspections, surveillance actions, and compliance checks are documented at the health unit level either on a log or inspection form. In many units, the activity is transcribed to the CISS system for monitoring. As in British Columbia the documentation can be either manual or computerized at the health unit level. The CISS system was found to be insufficient to record all of the information needed to run the enforcement program and therefore, health units do not have a good database of inspection and compliance or surveillance activity by retailer.

Observation:

Each province has a system for logging inspection and compliance activity. The systems used vary, and are generally manual. The Ontario CISS system is used to record activity counts. A few British Columbia health units have developed database systems to track retailers and to generate reports and analyses of non-compliance. In most cases, systems for tracking retailer compliance are inadequate.

Line of Inquiry

15. Are there procedures for handling, documenting, and following up on complaints from the public?

- *Are these procedures followed?*

Finding:

Handling of complaints varies considerably. Some jurisdictions maintain very formalized tracking systems, in which complaints are logged and investigated shortly thereafter. In other jursdictions complaints are added to a list of retailers previously found to be non-compliant and a follow-up compliance check is done at a later stage. The discussion below describes the approach taken in the various provinces that have Agreements.

Prince Edward Island has implemented a 1-800 number, however, it is not often used by the public. As complaints are lodged infrequently, a form is filled out for every complaint received. If the complaint involves a minor, there is a requirement that the parents be willing to allow the minor to appear in court in the event of a prosecution. No log is kept of the volume of complaints

New Brunswick has no formal, written procedures in place for handling complaints. Complaints from the public are documented and follow-up is carried out. Comments related to complaints are recorded in the daily activity reports. Retailers are notified regarding complaints.

In **Newfoundland and Labrador** complaints may or may not be formally recorded on the GSC Complaint Form. Overall, inspectors note very few complaints regarding sales to minors. This is attributed to a lack of public awareness regarding the legislation. The majority of complaints that are received regarding tobacco are related to the Smoke Free Environment Act.

In **Nova Scotia** complaints are recorded on a TCU Tobacco Complaint Form. Data captured includes:

- date of complaint;
- complainants name (if provided);
- suspect; and,
- narrative of complaint.

All complaints are investigated, and regardless of whether a charge is laid, or if the file is closed (i.e., no charge), the complainant is informed. This reinforces the perception that the Act is taken seriously, and is seen as good customer service.

British Columbia health units/health departments record complaints with the details put in a standardized complaint form. Tobacco-related complaints are referred to an appropriate inspector for follow-up. A complaint record is attached to a copy of the inspection report sent to the province. All complaints are investigated.

Ontario complaints are recorded and assigned to an inspector for follow-up/investigation (often within 24 hours). A letter is then sent to the retailer and if warranted, the retailer is targeted for surveillance and a second letter is sent if the retailer is found to be in noncompliance.

Observation:

All of the provinces have systems for following up on complaints. However, there is often no formal tracking done of complaints received.

Line of Inquiry

16. *Are there procedures for following up on non-compliance?*

- *Are these procedures followed?*

Finding:

We found that the procedure for follow-up on non-compliance varies by province. In most of the Contribution Agreement provinces, non-compliant retailers are subjected to either one or two additional checks for non-compliance. Where one additional check is performed, ticketing usually ensues if there is non-compliance. Where prosecution is required, two additional checks of non-compliance may occur (as per the federal guidelines). In Ontario, surveillance has been used as well as compliance checking for enforcement purposes. Where surveillance is used, ticketing usually occurs immediately.

In **Prince Edward Island**, if a vendor is non-compliant after the first compliance check, the inspector enters the store and explains the situation. An information letter is also sent to the retailer, both in the event of compliance and non-compliance.

Should a vendor be in non-compliance after the second compliance check, the inspector enters the store and issues a warning summary offence ticket (which does not entail payment).

Signage violations are remedied upon identification (i.e., appropriate signage is provided to the retailer when a violation is noted).

In **New Brunswick** there are no written procedures for day-to-day operations. With respect to non-compliance, if a first-time violation is identified (e.g., regarding signage), corrective measures will take place immediately (i.e., new signs will be given to the vendor). The vendor will also be briefed regarding the tobacco regulations/requirements and will receive a verbal or written warning.

A second violation will result in a ticket ($100 for first offence) which the vendor can argue against in court (at which point a court imposed fine may be levied). Second offences may also result in a one month suspension of the vendor's tobacco sales license.

No follow-up activities are undertaken based on compliance checks, as these checks have not yet been undertaken in New Brunswick. However, procedures for undertaking compliance checks have been developed.

