ALGOMA PUBLIC HEALTH BOARD MEETING
FEBRUARY 24, 2016 @ 5:00 PM
SAULT STE MARIE ROOM A&B 1ST FLOOR, APH SSM

ADDENDUM

10) Addendum

a. Harm Reduction PowerPoint – Revised item 4.0 a. — Sandra Byrne, Manager of Community Alcohol Drug Assessment Program

b. Budget Update Elliot Lake Office Renovations – Addition to item 6.0 b. — Ian Frazier, Committee Chair

Additions to 8.0 Correspondence Items – *For Information Only*

c. Basic Income Guarantee — Lee Mason, Board Chair
   i. Letter to Minister Matthews from North Bay Parry Sound District Health Unit dated February 22, 2016

d. Cannabis Regulation and Control — Lee Mason, Board Chair
   i. Letter to Prime Minister Trudeau from Durham Region Health Department dated February 8, 2016
   ii. Letter to Prime Minister Trudeau from Middlesex-London Health Unit dated February 12, 2016

e. Patients First: A Proposal to Strengthen Patient-Centred Health Care in Ontario — Lee Mason, Board Chair
   i. Letter to Minister Hoskins from Haliburton, Kawartha, Pine Ridge District Health Unit dated February 18, 2016
   ii. Letter to Minister Hoskins from Ottawa Public Health dated February 18, 2016

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Harm Reduction - Needle Exchange Program

February 24, 2016

Presented by:
Sandy Byrne, MSW, RSW
Manager of CADAP, CMH District, SFO, Youth Engagement,
Needle Exchange Program, North Algoma District Manager

Defining Harm Reduction

Any evidenced based practice or policy used to reduce drug related harm without requiring the cessation of drug use.

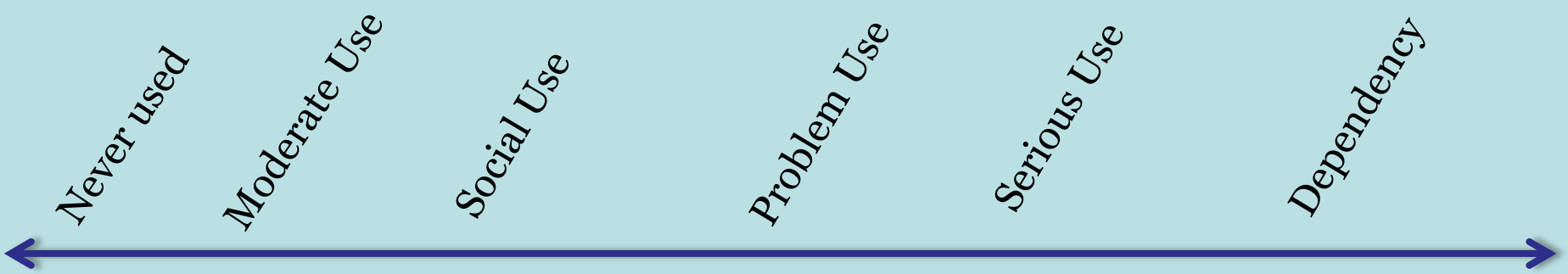
The Needle Exchange Program (NEP) focuses on:

- Reducing the risk or rate of HIV, HEP B, and HEP C, high risk drug use and unsafe sexual behaviour.
- Addressing issues related to social determinants of health by providing a positive contact with health care professionals

As a 'use tolerant' approach:

- NEP helps reduce the stigma attached to substance use by recognizing the intrinsic value of human beings and non-judgemental services.
- The immediate reduction of risk encouraging clients to use clean supplies every time they use substances.
- Reduces the number needles found in the community

Continuum of Substance Use from a Health Promotion Perspective



Supply reduction: interventions that restrict access to a substance (particularly for populations considered vulnerable to harm) Education, Prevention Messages Low risk drinking guidelines, moderation

Demand reduction: services to reduce the number of individuals who use substances, the amount they use or the frequency of use

Harm reduction: interventions that seek to reduce the harmful consequences even when use remains unchanged (provide supplies, education)

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Disease Prevention/Health Protection Program Delivery Models

The board of health shall ensure access to a variety of harm reduction program delivery models which shall include the provision of sterile needles and syringes and may include other evidence-informed harm reduction strategies in response to local surveillance.

- NEP site locations/staff
- Services
- Supplies

Ontario Public Health Standards: Infectious Diseases Prevention and Control Needle Exchange Program Assessment and Surveillance Requirements

The board of health shall conduct surveillance of distribution of harm reduction equipment/supplies. Algoma District NEP Stats:

NEP Stats	2013	2014	2015 Jan-Jun
Total Contacts	1330	1233	699
Needles Distributed	166,453	215,197	80,357
Needles Returned	64,300 (38%) *	87,507 (41%) *	41,019 (51%) *
Gender	Male – 59% Female – 41%		
Average Age	39		33
Condoms Distributed	2147	2300	1290
Substances reported: cocaine, morphine (other opioids)			Cocaine, opiates, morphine
***Provincial return rates was 74-78% (2009)**			

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Disease Prevention and Health Protection Community Partners/Priority Populations

The board of health shall engage community partners and priority populations in the planning, development, and implementation of harm reduction programming.

- GHC HIV/AIDS Resource Program (HARP)
- City of Sault Ste. Marie
- John Howard Society
- Sault College
- APH Volunteers
- Needle Exchange Committee
- NEP Managers Teleconference (Provincial)
- Public Awareness initiatives
- Participant Surveys

New Developments

- Safe Inhalation supplies
- Needle Drop Bins
- Adding NEP to the APH Website

Limitations

- NEP services are not offered throughout the district
- Funding/staffing
- Limited hours
- Low needle/syringe return rates

Thank You

Questions?

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BUDGET UPDATE - Elliot Lake Office Renovations **Feb. 10/16**

Inflow		
Insurance Settlement Funds (need approval move GIC into operating)	$ 374,939.89	
RBC Bank Loan (Dec 9/15)	$ 350,000.00	
Total Inflow		$ 724,939.89
Outflow		
Construction - Payment #1 - (Dec. 9/15)	$ 101,137.50	
Construction - Payment # 2 (Feb. 1/16)	$ 127,683.00	
Architect - Payment # 1 (Feb. 1/16)	$ 48,950.24	
Total Outflow as of Feb. 10/16		$ 277,770.74
Projected Inflows		
Battery Rebate (architect negotiating with contractor)	??	
Projected Outflows		
Balance of Construction	$ 351,315.50	
Balance of Architect	$ 5,438.92	
Furniture & Assembly	$ 36,630.00	
IT	$ 21,000.00	
Phone	$ 5,579.00	
Moving	$ 15,000.00	
		$ 434,963.42
Surplus/(Deficit)		$ 12,205.73

* note: outflows do not include HST (APH will recoup majority of HST expense)

North Bay Parry Sound District Health Unit
Bureau de santé du district de North Bay-Parry Sound

in your community . . . here for your health

681 Commercial Street, North Bay, ON P1B 4E7 TEL 705.474.1400 FAX 705.474.8252
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myhealthunit.ca TOLL FREE 1 800 563 2808

February 22, 2016

The Honourable Deb Matthews
Deputy Premier
President of the Treasury Board
Minister Responsible for the Poverty Reduction Strategy
Room 4320
99 Wellesley Street West
Toronto, ON M7A 1W3

Dear Minister Matthews,

As the Minister responsible for the Ontario Poverty Reduction Strategy, I am writing to inform you of the resolutions passed on January 27, 2016 at the North Bay Parry Sound District Health Unit Board of Health meeting. These resolutions focus on increasing incomes in Ontario in an effort to reduce food insecurity and poverty rates.

According to the 2015 Nutritious Food Basket data, the cost of healthy eating for a family of four in the North Bay Parry Sound District is approximately $837 per month. When this amount is combined with local rent rates and compared to several income scenarios, it is clear that those receiving social assistance and earning minimum wage do not have enough money for all the costs of living, including nutritious food. Our 2015 Cost of Healthy Eating Report and associated infographic include more information on these income scenarios and are included in this package for your reference.

Household food insecurity is defined as inadequate or insecure access to food because of financial constraints. Food insecurity greatly impacts health and wellbeing, which makes it a serious public health problem. Adults who are food insecure have poorer self-rated health and are more likely to suffer from chronic conditions such as diabetes, high blood pressure and anxiety. Children who experience food insecurity have an increased risk of developing asthma and depression in adolescence and early adulthood. In addition, being food insecure is strongly associated with being a high cost health care user. Research clearly highlights poverty as the root cause of food insecurity.

The most common community level response to food insecurity is food charity programs, including food banks and soup kitchens. While food charity is well meaning, it does not decrease food insecurity. The North Bay Parry Sound District Health Unit Board of Health has endorsed the Ontario Society of Nutrition Professionals in Public Health's (OSNPPH) *Position Statement on Responses to Food Insecurity*, highlighting food charity as an ineffective and counterproductive response to food insecurity and calling for the implementation of a basic income guarantee as a long term solution to truly address poverty in Ontario.

