

18 November 1991

4-2234

REPORT ON PARTICIPATION IN THE INTERNATIONAL REVIEW PANEL
ESTABLISHED BY THE CANADIAN CANCER SOCIETY
TO REVIEW THE RESEARCH PROGRAMS OF
THE NATIONAL CANCER INSTITUTE OF CANADA
HELD AT THE OFFICES OF
THE NATIONAL CANCER INSTITUTE OF CANADA
24-26 OCTOBER 1991

I don't want to write a book but will summarise some of the interesting and relevant issues and attach one or two documents of interest.

The Canadian Cancer Society is one of the most effective cancer societies I know and is certainly one of the most effective fundraisers. They received an additional fillip in the form of the Terry Fox Run income which has allowed them to expand their cancer research activities. However, their structure is intriguingly different to everybody else's. In essence, the Canadian Cancer Society is the parent body, the public front, the fundraiser, the deliverer of programs across the board from public education to palliative care but is **not** the research organiser. The National Cancer Institute of Canada lives in the same building, shares the same Chief Executive Officer, has its own Board but shares the senior Board of the CCS and, under a formula which is reviewed from time to time, is generally given 50% of the money received in a given year and told to get on with the job of supporting research. Dr. Peter Scholefield has been their Research Director for a couple of decades and is a creative, flexible and intelligent person who has done an extremely good job. I must pay a tribute, which makes me feel fairly humble, to their ability to manage and organise all their programs, particularly research and training. I have available for those who are interested some limited copies of their 25th edition of their document "*Support for Research and Training*" which sets out the ways in which they sponsor research and also their strategies. Also attached is their strategic plan - this is a document of the CCS not merely the NCIC. Again it's a considerable tribute to the way they organise their activities.

They are, of course, both a **national** organisation and well-off financially. Their income from their population of 25 million is of the order of \$80 million at latest estimate. Hence, research receives \$40 million. This is about a \$1.75 per head of population (Victoria's research contribution would be about \$1.25). The Australian and Canadian dollars are somewhat similar.

Although they live next to North America their pattern of medical practice, medical system, medical training system and research system are much more similar to ours

A somewhat gloomy feature of their present environment is a ~~significant~~ ~~more~~ ~~aggressive~~ withdrawal, by the government, of infrastructure and ~~development~~ ~~support~~ funds from the university system. This means that their grant in ~~and~~ ~~system~~ (which is where they spend most of their money - see the attached set of ~~charts~~ ~~for~~ ~~the~~ ~~black~~ ~~system~~ ~~labelled~~ ~~Individual~~ ~~Grants~~ ~~at~~ ~~92.1%~~ ~~Appendix~~ ~~1~~) is under ~~severe~~ ~~pressure~~ to provide investigator salaries and infrastructure support as well as ~~equipment~~. The Review Panel suggested that, given the clout of the CC's within ~~Canada~~, they should play a lead role in lobbying the government to reverse this. The ~~trend~~ is also apparent in Australia but is clearly more serious in Canada. It was ~~interesting~~ to examine this system within a panel chaired by a distinguished American, Dr. Bernard Weinstein, of Columbia University. He works within the American system, in which the universities have dumped, *holus bolus*, all the responsibility for cancer research on the US National Cancer Institute, plus a number of private support sources. This means that the universities are endowed by the US NCI with everything required for the function of cancer research starting with the Professor, the office space, the secretarial support, the equipment, investigator support, research assistants and consumables. The Canadians and Americans in the Review Panel had a rule of thumb view that grants in America needed to be **twice** the size of those in Canada in order to provide an individual research worker with the same resources. I can't make a comparison for Australia.

The structure of the CCS/NCIC causes no administrative problems within their head office or in the provinces. However, it has (probably) led to a sharper division between the scientific community and the other activities of the cancer societies. I came away with the fairly strong feeling that our scientists know a lot more about what happens in terms of public education, behaviour change, tobacco smoking, SunSmart, patient welfare and clinical activities, than the basic scientists supported by the NCI who simply receive their money through a grant giving system and have little association with the CCS. This undoubtedly creates some tensions, particularly when the CCS sees gaps in the spectrum of cancer research and perceives need for change within NCIC. Since the administrations are so complementary and close there are no difficulties at this level but the gap between the basic research community and the active boards of the NCIC and the CCS is rather large and both NCIC and CCS look to the average research worker rather like mere remote funding organisations.

Both the CCS, the Board of the NCIC and the Board of the joint body, driven aggressively by Peter Scholefield, the Director of NCIC have wished to bring onstream a research program in behavioural science and to ally it to a much more scientific approach to "cancer control" activities such as mammographic screening, the delivery thereof, and the relevant evaluations and the performance indices which are of consequence. These things are actively discussed within ACCV at the level of the Breast Study Committee, the VCOG and the MSC. They do not appear to be a major subject for discussion among the basic research community in Canada. Peter Scholefield regards David Hill's unit as the best he has seen and, as many committee members are aware, David has been invited to visit Canada a couple of times during the development of their behavioural science initiative. Peter had the view that there was a need for such activity for some time **before** he came across some of David's publications so his discovery was incidental. It was this discovery which led him to bring a delegation of Canadians to visit us a couple of years ago and which has contributed substantially to the attached position paper on behavioural science (actually I have provided only selected pages - Appendix 2) which has been adopted and wholeheartedly endorsed by the Boards of both CCS and NCIC. They are currently advertising for a director of their intra mural unit and expect to establish several other units across the country as soon as possible. At least a couple of these will be associated with major cancer centres. A similar initiative was taken by the CCS in relation to epidemiology in the late seventies, and this is perceived as having paid off well. Obviously the behavioural science initiative will only succeed if they can make the right appointment, and they are hopeful of doing this.

An unspoken agenda within this Review Panel, plus the new initiative in behavioural science, is to address the difficulty they have, as a national body with two separate arms,, bringing a more scientific focus into their cancer control activities. They are well aware that their public education programs do not undergo the sort of evaluation that ours do but (as do we) they seek a **basic** behavioural science unit as well as a unit which will provide **evaluative** services.

Given that they are a large and even more disparate country than Australia, service delivery varies sharply, provincial government contributions to cancer research and cancer control vary from nil to the substantial, the attitudes of the provincial divisions of the CCS vary similarly and they have within their national structure all the same tensions that we see within the Australian Cancer Society. There is certainly

considerable resentment among some of the smaller provinces (which do not have the critical mass to obtain a significant research capacity) over the perceived "tax" of 50% levied by CCS for cancer research through the NCIC. The Review Panel suggested that making some of the smaller provinces focal points for excellence in its specific cancer control activities might be a way to lessen this tension and it seems likely that such may be an outcome of the review.

Although they have had a committee looking at **cancer control** for several years, it has hastened rather slowly and they are behind with the establishment of a suitable shopping list of cancer control indices. They have yet to embark on ways of finding, collecting and collating, as well as bringing into existence, the data necessary for monitoring proper cancer control. In this respect we have some reason to feel comfortable - our mammographic screening plan will have a register of mammograms from the beginning, will have built-in quality controls, assessments of biopsy rates and assessments of response rates to invitations as well as a registry of minimal cancers together with a clear knowledge of what treatment is offered to Victorian women. We can say something similar about the cervical cancer program we have in place. We have good long term trendlines for smoking in schools and among the adult population; for sun related behaviour; for melanoma thickness (recorded in all Australian cancer registries) all of which are surrogate markers for potential changes to the incidence and mortality of the relevant cancers.

Having accentuated the positive elements of provincialism in a neat little state containing four million people, I should emphasise that the way in which cancer research is organised in Canada is extremely impressive and, although my mind boggles at the thought of trying to politic the six Australian states into centralising their cancer research funds, I would have to confess that the way in which they spend their money is very well organised. It is, however, important to add that they have not established, on a per capita, basis anything like the number of substantial research institutions which exist in Victoria, for example, and that contributions to cancer research from the federal government in Canada is small for the simple reason that the CCS is perceived to have so much money that the NCIC is allowed to carry virtually the total responsibility for cancer research without significant federal support. There is, of course, some quite important provincial support in a number of the provinces, notably Ottawa and British Columbia.

Another pleasant item was the presentation of the Canadian program on clinical trials. I'm looking for some follow-up information but it is neatly, even elegantly, organised, and is funded on the basis that each case entered into a clinical trial results in a grant to the registering institution of \$1,220. A similar amount is required for the administration and analysis of trials i.e. \$2,500 a case in total. Canada enters about 1,200 cases per year (the figure of patients entered into American trials was not available). Again it is clear that the NCIC picks up the total cost of participation in clinical trials whereas in Victoria we find a rather loose knit but well organised cooperative system with the trials driven by groups of people with some fire in the belly, the analysis done in one of a number of sites, quite a number of enthusiastic oncology units treating patients in phase one and phase two trial protocols, and quite a significant participation in national and international trials. Hence, the costs of placing patients in such trials is diffused throughout the hospital system as well as within the Anti-Cancer Council, and I came away feeling that the clinicians within the VCOG who have worked so actively and enthusiastically to develop this sort of activity in Victoria deserve significant credit. Members will recall the recent discussion about Victoria having to carry an inordinate share of the burden of the International Breast Cancer Trial Study Group - although this is an extra burden, it is a tribute to our clinicians. (On a per capita basis we would expect to see 200 patients entered into clinical trials if we were to match the Canadian funded initiative. The number actually entered in ACCV associated trials in recent twelve month period was approximately 700.) This arithmetic, of course, leaves out participation by Canadian institutions in American trials which is probably quite significant. Nevertheless, I'm encouraged to continue our support for clinical trials and, when possible, to increase it. There is no doubt that it is a first class mechanism for getting rapid technology transfer from the developmental laboratory to the patient.

Finally, some summary figures may be of interest. The NCIC gives twelve grants per million inhabitants per annum. Grants are usually \$80,000 i.e. two personnel and some maintenance. They turn over at least 10% each year i.e. 10% are dumped and 10% of new grants are added. 10% of their grants are greater than \$100,000, 1% of their grants are greater than \$200,000. Most of their post-doctoral training is done in America by Americans for interesting reasons - see the PS. They support 37 career investigators which equals 1 in 8 of the grantees. The Terry Fox funds allowed them to introduce the concept of investigator **teams** to some weaker universities and to introduce some physician/scientist training programs. They grant money frequently on

the basis of person years or person months and sometimes sponsor team investigations which means they select the team and its leader and allow the team to recruit the senior workers. The system is pretty flexible. They are able to fund 30% of all grants applied for.

PS. The reason for post-doctoral fellows from Canada being trained in America, particularly physicians, is that the average Canadian student is fully funded by the government for his education and emerges debt free, whereas the average American medical student emerges with a debt of approximately \$100,000. Accordingly, post-doctoral fellowships are not attractive (with a stipend of \$42,000) to a recent medical graduate with a debt of \$100,000 whereas they are attractive to a Canadian and, of course, many other nationals. It's interestingly bizarre that the American refusal to fund undergraduate medical education with taxpayers' money means that the NCI is funding international post-doctoral education with taxpayers' money instead.

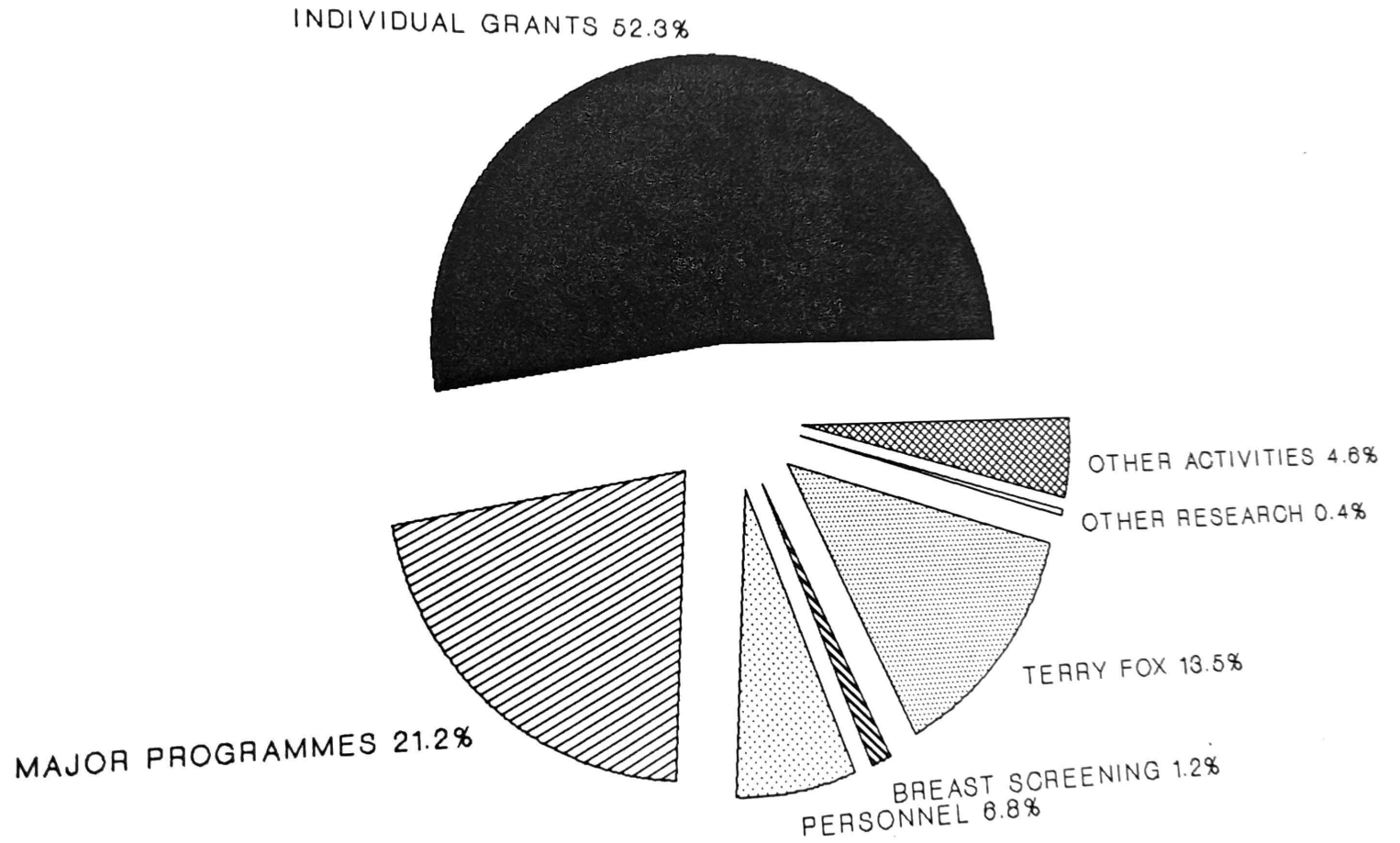
All in all it was an enlightening and stimulating trip as this report obviously reflects.



Nigel Gray

Att. 25th Edition of *Support for Research and Training*
CCS Strategic Plan
Charts re research grants

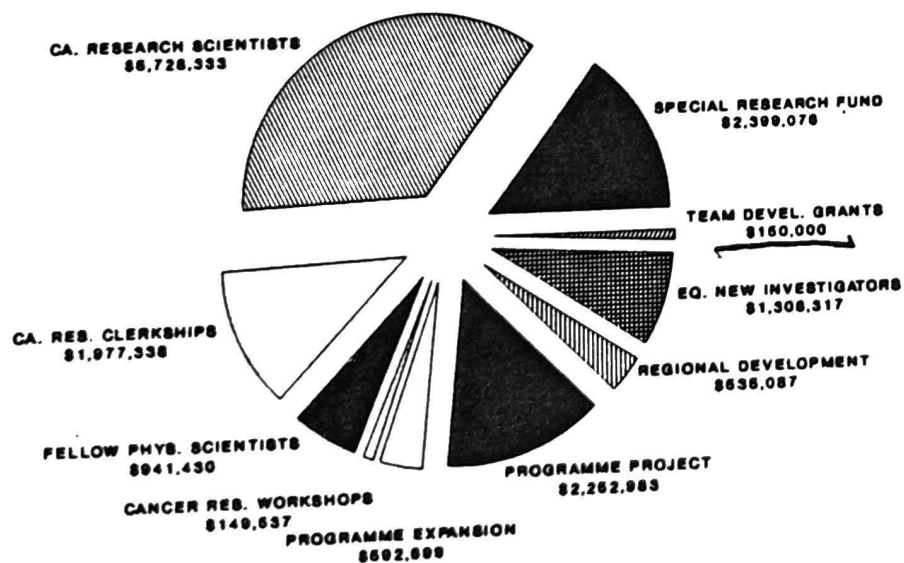
NATIONAL CANCER INSTITUTE OF CANADA 1989-90 EXPENDITURES



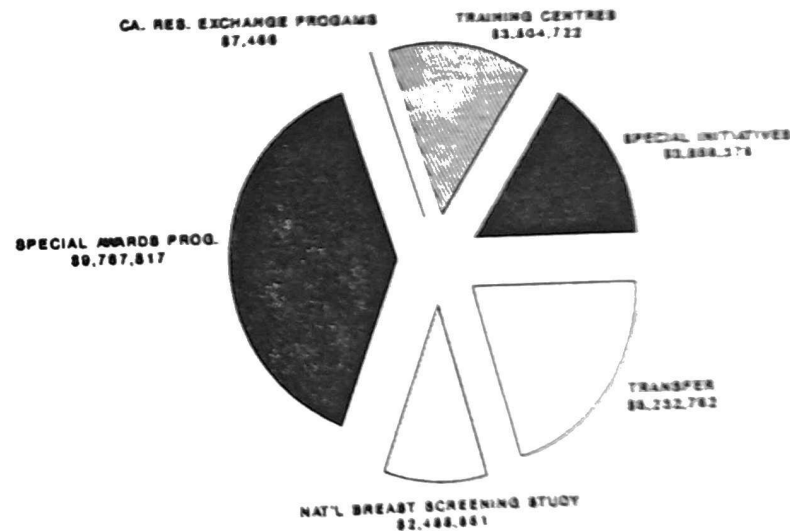
NATIONAL CANCER INSTITUTE OF CANADA TERRY FOX CANCER RESEARCH FUNDS

(UP TO 1990 - \$41 MILLION)