In **Newfoundland and Labrador** signage violations are remedied upon identification (i.e., appropriate signage is provided to the retailer when a violation is noted).

Results of administrative compliance checks are documented in a letter sent to all retailers involved in the checks, indicating the results (i.e., compliance or non-compliance) for their particular establishment.

No procedures are in place for ticketing or prosecutions based on compliance checks. However, the Ministry of Health and the Department of Government Services and Lands are investigating alternative methods of penalizing non-compliant retailers.

Nova Scotia also follows up on non-compliance with a written warning, and repeat compliance checks. It was noted that, in Nova Scotia, compliance checks for prosecution purposes take more time than checks for administrative purposes as additional steps are required.

In **British Columbia** warning letters are sent out (some units hand deliver them) after a first round of compliance checks. The second round check is used for enforcement. A ticket is issued after failing the decoy/purchase required in the second round check. Some of the health units do compliance sweeps followed up by second round decoy purchases. Other health units have completed the inspections but have not as yet initiated compliance checks. Others have done compliance checks but have not followed up with decoy purchases. Finally there appear to be some health units that are doing inspections and complaint investigations only.

In **Ontario** there is much variability in the procedures used. Some of the health units do compliance "sweeps" or surveys to establish who are the non-compliant retailers. Most of the health units appear to be complaint driven, or do mainly inspections and surveillance. In some health unit areas, retailers may be targeted for surveillance while in others, retailers may be selected for a follow-up non-compliance survey. Normally ticketing follows repeated failed compliance checks. If caught selling through surveillance action, the retailer will be ticketed immediately.

Observation:

We concluded that there is no consistent approach to following up on non-compliance by the provinces with a Contribution Agreement. While the Health Canada procedures recommend two rounds of compliance checks followed by decoy purchases, the provinces (and in some cases health units) have followed a number of approaches:

- inspection activity and addressing complaints only;
- use of surveillance techniques to respond to non-compliance;
- the two-round compliance checks followed by a decoy purchase; and,
- a single round compliance check, followed by a decoy purchase attempt.

3.5 Audit Issue 5: Terms and Conditions of Contribution Agreements

Line of Inquiry

17. To what extent have the terms of the Agreement been fulfilled?

- *Have agreed upon activities been completed?*
- *Was appropriate reporting of activity (as stipulated in the Agreement) carried out?*
- *Did appropriate recording and billing of expenditures take place?*

Finding:

Our overall finding is that each of the provinces has met its obligations under the Contribution Agreement. In the case of Prince Edward Island, Nova Scotia, New Brunswick and Newfoundland and Labrador, the work units claimed were transparent and traceable. In British Columbia and Ontario, the claimed work units are credible, however, because each province has had difficulty collecting appropriate data on enforcement activity, we could not verify whether the activities claimed as done are accurate. An examination of overall activity reports does indicate that most provinces have actually exceeded the Contribution Agreement targets.

We also noted that in British Columbia and Ontario, the work units claimed have been clustered in a small number of health units. This means that some of the health unit/health departments in British Columbia and Ontario have been overachieving while others have been underachieving. However, it was noted that the Contribution Agreements for both provinces specify that the enforcement program pay particular attention to *"balanced enforcement activity across all health regions in the province*."

Following are specific findings related to the Agreements:

In **Prince Edward Island**, it was noted that inspections and compliance checks are being carried out as per the Agreement. Prince Edward Island is routinely filling out the Quarterly Report relating to the Enforcement of Tobacco Legislation. The method used to calculate the volume of work and apply the funding formula and ratios to bill Health Canada was found to be appropriate.

In **New Brunswick** a review of 1996 activity reporting was completed which documented the tobacco enforcement activities undertaken by inspection staff. The reporting is consistent with Health Canada reporting requirements. Appropriate recording and billing of expenditures took place.

For the 1995-1996 fiscal year, New Brunswick accomplished 131 more hours of tobacco enforcement activity than were allocated in the Contribution Agreement (3131 hours completed, 3000 hours allocated).

In **Nova Scotia** a review of quarterly reports was performed indicating that appropriate completion of activities, reporting, and billing took place. The review of the reports indicated that the TCU recorded more activity units than specified in the Contribution Agreement for both the 1995/96 and 1996/97 fiscal years.

In **Newfoundland and Labrador**, a review of quarterly reports was performed indicating that appropriate completion of activities, reporting, and billing took place.

The review of the reports indicated that the Newfoundland and Labrador Regional Offices recorded more activity units than specified in the Contribution Agreement for the 1995/96 fiscal year.