The North Bay Parry Sound District Health Unit Board of Health also endorsed the resolution passed by the Association of Local Public Health Agencies (alPHa) in June 2015, endorsing the concept of a basic income guarantee as a policy option for reducing poverty, and calling on federal and provincial representatives to prioritize joint federal-provincial consideration and investigation into a basic income guarantee.

We recognize improvements have been made in recent years to social assistance programs, and minimum wage has been increased. However, this is just the beginning in addressing food insecurity. Our

local data indicates more must be done to increase incomes and reduce poverty in Ontario in an effort to promote good health for all. Thank you in advance for taking the time to review this information and please consider the resolutions passed by the NBPSDHU Board of Health.

Sincerely,

James Chirico, H.BSc., M.D., F.R.C.P. (C), MPH
Medical Officer of Health/Executive Officer

Attachments (3)

C: Hon. Eric Hoskins Minister of Health and Long-Term Care (MOHLTC)
Hon. Helena Jaczek, Minister of Community and Social Services
Hon. Kathleen Wynne, Premier of Ontario
Anthony Rota, MP, Nipissing-Timiskaming
Tony Clement, MP, Parry Sound-Muskoka
Victor Fedeli, MPP, Nipissing
Norm Miller, MPP, Parry Sound-Muskoka
Ontario Society of Nutrition Professionals in Public Health
Linda Stewart, Executive Director, Association of Local Public Health Agencies
Member Municipalities
Ontario Boards of Health

North Bay Parry Sound District Health Unit
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myhealthunit.ca TOLL FREE 1 800 563 2808

NORTH BAY PARRY SOUND DISTRICT HEALTH UNIT
BOARD OF HEALTH

RESOLUTION

DATE: January 27, 2016 **MOVED BY:** John Stopper

RESOLUTION: #BOH/2016/01/10 **SECONDED BY:** Cheryl Hull

Whereas, *The Nutritious Food Basket Survey results show that many low-income individuals and families do not have enough money for nutritious food and other basic living expenses,[1] and*

Whereas, *The Board of Health for the North Bay Parry Sound District Health Unit recognizes the impact of adequate income on food security and other social determinants of health,*

Whereas, *food charity programs do not address the root cause of food insecurity, which is poverty,[3]*

Whereas, *a basic income guarantee would ensure all citizens would have an income sufficient to meet basic needs and live with dignity, regardless of work status,*

Now Therefore Be it Resolved, *That the Board of Health for the North Bay Parry Sound District Health Unit endorse the Association of Local Public Health Agencies (alPHa) resolution titled Public Health Support for a Basic Income Guarantee[4], and*

Furthermore Be It Resolved, *That the Board of Health for the North Bay Parry Sound District Health Unit endorse the Ontario Society of Nutrition Professionals in Public Health (OSNPPH) Position Statement on Responses to Food Insecurity[2], and*

Furthermore Be it Resolved, *That the Board of Health for the North Bay Parry Sound District Health Unit urge the Ontario government to prioritize the investigation into a basic income guarantee, and increase minimum wage and social assistance rates, indexed with inflation to reflect the costs of living including the ability to purchase nutritious food, and*

Furthermore Be It Resolved, *That the Board of Health for the North Bay Parry Sound District Health Unit continue to support the efforts of employees and community stakeholders that play a role in addressing food insecurity through social determinants of health work, and*

***Furthermore Be It Resolved**, that the Board of Health for the North Bay Parry Sound District Health Unit provide correspondence of these resolutions to district municipalities, Ontario Society of Nutrition Professionals in Public Health (OSNPPH), Association of Local Public Health Agencies (alPHa), the Honourable Anthony Rota (Nipissing-Timiskaming), the Honourable Tony Clement (Parry Sound-Muskoka), Victor Fedeli, MPP (Nipissing), Norm Miller, MPP (Parry Sound-Muskoka) Premier Kathleen Wynne, Deputy Premier Deb Matthews, the Honourable Helena Jaczek (Minister of Community and Social services) and the Honourable Dr. Eric Hoskins (Minister of Health and Long-Term Care).*

CARRIED: ✓	**DEFEATED:**
AS AMENDED:	**CHAIRPERSON:**

CONFLICT OF INTEREST DECLARED AND SEAT(S) VACATED:

1.	4.
2.	5.
3.	6.

RECORDED VOTE:

For:	Against:
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.
6.	6.
7.	7.
8.	8.
9.	9.
10.	10.

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The 2015 Cost of Healthy Eating: North Bay Parry Sound District

What is the Nutritious Food Basket?

The Nutritious Food Basket is a provincial survey tool that is used to calculate the cost of a basic nutritious diet. Each year, the North Bay Parry Sound District Health Unit conducts the survey with twelve grocery stores across the district to price food items that represent a basic healthy diet according to Canada's Food Guide and Canadian purchasing patterns. The results of the Nutritious Food Basket survey are then compiled into the annual Cost of Healthy Eating Report.

The list of 67 food items does not include processed and convenience foods, snack foods, or household non-food items such as cleaning products, toothpaste and toilet paper. The survey also assumes that people have the skills and ability to access, prepare and store food. The survey does not consider the additional costs of eating out or special occasions such as holiday or birthday celebrations.

Year after year the results of the survey continue to show that for many low income households in our district it may not be possible to pay rent, bills such as utilities and telephone, and buy nutritious food.

What is the cost of healthy eating in the North Bay Parry Sound District?

In 2015, the cost for a family of four to eat a basic healthy diet for one week was $193.30 or $837.03 a month.

2015 Income Scenarios in the North Bay Parry Sound District

- A 40 year old single man on Ontario Works with a total monthly income of $752.00 paying $550.00 per month in rent (which may or may not include heat and hydro) would need $281.10 to maintain the cost of a nutritious diet. This person would have a remaining income of -$79.10 per month.
- A single mother with a son and daughter on Ontario Works with a total monthly income of $2006.00 paying $896.00 per month in rent (which may or may not include heat and hydro) would need $632.92 to maintain the cost of a nutritious diet. This person would have $477.08 remaining per month.
- A family of four on Ontario Works with a total monthly income of $2,214.00 paying $1,131.00 per month in rent (which may or may not include heat and hydro) would need $837.03 to maintain the cost of a nutritious diet. This family would have $245.97 remaining per month.
- A single man on an Ontario disability support program with a total monthly income of $1,205.00 paying $720.00 per month in rent (which may or may not include heat and hydro) would need $281.10 to maintain the cost of a nutritious diet. This person would have $203.90 remaining per month.
- A 75 year old single woman on an old age security/guaranteed annual income with a total monthly income of $1556.00 paying $720.00 per month in rent (which may or may not include heat and hydro) would need $204.88 to maintain the cost of a nutritious diet. This person would have $631.12 remaining per month.

- A minimum wage earner with a family of four with a total monthly income of $2,900.00 paying $1,131.00 per month in rent (which may or may not include heat and hydro) would need $837.03 to maintain the cost of a nutritious diet. This person would have $931.97 remaining per month.
- A family of four with the Ontario median income of $6,952.00 paying $1,131.00 per month in rent (which may or may not include heat and hydro) would need $837.03 to maintain the cost of a nutritious diet. This family would have $4983.97 remaining per month.

Monthly income includes additional benefits and credits. A family of four consists of a man and a woman, both age 35, a boy age 14, and a girl age 8. The Health Unit can provide references for income calculations. Please contact Erin Reyce, RD at 705-474-1400 ext 2532 for further information.

The scenarios above only account for monthly rent and a basic healthy diet. Other monthly expenses may include heat, hydro, childcare, transportation costs, insurance, prescriptions, dental care, telephone, costs associated with school and other unexpected costs.

Even with careful planning and budgeting low income families are unable to cover all of their necessary expenses and afford a basic healthy diet. In these situations food becomes a discretionary expense. People may skip meals or fill up on less nutritious foods, resulting in poor diets.

In 2013, 12.5% of households were food insecure in Ontario. [1] Families with children are greatly affected, with local data showing that 1 in 3 families with children are food insecure. [2] The source of household income is also important. 68% of households reliant on social assistance experience food insecurity.[1] 61% of food insecure households in Ontario were reliant on employment wages[1].These numbers demonstrate that current social assistance and minimum wage rates do not reflect the true costs of living.

How does income impact health?

Household food insecurity is defined as inadequate or insecure access to food because of financial constraints. Poverty is the root cause of food insecurity.[3]

Food insecurity greatly impacts health and wellbeing. Adults who are food insecure have poorer self-rated health and are more likely to suffer from chronic conditions such as diabetes, high blood pressure and anxiety. Children who experience food insecurity have an increased risk of developing asthma and depression in adolescence and early adulthood. [1] In addition, being food insecure is strongly associated with being a high cost health care user.[3]

What is the solution?