CONTINUING PROGRAMS \$16,034,800



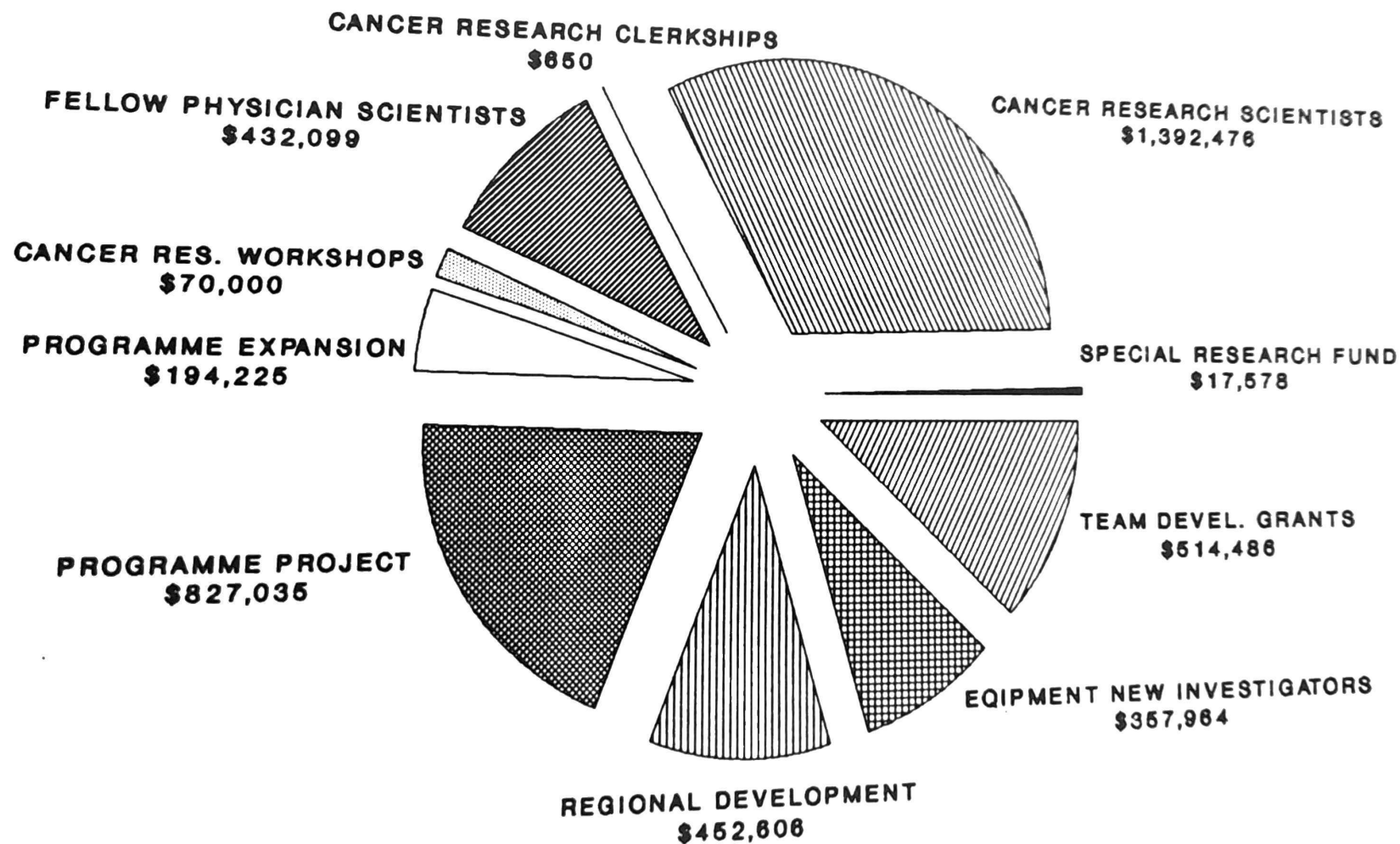
DISCONTINUED SUPPORT \$24,857,794



NATIONAL CANCER INSTITUTE OF CANADA

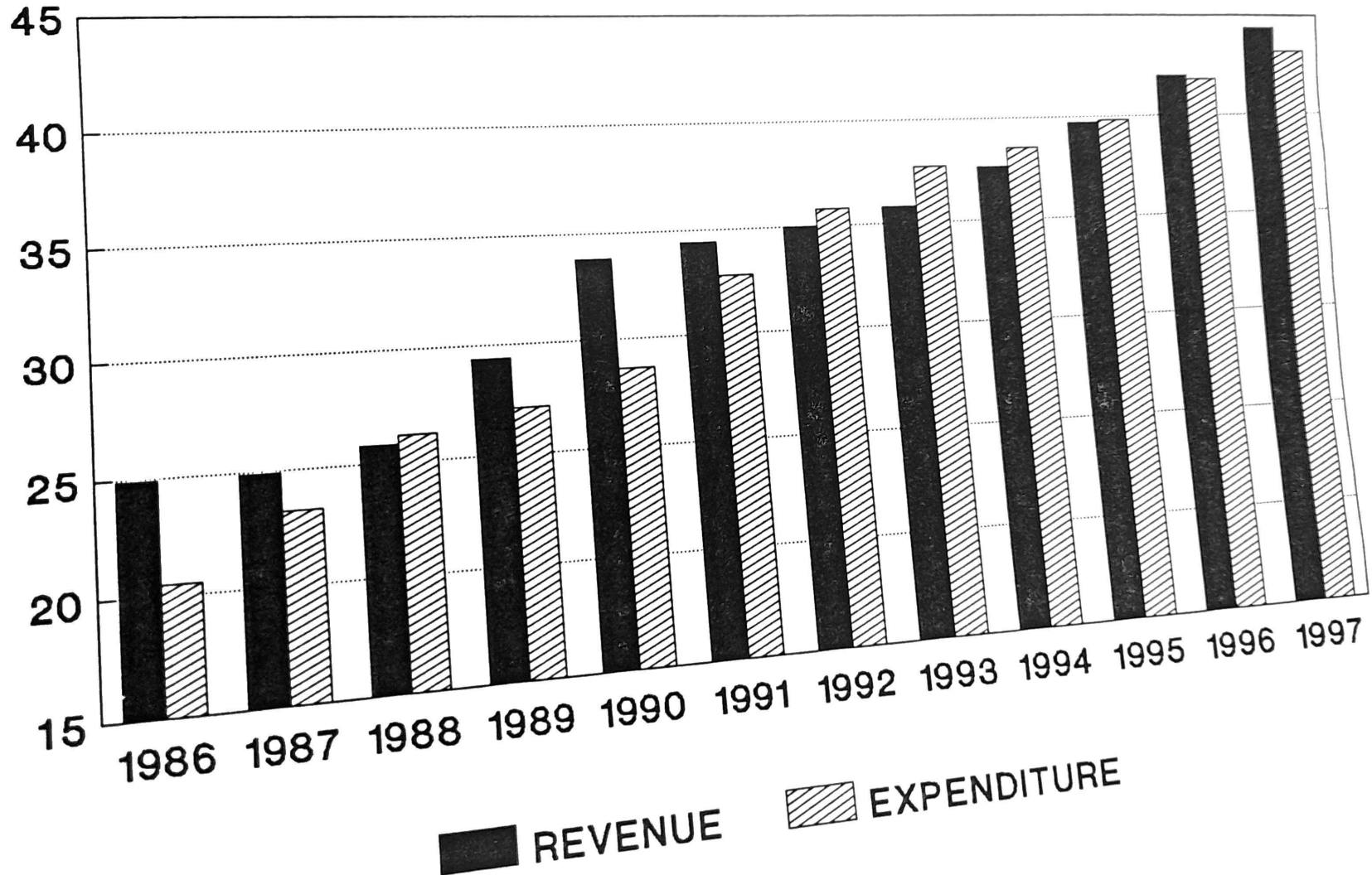
TERRY FOX CANCER RESEARCH FUNDS

(1990-91 BUDGET - \$4.3 MILLION)



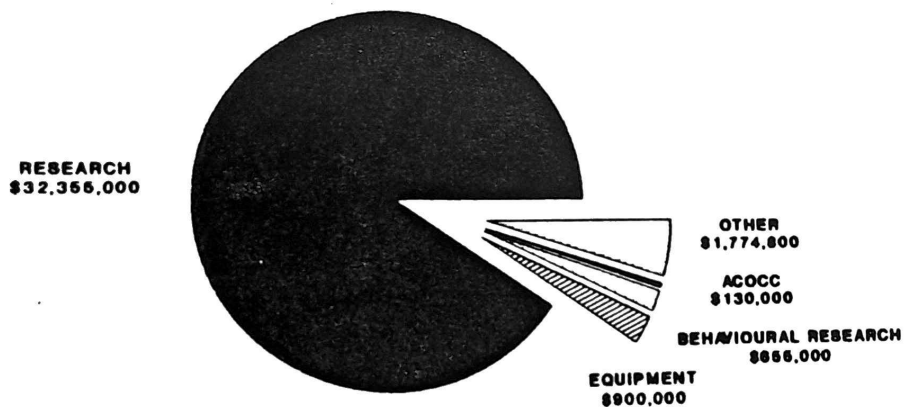
NATIONAL CANCER INSTITUTE OF CANADA GENERAL RESOURCES REVENUE, EXPENDITURE

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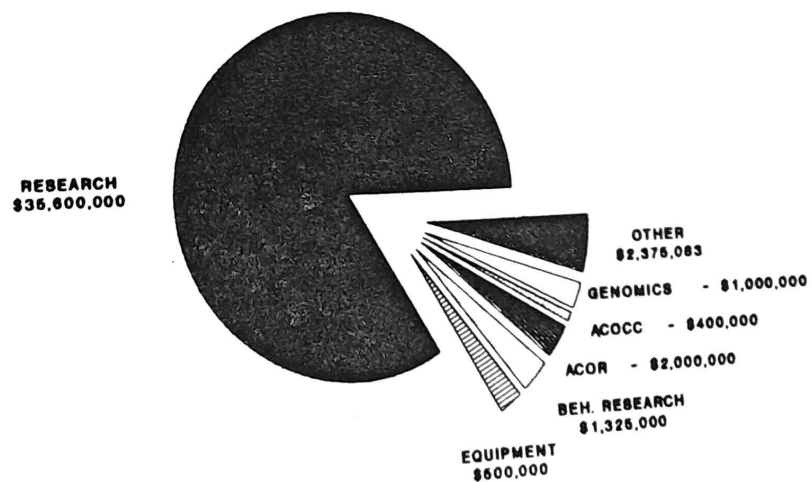


NATIONAL CANCER INSTITUTE OF CANADA GENERAL RESOURCES

EXPENDITURES
1991-92



EXPENDITURES
1996-97



REPORT OF THE
JOINT TASK FORCE ON BEHAVIOURAL RESEARCH
AND
PROGRAMME EVALUATION
OF THE
CANADIAN CANCER SOCIETY
AND THE
NATIONAL CANCER INSTITUTE OF CANADA

January 1991

1.

EXECUTIVE SUMMARY

The Joint Task Force on Behavioural Research created by the Boards of Directors of the Canadian Cancer Society and the National Cancer Institute of Canada has consulted widely within these two bodies and among experts in the field. It has concluded that programmes in behavioural research and programme evaluation should be initiated via modification of existing programmes of the Institute and the establishment of an intramural programme. Details are proposed for modification of Institute programmes in order to support investigator initiated projects, as well as the educational and training programmes in behavioural research. Behavioural scientists would be included in peer review and policy setting activities, and the modified programmes would be appropriately marketed to the social science communities. Detailed recommendations are made on how an intramural programme, directed by a qualified investigator, might best operate to ensure that the needs of the Canadian Cancer Society are met while maintaining the high academic standards of the National Cancer Institute of Canada. An essential feature of the proposed intramural programme would be for most of its research activities to be mounted through the interaction and collaboration with a network of nodes. It is proposed that an Implementation Committee be established and that it also act as a selection committee for the director of the intramural programme.

2.

INTRODUCTION

2.1 Historical

At the 32nd Annual Meeting of the National Cancer Institute of Canada in May 1978, Mr. D. F. MacGowan and the late Dr. R. S. Bush made pleas for increase in the level of research activity directed to improving the lot of individuals suffering from terminal cancer. The response of the Institute was to organize a workshop on Quality of Life research. This led to a number of successful applications for research grant support and undoubtedly influenced the career path of a small number of individuals. However, the level of activities remained small and, in retrospect, it seemed likely that this was an idea "whose time had not yet come". By 1986, the perceived role of the social sciences in oncology had begun to change - contact had been made with the newly organized Centre for Behavioural Research in Cancer of the Anti-Cancer Council of Victoria and strategic planning had been initiated by both the Society and the Institute in anticipation of celebration of the 50th Anniversary of the Canadian Cancer Society in 1988. The strategic plans resulting from these deliberations identified an important area of congruence. The plans of the Society clearly called upon the Institute to support research which would provide a solid scientific base for the programmes of the Canadian Cancer Society and a means for evaluating them. The strategic plan of the Institute highlighted a need for the Institute to work in close cooperation with its partner, the Canadian Cancer Society. The result was a recommendation by the Joint Liaison Committee to the two Boards of Directors that a Joint Task Force on Behavioural Research and Programme Evaluation be created.

2.2 Mandate

The mandate of the Joint Task Force is contained in a motion passed by the two Boards of Directors, a copy of which is attached as Appendix 1. In brief, the terms of reference encourage the National Cancer Institute of Canada to develop a programme in behavioural research and programme evaluation which would meet and maintain the highest academic standards and contribute to meeting the needs of the Canadian Cancer Society by providing for interaction with the programme areas of the Canadian Cancer Society.

2.3 Definitions

The Task Force accepted the broadest possible definitions for the terms "Behavioural Research" and "Programme Evaluation". Broad areas of cancer control research, development and application were considered relevant to the deliberations of the Task Force, and this is reflected in the consultations sought and the submissions obtained. A full description of the frameworks involved in these definitions is found in Appendix 2, detailing the consultations presented, and in the conclusions, item 1.

- (ii) soliciting comments from a large number of stakeholders
- (iii) inviting acknowledged experts and groups with special interests to make presentations to the Joint Task Force
- (iv) visits by members of the Joint Task Force and members of the Executive staff to individuals whose experience could contribute to the deliberations.

As a result, the first meeting of the Joint Task Force was essentially a planning meeting, the next six were devoted to receiving and analyzing input, and the final two meetings were devoted primarily to constructing a model and discussing drafts of the final report. It was originally anticipated that the final report would be presented at the October Meetings of the Boards of Directors of the Society and the Institute but, with the permission of both Boards, an interim report was provided in October 1990 and this final report will be presented in February 1991.

3.2 List of Consultations

The Task Force was very gratified with the number of experts willing to generously donate their time to inform us of the details of their area of expertise and their opinion on the recommendations the Task Force should explore.

Summaries of the presentations made are provided in Appendix 2. A vast amount of background reading material was provided to the Task Force. Access to this material is available through the National Office staff. The following is a list of presentations made by consultants to the Task Force in order of their appearance:

Dr. M. Francis, Ontario Ministry of Health

Dr. I. Rootman, Chief, Health Promotion Unit,
Health & Welfare Canada

Dr. M. J. Ashley, Chairman, Department of Epidemiology &
Biostatistics, University of Toronto

Dr. H. Skinner, Chairman, Department of Behavioural
Science, University of Toronto

Dr. R. Corcoran, Assistance Vice-President for Research
and Evaluation, Public Education Department,
American Cancer Society

Dr. E. Maunsell, Department of Epidemiology,
Laval University, grantee of the NCIC investigating
psychological distress in breast cancer patients

- Mr. J. Farber, Social Scientist, St. Boniface General Hospital
Winnipeg; Founding President, Canadian Association of
Psychosocial Oncology
- Dr. A. Cunningham, Senior Scientist (Psychosocial Oncology),
Ontario Cancer Institute, Toronto
- Dr. R. Cameron, Chairman, Department of Health Studies,
University of Waterloo
- Dr. H. Stam, Psychosocial Oncologist,
University of Calgary
- Dr. A. Fuks, Chairman, Advisory Committee on Research, NCIC
- Dr. D. Hill, Director, Centre for Behavioural Research,
Anti-Cancer Council of Victoria, Melbourne
- Dr. J. Cullen, Director, American Medical Cancer Centre, Denver

3.3 Presentations by CCS Divisions and Committees

At the 187th Meeting of the National Board of Directors of the Society on 1/2 June 1990, Dr. Baker reported that the Joint Task Force would like to receive submissions from the Canadian Cancer Society at a meeting which had been scheduled to follow the October Meeting of the National Board of Directors i.e. on 13/14 October 1990. Two Divisions (Saskatchewan and Prince Edward Island), two national programme areas (Public Education and Patient Services) and the Joint Committee on Medical Affairs indicated their wish to make formal presentations and a written submission was received from the National Director of Public Issues. In addition, Dr. Baker declared that the Saturday afternoon session of the 6th Meeting on 13 October 1990 would be open so that any stakeholders attending the National Board of Directors Meeting who wished to participate but had not made written submissions would be able to do so.

Summaries are provided in Appendix 2 of the following presentations:

- Open Session with various participants in the CCS Board Meeting
- Joint Committee on Medical Affairs, Dr. P. Mirwaldt
- Saskatchewan Division, Mr. H. Ellis and Mr. G. Thomas
- Prince Edward Island Division, Mr. J. Hennessy and
Mrs. S. Loucks
- National Patient Services Committee, Mr. J. Young and
Ms. P. Thomsen
- National Public Education Committee, Ms. J. Birdsell and
Ms. C. Moyer

3.4 Visits and Meetings

Various members of the Task Force, individually or in teams, visited with experts who were unable to come to meetings of the full Task Force. Brief summaries of the following visits and meetings are provided in Appendix 2:

Visit of the NCIC/CCS delegation to Behavioural Research Units in Australia

Meeting with Dr. J. F. Mustard,
Canadian Institute for Advanced Research, Toronto

Visit to Social Programme Evaluation Group,
Faculty of Education, Queen's University

Meeting with Dr. E. Einsedel,
Professor of Communication Studies,
University of Calgary

Meeting with Dr. G. Kok, Department of Health Education
University of Limburg, Maastricht

Meeting with Dr. Anne Charlton,
Cancer Research Campaign, Education and
Child Studies Group, Manchester

Meeting with COMMIT programme, University of Waterloo

Meeting with Dr. N. Roos,
University of Manitoba Centre for Health Policy
and Evaluation.

3.5 Submissions

In response to a wide circulation of invitations to comment on the mandate of the Joint Task Force supportive letters were received from:

- o the Ministries of Health of the provinces of Alberta, British Columbia, Manitoba, Newfoundland and Labrador, and Prince Edward Island
- o the Ontario Division of the Canadian Cancer Society
- o the Medical Research Council
- o the Universities of Guelph and Toronto, Dalhousie University, and Thunder Bay Regional Cancer Centre

- D. Palliative Care - quality of life
- health policy etc.
- E. Cost-effectiveness research
- F. Statistical Systems - development
- evaluation etc.

Framework 3: (Dr. R. Corcoran, American Cancer Society)

In this framework, the phases of an organized programme in behavioural research and programme evaluation are outlined. The programme would consist of following phases:

- A. Hypothesis development
- B. Hypothesis testing
- C. Efficacy - pilot studies
- D. Effectiveness trials -- does it work?
- E. Implementation trials - demonstration projects
- F. Diffusion and dissemination - technology transfer

This framework was important in helping the Task Force to visualize an important role for an organized programme, led by an expert director, but allowing for wide participation by various groups ("nodes").

A similar categorization was provided by Dr. David Hill (Anti-Cancer Council of Victoria) whose categories were:

- A. Basic
- B. Formulative
- C. Interventional
- D. Evaluative
- E. Behavioural Surveillance

He found that these categories allowed application of his programme to - Public Education
- Service Welfare
- Fund Raising
- Cooperative Trials Groups
- Epidemiological Studies etc.

in Programme Evaluation and academic expertise in Behavioural Research. Research and Evaluation efforts would need to be performed, stimulated and coordinated in various centres or "nodes" which might include CCS Divisions, CCS National Committees, Universities, Institutes, Agencies etc. across the country.

- (iii) All programmes would be expected to maintain the highest academic standards, and such standards would be applied in the assignment and review of resources.
- (iv) Evaluation of the consequences of all recommendations would need to be carried out after an appropriate interval.