A review of **British Columbia** indicated that the British Columbia Agreement provides for the number of work units, the rate per hour and the need to have 90% compliance, investigations and referrals. Health Canada will not pay for routine inspections. The Province receives monthly summaries from each of the health units/health departments, as well as back-up inspection reports substantiating the workloads reported. The Tobacco program enforcement coordinator at the MoH reviews the actual inspection report forms and attributes health units/health department activity as he believes appropriate. In this way the monthly summaries are adjusted by the MoH to ensure consistency.

British Columbia maintains a cumulative report of progress towards the Agreement work units. There is no one system or report that provides a temporal picture of progress as the reporting system has been changing over the life of the Agreement. In addition, Health Canada's reporting requirements have also changed complicating the situation. The cumulative results are obtained by adding the month to a previous cumulative report. Part of the report comes from a computerized database and part is manual.

Based on our review, the invoices provided by British Columbia appear to be defensible. The underlying health unit/health department reporting can not be easily tracked, as the Coordinator has built up the activity statistics based on the inspection forms, and the reported activities such as inspections, compliance checks etc are open to some interpretation.

We reviewed compliance with the Agreement in **Ontario**. Nominally the reporting is consistent with the Health Canada requirements. Our main concern was that the monthly reporting completed by the health units, and which are aggregated by MoH in Toronto consists of a summary report of activity, with no back-up support. Furthermore, there is no system (such as CISS), that can be used to validate the activity counts. As a result the Tobacco program enforcement coordinator must review and revise the numbers, based on his interpretation of activities undertaken. We could not determine the basis for this adjustment in the monthly reports.

Observations:

We found that all of the provinces with Contribution Agreements were in compliance with the respective federal-provincial Agreements. Invoicing of Health Canada, is generally based on activity counts which are converted to work units as required in the Agreements. We found that in Prince Edward Island, Newfoundland and Labrador, Nova Scotia, and New Brunswick, the work units are transparent and the activities completed are visible. In British Columbia and Ontario, activities are completed at the health unit/health department level, and reports are sent to a Tobacco program enforcement coordinator in the respective Ministries of Health. Our review indicated that the available reports and documentation in the MoH office was insufficient to verify the validity of the

activities and work units reported. We must note that it appears that both provinces actually exceeded their commitments under the Agreement, however, it is not possible to verify the exact numbers.

Line of Inquiry

18. What deficiencies are evident?

We noted a number of deficiencies in the Agreements which we think should be addressed in the future.

1. We noted that the Contribution Agreements are based on activity measures rather than performance measures related to effectiveness of enforcement (e.g., coverage, compliance rates achieved, etc.) Without indicators of coverage, there is no way of correlating the provincial activities with coverage standards.

2. We noted that the Agreement does not include standards of coverage for the key activities in the enforcement program. In our view, funding of activities should be based on frequency of occurrence per retailer per year. The precise standard could be negotiated with each province, but we recommend that a national coverage standard be imposed, based on the fact that there is federal legislation which must be upheld and enforced by the provinces under the Agreements.

3. Contribution Agreements do not require sustainability of the program by either the federal or the provincial government, although it appears to be a widely held opinion that if enforcement activities decline, compliance rates will decline fairly quickly. We would recommend that future Agreements have provision for sustainability by the province if federal funding ceases.

4. The Contribution Agreements do not require monitoring/evaluation of effectiveness vis-a-vis youth procurement of tobacco products and smoking rates by the provinces. This means that reliance is being placed on the enforcement activity alone for reduction (presumably) of youth procurement of tobacco products and smoking without provision for evaluation of the desired outcomes, i.e., reduction in access to tobacco products and reduction in youth smoking rates. A future Agreement should require ongoing monitoring of longer term impact indicators such as access of tobacco products by youth and youth smoking rates. This will permit an adjustment in the enforcement program, if the desired results are not forthcoming.

5. It is recognized in the literature that reducing youth access to tobacco and smoking rates requires: enforcement, information and education, community awareness and support. The Contribution Agreements only cover compliance and do not require a comprehensive approach on the part of the province. Future Agreements should either be co-ordinated with other TDRS activities to assure maximum impact or require that complementary activities be undertaken.

6. There is no assurance in British Columbia and Ontario that reported activities are completely accurate:

   - although reports are being received from each of the health units/health departments, the accuracy of these reports is variable and difficult or impossible to verify precisely; however, the activity levels look reasonable and it is obvious that activity is taking place;
   - reporting has taken place as per the Agreement; and,
   - recording and billing of expenditures are as per the Agreement.

Most provinces have failed to develop satisfactory systems to track compliance activity and to do analyses of retailer non-compliance.