Community responses to food insecurity such as food banks and meal programs provide some low income individuals and families temporary hunger relief. However, they do not to address the root problem, which is poverty. These programs will never be enough to truly address food insecurity.

The only long term solution to food insecurity is to reduce poverty rates. Many groups are calling on governments to investigate the implementation of a basic income guarantee (also known as guaranteed annual income) which would ensure adequate income for all, regardless of work status.

Advocacy efforts to provincial and federal governments are needed to support policy change to improve the social safety net, and in turn, promote health and wellbeing for all, including:

- More stable employment opportunities (i.e. full time employment opportunities with medical benefits)
- The investigation of a basic income guarantee for all
- Immediate increased minimum wage and social assistance rates to reflect the actual cost of living and indexed annually to inflation

Additional Resources

- PROOF, Research to Identify Policy Options to Reduce Food Insecurity: http://nutritionalsciences.lamp.utoronto.ca/
- Basic Income Canada Network http://www.basicincomecanada.org/about_basic_income
- Ontario Society of Nutrition Professionals in Public Health – Position Statement on Responses to Food Insecurity http://www.osnpph.on.ca/news/membership/news/osnpph-releases-position-statement-on-responses-to-food-insecurity
- Ontario Poverty Reduction Strategy: http://www.ontario.ca/home-and-community/realizing-our-potential-poverty-reduction-strategy-2014-2019
- Do the math challenge: http://dothemath.thestop.org/
- Call 705-474-1400 or 1-800-563-2808 and ask to speak with a Public Health Dietitian

References:

1. Tarasuk, V, Mitchehll, A, Dachner, N. (2015). *Household food insecurity in Canada, 2013.* Toronto: Research to identify policy options to reduce food insecurity (PROOF). Retrieved from http://nutritionalsciences.lamp.utoronto.ca/
2. North Bay Parry Sound District Health Unit. (2014). *NutriSTEP® Screening - 2013.* North Bay, ON: North Bay Parry Sound District Health Unit.
3. Ontario Society of Nutrition Professionals in Public Health. (2015). *Position Statement on Responses to Food Insecurity.* Retrieved from http://www.osnpph.on.ca/upload/membership/document/position-statement-2015-final_1.pdf#upload/membership/document/position-statement-2015-final.pdf

The Cost of Healthy Eating

North Bay Parry Sound 2015

$837

Local monthly cost to feed a family of 4.

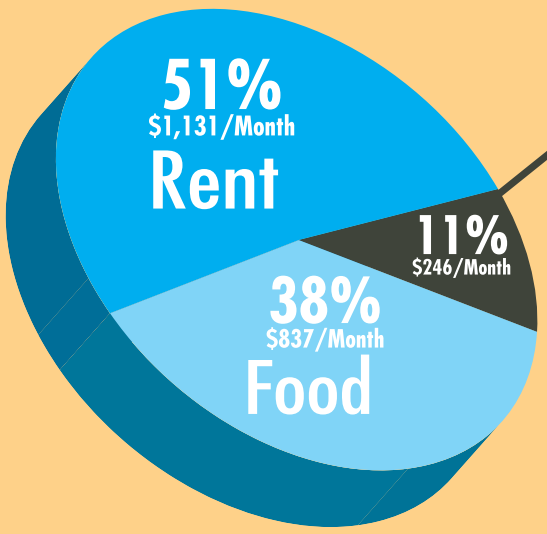
Household food insecurity =

- Not enough money to buy healthy food
- Higher rates of:
  - Diabetes
  - Heart disease
  - Depression
  - High blood pressure

1 in 8 Ontario households are food insecure.

Social assistance rates are inadequate.

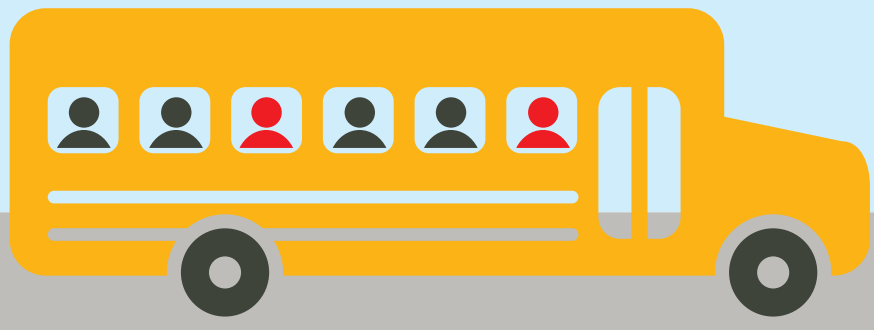
For a family of four on Ontario Works in our district:



Left For

Utilities
Telephone
Childcare
Transportation
Clothing
Insurance
School costs
Etc...

61% of food insecure households in Ontario have income from employment.



1 in 3 households with children in our district struggle to put food on the table.

Poverty is the root cause of food insecurity.

"Implement a guaranteed annual income."

"Health benefits for all."

"Strengthen employment standards to reduce unstable employment and improve working conditions."

"Increase social assistance rates."

What can you do? Share these messages. Learn about food insecurity and poverty. Support programs that increase access to healthy food. Talk to your local MP and MPP.

Learn more

www.myhealthunit.ca

@NBPSDHealthUnit

facebook.com/NorthBayParrySoundDistrictHealthUnit

North Bay Parry Sound District Health Unit

Le coût d'une alimentation saine

dans la région de North Bay Parry Sound - 2015

837 $

Le coût moyen pour nourrir une famille de 4 par mois.

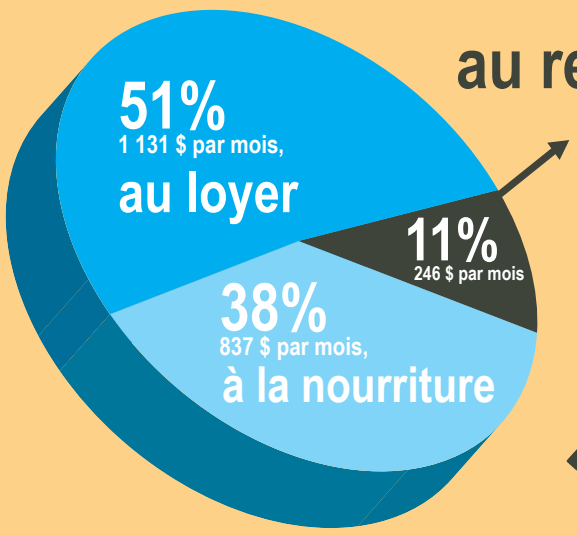
L'insécurité alimentaire d'un foyer signifie =

- **Pas assez d'argent pour acheter des aliments nutritifs**
- **Des taux plus élevés de :**
  - diabète
  - maladies cardiaques
  - dépression
  - tension artérielle élevée

1 ménage sur 8 en Ontario se trouve en situation d'insécurité alimentaire.

Les taux d'aide sociale sont trop faibles.

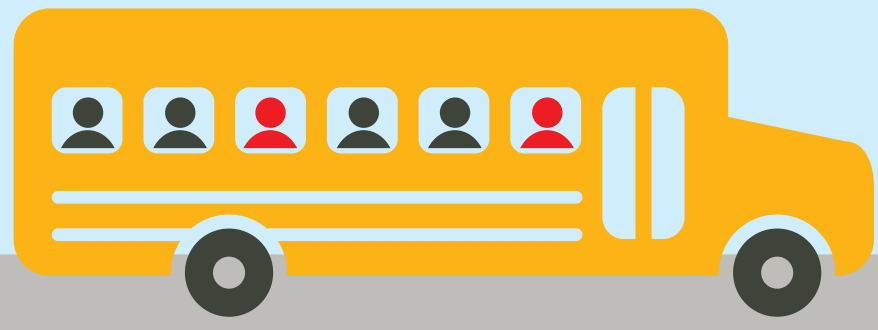
Une famille de quatre dans notre district recevant du soutien du programme Ontario au travail consacre :



au reste :

Services publics
Téléphone
Frais de garde
Transport
Vêtements
Assurance
Fournitures scolaires
Etc...

61% des ménages se trouvant en situation d'insécurité alimentaire en Ontario ont des revenus d'emploi.



1 ménage sur 3 comptant des enfants dans notre district a du mal à nourrir la famille.

La pauvreté est la cause première de l'insécurité alimentaire.

« Mettez sur pied un revenu annuel garanti. »

« Assurance-maladie pour tous. »

« Renforcez les normes d'emploi pour réduire les emplois précaires et améliorer les conditions de travail. »

« Augmentez les taux d'aide sociale. »

Que pouvez-vous faire? Transmettez ces messages. Renseignez-vous sur l'insécurité alimentaire et la pauvreté. Appuyez les programmes qui améliorent l'accès aux aliments nutritifs. Parlez à votre député fédéral et provincial local.