5. RECOMMENDATIONS

5.1 Objectives

The Joint Task Force recommends the adoption of the following objectives defined by the two Board of Directors and derived from its terms of reference:

- (i) THAT THE NCIC ESTABLISH A PROGRAMME FOR BEHAVIOURAL RESEARCH AND EVALUATION
- (ii) THAT THE PROGRAMME BE DESIGNED
 - a) TO DEVELOP AND PROMOTE BEHAVIOURAL RESEARCH AND PROGRAMME EVALUATION IN THE CANCER FIELD
 - b) TO MEET AND MAINTAIN THE HIGHEST ACADEMIC STANDARDS
 - c) TO CONTRIBUTE TO MEETING THE NEEDS OF THE CANADIAN CANCER SOCIETY (SUCH AS PROGRAMME EVALUATION) AND TO PROVIDE FOR EXTENSIVE AND EFFECTIVE TWO WAY INTERACTION BETWEEN THE PROGRAMME AND THE PROJECTS UNDERTAKEN WITHIN THE PROGRAMME AREAS OF THE CANADIAN CANCER SOCIETY.

5.2 Overview

The Joint Task Force recommends that in order to meet the above objectives, a new programme be developed with two pillars.

- 5.2.1 The first pillar is designed to encourage and fund investigator-initiated projects in behavioural sciences

of limited use for those interested in psychosocial oncology. The problem lies in frequent switches in focus and inconsistency among the questions and responses which have made for difficulties when comparisons are undertaken. He made a plea for regional involvement, citing the potential inadequacy of a programme with only a central activity, the danger of provincial hostilities and the possibility that needs may be different in various parts of the country. In looking at the involvement of the Society and its programme, Dr. Stam emphasized that "we should look at what we want rather than what we have".

Dr. A. Fuks

At the 5th Meeting, there was also a presentation by Dr. A. Fuks (Chairman of the Advisory Committee on Research of the Institute). This Committee, ACOR, has a broad mandate which is to advise the Board of Directors on all aspects of cancer research and this has been interpreted as a requirement to accept responsibility for review and administration of programmes in behavioural research. ACOR is supportive of the concept of a new initiative in this area and has already discussed how best to utilize existing programmes for this purpose. ACOR has recommended to the Board of Directors that its membership be increased by the addition of an individual with expertise in cancer control research (subsequently approved by the Board of Directors). In addition, the Institute has requested the Public Relations Committee of the Society to develop a marketing strategy which would emphasize selective programmes of the Institute, particularly those in the area of behavioural research.

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At the 7th Meeting, there was an opportunity to consult with Dr. J. Cullen of the AMC Centre in Denver and Dr. D. Hill of the Anti-Cancer Council of Victoria. It was also possible to arrange for Dr. Cullen and Dr. Hill to make brief presentations to the National Public Education Committee which was meeting on the same day.

Dr. D. Hill

Dr. Hill, in describing the operations of his Centre, noted that his budget is \$0.5 million per annum and its primary responsibility is to serve the needs of the State of Victoria which has a population of 4.2 million. The budget of the Anti-Cancer Council of Victoria is \$8 million per annum and the Centre is responsible for administration of the QUIT programme which has a budget of \$3.5 million per annum. In describing the activities of his Centre, Dr. Hill referred to the vision leading to its creation, the present opportunities, the activities of the Centre, the aims of the Centre, its operation, the early problems (recruiting, focus and building confidence), the areas of research (from prevention to coping), the nature of the output, the academic links, the hazards (too applied vs. too theoretical, service demands, the limited resources)

finishing programmes and low critical mass), international trends and what expectations might be realistic. During the discussion period, Dr. Hill suggested that it may be better for research involving patients to be done in locations where there is accessibility to patients and he discussed in some detail the way in which programme personnel of the Council are now working closely with research personnel and vice versa.

Dr. J. Cullen

During his presentation, Dr. Cullen pointed that the basis for the Pap test was discovered in the 1920s, the basis for mammography screening was laid in the 1930s and the basis for prevention of lung cancer was identified in the 1950s. In the United States, the American Cancer Society has led the crusade to implement these cancer control programmes and the community is now becoming conscious of the need to overcome behavioural pathogens in the same way that it has overcome microbial pathogens. He emphasized the benefits to be gained from consensus conferences and readily agreed that cancer control research is more than prevention. There is a continuum in which basic research in hypothesis development leads to method development to controlled intervention trials to defined population trials and ultimately to demonstration and implementation. He also noted that nationwide prevention and health services programmes must eventually be the data set from which new hypotheses are carved.

During the general discussion with Dr. Hill and Dr. Cullen, Dr. Hill confirmed that he is authorized to set priorities for the Centre and this cause no difficulty in practice. He would probably be reluctant to lead a group whose full time responsibility was to meet service commitments but would probably be ready to accept an appointment with a reasonable balance between his own priorities and meeting those set for him. In the opinion of both visitors, programme people would have to be involved if implementation is to be achieved.

PRESENTATIONS BY CCS DIVISIONS AND COMMITTEES

Open Session, 13 October 1990

During this session, the following comments were made:

- o some form of network will be required if the behavioural research programme is to meet the needs of all parts of Canada
- o when the Epidemiology Unit was first set up by the Institute, it established multiple networks, one for each individual study

Director's Office

MEMORANDUM

DATE: 10 October 1991
 TO: Executive Committee
 FROM: Nigel Gray

4-2199

This note merely reports that I attended the UICC Executive Committee in Budapest at the end of September. It was a brief three-day meeting and the most important item about which to inform you is that the UICC is in fairly good financial shape - it seems to have garnered another million dollars for its programs - and that everything is going very smoothly at present. In addition I have accepted a non-resistable invitation from the Canadian Cancer Society to participate in a review of all the programs of their National Cancer Institute (which consumes half of their total income) on October 24-26. This is to constitute a major reappraisal of their research funding and its future directions. The other members of the panel are listed:

- Dr. I.B. Weinstein, Director, Comprehensive Cancer Center, New York, N.Y.
 Frode Jensen Professor of Medicine
 Professor of Public Health and Genetics and Development
 Member of the previous External International Review Team
 Chairman of the current External International Review Team
- Dr. G. Connell, Vice Chairman, Demand and Supply Plan Hearing, Ontario
 Hydro, Toronto, Ontario
 Past President, University of Toronto
 Past President, University of Western Ontario
- Dr. P.F. Engstrom, Vice President for Population Science, Fox Chase Cancer
 Center, Philadelphia, P.A.
- Dr. S.O. Freedman, Director of Research, Jewish General Hospital, Montreal,
 Quebec
 Past Vice Principal, McGill University
- Dr. C.S. Muir, Director, Cancer Registration in Scotland, Edinburgh, Scotland
- Dr. H. zur Hausen, Chairman and Scientific Director, German Center for
 Research on Cancer, Heidelberg, Germany

It should be an extremely educational experience.

- W. G.

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Phyllis H. Hood

March 8, 1990

19 MAR 1990

Miss Adrienne J. Holzer
Secretary to the Council
Anti-Cancer Council of Victoria
Keogh House
1 Rathdowne Street
Calton South, Australia
3053

Dear Adrienne:

Thank you for the reports. Enjoyed reading them and have taken the liberty of circulating the information to the two Directors who must vote on these issues.

At the national level, the Board has agreed in principle to developing a Behavioral Research Program jointly with the National Cancer Institute. I rather doubt, though I may be off base, that we will develop a physical facility. Rather, I see us using the same format, ie, applications from university settings, and health care institution to manage the research funding and supervise the research.

My thanks again for keeping me informed.

Yours sincerely,

Phyllis H. Hood (Mrs.)
Executive Director

/ct

CANCER Communications Conference (Jan/90)

SMOKING CONTROL AROUND THE WORLD

- LEGISLATIVE STRATEGIES IN CANADA

...ion of David Hill, Past National Vice-
-1989 Chairman of the Public Issues
Cancer Society. David is currently a
e Ottawa law firm of Perley-Robertson,
... McDougall.

1) Lobbying successes in Canada

- November 17, 1986 - the federal government announces new legislation banning smoking on all domestic and transborder flights of 2 hours or less
- 1987 - the national health coalition stops the establishment of a national marketing board for tobacco
- February 11, 1987 - the Canadian Cancer Society convinces the Toronto Star, Canada's largest daily, to no longer accept tobacco ads
- June 8, 1988 - Tobacco Products Control Act (Bill C-... passed by Parliament. The provisions are:
 - phasing out of tobacco advertising
 - magazine and newspapers: Jan. 1, 1989
 - signs/billboards: Jan. 1, 1991
 - retail signs: Jan. 1, 1993
 - restrictions on brand name tobacco promotions
 - no free distribution of samples
 - no rebates, contests or prizes
 - no use of tobacco brand names on non-tobacco items
 - prominent health warnings
 - on packages
 - on billboards
 - toxic constituent list on packs
 - health information leaflets in packs

Do NOT
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another copy
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A4

For
Copies
only

- existing legal obligation to fully warn consumers is retained
- provision to government of data on toxic constituents of tobacco and tobacco smoke, as well as sales, advertising and sponsorship data
- \$100,000 - \$300,000 fines
- June 28, 1988 Non-smokers' Health Act (Bill C-204) is passed by Parliament. The effect of the Act is a prohibition on smoking on all intercity bus operations in Canada as well as on trains with fewer than three cars. Longer trains will only permit smoking on 1/3 of the seats in 1/3 of the cars on the train. Smoking is also prohibited in federal workplaces (except designated smoking rooms ventilated to the outside). This applies to all federal employees -- including those of some 40 Crown Corporations -- and those who work in national and international rail, road, shipping and air transportation services, pipeline agencies, interprovincial and international communications, broadcasting, banks, grain handling and uranium mining.

The airlines industry put up an eleventh-hour lobby to scuttle plans to make international flights smoke-free. The Cabinet Committee nevertheless sided with the health community and made these flights smoke-free. Enormous pressure was then put on the Government by the airlines industry to reverse this decision. The final decision was that the industry got an extension of the starting date for the smoking ban on international flights until July 1, 1990. The national health coalition will cooperate with the airlines in promoting smoke-free international flights with our sister organizations in other countries if we have assurances that the airlines will not lobby behind our backs for further extensions or a reversal of Government policy.

- April 27, 1989 - The federal government increased tobacco taxes by approximately \$4.00 a carton. Tobacco consumption in Canada fell by approximately 6% in 1989, probably a larger drop than any other industrialized country.

- Plans for 1990

- new legislation controlling tobacco sales to minors
 - \$5,000 fines for selling tobacco to minors
 - strict controls on vending machines
- further strengthening of Tobacco Product Control Regulations
 - addiction warning on packs
 - education leaflets inside packs

II. Historical Background

- Failure of the medical model - health organizations in Canada had been dominated by health professionals trained to look at biological causes of illness, rather than social factors. Physicians are not used to taking actions which would normally get people angry at them. Financial resources have been made available to health professionals to do things which do not cause controversy, such as medical research.
- 1985 - The Sleeping Giant awakes
- 1986 - Establishment of the Public Issue Committee with a "fast track" mechanism
- 1986 - CCS hires professional staff

III. 10 minute excerpt from award winning video "Lobbying for Lives: Lessons from the Front"

IV. Elements of the War Room Campaign

- direct lobbying of Members of Parliament
- full page paid advocacy advertisements signed by the Canadian Cancer Society and other groups
- op. ed. page articles written for the media
- legislative submissions
- oral and written presentations before Parliamentary committees

- Cancer Society Ottawa Office (War Room) 3 blocks from Parliament
- public opinion polls
- media interviews and conferences
- Western Canada media tour
- letters and phone calls to MPs
- letters to the editor
- 35,000 black-bordered postcards sent to MPs from Cancer Society volunteers
- at the start of almost every meeting, regardless of the level, the Cancer Society and other organizations, set aside 10 minutes for those present to write a letter to federal politicians.
- when Member of Parliament Ron Stewart, a tobacco wholesaler, spoke against Bill C-51 in the House of Commons, the health lobby put out a circular to 30,000 homes in his electoral district charging him with conflict of interest. The Cancer Society put out a news release saying that Stewart was only its first target. Other MPs opposing the bill would receive similar treatment.
- petitions collected by physicians.
- MPs were blitzed with phone calls when they returned home from Ottawa on holiday breaks.
- a public challenge to the tobacco industry for a televised national debate (it ducked)
- detailed tracking of the position of each MP and Senator on Bills C-51 and C-204

V. Internal battles within the Cancer Society

VI. Fourteen reasons for success on tobacco ad ban

- 1) Scientific evidence supported health position
- 2) Lynn McDonald and Bill C-204 put pressure on C-51
- 3) Minister of Health Jake Epp, our best lobbyist
- 4) The health lobby - united we stood

- 5) Support from all three political parties
- 6) Support in the bureaucracy
- 7) Ministerial staff support
- 8) Newspaper support
- 9) Public support
- 10) Fewer smokers
- 11) No real opposition from civil liberty groups
- 12) Early enough introduction in the Parliamentary session
- 13) Parliamentary Reform and luck
- 14) Mistakes by the tobacco industry

VII. Presentation by Ken Kyle, Director of Public Issues,
Canadian Cancer Society, Ottawa

Ways in which the health lobby could have improved its
campaign

- earlier start
- fewer delays in lobbying after each hurdle
- more health organizations could have been more
meaningfully involved
- advance planning
- support from provincial/territorial ministers of
health
- support from advertisers

VIII. Lessons learned from our lobbying experiences in Ottawa

- 1) Ensure that volunteers in health charities are
completely behind professional staff efforts.
- 2) Ensure that health organizations have some
professional expertise in lobbying.
- 3) Don't be afraid to play "hard ball" -- this will only
bring respect from government.
- 4) Use the media to mobilize public support.
- 5) Be careful in the timing of various components of your
campaign.
- 6) Take advantage of opportunities, such as mistakes by
the tobacco industry.

- 7) Frame the debate in health terms.
- 8) Use international resources.
- 9) Work on the outside (polls, publicity, advocacy ads in newspapers) and also on the inside (meetings with politicians and their staff, briefs, etc.)
- 10) Enlist politicians as fellow lobbyists.
- 11) Ensure a balance between leading the public and maintaining a broad level of public support.
- 12) Recognize that lobbying decisions will sometimes be at variance with views of some members in some of the organizations in the coalition.
- 13) Within a particular organization there will not be time to develop a broad consensus on some issues. For example, the Board of Directors of a health charity cannot make decisions regarding tactics and timing.
- 14) Coalitions are the key.
 - the workload can be shared
 - politicians can see broad community support
 - prevents sister organizations from inadvertently working against the objective.
 - power and credit for success must be shared.
 - overcome problems of working together.

IX. What needs to happen in other countries to have the same success.

- 1) Senior volunteer support
- 2) Substantial financial and human resources
- 3) Limit the objectives
- 4) Build on success

TO SEE WHETHER BILL C-51 AND BILL C-204 DESERVE FINAL APPROVAL

QUESTION #1

Since first reading of Bill C-204 (Non-Smokers' Health Act) on October 06, 1986 and the announcement of Bill C-51 (Tobacco Products Control Act) on April 22, 1987 — how many Canadians have been diagnosed with lung cancer?

ANSWER: 23,000 Canadians

QUESTION #2

Since the announcement of the 2 bills, how many Canadians have died from lung cancer?

ANSWER: 20,000 Canadians

Bill C-51, which will stop tobacco advertising, was introduced by a government with a huge majority and was promoted as a key element of Canada's public health policy. It has the support of both opposition parties in the House of Commons, has been endorsed by every major health organization in the country and is supported by a large majority of Canadians.

Bill C-204, a private Member's bill, has received approval in principle, is similarly endorsed by health groups and is complementary to Bill C-51.

QUESTION #3

What is holding up final reading of Bill C-51?

ANSWER: We don't know, do you?

Members of Parliament — please move quickly to pass Bill C-204 and Bill C-51.

CANADIAN CANCER SOCIETY
77 Metcalfe Street, Ottawa K1P 5L6 (613) 234-9539

Other organizations supporting these two bills are:

CANADIAN ASSOCIATION OF HOSPITAL AUXILIARIES • CANADIAN ASSOCIATION OF OCCUPATIONAL THERAPISTS • CANADIAN ASSOCIATION OF OPTOMETRISTS • CANADIAN ASSOCIATION OF PATHOLOGISTS • CANADIAN CHIROPRACTIC ASSOCIATION • CANADIAN COUNCIL OF CARDIOVASCULAR NURSES • CANADIAN COUNCIL ON SMOKING AND HEALTH • CANADIAN DENTAL ASSOCIATION • CANADIAN HEART FOUNDATION • CANADIAN HOME AND SCHOOL AND PARENT-TEACHER FEDERATION • CANADIAN HOSPITAL ASSOCIATION • CANADIAN LUNG ASSOCIATION • CANADIAN MEDICAL ASSOCIATION • CANADIAN NURSES'S ASSOCIATION • CANADIAN TEACHERS' FEDERATION • NATIONAL ACTION COMMITTEE ON THE STATUS OF WOMEN • NATIONAL CANCER INSTITUTE OF CANADA • NON SMOKERS' RIGHTS ASSOCIATION • PHYSICIANS FOR A SMOKE-FREE CANADA • ROYAL COLLEGE OF PHYSICIANS AND SURGEONS OF CANADA • THE COLLEGE OF FAMILY PHYSICIANS OF CANADA • UNITED CHURCH OF CANADA

To Members of the Public: Help strengthen this message by contacting your Member of Parliament. For the name or telephone number of your MP, call Elections Canada at 1-800-267-8683. Write your MP quickly, at the House of Commons, Ottawa, Ontario K1A 0A6. No postage is required.

HOW MANY THOUSANDS OF CANADIANS WILL DIE FROM TOBACCO INDUSTRY PRODUCTS MAY LARGELY BE IN THE HANDS OF THESE TWO MEN



Prime Minister
Brian Mulroney



Lobbyist
William H. Neville

In a few hours, a small group of Members of Parliament will begin the clause-by-clause review of two proposed bills. They could become the most important federal laws in disease prevention and health promotion in over a decade. In fact, the health community believes that the Committee's decisions will greatly influence illness and death rates from cancer and other diseases for decades to come.

The House of Commons Committee, dominated by Conservative MPs, will review two critical bills: the **Tobacco Products Control Act** (Bill C-51) and the **Non-smokers' Health Act** (Bill C-204). We believe the wishes of two powerful Canadians, Prime Minister Brian Mulroney and tobacco lobbyist William Henry Neville, will have a major influence on the final outcome.

At 35,000 deaths each year, tobacco industry products kill more Canadians annually than would be killed by the collision of two fully-loaded jumbo jets every week for a year. These bills are moderate, reasoned responses to a health problem of this magnitude.

Bill C-51 would ban tobacco advertising and prevent the industry from using arts activities and sports/fitness events for the purpose of promoting tobacco sales. Bill C-204, MP Lynn McDonald's private member's bill, would bring tobacco under the **Hazardous Products Act**. It would also regulate involuntary smoking in inter-provincial transportation and workplaces under federal jurisdiction.

Bills C-51 and C-204 are supported by hundreds of organizations representing millions of Canadians. These bills constitute world precedent-setting legislation. Passage of this legislation would represent the first time a government, in a tobacco growing country, had sufficient integrity to withstand the muscle of the tobacco lobby.

Let us be clear. To date, the Prime Minister's government has acted with courage and integrity to bring the government bill this far. As it stands, Bill C-51 represents policy for a government with a huge majority. To their credit, the Liberal and New Democratic parties have set aside partisan politics to give Bill C-51 all-party approval. In other words, if the Prime Minister wants Bill C-51 to pass without being weakened, we think the House of Commons Committee will support him.

If these bills pass, the Prime Minister and Health Minister Jake Epp will be the recipients of praise from coast-to-coast. And the government will attract international acclaim.