Appendix A:

List of Interviewees

List of Interviewees

Health Canada - Office of Tobacco Control

1. L. Rondeau
2. S. Hall
3. F. Pégeot (now with Federal-Provincial Affairs)

Health Canada - Regional HPB Offices

1. L. Kane

   Atlantic Region (St. John’s, Newfoundland)

1. M. Lapointe

   Atlantic Region (Halifax, Nova Scotia)

1. E. Nickerson

   Atlantic Region (Halifax, Nova Scotia)

1. P. Darling

   Atlantic Region (Halifax, Nova Scotia)

1. D. Dionne

   Quebec Region

1. D. Wilkes

   Ontario Region

1. D. Stitt

   Central Region

1. G. Evoy

   District Manager, Alberta & NWT

1. D. Shelley

   Western Region

1. I. Chan

   Western Region

Provincial

1. R. Coates

   Environmental Health Services, Newfoundland Dept. of Health

1. W. Moores

   Newfoundland Department of Government Services and Lands

1. B. Savory

   Provincial Tobacco Coordinator

1. L. Gallant

   Prince Edward Island Department of Health

1. M. Ungurain

   Tobacco Control Unit, Nova Scotia Department of Health

1. L. Bennett

New Brunswick Department of Finance, Account Managment, Revenue Division

1. C. O'Connel

New Brunswick Department of Finance, Account Managment, Revenue Division

1. Dr. M. Scott

New Brunswick Department of Health

1. G. Conway

Ontario Ministry of Health

1. B. Phillips

British Columbia Ministry of Health

1. S. Little

British Columbia Ministry of Health

Health Units

Ontario

1. P. Jarman

Windsor-Essex County Health Unit

1. M. Mitchell

Scarborough Health Unit

1. J. Chan

Etobicoke Health Unit

1. T. Allan-Koester

Perth District Health Unit

1. D. McMillan

Middlesex-London Health Unit

1. P. Scharfe

Toronto Health Unit

1. C. Orr

Leeds, Grenville, Lanark District Health Unit

1. A. Raven

J.-G. Albert

Ottawa-Carleton Health Unit

1. S. Monaghan

B. Mindell

City of York Health Unit

British Columbia

1. H. Langemann

City of Vancouver Health Department

1. T. Shun

G. Embree

City of Burnaby Health Department

1. G. Rice

Larry Percival

Upper Fraser Valley Health Unit

1. K. Higo

City of Richmond Health Department

1. B. Vath

Cariboo Health Unit

1. A. Thomas

Peace River Health Unit

1. K. Coueffin

New Westminister Health Department

1. K. Christian

South Central Health Unit

1. R. Seltenrich

Skeena Health Unit

Government Services Offices - Newfoundland

1. S. Williams

St. John's

1. G. Perry

Clarenville

1. G. Budgell

Gander

1. R. Ledrew

Gander

1. D. Johnson

Happy Valley/Goose Bay

Tobacco Enforcement Staff

Newfoundland

1. T. Budgell
2. C. Hann
3. D. White

Prince Edward Island

1. D. MacIntosh
2. R. T. McCullough

New Brunswick

1. R. Fortin
2. J. Landry

Nova Scotia

1. E. McColloch

Quebec

1. M-A. Marcoux
2. M. Thibault

Ontario- Provincial

1. J. Welch
2. Nana
3. E. Webb
4. B. Ryan
5. N. Lassard
6. C. Woznik-Mucci
7. M. Vas Concelos
8. M. Patel
9. L. Gini
10. G. Blair
11. E. Reddick
12. B. Foster
13. D. McWilliam
14. J. Burnett
15. V. Yershenko
16. R. Patten
17. K. Greenwood
18. K. Flannigan
19. B. Frattini
20. S. Deegan
21. L. Korte
22. V. Chiefari
23. T. Pacifico

Ontario-Federal

1. A. DeBoer
2. B. Gilchrist
3. J. Zeggil
4. M. Benaissa

Manitoba

1. R. Dunbar
2. J. Shannon

Saskatchewan

1. L. Koehler
2. E. Thorne

Alberta

1. N. Tunke
2. P. Thirnbeck
3. R. Neilsen
4. R. Reid
5. C. Ellams

British Columbia

1. D. Luka
2. D. Quibelle
3. J. Manning
4. J. Yee
5. S. Bodani
6. K. Klepachuk
7. C. Tung
8. B. Wojciechowski
9. K. Herle

Retail Associations

1. L. Dumulong

National Association of Tobacco and Confectionary Distributors

1. J. Geci

Canadian Council of Grocery Distributors

1. P. Flach

Canadian Coalition for Responsible Tobacco Retailing