Pour en savoir plus

www.myhealthunit.ca @NBPSDHealthUnit facebook.com/NorthBayParrySoundDistrictHealthUnit

Bureau de santé
du district de North Bay-Parry Sound

DURHAM REGION

The Regional Municipality of Durham

Corporate Services Department - Legislative Services

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Matthew L. Gaskell
Commissioner of Corporate Services

February 8, 2016

The Right Honourable Justin Trudeau
Prime Minister
House of Commons
Ottawa ON K1A 0A6

COPY

RE: Memorandum from Dr. Robert Kyle, Commissioner & Medical Officer of Health, dated January 12, 2016 re: Cannabis Regulation and Control (Our File No. P00)

Honourable Prime Minister, please be advised the Health & Social Services Committee of Regional Council considered the above matter and at a meeting held on January 27, 2016, Council adopted the following recommendations of the Committee:

A) That the correspondence dated December 1, 2015 from the Sudbury & District's Medical Officer of Health, urging the Government of Canada to adopt a public health approach if it proceeds with its election commitment to legalize, regulate and restrict access to marijuana be endorsed;

B) That the Federal government and province provide additional funding to municipalities to help offset any higher social costs resulting from legalization of marijuana; and a copy of the resolution be provided to Federation of Canadian Municipalities, Association of Municipalities of Ontario, local MPs and MPPs; and

C) That the Prime Minister of Canada, Minister of Health, Minister of Justice and Attorney General of Canada, Durham MPPs, alPHa and all Ontario boards of health be so advised.

Attached is a copy of the Memorandum from Dr. Robert Kyle, Commissioner and Medical Officer of Health dated January 12, 2016 regarding Cannabis Regulation and Control.

Debi A. Wilcox, MPA, CMO, CMM III
Regional Clerk/Director of Legislative Services

DW/np

Attach.

"Service Excellence for our Communities"

If this information is required in an accessible format, please contact the Accessibility Co-ordinator at 1-800-372-1102 ext. 2009.

c: The Honourable Jane Philpott, Minister of Health
The Honourable Jody Wilson-Raybould, Minister of Justice and Attorney General of Canada
Joe Dickson, MPP (Ajax/Pickering)
Whitby/Oshawa Constituency Office
The Honourable Tracy MacCharles, MPP, (Pickering/ Scarborough East)
Granville Anderson, MPP (Durham)
Jennifer French, MPP (Oshawa)
Laurie Scott, MPP (Haliburton/Kawartha Lakes/Brock)
Mark Holland, MP (Ajax)
Mr. Erin O'Toole, MP (Durham)
Jamie Schmale MP (Haliburton/Kawartha Lakes/Brock)
Kim Rudd, MP (Northumberland/Peterborough South)
Dr. Colin Carrie MP(Oshawa)
Jennifer O'Connell, MP (Pickering/Uxbridge)
Celina Caesar-Chavannes MP (Whitby)
L. Stewart, Executive Director, Association of Local Public Health Agencies (alPHa)
P. Vanini, Executive Director, Association of Municipalities of Ontario (AMO)
B. Carlton, Chief Executive Officer, Federation of Canadian Municipalities (FCM)
Ontario Boards of Health
R.J. Kyle, Commissioner & Medical Officer of Health

DURHAM REGION

The Regional Municipality of Durham

HEALTH DEPARTMENT

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An Accredited Public Health Agency

MEMORANDUM

TO: Chair L. Coe and Members
Health & Social Services Committee

FROM: Dr. Robert Kyle

DATE: January 12, 2016

RE: Cannabis Regulation and Control

On December 1, 2015, Sudbury & District's Medical Officer of Health forwarded the appended correspondence to all Ontario boards of health for support (Appendix A).

In essence, the correspondence urges the Government of Canada to adopt a public health approach if it proceeds with its election commitment to legalize, regulate and restrict access to marijuana.

The components of such an approach include controlled availability, age limits, low-risk use guidelines, pricing, advertising restrictions, and general and targeted prevention initiatives (Appendix B {CAMH Cannabis Policy Framework Paper}).

Endorsing this approach is consistent with the mandate of Regional Council, as Durham's board of health, to reduce the frequency, severity and impact of preventable injury and of substance abuse (*Ontario Public Health Standards)*.

Accordingly, I recommend that the Health & Social Services Committee recommends to the Regional Council that:

a) The correspondence of the Sudbury & District Board of Health regarding cannabis regulation and control is endorsed; and

b) The Prime Minister of Canada, Minister of Health, Minister of Justice and Attorney General of Canada, Durham's MPPs, alPHa and all Ontario boards of health are so advised.

Respectfully submitted,

R.J. Kyle, BSc, MD, MHSc, CCFP, FRCPC, FACPM
Commissioner & Medical Officer of Health

Sudbury & District

Health Unit

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December 1, 2015

VIA ELECTRONIC MAIL

The Right Honourable Justin Trudeau
Prime Minister of Canada
House of Commons
Ottawa, ON K1A 0A6

Dear Prime Minister Trudeau:

Re: ***CANNABIS REGULATION AND CONTROL: Public Health Approach to Cannabis Legalization***

At its meeting on November 19, 2015, the Sudbury & District Board of Health carried the following resolution #54-15:

WHEREAS the election platform of Canada's recently elected federal government includes the intention to legalize, regulate, and restrict access to marijuana; and

WHEREAS within the current criminalization context, cannabis is widely used in the SDHU catchment area: 23.5% of youth used in the previous 12 months, 52.3% of people aged ≥19 have tried cannabis and 13% currently use cannabis; and

WHEREAS the health risks of cannabis use are significantly lower than tobacco or alcohol but are increased in those who use it frequently, begin at an early age and/or who have higher risk of cannabis-related problems (i.e. certain psychiatric conditions, cardiovascular disease, pregnancy); and

WHEREAS a public health approach focused on high-risk users and practices – similar to the approach favoured with alcohol and tobacco that includes strategies such as controlled availability, age limits, low risk use guidelines, pricing, advertising restrictions, and general and targeted prevention initiatives – allows for more control over the risk factors associated with cannabis-related health and societal harms; and

WHEREAS the Ontario Public Health Standards require boards of health to reduce the frequency, severity, and impact of preventable injury and of substance misuse;

THEREFORE BE IT RESOLVED THAT the Sudbury & District Board of Health support a public health approach to the forthcoming cannabis legalization framework, including strict health-focused regulations to reduce the health and societal harms associated with cannabis use; and

FURTHER THAT this resolution be shared with the Honourable Prime Minister of Canada, local Members of Parliament, the Premier of Ontario, local Members of Provincial Parliament, Minister of Health and Long-Term Care, Federal Minister of Health, the Attorney General, Chief Medical Officer of Health, Association of Local Public Health Agencies, Ontario Boards of Health, Ontario Public Health Association, the Centre for Addiction and Mental Health, and local community partners.

Members of the Sudbury & District Board of Health respectfully request that the Right Honorable Prime Minister use a public health approach to the regulation and legalization of cannabis in Canada.

Sincerely,

Penny Sutcliffe, MD, MHSc, FRCPC
Medical Officer of Health and Chief Executive Officer

cc: Hon. Jody Wilson-Raybould, Minister of Justice and Attorney General of Canada
Hon. Jane Philpott, Minister of Health
Carol Hughes, MP Algoma, Manitoulin, Kapuskasing
Paul Lefebvre, MP Sudbury
Marc Serré, MP Nickel Belt
Hon. Kathleen Wynne, Premier of Ontario
Hon. Madeleine Meilleur, Attorney General of Ontario
Glenn Thibeault, MPP Sudbury
France Gélinas, MPP Nickle Belt
Michael Mantha, MPP, Algoma-Manitoulin
Dr. David Williams, Chief Medical Officer of Health (Interim)
Linda Stewart, Executive Director, Association of Local Public Health Agencies
Pegeen Walsh, Executive Director, Ontario Public Health Association
Dr. Catherine Zahn, President and Chief Executive Officer, Centre for Addiction and Mental Health
Ontario Boards of Health

camh Centre for Addiction and Mental Health

The CAMH Cannabis Policy Framework

Jean-François Crépault
Senior Policy Analyst
CAMH Communications and Partnerships

Today's presentation

- CAMH's updated position on cannabis policy: legalization with strict health-focused regulation
- The evidence on which this position rests
- How we got there
- Questions and discussion

Background

- CAMH's strategic plan, *Vision 2020 tomorrow.today*, renews CAMH's commitment to public policy development
- CAMH has a long history of public policy development
- We have recommended reform of Canada's system of cannabis control since 1997
- In 2013, CAMH began revisiting its position in light of recent research and policy developments

camh 3

WHAT WE KNOW

camh 4

#1: Cannabis is the most commonly used illegal drug in Canada

camh

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Prevalence

% of the Ontario population using cannabis at least once in 2013	
General population (age 18+)	14.1
By gender	
Men	17.6
Women	10.8
By age	
Grades 7-12	
Age 18-29	40.4
Age 30-39	
Age 40-49	8.4
Age 50+	

camh

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Prevalence (cont'd)