THE NEVILLE FACTOR

One thing could stand in the way. Bill Neville, perhaps the most powerful lobbyist in Canada and a friend of the Prime Minister, Neville is also the newly-appointed President of the Canadian Tobacco Manufacturers' Council.

The industry knew what it was doing when it hired Bill Neville. He was Chief of Staff for one conservative

Prime Minister and was responsible for setting up the Prime Minister's Office for the current government. Neville's credentials as a professional lobbyist are impeccable.

Bill Neville's assignment has been to derail these Bills or, at the very least, to extract compromises from the government which will minimize the reduction in tobacco sales. Unfortunately, his task flies in the face of the health objectives of the government and the entire Canadian health community.

Given the enormous death rates caused by the tobacco products Bill Neville is defending, there is a danger that every point he wins and every compromise he extracts could have the potential to translate into tens of thousands of deaths over time.

On the other hand, the Prime Minister has renewed a commitment to progressive social policy. Given the enormity of the death rates, every pro-health amendment the government-dominated Committee approves, every time the Committee votes to maintain the integrity of these bills, there is a potential for the savings of tens of thousands of lives.

NO COMPROMISES WITH EPIDEMICS

The pro-tobacco influences are seeking one amendment which has the potential to "gut" Bill C-51. They can live with a ban on conventional advertising as long as arts and sports sponsorships are protected. The industry knows that the money spent on conventional advertising can simply be shifted to sponsorships. And, frequently, sponsorships can more effectively promote tobacco products than conventional ads. The protection of sports sponsorship would provide the industry with the perfect escape route.

Our position has to be "no compromises on epidemics. No compromises with death rates of this magnitude. And no compromises on sponsorship!"

THE ISSUE IS INTEGRITY

The issue in the eleventh hour is simply this. Will the influence of a powerful industry and a skilled lobbyist override 50,000 scientific studies demonstrating the association of tobacco industry products with death and disease? Will the millions of dollars spent by this industry to defeat this bill run roughshod over the courageous leadership of the Minister of Health and his entire department, over Canadian health and human service organizations united as they have never been before, over the leadership of the Liberal and New Democratic parties, and over the substantial majority of Canadians which polls demonstrate consistently support these legislative initiatives?

We appeal to the Prime Minister and the Committee on Bills C-51 and C-204 to back integrity. Young Canadians will be in their debt for generations to come. And, we think that William Henry Neville, deep down, will understand.

ASSOCIATION DES CONSEILS DES MÉDECINS,
DENTISTES ET PHARMACIENS DU QUÉBEC
CANADIAN CANCER SOCIETY
CANADIAN COUNCIL ON SMOKING AND HEALTH
CANADIAN TEACHERS' FEDERATION
NATIONAL ACTION COMMITTEE ON THE STATUS OF WOMEN
NON-SMOKERS' RIGHTS ASSOCIATION
PHYSICIANS FOR A SMOKE-FREE CANADA

5. Generic packaging

The *TPCA* does not end all tobacco advertising. The most important tobacco ads may be the cigarette packs themselves. Millions of dollars have been spent giving the packages alluring images. Now, with the benefit of an obvious loophole in the *TPCA*, the industry will shift much of the advertising money into payment for prominent space at retail outlets. Arrangements may be made for cigarette packages to be seen in movies and videos.

All tobacco products must be sold in identical, plain (generic) packages with the only distinguishing feature being the brand name. This would remove the package allure, prevent the infiltration of movies and videos, and cut the promotion of sales in stores.

6. Tobacco tax reform

Tobacco tax increases discourage tobacco consumption, especially among the young. The federal government has moved decisively in this area in the 1989 budget. The government must now ensure that the tax your own tobacco is totally eliminated. This would remove the incentive for smokers who might normally proceed with work and the government's increased tobacco tax revenue should be reflected in increased funding for public health education on tobacco.

7. Effective education campaigns

Given the huge revenues obtained from tobacco taxes, there must be increased funding for campaigns directed especially to young Canadians to help them reject pressures to begin smoking. The federal government should also take a variety of initiatives to encourage "stop smoking" courses, eg. tax credits for such programs.

8. A ban on spitting tobacco

With cigarette consumption dropping, efforts are increasing to market spitting or chewing tobacco to young Canadians. As in Australia, a ban on the product must be introduced before an epidemic of mouth cancer and other diseases is created.

9. Test cases for product liability law suits

Canadians with tobacco-caused diseases who were addicted to tobacco, perhaps before the age of responsibility, may have rights to damages in product liability law. These rights should not be denied because these

harmed are not wealthy enough to challenge an industry with an overwhelming financial advantage.

The industry has ignored its obligation in not law to warn its customers of addiction and other risks. That could be leading to lower costs for other plaintiffs and be precedents for the government funding litigation where one side is financially handicapped.

10. End government promotion of tobacco sales to Third World countries

There is a growing sense of repugnance for tobacco conglomerates which use unscrupulous marketing practices to market tobacco in disadvantaged Third World countries. Our tax dollars must not be used to fund government involvement in selling tobacco.

Endorsors

- Canadian Association of Hospital Auxiliaries
- Canadian Cancer Society
- Canadian Chiropractic Association
- Canadian Council on Smoking and Health
- Canadian Dental Association
- Canadian Home and School and Parent Teacher Federation
- Canadian Hospital Association
- Canadian Lung Association
- Canadian Medical Association
- Canadian Nurses Association
- Canadian Pharmaceutical Association
- Canadian Physiotherapy Association
- Canadian Public Health Association
- Canadian Teachers' Federation
- Non-Smokers' Rights Association
- Physicians for a Smoke-Free Canada
- The Canadian Association of Optometrists
- The Canadian Society of Respiratory Therapists
- The College of Family Physicians of Canada
- The Royal College of Physicians and Surgeons of Canada
- United Church of Canada

Give kids a hand

1. Support our 10 Point Plan to Treat the Epidemic Like an Epidemic. Write your Member of Parliament, House of Commons, Ottawa, Ontario K1A 0A6. No stamp is required. Call Elections Canada 1-800-267-8683 (toll free) for your MP's name or address, if unknown.
2. First write your MP. Ask for action on the 10 Point Plan. Then write the Hon. Perrin Beatty, Minister of Health, same address. Or send him a copy of your MP's letter.
3. Contact your local health agencies, health and hospital boards, board of education, union, etc. Ask them to pass a motion in support of the 10 Point Plan. Ask them to distribute this pamphlet.
4. Ask your doctor to write. And, write the editor of your paper.

CANADIAN CANCER SOCIETY SOCIÉTÉ CANADIENNE DU CANCER

Send your request for more information to:

NATIONAL CAMPAIGN FOR ACTION ON TOBACCO P.O. Box 2310, Station D, Ottawa, Ontario K1P 5W5 Phone (613) 230-4211 or (613) 234-9539



Like an epidemic

Like an epidemic, the tobacco epidemic is spreading rapidly. In 1988, the tobacco industry spent more than \$1 billion on advertising. The industry has spent more than \$1 billion on advertising in the past year alone. The industry has spent more than \$1 billion on advertising in the past year alone. The industry has spent more than \$1 billion on advertising in the past year alone.

The passage of the TPCA created warnings that are not

The passage of the TPCA created warnings that are not nearly as effective as those in other countries. The industry has spent more than \$1 billion on advertising in the past year alone. The industry has spent more than \$1 billion on advertising in the past year alone. The industry has spent more than \$1 billion on advertising in the past year alone.

1. Tough Regulations under the Tobacco Products Control Act

The potential world precedent-setting TPCA bans tobacco advertising in newspapers and magazines and on billboards as well as most sports and arts events. The industry has spent more than \$1 billion on advertising in the past year alone. The industry has spent more than \$1 billion on advertising in the past year alone. The industry has spent more than \$1 billion on advertising in the past year alone.

10 Ways to give kids a chance

As a chance of the enormity of the death rates, any of the following reforms which are not undertaken could lead directly to thousands of preventable deaths amongst children and future generations of children. The National Campaign for Action on Tobacco wants these reforms: 1. Tough Regulations under the Tobacco Products Control Act.

2. Strict enforcement of the Tobacco Products Control Act

There have been many reports of violations of both the TPCA and the TPCA. The industry has spent more than \$1 billion on advertising in the past year alone. The industry has spent more than \$1 billion on advertising in the past year alone. The industry has spent more than \$1 billion on advertising in the past year alone.

3. Prevention of sales to children

The Minister of Health must be willing to make a commitment of resources sufficient to ensure that the TPCA is rigorously enforced. The industry has spent more than \$1 billion on advertising in the past year alone. The industry has spent more than \$1 billion on advertising in the past year alone. The industry has spent more than \$1 billion on advertising in the past year alone.

4. A strong defence of the Act

The tobacco industry has attacked the TPCA in many languages. The industry has spent more than \$1 billion on advertising in the past year alone. The industry has spent more than \$1 billion on advertising in the past year alone. The industry has spent more than \$1 billion on advertising in the past year alone.



While the above regulations would be more effective than the warnings currently being used, And more effective than the warnings currently being used, And more effective than the warnings currently being used, And more effective than the warnings currently being used.

more effective warning designs

More external package warnings are needed. They must at least be designed to reflect the nature of the risks of tobacco. The industry has spent more than \$1 billion on advertising in the past year alone. The industry has spent more than \$1 billion on advertising in the past year alone. The industry has spent more than \$1 billion on advertising in the past year alone.

rotated comprehensive warnings and educational leaflets inside cigarette packages

Messages could be the most important reform. The industry has spent more than \$1 billion on advertising in the past year alone. The industry has spent more than \$1 billion on advertising in the past year alone. The industry has spent more than \$1 billion on advertising in the past year alone.

no more delays

The TPCA was passed in June 1988. Yet some of the first round warnings on tobacco packages may not reach the shelves until 1991. The industry has spent more than \$1 billion on advertising in the past year alone. The industry has spent more than \$1 billion on advertising in the past year alone. The industry has spent more than \$1 billion on advertising in the past year alone.

many children start smoking before their

Many children start smoking before their fifth birthday. The industry has spent more than \$1 billion on advertising in the past year alone. The industry has spent more than \$1 billion on advertising in the past year alone. The industry has spent more than \$1 billion on advertising in the past year alone.

Treat the epidemic like an epidemic

Canadians want to end special treatment for the tobacco industry

Warning leaflets appear in packages of many drugs and hazardous products sold. Such warnings are inserted because manufacturers have a duty in law to warn their customers of any risk involved in the use of their products.

Why is there no such warning in cigarette packages? The law clearly indicates that the kind of weak general warning used voluntarily by the industry is not adequate. Nor will the four warnings which will appear on packages later in 1989 be

sufficient. For tobacco products, this means warnings of over 12 terminal diseases tied to tobacco, and warnings of addiction. This is in accord with existing *truth* laws, the cigarette makers would have to produce a Big Warning, one that would force a condition of "informed consent" between manufacturer and user.

For years, the industry has chosen to ignore its obligations. Presumably, the manufacturers decided that a fair warning would cost them more in lost sales than the industry would lose in

product liability law suits. The Tobacco Products Control Act was passed, in part, to force the manufacturers to correct this problem. The *TPCA* can help accomplish this by requiring warning leaflets, like the one below, inside cigarette packs. When Health and Welfare Canada fails to force the industry to put a comprehensive warning inside of its packaging, the government implicitly endorses the industry's continued flouting of Canadian tort law.

Will the smoker read this warning?

Many smokers won't. But that is also a truism for warnings for other products. The message will still get through to many. The smoker's husband or wife will read it, or the children. The smoker they express will encourage the smoker to rethink tobacco. If only a small percentage of smokers respond to the warning, the savings in lives will number in the tens of thousands over time.

This warning is a comprehensive warning. Other warnings, designed to appeal to children and teens, adolescent girls, pregnant smokers, and less educated smokers could be inserted in cigarette packs on a rotating basis.

"The Test of Relative Inconvenience"

Governments have been reluctant to inconvenience the tobacco industry. Yet, thousands of victims of tobacco have been inconvenienced.

Implementing public health measures frequently inconveniences people. The larger the problem, the greater the inconvenience that manufacturers must be made to accept. Any "test of relative inconvenience" demands that tobacco companies do everything necessary, regardless of inconvenience, to ensure that consumers make choices based on "informed consent."

The law does not recognize the ability to pay or the degree of inconvenience involved in determining a manufacturer's duty to warn.

Poor knowledge levels

A government poll shows that only 28 percent of Canadians could remember that tobacco causes heart disease. Tobacco-caused heart disease is the leading cause of death from tobacco. Another poll found that only 4 percent of Canadians aged 12-29 could recall that tobacco is addictive or habit forming. This lack of knowledge must be corrected.

Could this warning fit in a cigarette pack?

There are precedents for warnings this large fitting such packages. Or, a warning could be affixed to the outside, with or without a wrapping.

WARNING

TOBACCO IS ADDICTIVE AND TOBACCO KILLS

Read this warning carefully. Your life may depend upon it.

Warning: Smoking is a very serious risk to your health. Each year, 35,000 Canadians die from cancer, heart and lung diseases caused by smoking. The nicotine in tobacco is an addictive drug, in the same sense that heroin or cocaine are addictive. Tobacco can cause disease and death even at low levels of use.

Smoking by pregnant women causes premature birth, low birth weight and spontaneous abortion. Tobacco smoke pollutes the air and is a cause of disease including lung cancer in non-smokers who inhale environmental tobacco smoke.

Low tar, "light" or "mild" cigarettes are not "safe" cigarettes and have not been shown to reduce the risk of premature death from tobacco products. Quitting smoking now significantly reduces serious risks to your health.

CRITICAL QUESTIONS ABOUT SMOKING AND HEALTH...

1 Is smoking a "scientifically proven" health hazard?

Yes. There is no longer any scientific controversy about tobacco being a powerful health hazard. Tobacco causes many diseases, including cancer, cardiovascular disease, disability and death.

2 Cigarettes are "safe" cigarettes?

No. There is no evidence to suggest that these cigarettes bring a significant benefit to a smoker's life expectancy or overall rate of death. When smokers of regular or "high tar" cigarettes switch to "low tar" or "light" cigarettes, they frequently continue to smoke more cigarettes per day. The levels of tar which contains cancer-causing chemicals and the addictive drug "nicotine."

3 What diseases are caused by smoking?

Smoking causes three major classes of disease: cardiovascular disease, cancer and chronic lung disease.

Cardiovascular Disease

Coronary heart disease is Canada's major cause of death. Smoking causes almost one third of all coronary heart disease deaths (fatal heart attacks). About one half of first heart attacks are fatal. More than 14,000 Canadians die each year from heart attacks caused by smoking.

Strokes frequently cause severe disability or death. Strokes are strongly linked to tobacco use. Other arterial diseases are also linked to smoking. For example, tobacco-related peripheral vascular disease, a disease which restricts blood flow to the limbs, can result in gangrene and amputation.

Cancer

Smoking causes 30 per cent of all cancer deaths in Canada; it is the major single cause of cancers. Tobacco products cause cancers of the lung, larynx, mouth, tongue, throat and esophagus and are linked to cancers of the bladder, pancreas and kidney. About 10,000 Canadians die each year from tobacco-caused lung cancer alone.

Chronic Obstructive Lung Disease

These illnesses include emphysema, chronic bronchitis and asthma. Emphysema, a non-cancerous lung disease which destroys breathing capacity, is almost exclusively a disease of smokers. More than 80 per cent of emphysema deaths are caused by smoking. Over 6,000 Canadians per year die from this disease.

4 Is tobacco really addictive?

Yes. And nicotine is the powerfully addictive drug in tobacco. Nicotine is addictive in the same pharmacologic sense as illicit drugs like heroin and cocaine.

5 If I get lung cancer, what are my chances of being cured?

Very low. Ninety per cent of lung cancer victims die within 5 years. Most die within 2 years. Over 90 per cent of lung cancer victims are smokers. If you get cancer of the oral cavity, you risk severe disfigurement and death. Only half of those who contract oral cancer survive 5 years. Your chances of survival are shown below. Your best chance of a cure from a tobacco disease involves stopping smoking now.

6 Why is it that all smokers do not get lung cancer?

There are over 4,000 different chemicals in tobacco smoke. Therefore, it is not surprising that even a smoker drinks beer because of being happy. Many all smokers who die from lung cancer can smoke. And, of course, some smokers will die of a non-tobacco related disease.

7 How does smoking affect the average loss of life expectancy from smoking is about 10 years.

The average loss of life expectancy from smoking is about 10 years. This is not true for tobacco to cause death from lung cancer, heart attacks and other diseases among relatively young adults.

8 If I become pregnant, can smoking harm my child?

Yes. Maternal smoking causes low birth weight, fetal death, neonatal death and spontaneous abortion. Smoking may adversely affect the child's long term growth, intellectual development and behaviour. More than 5,000 spontaneous abortions and 500 neonatal deaths per year are caused by maternal smoking. Women who smoke and use oral contraceptives have a much greater risk of stroke.

9 Does my smoking present a health risk for non-smokers sharing my air supply?

Yes. Second-hand tobacco smoke or environmental tobacco smoke is the cause of disease, including lung cancer, in healthy non-smokers. Children of parents who smoke compared to children of non-smoking parents have an increased frequency of respiratory infections and symptoms.

10 Is smoking a pipe or cigar safe?

No. All smokers have an increased risk of lip, mouth, and tongue cancer, no matter what they smoke. And all smokers, even those who do not inhale the smoke directly - including pipe and cigar smokers - have increased risk of lung cancer and other diseases.

11 How does smoking compare to other causes of preventable death like alcohol or car accidents?

Tobacco is Canada's major cause of preventable death. Smoking kills at least 4 times the number of Canadians who die due to alcohol abuse and at least 6 times the number who are killed in car accidents, including alcohol-related traffic accidents.

12 How do I quit smoking?

Most ex-smokers quit "cold-turkey." In other words, they simply make the decision to quit and follow through on their decision with no assistance from others. Some ex-smokers obtained assistance through smoking cessation clinics in their community. If you wish to receive information on how to stop smoking, write the Minister of Health, Health and Welfare Canada, Ottawa KIA 0A6. Information may also be obtained from your local cancer, heart or lung association or from your board of health.

EFFECTS OF TOBACCO-CAUSED DISEASES IN CANADA

| Disease | Probable Effects | Prognosis | Tobacco-Related Deaths Annually |
|----------------------------------|--|--|---------------------------------|
| lung cancer | pain from treatment and disease, death | 1 chance in 10 of living 5 years | 10,600 |
| cancer of the esophagus | pain and death | | 800 |
| oral cancer | disfigurement, pain, death | 6 chances in 10 of living 5 years | 900 |
| bladder cancer | disfigurement, pain, death | | 900 |
| coronary heart disease | heart attack, disability and death | only 1 chance in 2 of surviving first heart attack | 15,000 |
| stroke | paralysis and death | progressive deterioration | 3,500 |
| emphysema and chronic bronchitis | disability and death | progressive deterioration | 5,000 |

Warn like the industry promotes

We've used a large warning head in red with a black border to indicate the gravity of the health risk. Our insert uses two colours. But the government can force the industry to use full colour inserts. The industry didn't produce its advertising in black and white to encourage smoking. There is no excuse for the government to produce black and white warning leaflets to discourage smoking.

The law allows the government to dictate the colours, the size, the target audiences and the text for rotating messages, all at no cost to the taxpayer. If the government shows leadership, the inserts could become the most effective health education effort the world has ever seen.

Concessions can cost thousands of lives.

Normally, the regulations-setting process involves the government sitting down with an industry and talking over mutually acceptable regulations. This system works if both the government and the industry want to avoid problems.