- 14% of adults (18+) and 23% of high-school students report using cannabis in the past year
  - Prevalence rises to 40% for ages 18-29
- Since 1996, prevalence has trended upward for both men and women and for almost all age groups, but:
  - High-school students have shown a steady and significant decrease in the past 10 years
  - Overall, rates of cannabis use Ontario have been relatively flat since 2005

camh 7

Consumption patterns

- ~50% of past-year cannabis users consume it at least once a month
- ~25% of past-year users consume it every day
- ~4% of the total adult population and 3% of high-school students use cannabis every day
- ~20% of users account for 80-90% of consumption

camh 8

#2: Cannabis use carries health risks

camh 9

Health risks and harms

- Cannabis is not a benign substance
- Particularly when used frequently (daily or near-daily), cannabis is associated with increased risk of:
  - problems with cognitive and/or psychomotor functioning
  - respiratory problems
  - dependence
  - mental health problems

camh 10

Cognitive / psychomotor functioning

- Frequent cannabis use can negatively affect memory, attention span, and psychomotor performance
- May reduce motivation and learning performance
- Impacts the skills necessary for safe driving and substantially increases a person's risk of motor-vehicle accidents
- Impaired driving is the main contribution of cannabis to Canada's burden of disease and injury

camh 11

Respiratory problems

- Smoking cannabis irritates the respiratory system
- Like tobacco, cannabis smoke contains tar and other known cancer-causing agents
- People who smoke cannabis often hold unfiltered smoke in their lungs for maximum effect, which adds to these risks

camh 12

Dependence

- Long-term frequent use of cannabis can lead to dependence
- People with dependence may experience difficulty quitting or cutting down and may persist in using the drug despite negative consequences
- About 9% of cannabis users develop dependence

camh 13

Mental health problems

- Frequent (daily or near-daily) cannabis use is associated with mental health problems:
  - It can increase the likelihood of mental illness in individuals who have a pre-existing vulnerability to it
  - It can exacerbate symptoms in people already experiencing mental illness
- High-potency cannabis places users at higher risk of mental health problems than low-potency cannabis
- This association is robust but not yet well understood; causality has not been determined

camh 14

#3: Cannabis-related harm is concentrated among a limited group of high-risk users

camh

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Where risk of harm is concentrated

- Two main factors are associated with long-term harm from cannabis use:
  - early initiation
  - frequent (daily or near-daily) use
- Cannabis-related harm is concentrated among a limited sub-group of users who use cannabis frequently and/or began to use it at an early age

camh

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Early initiation

- Early regular use of cannabis is associated with a number of adverse outcomes including:
  - low levels of educational attainment
  - higher likelihood of subsequently using other illegal drugs
  - increased risk of developing mental health problems
- Cannabis use before the age of 18 increases the risk of developing schizophrenia
- For adult users, the cognitive problems associated with regular use diminish after about a month, but these may not be reversible in adolescent users

camh 17

Other areas of high risk

- Cannabis potency (THC content)
- Delivery mechanism (smoking vs. use of vaporizers or edibles, etc.)
- At the levels and patterns of use reported by most adult cannabis users, the health risks are relatively modest – significantly lower than tobacco or alcohol

camh 18

Lower-risk cannabis use guidelines

- The health harms of cannabis are associated with a number of factors that are potentially modifiable
- Risk of harm can be greatly reduced if:
  - use is delayed until early adulthood
  - frequent use is avoided
  - users shift away from smoking cannabis towards less harmful (smokeless) delivery systems
  - less potent products are used
  - people with higher risk of cannabis-related problems (e.g. a personal or family history of psychosis) consider abstaining altogether

camh 19

#4: Criminalization of cannabis use causes additional harms... without dissuading it

camh 20

The legal status of cannabis

- The production and possession of cannabis are governed by criminal law under the Controlled Drugs and Substances Act (CDSA)
- Maximum sentence for first-time offenders: $1,000 fine, 6 months in jail (higher penalties thereafter)
- Mandatory minimum sentences for some possession offences

camh 21

The costs and harms of prohibition

- 60,000 Canadians are arrested for possession of cannabis every year – nearly 3% of all arrests
- About 700,000 Canadians carry a criminal record for this offense
- The annual cost of enforcing cannabis laws (including police, courts, and corrections) in Canada is estimated at $1.2 billion
- Cannabis laws tend to be applied inequitably, with marginalized and vulnerable populations disproportionately targeted

camh 22

The failure of prohibition

- Tougher penalties do not lead to lower rates of use
- Canada has higher rates of cannabis use than countries with relatively permissive approaches to cannabis control
- Prohibition has not succeeded in reducing or mitigating cannabis-related harms
- Prohibition has exacerbated the health harms of cannabis and has created costly social ones as well

camh

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In modern societies, a finding of adverse effects does not settle the issue of the legal status of a commodity; if it did, alcohol, automobiles, and stairways, for instance, would all be prohibited, since use of each of these results in substantial casualties.

Source: Room et al., Cannabis policy: Moving beyond stalemate, *p. 15*

camh

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POLICY OPTIONS FOR CANNABIS CONTROL

camh

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Decriminalization

- Removes possession of small amounts of cannabis from the sphere of criminal law
- Instead it becomes a civil violation punishable by a small fine
- Decriminalization can reduce some of the adverse social impacts of criminalization:
  - It can reduce both the number of people caught in the criminal justice system and the cost of enforcement
  - No evidence that it causes an increase in cannabis consumption or cannabis dependence

camh

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Why not decriminalization?

- Cannabis remains unregulated, so users know little or nothing about its potency or quality
- Does not give government additional tools to tackle health risks and harms
- There can be unintended consequences:
  - net-widening
  - secondary criminalization
  - inequitable application
- As long as cannabis use is illegal, it is difficult for health care or education professionals to address and help prevent problematic use

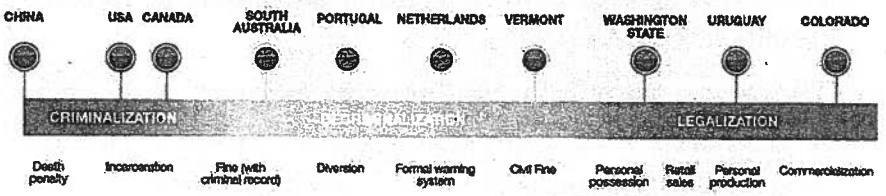
camh 27

Legalization

- Many models for legal cannabis are possible
  - In all cases, production, distribution, and possession are removed from the ambit of criminal law
  - Regulations are then set... or not
- Eliminates the social harms and costs of prohibition
- Presents governments with the possibility of regulating cannabis to mitigate its health risks
- Health impact depends on regulatory decisions and how they are implemented

camh 28

Regulatory continuum



Source: Canadian Centre on Substance Abuse

camh

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Colorado and Washington (US)

	Colorado	Washington
Minimum purchase age	21	
Public use	Prohibited	
Impaired driving limit	5 nanograms / ml THC in the blood	
Personal possession	Up to one ounce	
Personal production	Individuals can grow up to 6 plants (3 mature at one time)	Not permitted
Medical access	State-regulated retail system maintaining a dual system	Unregulated supply system implementing a consolidated system
Initial sales	Full implementation built on existing medical retail	Gradual scale-up of a completely new system

Source: Canadian Centre on Substance Abuse

camh

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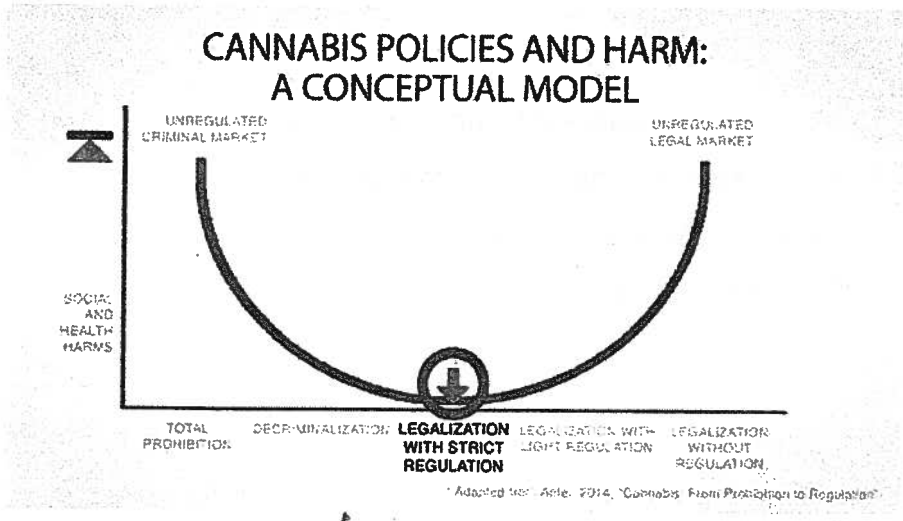
Legalization with strict regulation



camh

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CANNABIS

CAMH recommends legalization with strict regulation

CAMH offers 10 basic principles to guide regulation of legal cannabis use.