This system breaks down because the tobacco industry, never before regulated, doesn't fit the mold. Everything the government does is not in the best interests of the industry. Because of huge tobacco death rates, every concession the industry receives has the potential of leading, ultimately, to thousands of preventable deaths.

The government should not be discussing rules with which this industry will be comfortable.

Delays also cost lives

In the first round of regulations-setting, the government had over 6 months to produce a warning insert for the industry. The health community produced its warning in two weeks. We were told that the failure to produce the insert was a "policy decision."

Canadians want action!

This warning has been endorsed by 20 of Canada's largest health and medical organizations which represent millions of Canadians as an acceptable draft of one warning. The warning is subject to final editing, of course. We want Health and Welfare Canada to mandate several insert warnings and educational leaflets.

NATIONAL CAMPAIGN FOR ACTION ON TOBACCO

P.O. BOX 2310, STATION D, OTTAWA, ONTARIO K1P 5W5

WARNING

The Americans, British, Australians and Scandinavians have them. We don't. And people are dying.

Dear Prime Minister:

Last week, the United States Surgeon General issued his landmark report on tobacco addiction. That report sent a shock wave through the international tobacco industry. The best minds in medical science, including Canadian experts in the field of drug addiction, concluded that nicotine in tobacco "is a powerfully addicting drug."

Not just habit-forming, but addictive. Addictive, said the Surgeon General, in the same pharmacologic and behavioural sense as heroin and cocaine. The only real difference, observed this massive report, is that heroin and cocaine are illicit.

The Surgeon General also pointed out what many Canadians now know. Virtually all new customers for the tobacco industry come from the child and adolescent market. Many and perhaps most are addicted before the age of responsibility.

Children deserve a chance

Where is the warning on cigarette packages that tobacco is addictive? Your government's research shows that the overwhelming majority of youngsters are unaware of this serious risk. Where are the warnings promised in Bill C-51, your long-delayed Tobacco Products Control Act?

Addiction is only one of the serious risks. Where is the warning for lung cancer on cigarette packages? The Americans have such a warning. The British have one. The Australians and New Zealanders have one. The Scandinavians have one.

There are even more heart disease deaths from industry products than tobacco-caused lung cancer deaths. Where is the warning for death from heart disease? The Americans have one. The British have one. And so do the Australians, New Zealanders and Scandinavians.

Our children count, too!

And how about the warning about fetal injury and spontaneous abortion caused by maternal smoking? Yes, the Americans, British and Scandinavians have these too. We think Canadian children and adolescents deserve the same chance as young people from other countries.

The present industry warning has been called "absolutely ridiculous" by Health Minister Jake Epp. That hopelessly inadequate warning has not changed in 16 years. Please take the

time to look inside the packaging for some of the over-the-counter drugs. Note the extensive, detailed warnings on the leaflet inside. None of the products which carry these warnings kill 36,000 Canadians a year. Your government had four years to produce meaningful warnings. Yet, nearing the end of your term, Canadians are still waiting. When will you bring Bill C-51 before the House of Commons for final reading?

How will you vote on Bill C-204?

Bill C-204, the Non-smokers' Health Act is a precedent-setting private member's bill designed to bring tobacco under the Hazardous Products Act, where this product rightfully belongs. Bill C-204 has all-party support. Under new rules of the House, it comes to a critical vote next week.

Bill C-204 would make a warning of addiction possible. And a warning for lung cancer and a dozen other causes of death all tied to tobacco. Will you show your leadership next week and vote for Bill C-204? Will you side with the kids?

Why are these bills delayed?

Bills C-51 and C-204 have all-party support. They are supported by huge, highly-respected

organizations representing millions of Canadians. The polls show solid public support. And the opposition parties have stated that these bills will be processed quickly. How, then, can the "crowded agenda" be used as an excuse for continued delays?

Who will decide?

In the next few days, we will find out who sets health policy for Canadians: Health Minister Jake Epp and his scientific experts supported by the entire national health community? Or will it be a foreign-controlled tobacco lobby with a history of deceptive and callous corporate behaviour?

Mr. Prime Minister, we are running out of time in this Session when the House may prorogue and Bill C-51 may die. To date, you have acted with courage and integrity on this issue. Your leadership has been strong. If you act quickly and positively on these bills, you will change the disease patterns of a nation. Your statesmanship will generate national and international acclaim. Yes, young Canadians will be in your debt for generations to come.

What is causing the delay?

"For the moment, however, the three parties are negotiating in good faith, as the opposition parties are expected to indicate to the Tories which bills they are willing to let sail through the Commons with virtually no additional debate. In this category... (is Bill C-51)... legislation to ban tobacco advertising and restrict tobacco promotion?"

The Globe and Mail
May 6, 1988

• CANADIAN ASSOCIATION OF HOSPITAL AUXILIARIES • CANADIAN ASSOCIATION OF OCCUPATIONAL THERAPISTS • CANADIAN ASSOCIATION OF PATHOLOGISTS • CANADIAN CANCER SOCIETY • CANADIAN CHIROPRACTIC ASSOCIATION • CANADIAN COUNCIL OF CARDIOVASCULAR NURSES • CANADIAN COUNCIL ON SMOKING AND HEALTH • CANADIAN DENTAL ASSOCIATION • CANADIAN HEART FOUNDATION • CANADIAN HOME AND SCHOOL AND PARENT-TEACHER FEDERATION • CANADIAN HOSPITAL ASSOCIATION • CANADIAN LUNG ASSOCIATION • CANADIAN MEDICAL ASSOCIATION • CANADIAN NURSES ASSOCIATION • CANADIAN PHARMACEUTICAL ASSOCIATION • CANADIAN PHYSIOTHERAPY ASSOCIATION • CANADIAN TEACHERS' FEDERATION • NATIONAL ACTION COMMITTEE ON THE STATUS OF WOMEN • NATIONAL CANCER INSTITUTE OF CANADA • NON-SMOKERS' RIGHTS ASSOCIATION • PHYSICIANS FOR A SMOKE-FREE CANADA • ROYAL COLLEGE OF PHYSICIANS AND SURGEONS OF CANADA • THE CANADIAN ASSOCIATION OF OPTOMETRISTS • THE COLLEGE OF FAMILY PHYSICIANS OF CANADA • UNITED CHURCH OF CANADA

NATIONAL CAMPAIGN TO PASS BILL C-51

77 Metcalfe Street, Ottawa K1P 5L6 (613) 234-9539 or (416) 928-2900

To Members of the Public: Help strengthen this message by contacting your Member of Parliament. For the name or telephone number of your MP, call Elections Canada at 1-800-267-8683. Write your MP quickly, at the House of Commons, Ottawa, Ontario K1A 0A6. No postage is required.

Typeset by Friends at Qualitytype Co.

Anti-Cancer Council of Victoria



LR-C

31st January, 1990

Mrs Phyllis Hood,
Executive Director,
Canadian Cancer Society
565 West 10th Avenue,
VANCOUVER BC V5S 4J4
CANADA

Dear Phyllis,

Thank you for your Christmas greetings.

No, we have no strong feelings about whether a Behavioural Science Unit should be in-house or out-house. It depends very much upon the organisation, its programs and activities. We were fortunate to have the Cancer Epidemiology Centre also in-house together with a well established Education Unit and a well funded Smoking and Health Program.

I have taken the liberty of enclosing the last two reports of the Centre to our Executive Committee. They are fairly detailed and I'm sure you will find them interesting.

Best wishes to you and your staff for a happy and successful 1990.

Yours sincerely,

Adrienne J. Holzer (Miss)
Secretary to the Council

cls:

so pleased to receive your
letter. Enjoyed your visit & your
information on your Behavioural
Research Center which is of
interest to our organization
as you are aware.

Whether we set up a physical
unit or fund research in
university settings is now
under debate. The latter is the
concept for funding medical
research & seems to make sense
to me. Would be pleased to
receive your comments if
you lean one way or the other

All the best

Phyllis Hood

18 JAN 1990

Season's Greetings
and
Best Wishes
for a
Happy New Year.

from Phyllis Hood &
Staff, CC S., BC & Yukon
Division

Love & Respect
to all.

January 17 1990

41-878

MEMORANDUM TO: Executive, Finance and Medical & Scientific Committees

FROM: Nigel Gray

=====

International developments in tobacco control

My recent visit to Washington to participate in the development of the American Cancer Society's Trade for Life program was full of fascination and is reported elsewhere.

The outcome of the meeting, as described in the report presented elsewhere, was a set of decisions to establish inside the USA a Trade for Life coalition between heart, lung and cancer (but led by cancer) which will focus on USA tobacco export policy. To complement this there will be an international coalition, also of heart, lung and cancer (and also led by cancer, through the UICC) to organise external pressure on the USA.

Following this meeting was the National Communication Conference of the American Cancer Society at which I was invited to present the story of the Victorian Tobacco Bill of 1987 and the Australian restriction on print advertising achieved in the federal parliament just before the end of 1988.

The transcript of that presentation will be available as a separate document.

A summary of the federal campaign to abolish print advertising is also attached.

The Canadian presentation was extremely interesting and the following comments may be of interest:

In summary, the Canadian Cancer Society finished up with, overtly, the leadership role in a coalition between heart, lung and cancer which launched a concerted, carefully planned attack on the Canadian cabinet in a pre-election environment.

It was clear from the beginning that cabinet did **not** wish to do anything about tobacco.

The approach of the coalition was aggressively confrontationist and succeeded, finally, in that achieved a backbench revolt which overturned cabinet's intention to do nothing about the Private Members Bill (C51) which aimed to abolish all forms of tobacco advertising.

The presentation in Washington was by David Hill - a lawyer/volunteer who not only made it clear that he believed the Canadian coalition had been

appropriately aggressive but that he thought the American Cancer Society was dragging its feet; should get off its backside; and should do the same.

To further their campaign the Canadian Cancer Society had hired a full time lobbyist (Ken Kyle) who confessed that one of his major difficulties was to bring the non cancer partners in the coalition to a state of willingness whereby they would agree to the degree of aggression which he believed was required for the coalition to succeed.

They were successful in doing this but it is unusual for cancer societies to hire lobbyists. Once having adopted the strong stance they have sustained it and have now committed themselves to spending, initially \$200,000, but up to \$1-million in legal fees in order to intervene in the court case which the tobacco industry is bringing to attempt to overturn the legislation.

One of the interesting outcomes of their aggressive stances to promote Bill C51 was a widespread public awareness, and approval, of their activities (demonstrated by opinion poll).

Further, they asked the public, via such a poll, whether they would be willing to see the Canadian Cancer Society fund legal fees to handle the tobacco industry's legal challenge and whether or not Canadians would be more or less inclined to give to the cancer society for this purpose. 28% of the population said they would be more inclined; only 2% said they would be less inclined. The rest of opinion was relatively indeterminate.

This, together with other evidence, leads the Canadians to the belief that the strong position they have adopted has enhanced their public standing and enhanced their fundraising. Further, it has given them a mandate to maintain their strong stance and to engage in legal action to defend the legislative gains which they have won.

The background to this story is fascinating, as my own sources suggest that the first thing that had to be done **before** the Canadian coalition could either be formed or develop aggressive strategies, was that the society itself had to be persuaded that they were a good thing. The CCS was, in essence, invaded by the Canadian Movement for Non Smokers Rights (led by Garfield Mahood) who took the view that the CCS was, like the ACS, a "sleepy giant", albeit a rich one. This was probably a fair assessment and it required some extremely intelligent and well targeted lobbying **within** the CCS before a mandate was gained to take the stance which they eventually did. Although, as David Hill presents it, the CCS was the leader in developing the aggressive strategy, my own assessment is that the CCS required a lot of pushing before it was brought up to speed by the Canadian Non Smokers' Rights Movement. However, once having made the commitment, they stuck with it in the most remarkable way, and were successful. As an example of the sort of tactics they used I append some advertisements which were a key element in the final days of the campaign. In it they have personally attacked both the prime minister of Canada and one of his closest friends and advisers (Richard Neville) who had been hired by the Canadian tobacco industry as a lobbyist. The implication of this advertisement was that if the government did nothing about tobacco, that this would be because of the close relationship (by implication a corrupt one)

between the industry's lobbyist and the prime minister. This is pretty strong stuff but was obviously crucial at that key point in the campaign.

Comparisons between the Australian story and the Canadian one are extremely interesting as we used a similar type of political analysis and certainly had a clearcut strategy to apply the blowtorch of publicity to the feet of both the Australian government and the opposition. Also attached as an appendix is a short summary of the timing of the Australian campaign, largely organised from the Anti-Cancer Council of Victoria but working in (albeit relatively loosely) coalition with the Western Australian branch of the AMA plus the federal president.

I think it unlikely that the American Cancer Society is ready to accept the Australian and Canadian examples as a model for their own strategy. The ACS is inherently extremely conservative and has made little progress towards impairing the credibility of the tobacco industry - a feature of both the Canadian and Australian scenes.

h.g.

Encls: Canadian Political Advts.
Appendix: Summary of the Aust. campaign to ban print advertising of tobacco

SUMMARY OF THE AUSTRALIAN CAMPAIGN TO BAN PRINT ADVERTISING
OF TOBACCO

This campaign had to be directed at Federal Parliament because the power to control print advertising appears to lie in its hands under its "corporations power".

The executive committee has received verbal reports about this and will recall the commencement of the campaign in Victorian Cancer News.

The government and the opposition were clearly unwilling to do anything about print advertising, despite a strong desire to do so within the backbench of both parties and an unquestioned (approximately two-thirds) majority of backbench opinion in favour of such action.

There is little doubt that the tobacco industry has made major contributions to both political parties within the last 6-9 months. This became apparent via a hardening-up of the attitudes and activities of Senator Graeme Richardson within the labor party (the individual through whom tobacco industry interests are generally reflected) and a leading member of the right-wing faction of the New South Wales ALP. In the case of the liberal party it was manifested by a backflip by Senator Richard Alston (Communications spokesman) between an interview I had with him some five months ago and the position adopted by the party two to three months later. In my original interview it was clear he understood that promoting the interests of the tobacco industry was extremely unpopular; was a vote loser; and was against the wishes of the majority of the members of the parliamentary liberal party.

A month or two after that he was defending the party's decision to put the matter into a committee of enquiry, which would flow from the current parliamentary session into next year and presenting a series of arguments lifted straight from the tobacco industry's party line (certainly a set of arguments which he had found unpersuasive a couple of months previously).

The Australian Democrats, after discussions with us, and on the basis that we would be running a strong facilitatory lobby, made a decision that their major initiative for the parliamentary session at the end of 1989 would be a private member's bill to control all forms of tobacco advertising. The primarily meant print advertising but carried, as a sting in its tail, a clause which would have outlawed sporting sponsorship.

As a second string to their bow, sporting sponsorship can (and probably will) be attacked via a proposed amendment to the Broadcasting and Television Act on which we have been working with them and others for some time.

The political position of the democrats is of considerable importance vis a vis the forthcoming federal election. There are nine marginal seats which are expected to decide the next federal election. Four of them are in Victoria. The normal distribution of democrat preferences (which are **not** directed by the party) is 6% Liberal, 12% Labor. Democrat voters' feelings on the tobacco issue is significantly stronger (about 10%) than it is among liberal and labor voters although opinions in favour of tobacco advertising restrictions are in excess of two-thirds among all voters.

A swing of a few per cent in democrat preferences would be quite enough to change the outcome in a number of the marginal electorates which will decide the federal election. This analysis was one which the democrats had not perceived, neither had the government or the liberals.

However, when presented, the analysis was extremely persuasive. It was presented directly to Senator Robert Ray (the ALP numbers man); and also, emphatically, by Senator Peter Baume in the liberal party room. It appears to have been instantly understood and appreciated by the senior echelons of both parties.

What remained to be done was the organisation of publicity so that neither party could hide from the electorate their attitudes to this initiative by the democrats.

Members are probably aware that neither of the major parties normally supports **any** democrat proposals as they are basically antagonist to "splinter" parties.

The issue was due for discussion by federal cabinet on Tuesday December 5. On Monday December 4 we placed the attached advertisement in various newspapers and faxed a copy to each member of parliament. In addition we contacted Michelle Grattan; ABC radio's "PM" and ABC TV's "7.30 Report". On Monday (the day **before** cabinet's decision) all these three press sources started asking questions of cabinet members which made it clear that the issue was not buried and was going to be the object of press publicity. Such publicity occurred on the Tuesday and Wednesday but I feel sure that the questions asked on **Monday** were the crucial intervention. On Tuesday cabinet made the right decision despite a last minute attempt by Senator Richardson to suggest that it was impractical to do such a thing because "sport needed the money". On hearing about this comment on Tuesday morning I sent the December 5 fax to all members of cabinet. This reached all their offices by 11 a.m.

On Tuesday night the government's position was cemented by the appearance, to my total surprise, of the prime minister on the "7.30 Report". I would like to show this interview to the committee.

On Wednesday morning the liberals were still in a state of acute indecision and the senior echelon of the party was still resisting the initiative.

Discussions in the party room were extremely vigorous but it was not until the intervention of Andrew Peacock at 11 o'clock on Thursday that the liberal party finally made up its mind to **support** the position adopted by the government. There is no doubt that they were aware that they would be ridden over by the prime minister mounted on a white charger if they maintained support for the tobacco industry's position, as this would give the government an extremely attractive opportunity to make political capital.

It is of some interest that Senator Robert Ray, who controls the agenda for the upper house debates, refused to schedule the democrats' private members bill until given a clear assurance by the prime minister that, if passed by the senate, he would guarantee that the government would pass it in the lower house. This seems to have been the driving force behind the prime minister's willingness to appear and make the necessary concessions (albeit through gritted teeth) on the "7.30 Report" on Tuesday night.

The rest is now history. The Democrats' private members bill was debated for one hour only and was passed by the senate. It was passed a couple of weeks

later by the house of representatives and will be proclaimed in the first half of 1990.

This private members bill is the thirteenth to pass parliament since federation; the fourth emanating from the upper house to succeed since federation; and the first ever presented by the Australian Democrats.

Cabinet's support for the democrats bill was limited to abolition of advertising in the print media.

The battle over the amendments to the Broadcasting & Television Act is still to come and the outcome is difficult to predict as it depends very much on the timing of the introduction of the B&T Act into parliament and its relationship to the next election.

Attach:

Collection of relevant letters, press clippings and editorials arranged chronologically from back to front. The two most recent **letters** followed the passage of the print bill and referred to the Broadcasting & Television Act. The "modified" press clippings were sent to each parliamentarian to make certain the press views were read by them.

41-879

Sixth National CANCER Communications Conference (Jan/90)

WORKSHOP 21 --SMOKING CONTROL AROUND THE WORLD

- LEGISLATIVE STRATEGIES IN CANADA

- I. Outline of presentation of David Hill, Past National Vice-President and 1986-1989 Chairman of the Public Issues Committee, Canadian Cancer Society. David is currently a senior partner in the Ottawa law firm of Perley-Robertson, Panet, Hill and McDougall.
- 1) Lobbying successes in Canada
- November 17, 1986 - the federal government announces new legislation banning smoking on all domestic and transborder flights of 2 hours or less
 - 1987 - the national health coalition stops the establishment of a national marketing board for tobacco
 - February 11, 1987 - the Canadian Cancer Society convinces the Toronto Star, Canada's largest daily, to no longer accept tobacco ads
 - June 28, 1988 - Tobacco Products Control Act (Bill C-51) is passed by Parliament. The provisions are:
 - phasing out of tobacco advertising
 - magazine and newspapers: Jan. 1, 1989
 - signs/billboards: Jan.1, 1991
 - retail signs: Jan.1, 1993
 - restrictions on brand name tobacco promotions
 - no free distribution of samples
 - no rebates, contests or prizes
 - no use of tobacco brand names on non-tobacco items
 - prominent health warnings
 - on packages
 - on billboards
 - toxic constituent list on packs
 - health information leaflets in packs

- existing legal obligation to fully warn consumers is retained
 - provision to government of data on toxic constituents of tobacco and tobacco smoke, as well as sales, advertising and sponsorship data
 - \$100,000 - \$300,000 fines
- June 28, 1988 Non-smokers' Health Act (Bill C-204) is passed by Parliament. The effect of the Act is a prohibition on smoking on all intercity bus operations in Canada as well as on trains with fewer than three cars. Longer trains will only permit smoking on 1/3 of the seats in 1/3 of the cars on the train. Smoking is also prohibited in federal workplaces (except designated smoking rooms ventilated to the outside). This applies to all federal employees -- including those of some 40 Crown Corporations -- and those who work in national and international rail, road, shipping and air transportation services, pipeline agencies, interprovincial and international communications, broadcasting, banks, grain handling and uranium mining.

The airlines industry put up an eleventh-hour lobby to scuttle plans to make international flights smoke-free. The Cabinet Committee nevertheless sided with the health community and made these flights smoke-free. Enormous pressure was then put on the Government by the airlines industry to reverse this decision. The final decision was that the industry got an extension of the starting date for the smoking ban on international flights until July 1, 1990. The national health coalition will cooperate with the airlines in promoting smoke-free international flights with our sister organizations in other countries if we have assurances that the airlines will not lobby behind our backs for further extensions or a reversal of Government policy.

- April 27, 1989 - The federal government increased tobacco taxes by approximately \$4.00 a carton. Tobacco consumption in Canada fell by approximately 6% in 1989, probably a larger drop than any other industrialized country.

Plans for 1990

- new legislation controlling tobacco sales to minors
 - \$5,000 fines for selling tobacco to minors
 - strict controls on vending machines
- further strengthening of Tobacco Product Control Regulations
 - addiction warning on packs
 - education leaflets inside packs

II. Historical Background

- Failure of the medical model - health organizations in Canada had been dominated by health professionals trained to look at biological causes of illness, rather than social factors. Physicians are not used to taking actions which would normally get people angry at them. Financial resources have been made available to health professionals to do things which do not cause controversy, such as medical research.
- 1985 - The Sleeping Giant awakes
- 1986 - Establishment of the Public Issue Committee with a "fast track" mechanism
- 1986 - CCS hires professional staff

III. 10 minute excerpt from award winning video "Lobbying for Lives: Lessons from the Front"

IV. Elements of the War Room Campaign

- direct lobbying of Members of Parliament
- full page paid advocacy advertisements signed by the Canadian Cancer Society and other groups
- op. ed. page articles written for the media
- legislative submissions
- oral and written presentations before Parliamentary committees

- Cancer Society Ottawa Office (War Room) 3 blocks from Parliament
- public opinion polls
- media interviews and conferences
- Western Canada media tour
- letters and phone calls to MPs
- letters to the editor
- 35,000 black-bordered postcards sent to MPs from Cancer Society volunteers
- at the start of almost every meeting, regardless of the level, the Cancer Society and other organizations, set aside 10 minutes for those present to write a letter to federal politicians.
- when Member of Parliament Ron Stewart, a tobacco wholesaler, spoke against Bill C-51 in the House of Commons, the health lobby put out a circular to 30,000 homes in his electoral district charging him with conflict of interest. The Cancer Society put out a news release saying that Stewart was only its first target. Other MPs opposing the bill would receive similar treatment.
- petitions collected by physicians.
- MPs were blitzed with phone calls when they returned home from Ottawa on holiday breaks.
- a public challenge to the tobacco industry for a televised national debate (it ducked)
- detailed tracking of the position of each MP and Senator on Bills C-51 and C-204

V. Internal battles within the Cancer Society

VI. Fourteen reasons for success on tobacco ad ban

- 1) Scientific evidence supported health position
- 2) Lynn McDonald and Bill C-204 put pressure on C-51
- 3) Minister of Health Jake Epp, our best lobbyist
- 4) The health lobby - united we stood

- 5) Support from all three political parties
- 6) Support in the bureaucracy
- 7) Ministerial staff support
- 8) Newspaper support
- 9) Public support
- 10) Fewer smokers
- 11) No real opposition from civil liberty groups
- 12) Early enough introduction in the Parliamentary session
- 13) Parliamentary Reform and luck
- 14) Mistakes by the tobacco industry

VII. Presentation by Ken Kyle, Director of Public Issues,
Canadian Cancer Society, Ottawa

Ways in which the health lobby could have improved its
campaign

- earlier start
- fewer delays in lobbying after each hurdle
- more health organizations could have been more
meaningfully involved
- advance planning
- support from provincial/territorial ministers of
health
- support from advertisers

VIII. Lessons learned from our lobbying experiences in Ottawa

- 1) Ensure that volunteers in health charities are
completely behind professional staff efforts.
- 2) Ensure that health organizations have some
professional expertise in lobbying.
- 3) Don't be afraid to play "hard ball" -- this will only
bring respect from government.
- 4) Use the media to mobilize public support.
- 5) Be careful in the timing of various components of your
campaign.
- 6) Take advantage of opportunities, such as mistakes by
the tobacco industry.

- 7) Frame the debate in health terms.
- 8) Use international resources.
- 9) Work on the outside (polls, publicity, advocacy and ads in newspapers) and also on the inside (meetings with politicians and their staff, briefs, etc.)
- 10) Enlist politicians as fellow lobbyists.
- 11) Ensure a balance between leading the public and maintaining a broad level of public support.
- 12) Recognize that lobbying decisions will sometimes be at variance with views of some members in some of the organizations in the coalition.
- 13) Within a particular organization there will not be time to develop a broad consensus on some issues. For example, the Board of Directors of a health charity cannot make decisions regarding tactics and timing.
- 14) Coalitions are the key.
 - the workload can be shared
 - politicians can see broad community support
 - prevents sister organizations from inadvertently working against the objective.
 - power and credit for success must be shared.
 - overcome problems of working together.

IX. What needs to happen in other countries to have the same success.

- 1) Senior volunteer support
- 2) Substantial financial and human resources
- 3) Limit the objectives
- 4) Build on success

November 20, 1987

Dear Constituent of Simcoe South:

Re: A Conflict of Interest for Ron Stewart, M.P.

We are writing to you about the position being taken by your Member of Parliament, Ron Stewart, with respect to *Bill C-51, the Tobacco Products Control Act* and *Bill C-204, the Non-Smokers' Health Act*. As officials of Canadian health organizations, we suspect that his efforts, perhaps arising out of a serious conflict of interest, will help to weaken or defeat these bills.

Whether a smoker or non-smoker, every Canadian has an interest in the health of children. And these bills, if anything, are designed to prevent young people from being lured onto the tobacco market. As our campaign theme states, these bills were introduced "to give kids a chance."

Bills C-51 and C-204 are among the most important health bills to ever come before Parliament. They would make tobacco industry products far less attractive for young people who are considering whether or not to begin smoking. Bill C-51 would ban tobacco advertising and promotion, a necessary step recommended by virtually every significant medical body in the world. Bill C-204 would bring tobacco under the *Hazardous Products Act*.

Bills C-51 and C-204 have been endorsed by the Canadian Cancer Society, Canadian Public Health Association, and by the Non-Smokers' Rights Association. In fact, the Canadian Medical Association feels so strongly about the importance of Bill C-51 that it has recommended that its physician members vote against any MP who opposes this legislation.

Because of his tobacco wholesale business, Mr. Stewart is caught in a serious conflict of interest and is actively lobbying behind the scenes to defeat this model legislation. In fact, with Bill C-51, he is undermining the position of his own Cabinet. We hold that Mr. Stewart, as MP, should ensure that the health of young people in his riding takes priority over his tobacco business. We believe that this dictates that Mr. Stewart make a choice between his commitment to represent his constituents competently and his interest in the tobacco industry.

Canada's health organizations think tobacco has several features which qualify tobacco for special treatment or, at the very least, to treatment in law similar to that given to other deadly, addictive products:

- 1 Tobacco is lethal.** At 35,000 deaths annually, tobacco industry products kill more Canadians than those killed annually by all accidents, including alcohol-caused traffic fatalities, fires, murders, suicides, AIDS and illicit drugs, **all combined**.
- 2 Tobacco is addictive,** as addictive for many users as heroin. Addiction, by definition, is the negation of freedom of choice.
- 3 Tobacco is the only legal product which kills when used exactly as intended.** Other products such as alcohol and sugar may be harmful when abused or used in excess. Tobacco is the only legal product which has no safe level of consumption.
- 4 Most of the industry's customers begin using its products as children or young adolescents and most are addicted before they reach the age of responsibility.**

If the tobacco industry is successful in defeating these bills, thousands of preventable deaths may be the ultimate cost. You might wish to ask Mr. Stewart some reasonable questions about his position bearing in mind that there are a number of phoney arguments which the tobacco industry and its friends are using to defeat these bills:

"Tobacco ad bans threaten freedom of choice."

The industry curiously fails to mention that "freedom of choice" ends when a product is addictive and that society does not give "freedom of choice" for critical decisions to children.

"Tobacco is a legal product."

The cigarette manufacturers present society with a non-option. Legislators cannot make illegal a product to which a third of its adult population is addicted. The product may be legal. But it is not ethical to help promote a product which causes so much unnecessary suffering. Tobacco is 'illegal' for children now. Why should the advertisements be legal when the product is illegal for children and when the ads legitimize the illegal product in the eyes of impressionable children?

"These bills amount to censorship and a dangerous precedent."

Bills C-51 and C-204 create no "censorship." The law recognizes well-established differences between the right of free citizens to express themselves and the right of a corporation to advertise what it pleases to whom it pleases. These bills would set no "dangerous precedent." Pharmaceuticals, although legal, may not be advertised to the public. And alcohol, although legal, is the subject of many advertising restrictions. Why should the tobacco industry be protected?

"Tobacco ad bans haven't worked in other countries!"

If tobacco ad bans don't work, why is the tobacco industry spending millions to fight legislation which won't cut the industry's sales?

We need your help:

1. Write your Member of Parliament, Ron Stewart, House of Commons, Ottawa K1A 0A6. You might suggest that he put the health of young Canadians ahead of his personal financial interests. He might wish to inform you that he will cease his pro-industry lobbying and work to support the Government's leadership. Send us copies of the letters and material Mr. Stewart sends to you. We will critique his response by return mail and, later, at election time.
2. Since letters to Mr. Stewart may not be passed on to the government, send copies, or better still, write, to the Rt. Hon. Brian Mulroney. Appeal to him for no more delays in this legislation. **Health organizations estimate that just the 6 month hold-up since these bills were first tabled may ultimately lead to thousands of additional unnecessary deaths.** Write: House of Commons, Ottawa K1A 0A6.
3. We urgently need your donations. The tobacco industry is spending millions to block this legislation. An effective counter campaign costs a lot of money. Send your cheque to the **NATIONAL CAMPAIGN TO PASS BILL C-51**. It will help fund the mailings we plan for other federal ridings. Please help today, before you forget.

Yours sincerely,

David Hill, Q.C., Vice President
CANADIAN CANCER SOCIETY

Victor Lachance, Executive Director
CANADIAN COUNCIL ON
SMOKING AND HEALTH

Garfield Mahood, Executive Director
NON-SMOKERS' RIGHTS ASSOCIATION*

Dr. Andrew Pipe, Chairman
PHYSICIANS FOR A SMOKE-FREE CANADA

* This mailing has been funded by the Non-Smokers' Rights Association as a contribution to the NATIONAL CAMPAIGN TO PASS BILL C-51. The NSRA is a non-profit health advocacy organization with members in every province. The NSRA has been leading the campaign to regulate the tobacco industry.



To the **NATIONAL CAMPAIGN TO PASS BILL C-51**

- Here's my donation of \$_____ to help your "Give Kids a Chance" Campaign.
- Enclosed is \$8.00 for your 38 page brief on Bill C-51 and tobacco industry deception, the same brief sent to Mr. Stewart and other MPs. Send me more information.

Name _____ Address _____

Apt. _____ City _____ Province _____ Postal Code _____

Mail to **NATIONAL CAMPAIGN TO PASS BILL C-51**
Suite 308, 344 Bloor Street West
Toronto, Ontario M5S 1W9



A message to Simcoe South constituents from some of Canada's major health organizations

If the most important health legislation to reach Parliament in years is weakened or fails to pass, it may be due, in large part, to the strenuous opposition of Ron Stewart, Progressive Conservative M.P. for Simcoe South.

NATIONAL
CANCER INSTITUTE
OF CANADA



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DU CANADA

Attachment 15
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- 6 OCT 1989

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CHIEF EXECUTIVE OFFICER
Douglas H. Barr, M.S.W.

EXECUTIVE DIRECTOR
P.G. Scholefield, Ph.D., D.Sc.

27 September 1989

To: Some of our many friends in Australia

Mr. Graeme Brien
Mrs. Sue Byrnes
Dr. Ken Donald
Mr. W.J.B. Earnshaw
Dr. Graham Giles
Dr. Nigel Gray
Mrs. Elaine Henry
Dr. David Hill
Ms. Adrienne Holzer

Mr. D.J. Lambert
Dr. Robin Marks
Dr. J. McCaffrey
Mr. H.E. Peterson
Mrs. Dorothy Reading
Dr. Rob Sanson-Fisher
Mr. K.W. Steel
Mrs. A. Voloschenko
Mr. Laurie Wright

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M. Douglas H. Barr, M. Serv. So.

DIRECTEUR EXECUTIF
P.G. Scholefield, Ph.D., D.Sc.

The purpose of this letter is to thank you, and through you to thank many of your colleagues, for your wonderful hospitality and for so freely sharing your insights and initiatives during our recent visit to Australia. Those who had not previously visited the continent were captivated by "the land of Aus" and quite overwhelmed by the friendliness of its people. All of us learned a great deal in the pursuit of our mission - we are now convinced of the potential benefits to be gained from developing a programme in Behavioural Research, we have three excellent but distinct models to guide us in formulating our own approach, we noted your trend to coordination while maintaining independent programmes and we were impressed with how effectively your pragmatic approach to problem solving gets the critical jobs done.

Since returning, the four of us have prepared a report (Dr. Margolese returned later than the rest of us) and a copy is enclosed for your perusal. If we have misunderstood or misinterpreted any of the information you provided, we would earnestly request you to point out our errors.

We live many miles away from you so our meetings will not be frequent but we look forward to continuing interaction for our mutual benefit. Please visit us whenever you have the opportunity.

Our best regards,

Peter Scholefield
for
Joan Anderson
Jack Laidlaw
Richard Margolese
Sam Smart

PGS:mpp
encl.

Report on A Visit to Australia

During the week beginning Monday 4 September 1989 a group consisting of Mrs. J. Anderson and Ms. S. Smart (Canadian Cancer Society), Dr. R.G. Margolese and Dr. P.G. Scholefield (National Cancer Institute of Canada) and Dr. J.C. Laidlaw (Society and Ontario Cancer Treatment and Research Foundation) visited Australia to learn about programmes concerned with behavioural research as applied to cancer. On Monday and Tuesday 4 and 5 September the group met with representatives of the Anti-Cancer Council of Victoria in Melbourne, on Wednesday and Thursday 6 and 7 September the group met with representatives of the Queensland Cancer Fund in Brisbane, on Friday 8 September the group met with representatives of the New South Wales Cancer Council in Sydney and on Saturday 9 September the group met with representatives of the Australian Cancer Society in Sydney. Throughout these visits the group was received with the utmost friendship and hospitality and wishes to place on record its appreciation for many kindnesses, for much understanding and for rewarding opportunities to share a commitment to a common cause.

There have been intermittent interactions between the Australian Cancer Society, various State Cancer Councils, the National Cancer Institute of Canada and the Canadian Cancer Society through the National Office and some of the Provincial Divisions. Of particular interest in the current context has been the establishment by the Anti-Cancer Council of Victoria of a Centre for Behavioural Research in Cancer under the direction of Dr. David Hill. This interest was increased as a result of meetings at the 14th International Cancer Congress in Budapest, by the visit of Dr. Scholefield to the Centre in Melbourne in September 1988 and by the visit of Dr. David Hill and Dr. Nigel Gray (Director of the Anti-Cancer Council of Victoria) to Toronto on UICC business in February 1989.

These continuing interactions have occurred at a time when the Society and the Institute have been examining the nature of their relationship during the course of their separate strategic planning activities. Their deliberations have emphasized the need for even greater collaboration between the Society and the Institute, they have led the Society to identify a need for help from the Institute in the derivation of new information on which to base programme activities and they have seen the Institute introduce new policies which would permit it to become more pro-active in determining the nature of research it supports so that the needs of the Canadian Cancer Society can be met. Finally, it should be pointed out that the Ontario Cancer Treatment and Research Foundation has been developing a similar interest in preventive oncology and the potential role of the Provincial Cancer Control Agencies was recognized through the participation of Dr. Laidlaw.

The classical concept of cancer control is a broad one which covers prevention, detection, treatment, rehabilitation and palliative care. More recently it has been recognized that

cancer control should also include the evaluation of factors which influence the incidence, prevalence and mortality from cancer. It is clear, therefore, that many organizations have a role to play in what has been described as "the drama of cancer". The Canadian Cancer Society, with the assistance of Health and Welfare Canada, called together representatives of many of these agencies in October 1988 to discuss the coordination of cancer control. A consensus was reached that there is a need to improve the coordination of activities in cancer control and the Canadian Cancer Society, together with Health and Welfare Canada, has subsequently undertaken to provide joint sponsorship of a Task Force on the Coordination of Cancer Control in Canada. It was expected that the visit to Australia would contribute valuable information for use by this Task Force since cancer control in Australia involves a Federal presence, extensive responsibilities vested in every State and active participation by the voluntary sector.

The stated purposes of the visit were therefore as follows:

- (i) to enable all members of the visiting team to learn about the various programmes in cancer control being conducted in New South Wales, Queensland and Victoria, particularly the initiatives in fields related to behaviour and the psychosocial sciences
- (ii) to discuss with our Australian colleagues how best to take advantage of their experience with differing approaches to cancer control in order to improve our own cancer control programmes
- (iii) to enable Dr. R.G. Margoless, who has agreed to become Chairman of a National Task Force on Coordination of Cancer Control, to learn first hand about the operation and degree of integration of some of the cancer control programmes in Australia.
- (iv) to discuss the development of approaches to coordination of cancer control in an environment where the political and territorial factors are as significant as they are in Canada

Meeting with Anti-Cancer Council of Victoria

This Council serves the State of Victoria which has a population of 4 million inhabitants, of whom more than 75% are located in the city of Melbourne. The Council is a State organization and is now 50 years old. There are 20 members of the Council which meets once a year and there is an Executive Committee of 14 members which meets on a regular basis. The Medical and Scientific Committee has 20 members, most of whom are

representative members and there are a number of sub-committees. In addition, the Anti-Cancer Council of Victoria hosts the Victoria Cooperative Oncology Group, a group of prominent clinical oncologists who are involved in studies of the effectiveness of measures for the treatment of patients with cancer. The general philosophy expressed by the Director, Dr. Nigel Gray, is that if you wish to influence people you must have data i.e. most of the programmes of the Anti-Cancer Council of Victoria are data driven. The senior staff consists of the Director, Dr. Nigel Gray; the Associate Director, Dr. David Hill, who is also Director of the Centre for Behavioural Research in Cancer; Dr. Robin Marks, Director of Programmes; Dr. Graham Giles who is Director of the Epidemiology Unit and the Cancer Registry; Ms. Adrienne Holtzer who is Secretary to the Council. These staff members have accepted major responsibility for the development and implementation of the policies and programmes of the Anti-Cancer Council of Victoria.