ESTABLISH A GOVERNMENT MONOPOLY ON SALES
Control boards provide an effective means of controlling consumption.

SET A MINIMUM AGE
Sales or supply of cannabis products to underage individuals should be penalized.

LIMIT AVAILABILITY
Place caps on retail density and limits on hours of sales.

CURB DEMAND THROUGH PRICING
Pricing policy should curb demand while minimizing the continuation of black markets.

CURTAIL HIGHER-RISK PRODUCTS AND FORMULATIONS
This would include higher-potency formulations and products designed to appeal to youth.

INVEST IN EDUCATION AND PREVENTION
Need both general and targeted initiatives for specific groups e.g. adolescents, people with a history of mental illness.

PROHIBIT MARKETING, ADVERTISING AND SPONSORSHIP
Products should be sold in plain packaging with warnings about risks of use.

PRODUCT INFORMATION SHOULD BE CLEARLY DISPLAYED
In particular, products should be tested and labelled for THC and CBD content.

ADDRESS & PREVENT CANNABIS-IMPAIRED DRIVING
Develop a comprehensive framework that includes prevention, education and enforcement.

ENHANCE ACCESS TO TREATMENT AND EXPAND TREATMENT OPTIONS
Include a spectrum of options from brief interventions for at-risk users to more intensive interventions.

Risks, and how to mitigate them

- Insufficient regulation / poor implementation
- Increased availability? Increased use?
- Sending the wrong message
- The profit motive

camh 33

Where to next?

- Federal election campaign 2015
  - Conservatives: status quo (+ possibly the addition of a ticketing option)
  - Liberals: legalization and regulation
  - NDP: decriminalization as a first step
  - Green Party: legalization and taxation as a budgeted revenue source

camh 34

In summary...

- Criminalization causes harm
- Evidence supports public health approaches to substance use
- Decriminalization could be an improvement over the current model, but it is problematic in many ways
- Legalizing cannabis would allow for more control over risk factors
- Any reform of Canada's system of cannabis control must include a strong focus on prevention and a range of interventions aimed at groups that are at higher risk of harm

camh 35

Thanks!

- **JF Crépault**

JeanFrancois.Crepault@camh.ca
416 535-8501 ext. 32127

camh 36

February 12, 2016

The Right Honourable Justin Trudeau
Prime Minister of Canada
House of Commons
Ottawa, Ontario K1A 0A6

Dear Prime Minister Trudeau,

Re: Cannabis: A Public Health Approach

At its meeting on January 21, 2016, the Middlesex-London Board of Health approved Report No.003-16 and its Appendix, supporting a public health approach to cannabis policy, including a strong framework of strict regulations to minimize health and social harms.

After receiving this report, the following motion was passed:

Moved by: Mr. Stephen Turner Seconded by: Mr. Trevor Hunter

That the Board of Health for Middlesex-London:

1) *authorize staff to advocate for an evidence-based public health approach to Cannabis in the context of legalization, including strict regulation for the non-medical use of cannabis, as well as its production, distribution, product promotion and sale; and*
2) *establish baseline data and mechanisms to monitor local use of cannabis in the coming years; and*
3) *forward this report and appendices to the Association of Local Public Health Agencies, the Ontario Public Health Association, Ontario Boards of Health, the Ontario Minister of Health and Long-Term Care, the federal Minister of Health, and other elected officials as appropriate.*

We applaud the Liberal government's commitment to developing an evidence based approach to cannabis regulation and control, and advocate for a strong public health focus in this regard.

Sincerely,

Jesse Helmer
Chair, Middlesex-London Board of Health

Dr. Christopher Mackie, MD, MHSc, CCFP, FRCPC
Medical Officer of Health & CEO

Cc:
Hon. Eric Hoskins, Ontario Minister of Health
Hon. Jane Philpott, Minister of Health
Hon. Kathleen Wynne, Premier of Ontario
Bill Blair, MP Scarborough-Southwest, Parliamentary Secretary to the Minister of Justice and Attorney General of Canada
Bev Shipley, MP Lambton-Kent-Middlesex
Irene Mathyssen, MP London-Fanshawe
Karen Vecchio, MP Elgin-Middlesex-London
Kate Young, MP London-West
Peter Fragiskatos, MP London-North Centre
Deb Matthews, MPP London-North Centre
Jeff Yurek, MPP Elgin-Middlesex-London
Monte McNaughton, MPP Lambton-Kent-Middlesex
Peggy Sattler, MPP London-West
Theresa Armstrong, MPP London-Fanshawe
Daniel Cho Program and Policy Assistant, Ontario Public Health Association
Linda Stewart, Executive Director, Association of Local Public Health Agencies
Pegeen Walsh, Executive Director Ontario Public Health Association
All Ontario Boards of Health

Encl.

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 003-16

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2016 January 21

CANNABIS: A PUBLIC HEALTH APPROACH

Recommendation

It is recommended that the Board of Health:

1. ***authorize staff to advocate for an evidence-based public health approach to Cannabis in the context of legalization, including strict regulation for the non-medical use of cannabis, as well as its production, distribution, product promotion and sale; and***
2. ***establish baseline data and mechanisms to monitor local use of cannabis in the coming years; and***
3. ***forward this report and appendices to the Association of Local Public Health Agencies, the Ontario Public Health Association, Ontario Boards of Health, the Ontario Minister of Health and Long-Term Care, the federal Minister of Health, and other elected officials as appropriate.***

Key Points

- Canada has one of the highest rates of cannabis use in the world.
- Police associations and public health organizations have expressed support for a new approach, and the federal government has indicated that they will legalize cannabis in their current mandate.
- Cannabis use is associated with a variety of health harms. The most concerning occur among youth and chronic heavy users.
- A public health approach to cannabis policy is recommended, including a strong policy framework of strict regulations to minimize health and social harms.

Background

In July 2015, staff reported to the Board of Health on work being undertaken to develop an evidence-based position on cannabis policy (see Report No. 047-15 from July).

Canada has one of the highest rates of cannabis use in the world with over 40% of Canadian adults having used cannabis in their lifetime. In Ontario, it is the most widely consumed illicit drug, with youth and young adults having the highest rates of use. The debate about the regulation of cannabis for non-medical use has been ongoing for decades in Canada and has gained interest with the election of the new Liberal government. Despite decades of legislation and international conventions aimed at eliminating cannabis, use has continued to increase globally. In response, various countries have adjusted or are in the process of adjusting their approach to cannabis legislation and control.

Portugal decriminalized the possession of all drugs for personal use in 2001 while implementing a national drug strategy at the same time. In 2013, Uruguay became the first country to legalize the personal use and sale of cannabis. In the United States, 15 states have decriminalized the possession of small amounts for personal use and in 2012 Colorado and Washington State became the first two states to legalize recreational use of cannabis, followed by Alaska, Washington DC and Oregon.

A comprehensive review of what cannabis is, prevalence of use, history of law related to cannabis, cannabis associated harms, synopsis of trends away from prohibition and positions of other Canadian agencies can be found in the attached report, Cannabis: A Public Health Approach (see Appendix A).

Public Health Approach

While the scientific evidence suggests that cannabis has a smaller public health impact than alcohol and tobacco, cannabis is associated with health risks which generally increase with frequent heavy consumption and use at an early age. Public health considerations include cannabis impaired driving, effects on youth brain development and mental health, respiratory system effects, use during pregnancy and risk of dependence. Criminalization of cannabis possession and use has not reduced use and has paradoxically resulted in increased health and social harms.

A public health approach addresses the public health concerns of cannabis use while aiming to eliminate or reduce the health and social harms resulting from its criminal prohibition. The Canadian Public Health Association (CPHA) asserts that a public health approach based on principles of social justice, attention to human rights and equity, evidence informed policy and practice and addressing the underlying determinants of health is the preferred approach to criminalization.

The Centre for Addiction and Mental Health (CAMH) is Canada's largest mental health and addiction teaching hospital, as well as one of the world's leading research centres in its field. In 2014, following extensive review of the research, CAMH scientific staff released the report "Cannabis Policy Framework" concluding that Canada requires a strong policy framework for cannabis, recommending legalization with strict regulations.

The policy framework by CAMH is consistent with the views of other agencies such as Canadian Public Health Association (CPHA) and the Canadian Centre on Substance Abuse (CCSA). Middlesex London Health Unit recommends an approach to cannabis policy that is consistent with CAMH. This recommended approach is also consistent with the Colorado Department of Public Health and Environment's public health framework for legal recreational marijuana. The federal government's approach to changing the legal framework around cannabis has also received support from such policing organizations as the Canadian Association of Chiefs of Police.