The stated aim of the Centre for Behavioural Research on Cancer is "to provide a behavioural science program to advance cancer prevention, detection, treatment and rehabilitation in Victoria by

- (a) conducting applied research to underpin preventive and educational interventions
- (b) collaborating in epidemiological studies
- (c) developing interest, expertise and research activity in academic institutions"

The Centre has a senior staff of two in addition to Dr. David Hill. Its budget was stated to be \$450,000 per annum from the Anti-Cancer Council of Victoria plus a further \$150,000 per annum from the Health Promotion Foundation but it was apparent that several of the activities in which Dr. Hill and his staff are engaged are funded on a project basis through the budgets of other programme areas e.g. the Public Education programme. Contracts are only accepted by the Centre if they are consistent with its policy and it was specifically stated that such contracts are not allowed to direct the research programme of the Centre. This should not be interpreted as meaning that the Centre operates in isolation since there is extensive two way interaction between the Centre and the programmes in Public Education, Patient Services and Fund Raising. In fact, it was stated that the Public Education programmes represent a rich resource for the Centre for Behavioural Research in Cancer. Dr. Hill meets every Monday morning with Dr. Nigel Gray and every Tuesday afternoon there is a meeting of Dr. Gray, Dr. Marks, Dr. Giles and Dr. Hill. Examples of projects undertaken by the Unit include (i) monitoring of smoking prevalence trends in children and adults (ii) evaluation of the effectiveness of the Quit Smoking Campaign (iii) determination of the obstacles to screening in

women who have never had a PAP smear and the design of an educational intervention (iv) evaluation of an educational package to help patients and their families cope with cancer, and (v) a study which indicated that solicitations sent with a postage prepaid envelope resulted in a 56% response rate while solicitations sent with a stamped envelope resulted in a 73% response rate. Dr. Gray and Dr. Hill feel that it is important to ascertain "whether what we think is going on is what is really going on".

The Anti-Cancer Council of Victoria owns the premises in which it is located and these premises house the Centre, the Cancer Registry for the State of Victoria, the Epidemiology Unit and all of the programmes and administrative services of the Council. This makes it possible for extensive interactions to occur on a daily basis and is certainly one of the strengths of the organization. A good example is the interaction of Dr. Hill with Ms. Dorothy Reading, Director of the Public Education Department. Information presented by Ms. Dorothy Reading confirmed a very active Public Education programme, particularly addressing cancer of the breast, cervix, skin and lung. The Centre sees the Public Education programme as a resource and the results of the scientific studies significantly influence the design, implementation and evaluation of Public Education programmes. However, the point was made that some Public Education programmes need to be initiated before all data are available.

The following points also emerged about the Centre for Behavioural Research in Cancer:

- (i) it has a role in the programmes of Patient Services, Fund Raising and Advocacy
- (ii) it has access to a three member Advisory Committee, one of whom is the Chairman of the Department of Psychology at Melbourne University
- (iii) Dr. Hill felt that another staff member at the Ph.D. level would be useful
- (iv) the Centre is currently training two Ph.D. students and there are several other students studying for M.Sc. and other degrees
- (v) the Centre is obviously well aware of all other programmes being undertaken by the Anti-Cancer Council of Victoria, it is highly respected and consulted within Australia and Dr. Hill is a frequent participant in international programmes
- (vi) the operation of the Centre is to be subject to review every five years

- (vii) some of the projects of the Centre are supported by grants from the Health Promotion Foundation of the State of Victoria. This fund receives support from a special tax on tobacco, some of which is to be used to support sports activities and some of which is available to support research into health promotion

Meeting with Queensland Cancer Fund

The governing body of the Queensland Cancer Fund is its Council, an organization which has 20 members and meets once a month. Four committees report to the Council (Management and Finance, Medical and Scientific, Education, and Support Service). The Executive Director, Mr. Graeme Brien, is a full voting member of the Council and the four committees. In addition there are several sub-committees plus Research Grant Assessment Panels etc. A major re-organization took place at the time of the appointment of Mr. Brien some three years ago and this has led to an increase in income from \$2.4 million in 1984 to \$6.55 million in 1989. A characteristic feature perceived by the visitors was the extensive nature of the interaction of the Queensland Cancer Fund with the Queensland Department of Health, an activity which has been greatly facilitated through the involvement of Dr. K.J. Donald, Deputy Director General of Health and Medical Services, who is also the current President of the Australian Cancer Society and Chairman of the Education Committee of the Queensland Cancer Fund. The nature of this interaction is well illustrated by the fact that the first formal meeting with the visitors was attended by Mr. H.E. (Tony) Peterson (Chairman of the Anti-Cancer Council), Mr. Graeme Brien (Executive Director), Mrs. Anna Voloschenko (Director of Education) and three representatives of the Queensland Department of Health (Dr. Ken Donald, Dr. Ian Ring and Dr. Ray Swannell).

The Fund occupies a spacious building which it owns (no mortgage) and the stated objective in designing the building was to erect a cancer centre rather than a block of offices. It includes a spacious assembly room which can be divided and which is used for educational purposes, a boardroom, an extensive underground parking garage and well designed offices etc. for the staff. There is also space for patient welfare activities, including private counselling areas and a wig room. The facility is used by a number of professional and private groups for their meetings which encourages interaction between the Fund and other organizations engaged in cancer control.

It is of interest to note that among the staff is one individual responsible for the recruitment and training of volunteers. All training programmes include a course in public speaking and not all volunteers "pass" the training programmes for which they have volunteered. In the Professional Education field support is provided for nurses organizations and there is opportunity for input into the curricula of both nurses and doctors.

Dr. Ken Donald provided interesting information on the development of a National Cancer Control Policy for Australia. From 1988 onwards, all Health Departments, the National Health and Medical Research Council, the Australian Institute of Health and the Consumers Health Forum will contribute standing members to a National Health For All Committee which will report to the Australian Health Ministers Advisory Council. As part of the deliberations of the Better Health Commission, the Commonwealth Government invited the Australian Cancer Society to prepare a National Cancer Control Policy and provided a grant to cover the expenses involved. It is expected that this plan will be revised every two years, that it will focus on primary and secondary prevention and that it will be used as a baseline by all States in Australia. Although a number of sub-committees have been active in preparing material for this plan, it was eventually written by a single individual. The Government has now set up programme planning teams and has once again delegated responsibility to the Australian Cancer Society which has constituted four Site Committees (Skin, Breast, Cervix and Lung). It should be noted that skin cancer is an important problem throughout Australia and public education programmes about skin cancer receive very high priority.

The plan for the establishment of a Behavioural Science Unit in Queensland envisages cooperation between the Queensland Cancer Fund, the Queensland Department of Health and the University. The Unit will be located within the University, the Department of Health will provide the University with \$200,000 per annum to hire four individuals and it will also provide \$300,000 per annum to support commissioned research. These latter funds will not be specifically directed to the Centre but will be available for open competition. The Queensland Cancer Fund will provide \$50,000 per annum to support one investigator in the Unit and will also support another individual on an intramural basis. In addition, the Fund will provide monies for commissioned research activities. The Unit will be housed within the Department of Preventive Medicine and the University will select the Director but the Queensland Cancer Fund will have to right to veto the choice. Activities will have to be acceptable to the Queensland Cancer Fund and there will be a five year review. It is also clear that the Queensland Department of Health will monitor the activities of the Unit.

Meeting with the New South Wales Cancer Council

New South Wales has a population of approximately 6 million and a little over one half of that population resides in the Sydney area. The New South Wales Cancer Council was set up in 1955 by the State of New South Wales and for many years was responsible for an Education programme, the operation of two research laboratories and the supervision of treatment facilities. Since 1986 the two research laboratories and the treatment facilities have been administered by Universities. Fund raising activities

increased following the appointment of Mrs. Elaine Henry as Executive Director in 1986 and in the most recent fiscal year income had increased to \$6 million. The New South Wales Cancer Council is administered by a Board of nine members most of whom are representative members and Mrs. Elaine Henry reports directly to the Board of Directors.

The Education programme covers all ages and special programmes have been developed for prevention of cervical and skin cancer as well as programmes in both primary and secondary schools. The Council has sponsored a research unit to work in conjunction with the Education programme and a notable success was the establishment of the Council's Cancer Education Research Project within the discipline of Behavioural Science in Relation to Medicine at the University of Newcastle under the direction of Dr. Rob Sanson-Fisher. When Dr. Sanson-Fisher returned to Australia from posts in the United Kingdom and the United States in 1981 he undertook a survey of the distribution of research funds and quickly discovered that very little investment was being made in behavioural research. This led him to become involved in the activities of the New South Wales Cancer Council and later to direct some of the operations of the Behavioural Science programme to cancer related issues. He has specialized in the study of behavioural change as a component of health maintenance and in ways to improve the quality of care medical practitioners are able to provide. The Behavioural Science programme is based on a multi-disciplinary approach and involves a Health Economist, an Epidemiologist, a Statistician, an Oncologist and a representative of Family Medicine in addition to Dr. Sanson-Fisher who is an Experimental Psychologist. The objectives have been to establish a centre of excellence, to carry out research in the field of behavioural science and to train individuals who will help to set new and higher standards. Undergraduate students in psychology are recruited for part-time work and it is expected that a number of these students will proceed to graduate work in the field of cancer control. The local community is the main location for the studies of Dr. Sanson-Fisher and his colleagues and community programmes are often developed in local small towns through the involvement of one local doctor and one school. Support of the Unit by the New South Wales Cancer Council amounts to approximately \$250,000 per annum and the total budget is raised to approximately \$1 million per annum as a result of awards from national and other granting agencies. The successful initiation of these activities has led to increasing interest in the activities of the Unit by other members of the Faculty.

Dr. Sanson-Fisher suggested that Behavioural Research is involved in Cancer Control at five levels:

- (i) development of appropriate methodology
- (ii) definition of the extent of the problem

- (iii) identification of individual and social factors leading to maintenance of health risk behaviours
- (iv) development and evaluation of cost efficient and acceptable interventions
- (v) development and evaluation of dissemination strategies

The Unit has already undertaken some interesting studies on attitudes vs. behaviour. For example, videotapes have been made of visits of patients to their doctors. In these cases the doctors have believed quite strongly that they were giving adequate counsel to their patients on prevention but the videotapes suggested that, in practice, preventive measures were not stressed.

Dr. Sanson-Fisher referred to parallel studies being carried out in New South Wales, Victoria and Queensland, and indicated that there was every expectation of continuing and increased interaction between the behavioural research programmes being set up in these three States.

The core staff of the Unit consists of Dr. Sanson-Fisher and other principal investigators, two Behavioural Scientists, one Statistician, four Data Managers and a part-time secretary. (Information was not obtained on which of these individuals is supported by the funds made available through the New South Wales Cancer Council).

Meeting with the Australian Cancer Society

This meeting was a less formal meeting and occurred during a luncheon cruise of Sydney Harbour. It was organized by Mr. Laurie Wright, the Executive Director of the Australian Cancer Society, and was attended by Dr. Ken Donald in his capacity as President of ACS, representatives of the New South Wales Cancer Council and several representatives of the local cancer treatment and research community. It provided an excellent opportunity for continuing dialogue and enabled the visitors to obtain detailed information on specific activities in their own areas of interest.

conclusions

1. The two Behavioural Science Units which operate in Melbourne and Newcastle are making significant contributions to the programmes of the Anti-Cancer Council of Victoria and the New South Wales Cancer Council, particularly the education programmes. Scientific studies provide the data used to conceive, design, implement, evaluate and revise programmes aimed at cancer control. In Melbourne, patient and family support programmes are studied for effectiveness and efficiency. The Behavioural Science Unit being established in Brisbane has the potential to make a similar contribution in the State of Queensland.
2. In all three States the organization of the Behavioural Research programme has been designed to take advantage of the local environment e.g. the research training of the intramural staff in Melbourne, the extensive interactions with the Department of Health and the Medical School in Brisbane, and the interest of an experienced investigator at the University of Newcastle for the programme in Sydney.
3. The initiation, acceptance and integration of a similar type of Behavioural Research programme would greatly strengthen the cancer control activities of the Canadian Cancer Society through development of the behavioural basis for interventions in such areas as prevention, early detection, patient services and fund raising. Such a programme could also provide evaluation of the effectiveness of such interventions.
4. A Canadian programme should be designed:
 - (i) to meet the needs of the Canadian Cancer Society
 - (ii) to meet and maintain the highest academic standards
 - (iii) to provide for extensive and effective two way interaction between such a programme and the projects undertaken within the programme areas of the Canadian Cancer Society
5. In order for benefit to be derived from the development of such a programme, a mechanism should be devised to promote a network of influence and interaction throughout Canada.

6. There is a growing tendency for State agencies in Australia to coordinate their activities for the common good. A case in point is the need to avoid the confusion resulting from the adoption of different policies on the recommended frequency of the PAP test.

RESEARCH NEWS . . .

Work on behaviour brings Canada to our door

BEHAVIOURAL research in Australia has generated such an impressive international reputation that researchers from the Canadian Cancer Council prefer to consult Australians on the matter rather than their neighbours in the United States.

The council is planning to set up its own behavioural research groups, and last week met the cancer councils in NSW, Victoria and Queensland to discuss the different methods by which research centres operate.

Dr Peter Scholefield, of the Canadian Cancer Council, said the programs developed in Australia in the area of behavioural research were very exciting, and much closer to Canadian aims than those in the US.

Research into behaviour looks at such factors as why people still smoke, why women do not have pap smears and why people do not stay out of the sun, despite the effects of such actions being widely known.

The research aims to develop strategies that can be implemented to change behaviour and so prevent cancer.

In NSW, behavioural research is carried out by the medical school at the University of Newcastle under Professor Robert Sanson-Fisher, with a grant from the NSW Cancer Council. In Victoria, the research group, headed by Dr David Hill, is a section of the Anti-Cancer Council. Queensland is expected to set up a similar system to that in NSW.



25 JUL 1989

12 July 1989

TO: DR. G. BALLANTYNE, President, Canadian Cancer Society
MR. D.H. BARR, Chief Executive Officer CCS/NCIC
MR. GRAEME BRIEN, Executive Director, Queensland Cancer Fund
DR. NIGEL GRAY, Director, Anti-Cancer Council of Victoria
MRS. ELAINE HENRY, Executive Director, NSW Cancer Council
DR. DAVID HILL, Director, ACCV Centre for Behavioural Research
in Cancer
DR. J.C. LAIDLAW, Executive Director, Medical Affairs, CCS
DR. R.G. MARGOLESE, President, National Cancer Institute of
Canada
MR. LAURIE WRIGHT, Executive Director, Australian Cancer
Society

In recent weeks the Boards of Directors of the Canadian Cancer Society (CCS) and the National Cancer Institute of Canada (NCIC) have been informed about the proposed visit of representatives of CCS/NCIC to Melbourne, Brisbane and then Sydney. The time has therefore come to finalize the arrangements and I would like to summarize what is proposed as follows:

Background

The Society and the Institute have a mutual interest in their joint efforts to decrease the incidence, morbidity and mortality from cancer. They have each contributed to this goal by the exercise of their own unique talents - the Society by its fund raising activities and the ability of its volunteers and staff to mount programmes throughout the country (such as in Public Education and Patient Services), the Institute by its ability to support cancer research activities and through the network of medical and scientific advisors available to its volunteers and staff. During the last five years opportunities have been developing for the two agencies to discuss issues of direct common interest and these issues are increasingly demanding the contributions of all available expertise. This tendency has been recognized in the strategic planning activities of the Society and the Institute and the realm of maximum mutual interest has been identified as the area known as "Cancer Control".

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FACE

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DIRECTEUR GENERAL
M. Douglas H. Barr, M. Serv. Soc.

DIRECTEUR EXECUTIF
P.G. Scholefield, Ph.D., D.Sc.

The primary need of the Society is to be provided with supplementary advice on Behavioural Analysis, Health Promotion and Programme Evaluation. The word "supplementary" is used advisedly since the Society continues to conduct highly sophisticated and effective programmes in the area of cancer control but it lacks an in depth background in the research expertise on which it would like to base its future activities. The Australian experience, particularly the recent creation of the Anti-Cancer Council of Victoria Centre for Behavioural Research on Cancer directed by Dr. David Hill, has emerged as a focal point in discussions of how the Society/Institute should interact in improving the Canadian programme in cancer control.

The advice of Dr. Gray and Dr. Hill was sought during their visit to Toronto in February 1989 and out of that visit has begun to emerge a vision of a new approach to cancer control by the Society/Institute. This vision must now be translated into reality and the proposed visit is expected to constitute a major step forward in that process.

Purpose of Visit

The purposes identified to date include the following:

- (i) to enable all members of the visiting team to learn about the various programmes in cancer control being conducted in New South Wales, Queensland and Victoria, particularly the initiatives in fields related to behaviour and the psychosocial sciences
- (ii) to discuss with our Australian colleagues how best to take advantage of their experience with differing approaches to cancer control in order to improve our own cancer control programmes
- (iii) to enable Dr. R.G. Margoese, who has agreed to become Chairman of a National Task Force on Coordination of Cancer Control, to learn first hand about the operation and degree of integration of some of the cancer control programmes in Australia
- (iv) to discuss the development of approaches to coordination of cancer control in an environment where the political and territorial factors are as significant as they are in Canada

The Visitors

The need for Dr. Margoese to learn first hand about the Australian programmes demanded his participation and it was felt that it would also be important for the President of the sister organization to be involved. It seems likely that Dr. Margoese will be accompanied by his wife and that Dr. Ballantyne will be accompanied by her husband (Dr. Trevor Sandy who, like Dr. Margoese, is a surgeon). Mr. Barr and I have been responsible for most of the planning

activities directed to the interactions between the Society and the Institute and we will accompany our Presidents. The final member of the team will be Dr. J.C. Laidlaw who is the Executive Director, Medical Affairs of the Society and is the Director of Research and Education for the Ontario Cancer Treatment and Research Foundation.

I would ask that (i) the current reservations be modified to include Dr. Ballantyne and her husband and (ii) Dr. Hill confirm whether or not he is able to share his expertise by accompanying the Canadian contingent to Brisbane and Sydney.

Timetable

The only fixed period is between the evening of Sunday 3 September and late afternoon on Saturday 9 September. The itinerary for this period is as follows:

Sunday 3 September

Register at: Rathdowne International Motel
49 Rathdowne Street
Carlton (Melbourne)
Victoria AUSTRALIA 3053
Tel: 3-662-3300
FAX: 3-663-3412

For international dialing from Canada, prefix 011-61-

Monday 4 September

Day to be spent with Dr. Gray and Dr. Hill at the Anti-Cancer Council of Victoria which is just a few doors away from the Motel.

Tuesday 5 September

Most of the day to be spent in continuation of the discussions with Dr. Gray and Dr. Hill.

Catch Ansett Air Flight 56 which leaves Melbourne at 6:40 p.m. and arrives Brisbane at 8:30 p.m.

Register at: Gregory Terrace Motor Inn
397 Gregory Terrace
Spring Hill, Brisbane
Queensland, AUSTRALIA 4000
Tel: 7-832-1769

Wednesday 6 September

Day to be spent with Mr. Graeme Brien and colleagues of the Queensland Cancer Fund.