Conclusion

While there are recognized and important health harms to cannabis use, these are modest in comparison to the health impacts of other drugs such as alcohol and tobacco. Despite prohibition, prevalence of the recreational use of cannabis has increased, and moreover, criminal prohibition has resulted in well documented health and social harms. The Ontario Public Health Standards mandates boards of health to reduce the frequency, severity and impact of substance misuse; with regards to cannabis, criminal prohibition is a barrier to effectively meet these objectives.

In the context of coming legalization, strict regulation for the non-medical use of cannabis, i.e. a public health approach to cannabis production, distribution, product promotion and sale, is recommended to best prevent and reduce health and social harms associated with cannabis use. This approach acknowledges that cannabis is not a benign substance and that policy built upon evidence-based regulations and controls is the recommended best approach to minimize the risks and harms associated with use.

The report was prepared by Ms. Mary Lou Albanese, Manager and Ms. Rhonda Brittan, Public Health Nurse, Healthy Communities and Injury Prevention Team.

Christopher Mackie, MD, MHSc, CCFP, FRCPC
Medical Officer of Health

This report addresses the following requirement(s) of the Ontario Public Health Standards:
Prevention of Injury and Substance Misuse Standard Requirement #2.

Appendix A to Report # 003-16

Cannabis: A Public Health Approach

January 8, 2016

For information, please contact

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Cannabis: A Public Health Approach. London, Ontario: Author.

Authors:

Mary Lou Albanese RN, BScN, MSA
Rhonda Brittan, RN, BScN, MPH, CCHN(C)

Table of Contents

1.0 Introduction

A public health approach to cannabis policy is needed in Canada. Despite prohibition, Canada has one of the highest rates of cannabis use in the world with over 40 % of Canadian adults having used cannabis in their lifetime. In Ontario, it is the most widely consumed illicit drug, with youth and young adults having the highest rates of use. While it is known that cannabis use has the potential for adverse health consequences, most notably for those who begin use at an early age and use it frequently, the current approach of criminalization has been shown to increase these harms while also causing significant social harm. Furthermore, data shows that Canada's possession laws are not enforced consistently across jurisdictions or populations, making criminal prohibition of cannabis possession an issue of health equity.

The debate about the regulation of cannabis has been ongoing for decades. Most recently the issue has gained momentum with the election of a Liberal government that made cannabis legalization part of its election platform. The December 4th, 2015 Throne Speech included a pledge to "legalize, regulate and restrict access to marijuana". Canadian public support for change to cannabis control has been growing, and internationally, the landscape of cannabis policy is changing at a rapid pace.

This report builds upon the report: *Cannabis – Health Implications of Decriminalization, Legalization, and Regulation*, which was provided to the MLHU Board of Health in July, 2015. This report will provide background information about cannabis and trends in use; provide an overview of the current evidence related to the health harms of cannabis and the harms stemming from the criminalization approach; briefly describe current law and the historic progression of Canadian law related to cannabis control, including how medical marijuana fits into the current regulatory landscape in Canada; and provide an overview of regulatory models that have moved away from prohibition and the lessons learned.

While taking into consideration the positions of leading Canadian organizations, this report will conclude with a recommendation for a regulatory approach to cannabis control that will reduce the risks of health and social harms.

2.0 Cannabis: What Is It?

Cannabis, more commonly called marijuana, is the dried flowers, fruiting tops and leaves of the cannabis plant, most frequently, *Cannabis sativa*. The cannabis plant contains several different *cannabinoids*, the psychoactive component being delta-9-tetrahydrocannabinol (THC). The level of THC varies depending on the part of the plant used, plant breeding, and product processing. Cannabis can be consumed by smoking, such as a "joint" or in a pipe or bong, ingested as an edible, or consumed in a liquid infusion (CCSA, 2015; Room et al., 2010).

Psychoactive substance is a name given to a classification of substances that affect mental processes such as mood, sensations of pain and pleasure, motivation, cognition and other mental functions. Cannabis can be considered in the context of other psychoactive substances which include alcohol, tobacco, some prescription medications, and even caffeine. Psychoactive substances, including cannabis, have been used both medically and non-medically by humans for thousands of years (CPHA, 2014; Health Officers Council of BC, 2011). People use cannabis for various reasons and it affects people in different ways. Typically it produces a state of relaxation, happiness and changes in perception. The level of THC in the product, the amount of product consumed, the user's previous experience with the drug, and mode of consumption will impact its effects. When smoked, effects will typically be felt by the user in about 10 minutes and rapidly dissipate; while when ingested, the effects of cannabis can take anywhere from 30 minutes to 2 hours to be felt, and can last several hours. (Monte, Zane & Heard, 2015).

3.0 Prevalence of Use

Globally: Cannabis is the most widely used illegal drug in the world. According to the United Nations Office of Drugs and Crime (UNODC) an estimated 160 million people - 4% of the global adult population used marijuana in 2005 (Room et al., 2010). Cannabis became popular in Western countries in the 1960's. While prevalence has shifted over years and decades, rates are highest among youth and young adults. Common patterns of use across countries suggest that penalties for personal use do not affect prevalence of use (Room et al., 2010).

Canada: Canada has one of the highest rates of cannabis use in the world, with more than 40% of Canadian adults having used cannabis in their lifetime and 10% reporting past year use. Youth have the highest prevalence of use, with 2012 data indicating that over 20.3% of youth aged 15-24 used marijuana in the previous year (Health Canada, 2014)

Ontario: Ontario use is consistent with Canada as a whole, with population surveys indicating that 14% of adults and 23% of secondary school students have used cannabis in the past year. While cannabis use is most common in youth and young adults, Ontarians aged 30 and over account for half of all use (CAMH, 2014).

The Ontario Student Drug Use and Health Survey (OSDUHS) is a population survey of Ontario students in grades 7 through 12. According to the 2015 OSDUHS, cannabis is the third most commonly used substance after alcohol and energy drinks. Cannabis use increases with each grade level, with 10.3% of 9th graders compared to 37.2% of 12th graders reporting past year use. Males and female rates of use are similar. While cannabis use has shown a gradual decline since 1999, about 2 % of students report using cannabis daily, which equals approximately 20,000 Ontario students. Age at first use has shown an increase over past decades. In 2015, the average age at first cannabis use reported among 12th-grade users was 15.3 years. For grade 7 students, less than 0.5% used cannabis for the first time before the end of grade 6, compared with 5% in 2003, and 7% in 1981 (Boak et al., 2015).

Middlesex-London: London and Middlesex data regarding prevalence of cannabis use is limited. Although the Ontario Student Drug Use and Health Survey (OSDUHS) does not analyse data at the county level, it does analyse data down the level of a Local Health Integration Network. Across regions, the OSDUHS did not find significant difference in student cannabis use (Boak et al., 2015).

4.0 History of Law Related to Cannabis

The laws and systems that have been put in place to manage substances, including cannabis, reflect the dominant social norms, beliefs and political stances of the times when they were created, rather than current scientific knowledge and evidence (CPHA, 2014).

Cannabis was added to the schedule of prohibited drugs under Canada's *Opium and Narcotic Drug Act* in 1923. While the first charge for cannabis possession was not laid until the 1930's, cannabis became a primary drug enforcement focus in the 1960's. By 1972 there were more than 10,000 arrests for possession and use, with many young Canadians receiving criminal convictions (Ontario Public Health Working Group, 2004). The *Controlled Drugs and Substances Act* was introduced during the 1990's and is the legislation that currently governs cannabis and other psychoactive drugs in Canada.

Globally, cannabis was widely used for medical purposes from the end of the 19th century continuing into the 1950's. In 1961 it was added to the strictest prohibition category of the 1961 Single Convention on Narcotic Drugs specifying that 'use of cannabis should be prohibited for all purposes medical and non-medical alike'. International prohibition of cannabis was further solidified in the 1988 Convention, making even possession a criminal offence under each signatory country's domestic law. Many countries, including Canada, are signatories to these international drug control Conventions, criminalizing the production, distribution, use and possession of cannabis (Room et. al., 2010).

Despite legislation and international conventions aimed at eliminating use of cannabis, by the early 1970's there was a growing realization that prohibition was not achieving its intended effect. Public inquiries and commissions occurred in several

countries, including Canada, concluding that the effects of criminalization were excessive and counterproductive and calling on lawmakers to eliminate or reduce criminal penalties for personal use (Room et al., 2010).

In Canada alone, the ineffectiveness and high cost of criminalization has been described, and a call to move away from absolute prohibition made, in several reports: the Le Dain Commission (1972); the Senate (1974); the Canadian Bar Association (1994); the Canadian Centre for Substance Abuse (1998); Centre for Addiction and Mental Health (CAMH) (2000); the Frasier Institute (2001); the Senate Special Committee on Illegal Drugs (2002); The Health Officers Council of British Columbia (2011); the Canadian Drug Policy Coalition (2013); the Canadian Public Health Association (2014) and CAMH (2014).