Thursday 7 September

Most of the day spent in continuation of the discussions with representatives of the Queensland Cancer Fund.

Catch Ansett Air Flight 137 which leaves Brisbane at 6:15 p.m. and arrives Sydney at 7:35 p.m.

Register at: Old Sydney Park Royal
[no further information available]

Friday 8 September

Day to be spent with Mrs. Elaine Henry and other representatives of the New South Wales State Cancer Council. I am also hoping that we will be able to meet Dr. Rob Sanson Fisher who is Director of the Council's Cancer Education Research Project within the Discipline of Behavioural Science in Relation to Medicine at the University of Newcastle.

Saturday 9 September

Mr. Laurie Wright is making arrangements for the visitors to meet with representatives of the Australian Cancer Society during the morning. This is to be followed by an informal lunch and the fixed part of our visit to Australia should finish in the early afternoon.

Travel Plans

All of the visitors are to make their own travel arrangements but they are requested to ensure bookings on the Ansett flights from Melbourne to Brisbane and Brisbane to Sydney so the party can travel together. It is my understanding that overseas visitors to Australia are eligible to receive discounts on Ansett flights within Australia.

Dr. Gray has suggested that the visitors consider the possibility of arriving in Australia in time for their biological clocks to reset themselves before we begin this week of sustained activity. I plan to arrive in Sydney on Friday to spend time with my son and his wife. Mr. Barr and Dr. Laidlaw plan on arriving early on the Sunday morning and hope to catch up on sufficient sleep before Monday morning. I know that Dr. Ballantyne and Dr. Margolese are planning on extending their visit to include holidays so it would be possible for them to take the advice of Dr. Gray into account.

Travel to Australia requires a visa and the application takes time to process so I suggest the visitors make a start as soon as possible. It is not possible to enter Australia without a visa.

Local Arrangements

Hotel reservations have kindly been made by Dr. David Hill (Melbourne), Mr. Graeme Brien (Brisbane) and Mrs. Elaine Henry (Sydney). I would ask them to please make the modifications referred to above.

Outcome

The outcome will be a report and the recipient(s) will depend on the recommendations. However if the eventual action is to be an intramural programme with the "core" costs provided by the Institute and the "project" costs provided by the Society, I would see the report going first to the Planning Committees of the two organizations and being considered by the Joint Liaison Committee before being submitted to the two Boards of Directors. Budgetary considerations would then become a major factor in determining how soon the plan could be implemented.

_____o_____

I hope I have covered the main issues in this memorandum. However, if I have omitted anything or if any aspect is unclear, please let me know.

Let's all look forward to a productive dialogue that will also be an outstanding experience.

My best regards.

Yours sincerely,



P.G. Scholefield, Ph.D.
Executive Director

Norman J. Basse

Bequest File

CLARK, DRUMMIE & COMPANY
BARRISTERS AND SOLICITORS
40 WELLINGTON ROW
P.O. BOX 6950 STATION "A"
SAINT JOHN, N.B.
E2L 4S3

PHONES:
OFFICE (508) 639-3800
RES. (508) 672-2723

June 21, 1993

Adrienne Joy Holzer
Secretary to the Council
Anti-Cancer Council of Victoria Carlton South
1 Rathdowne Street
Carlton South, Australia 3053

Dear Adrienne:

I'm very happy to provide you with samples of the bequests and deferred gifts materials of the Canadian Cancer Society.

The materials are designed for four main target groups:

- 1) Financial professionals
 - * Fact File Folder
 - * "Advantages of Charitable Giving"
- 2) General Public
 - * Public Service Announcements (in production)
- 3) Prospective Donors
 - * initial - receipt stuffers (2)
 - * interested - "Thinking of the Canadian Cancer Society in your Will" and charitable gifts of life insurance brochure (in production)
 - * committed - "Portfolio of Planned Giving Programs"
- 4) Cancer Society Volunteers
 - * volunteer recruitment video (seen at International Forum on Fund-Raising)
 - * Program Manual

At this point, we have not begun implementation of a marketing strategy for In Memoriam Gifts.

NATIONAL OFFICE

AFFILIATED WITH
THE NATIONAL CANCER
INSTITUTE OF CANADA
Suite 1702,
77 Bloor Street West,
Toronto, Ontario M5S 3A1
Telephone: (416) 961-7223
Fax: (416) 961-4189

PRESIDENT
Gwyneth J. Ballantyne, M.D.
CHIEF EXECUTIVE OFFICER
Douglas H. Barr, M.S.W.

BUREAU NATIONAL

AFFILIÉE
À L'INSTITUT NATIONAL
DU CANCER DU CANADA
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77 rue Bloor ouest,
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Télécopieur: (416) 961-4189

PRÉSIDENT
Gwyneth J. Ballantyne, M.D.
DIRECTEUR GÉNÉRAL
M. Douglas H. Barr, M. Serv. Soc.

The Society's bequests and deferred gifts program is the responsibility of the National Committee, which designed a marketing plan eighteen months ago and produced the marketing materials. Implementation of the program is the responsibility of the Society's ten provincial Divisions. Each Division is at a different stage of implementation, so the program is not yet fully functional across the country. We anticipate that we will not realize the full impact of our program for another three to five years. Evaluation is an ongoing process, but the statistical data we have collected so far is enclosed for your consideration.

It was a true pleasure for me to meet you and our other colleagues from around the world in Atlanta. During our five days together, I learned a great deal about fund-raising techniques and strategies to fight cancer that I know will be of great assistance to the volunteers of the Canadian Cancer Society. Thank you for sharing your experiences with us, and I hope we will have an opportunity to participate again in a similar conference.

Best personal regards,

Yours sincerely,

Alison Davis

Norman J. Bossé
Chairman, National
Bequests and Deferred Gifts
Committee

cc. Tom Rennie
Alison Davis

Enc.

NJB/mm

Addrienne -

There also enclosed are the materials you requested of Sam Smith Smart.

Best wishes,
AD.



BRITISH COLUMBIA
AND YUKON DIVISION

565 West 10th Avenue
Vancouver, B.C. V5Z 4J4
Telephone: (604) 872-4400

PRESIDENT
Elizabeth A. Pattie

EXECUTIVE DIRECTOR
Phyllis H. Hood

Ally Hall
Shelocks

15 MAR 1989

February 27, 1989

Miss Adrienne J. Holzer
Secretary to the Council
Anti-Cancer Council of Victoria
1 Rathdowne Street
Carlton South, Australia 3053

Dear Miss Holzer:

Further to your letter of February 13th, it would be our pleasure to have you visit our organization. The afternoon of Tuesday, May 30th would be the most convenient for us to meet to share with you the experiences of our Division. Our fund raising and management staff will be more than pleased to meet with you.

We look forward to your visit.

Yours very truly,

Phyllis Hood

Phyllis H. Hood (Mrs.)
Executive Director

/evw

FAX 604 879 4533

10-10-45 Admin *(Admin)*

11-12 - " F/R.

lunch

Phyllis Hood

MESSAGE CONFIRMATION REPORT

13/04/89 10:02
ID: 61#3#6633412

| SESS. | MODE | DATE TIME | TIME | DISTANT STATION ID | PAGES | DIAL | RESULT | |
|-------|------|-------------|--------|--------------------|---------|------|--------|------|
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CANADA

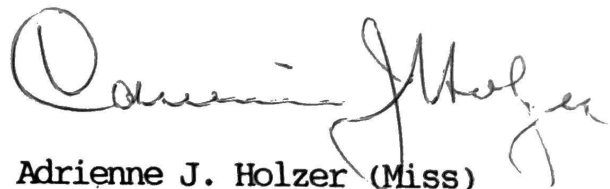
Dear Mrs. Hood,

Thank you for your letter of February 27th advising that the afternoon of Tuesday, May 30th would be the most convenient day for your fundraising and management staff to meet with me.

I am now finalising my arrangements and find that Thursday, 1st June would be more suitable for me. If it is possible to alter the arrangements to this date I would prefer it, but will try to fit in with 30th May if that is the only time available.

I look forward to hearing from you.

Yours sincerely,



Adrienne J. Holzer (Miss)
Secretary to the Council

13th February, 1989

lr-a-m

Ms. P.H. Hood,
Executive Director,
British Columbia & Yukon Division
Canadian Cancer Society
565 West 10th Avenue,
VANCOUVER, BC V524J4
CANADA

Dear Ms. Hood,

I am writing to enquire whether it would be possible for me to visit your organisation and meet with relevant members of your staff in May this year.

I have been Secretary to the Anti-Cancer Council of Victoria, Australia, for the past thirteen years. My responsibilities lie in the management of the Council's committees and general administration of the organisation, including an "overseeing role" of our major income producing programs.

Our two organisations have many similarities - we have both recently celebrated 50 years of cancer control and service, our population figures are similar, as is our income and expenditure, although our program emphasis differs slightly.

I am attending the First International Forum on Fundraising to be held in Atlanta on May 14-19. I will then be visiting Toronto, Banff (holiday) before arriving in Vancouver around Monday 29th or Tuesday 30th May.

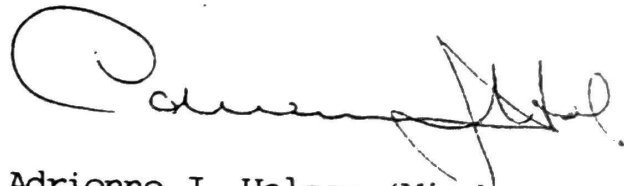
I know how busy you must all be, but I would appreciate a little time (a morning or afternoon) with both your fundraising and management staff.

Would you please let me know if this is convenient so that I can finalise my arrangements.

I have enclosed a copy of our last Annual Report which you may find of interest.

I look forward to hearing from you.

Yours sincerely,



Adrienne J. Holzer (Miss)
Secretary to the Council

Thursday 1st June
Friday 2nd June
Saturday 3rd June
Sunday 4th June
Monday 5th June
Tuesday 6th June
Wednesday 7th June
Thursday 8th June
Friday 9th June
Saturday 10th June
Sunday 11th June
Monday 12th June
Tuesday 13th June
Wednesday 14th June
Thursday 15th June
Friday 16th June
Saturday 17th June
Sunday 18th June
Monday 19th June
Tuesday 20th June
Wednesday 21st June
Thursday 22nd June
Friday 23rd June
Saturday 24th June
Sunday 25th June
Monday 26th June
Tuesday 27th June
Wednesday 28th June
Thursday 29th June
Friday 30th June

CANCER SOCIETY



DIVISION DE L'ONTARIO

1938-1988

1630 Yonge Street
Toronto, Ontario
M4T 2W6
Telephone: (416) 488-5100

DIVISION DE L'ONTARIO

1639, rue Yonge
Toronto (Ontario)
M4T 2W6
Téléphone: (416) 488-5100

F A C S I M I L E T R A N S M I T T E D M E S S A G E

TO: Adrienne Holzer - Anti-Cancer Council of Victoria

FROM: Dorothy Lamont - CCS - Ont. Div. Toronto

NUMBER OF PAGES:

DATE:

12-4-89

TIME:

(Including cover)

PLEASE NOTIFY SENDER IF ALL PAGES ARE NOT RECEIVED OR IF THEY ARE UNCLEAR.

Date Required

FOR INFORMATION:

FOR ACTION/
COMMENTS:

FAX (604)-8794533

Phyllis Hood - Vancouver Office

Originating FAX number: (416) 488-2872

04/13/89 416 488 2872 09:22 416 488 2872

CAN. CANCER SOC.

001/001

CANADIAN
CANCER
SOCIETY



SOCIÉTÉ
CANADIENNE
DU CANCER

ONTARIO DIVISION

1639 Yonge Street
Toronto, Ontario
M4W 2W6
Telephone: (416) 924-1234



A N S

FROM: Dorothy Lamont, Executive Director

NUMBER OF PAGES:

PAGES:

(Including cover)

PLEASE PRINT NUMBER OF ALL PAGES AND NUMBER OF PAGES

DATE RECEIVED:

FOR ACTION/
COMMENTS:

Date Required:

Miss Adrienne J. Roloff

1639 Yonge Street, Toronto, Ontario
number 1. (416) 879-4531.

Dorothy J. Lamont

Originaling File Number: 100-1-100-100-100

From THE BOARD OF DIRECTORS: LINDA M. ALEXANDER, President
President: RONALD J. POTTER

Address: 1639 Yonge Street, Toronto, Ontario M4W 2W6

Telephone: (416) 924-1234

Sample of a focus group
test of an earlier
version of "Thinking
of the CCS in Your
Will"

PRINT EVALUATION RESEARCH

Report: August, 1988

**Prepared for: Canadian Cancer Society
77 Bloor Street West
Suite 1702
Toronto, Ontario
M5S 3A1**

**Prepared by: Gillian Tuffin Research Ltd.
2323 Yonge Street, Suite 807
Toronto, Ontario
M4P 2C9**

GTR #1158

The Canadian Cancer Society is in the process of developing a Requests and Differed Gifts brochure to promote the idea of donating to the Society, through one's Will. The brochure focusses on the fact that the Society can assist the individual to give by

- a) supplying wording for clauses to be used in Will
- b) supply lawyers with further information
- c) spends money wisely

The brochure tested is a 3-panel folder with a return card attached.

The target audience for this brochure is women 40 +, with a 50,000 + income.

METHODOLOGY

This study was conducted by means of personal interviews in Toronto. A total of 15 interviews were completed. Respondents were selected randomly and were qualified on the basis that they fit the target audience as stated by the Canadian Cancer Society.

The brochure appeared to have a positive effect on attitudes toward donating to the Canadian Cancer Society.

The brochure appeared to be well understood as an expression that the Society

- a) needed financial support
- b) is an organization accountable for its funds
- c) is dedicated to finding a cure for cancer
- d) assists people with cancer

It should be noted that many respondents (12 of 15), ^{80%} felt that the brochure was too technical, i.e. 'not enough heart', 'too much legal talk'.

1) Assessment of brochure message interpretation.

Each of the respondents was asked to indicate what they perceived to be the "main message" of the brochure. They were then asked whether the brochure conveyed any other messages.

The single most frequently mentioned message was that of 'contributing to the Cancer Society' (75%). In addition, 25% of those questioned suggested that the main message was to make out your Will and give to the Cancer Society.

2) Total messages

In considering all responses offered, it was found that 95% of those questioned appeared to understand the message conveyed by the brochure, that is, 'think of the Cancer Society when preparing your Will'.

3)

Reaction to the Brochure

Having read the brochure, respondents turned it face down, and were then asked what they learned from it.

The need for financial support through a bequest was mentioned by the majority.

However, within this group the following unsolicited comments were given:

- a) 'too much legal information'
- b) 'how will the Cancer Society use my money'
- c) 'liked the illustration, the thought of helping a young family'
- *d) 'would not use the reply card (72%)'
- e) 'would like to know that my gift will really help'

* It would seem that this target audience (women 40+, income 50,000+), would not solicit information by use of a reply card. Many respondents suggested that if they wanted information they would use the telephone or write a formal letter. However most stated that having an address list was very helpful.

HAND RESPONDENT STATEMENT

Please read this brochure and turn it over when you have finished.

What did you learn from contents?

PROBE: What other things did you learn? _____

Still thinking about the brochure you just read, I would like you to tell me how clear or confusing you thought it was. To do this, use a scale from "1" to "10", where "1" means very confusing, and "10" means very clear.

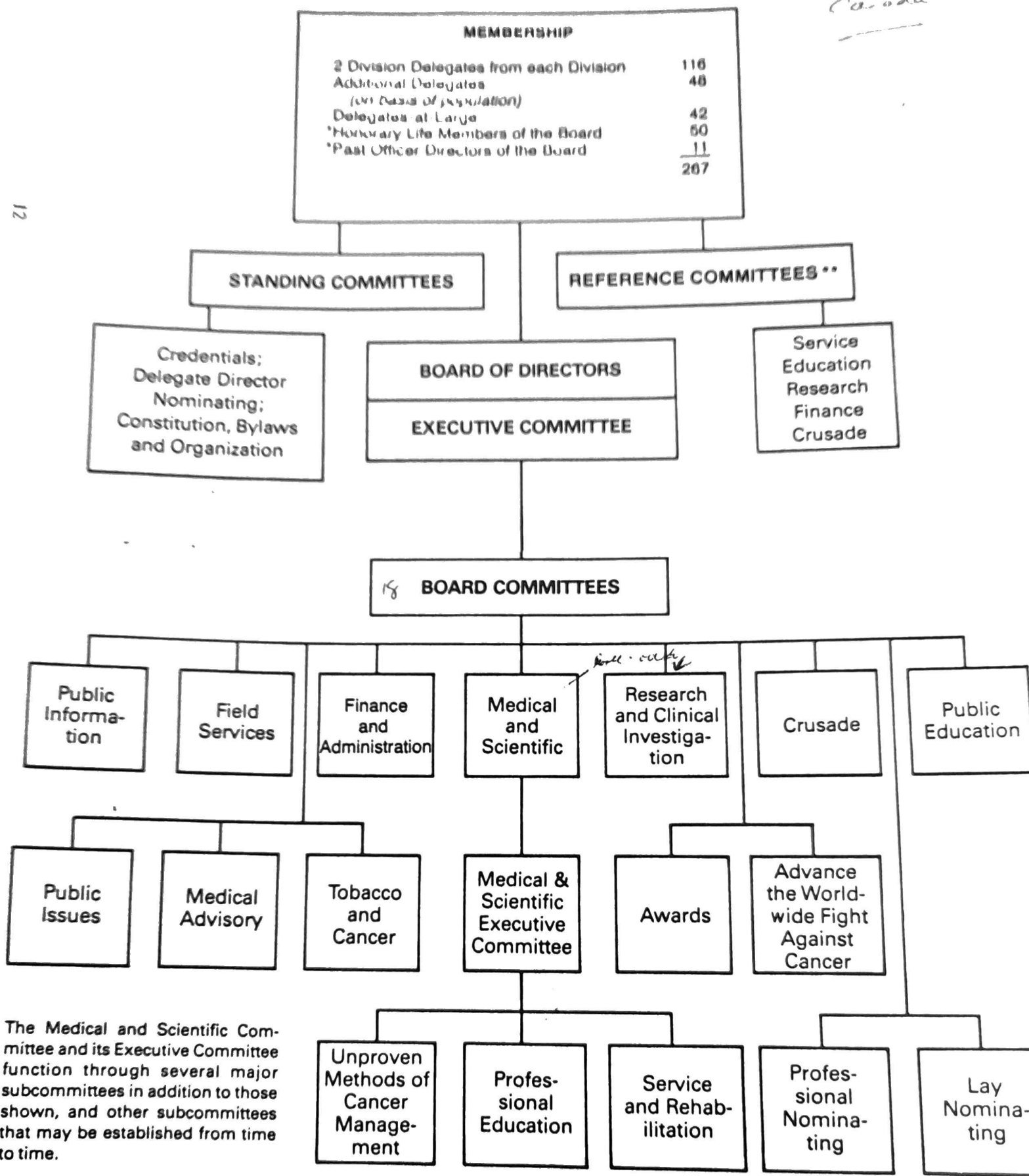
VERY CONFUSING

VERY CLEAR

1 2 3 4 5 6 7 8 9 10

File Canada

12



The Medical and Scientific Committee and its Executive Committee function through several major subcommittees in addition to those shown, and other subcommittees that may be established from time to time.

*As of date of publication. Elected annually — number varies
 **Called when appropriate.

International Comparisons

(\$ adjusted)