5.0 Current Canadian Law Related to Cannabis

Marijuana is classified as a Schedule II drug under the *Controlled Drugs and Substances Act* (CDSA). This means that it is illegal to grow, possess, distribute and sell marijuana. Convictions under the CDSA will result in a criminal record and may result in penalties ranging from fines to life imprisonment depending on the nature of the offence (CCSA, 2014).

In Canada in 2013, 58,965 incidents involving possession of cannabis were reported to police. Over 600,000 Canadians currently hold a criminal record related to cannabis possession (Canadian Drug Policy Coalition, 2015).

Marijuana is also regulated through international treaties to which Canada is a signatory (CCSA, 2014).

Drug-impaired driving is an offence under the Criminal Code of Canada (Beirness & Porath-Waller, 2015).

5.1 Medical Marijuana in Canada

The human body has naturally occurring endocannabinoids that act on the brain and nervous system. When the body's own endocannabinoids bind to specific receptors, symptoms, such as anxiety, convulsive activity, hypertension and nausea which can be caused by over-activity of the nervous system are reduced. When marijuana is consumed, these same cannabinoid receptors are activated. Although there are claims that marijuana can benefit a wide range of symptoms and diseases, more research is needed. Current evidence supports the medical use of cannabis for nausea, vomiting and chronic pain (Kalant & Porath-Waller, 2014).

Cannabis for medical use has been legal in Canada since 2001, initially under the *Marihuana Medical Access Regulations* (MMARs). Under the MMARs, legal access to marijuana for medical purposes could be granted to Canadians meeting certain requirements. Health Canada was responsible for issuing authorizations and approved individuals had the option of obtaining their medical marijuana through Health Canada, a designated grower, or growing their own (Kalant & Porath-Waller, 2014).

Effective 2014, the MMARs were replaced with the *Marihuana for Medical Purposes Regulations* (MMPRs). Individuals now must receive a prescription from a medical practitioner versus Health Canada, and users of medical marijuana no longer have the legal option of growing their own product (Kalant & Porath-Waller, 2014). There are limits to how much cannabis that an individual can possess at one time (Health Canada, 2015).

As of September 30, 2015 there were 26 Health Canada authorized, licensed producers in Canada under the MMPR, 14 located in Ontario. While some are licensed only to produce, others can both produce and sell. Licensed producers are highly regulated and routinely inspected by Health Canada. Licensing requirements are strict and include quality control standards, physical and personnel security measures, inventory management and stringent record keeping. Products must be shipped in child resistant packaging and meet labelling requirements with health warning messages as well as THC content (Health Canada, 2015).

6.0 Harms

While the scientific evidence suggests that cannabis has a smaller public health impact than alcohol and tobacco, cannabis, like other drugs, is associated with health risks. Evidence has shown that these health risks generally increase with frequent consumption (daily or nearly-daily) and when used at an early age.

6.1 Direct Health Harms

Cannabis-Impaired Driving: Research has shown that driving while impaired by cannabis is associated with performance deficits in tracking, reaction time, visual function, concentration, short-term memory, and divided attention which increases the risk of motor vehicle crashes (Beirness & Porath-Waller, 2015). Epidemiologic data suggests that cannabis users that drive while intoxicated have 2 to3 times the risk of motor vehicle crashes over a non-drug intoxicated driver and the higher the level of THC in the blood, the higher the risk of crash (Hall, 2014 & Colorado Department of Public Health and Environment [CDPHE], 2015). In comparison, intoxication with alcohol has been found to increase motor vehicle crash risk by 6 to15 times. The combination of cannabis with alcohol increases the risk of collision more than either substance on its own (Hall, 2014). CAMH currently has a study underway to determine the extent of relationship between cannabis consumption and driving ability.

The 2012 Canadian Alcohol and Drug Use Monitoring Survey (CADUMS) found that 2.6% of drivers admitted to driving within two hours of cannabis consumption at least once in the previous year (Beirness & Porath-Waller, 2015). Among young drivers, driving after using cannabis is more prevalent than driving after drinking alcohol; with 1 in 10 drivers in grades 10 -12 reporting driving within an hour of cannabis use at least once in the past year (Boak et al., 2015). The issue of cannabis impaired driving is particularly of concern for youth, as data indicates that young adults are at highest risk of injury and death from motor vehicle crashes while are also the highest users of cannabis.

In contrast to alcohol, testing for drugged driving is more complicated, inconsistent, and there is not a specific level of cannabis consumption that leads to intoxication. A very real policy challenge therefore is to define a THC level in blood that can define impairment (Room et. al., 2010). Detection of cannabis–impaired driving is further complicated by the fact that cannabis can remain detectable in the blood and urine for days, long after the effects have worn off. Thus even in cases of motor vehicle collisions, the detection of cannabis in body fluids does not necessarily mean that someone was impaired at the time of collision (Hall, 2014; Room et al., 2010).

Brain Development: In addition to the risk of motor vehicle collisions, there is growing evidence that regular cannabis use in adolescence can cause harm to the developing brain. Regular cannabis use beginning in adolescence and continuing through young adulthood appears to produce cognitive impairment, with unclear evidence on whether this impairment is fully reversible (Hall, 2014). Early, regular cannabis use has been associated with low levels of educational attainment, diminished life satisfaction, higher likelihood of developing cannabis use disorder, and increased risk of developing mental health problems (CAMH, 2014). Additionally, some research shows that regular adolescent cannabis users are more likely to use other illicit drugs, although the association is not fully understood (Hall, 2014). Given that a large portion of cannabis users are youth, youth cannabis use is a significant public health concern.

Mental Health: Research has found that individuals who use cannabis, especially frequent and high potency users, are at increased risk for psychosis and psychotic symptoms. Regular cannabis use in adolescence has been associated with increased risk of being diagnosed with schizophrenia (CAMH, 2014, CCSA, 2014).

Dependence: Although much lower than the dependence rates for other drugs (e.g., nicotine, alcohol and cocaine), about 9% of cannabis users develop dependence (CAMH, 2014). Cannabis has remained the third most common identified drug of dependence (behind alcohol and tobacco) in both Canada and the United States over the past 20 years (Hall, 2014). Long term frequent users have higher risk of dependence than those who use occasionally (CAMH, 2014). For Ontario youth, the 2015 OSDUHS survey found that among past year users about 7% of students grade 9-12 report symptoms of dependence.

Pregnancy: THC can pass through the placenta, as does carbon monoxide when cannabis is smoked (CDPHE, 2015). Maternal cannabis use during pregnancy has been shown to modestly reduce birth weight (Hall, 2014). There is also some evidence that cannabis use during pregnancy can affect development and learning skills throughout childhood, including children's cognitive functioning, behaviour, substance misuse and mental health (Porath-Waller, 2015).

Respiratory Problems: Regular cannabis smoking has been associated with respiratory symptoms of chronic bronchitis and reduced lung function (Hall, 2014). Cannabis smoke contains many of the same carcinogens as tobacco smoke. Furthermore, cannabis smokers tend to inhale unfiltered smoke, inhale more deeply and hold smoke in their lungs (Room et al., 2010). While there is some evidence that smoking cannabis can be a risk factor for cancers of the lung and upper respiratory tract, this association remains unclear as many cannabis smokers have also smoked tobacco (Hall, 2014). With regards to second hand cannabis smoke, few studies have been conducted. However, because of the similarities in composition between tobacco and marijuana smoke, marijuana second hand smoke is likely to be a similar public health concern (Springer & Glanz, 2015).

Product quality: The quality of cannabis sold on the illegal market is questionable, however hard to qualify due to lack of testing. There have been accounts of contamination with molds, bacteria and pesticides as well as other contaminants, including other drugs. Unknown contamination is a potential risk for health problems and disease outbreaks. Licenced producers of medical marijuana in Canada are required to grow under strict conditions and batches must be tested for contaminants.

6.2 Indirect Harms

The public health impact of cannabis cannot be fully understood without consideration of the impact of the policies and legal sanctions that have been put in place to manage it. Relative to the health dangers of the drug itself, there has been a growing concern about the disproportionate social harms stemming from its prohibition. A conviction for a marijuana related offence results in a criminal record that can reduce opportunities for education, employment, and travel. From a public health lens, the illegality of cannabis has hindered the ability of health and education professionals to effectively prevent and address problematic use (CAMH, 2014).

The consequences of cannabis criminalization were well described over a decade ago by the Senate Special Committee on Illegal Drugs: "In addition to being ineffective and costly, criminalization leads to a series of harmful consequences: users are marginalized and exposed to discrimination by the police and the criminal justice system; society sees the power and wealth of organized crime enhanced as criminals benefit from prohibition; and governments see their ability to prevent at-risk use diminished" (Senate Special Committee on Illegal Drugs, 2002 , p. 42).

The cost to enforce the current cannabis law is significant. In 2002 the estimated annual cost in Canada of enforcing cannabis possession laws, including police, courts and corrections, was 1.2 billion dollars (CAMH, 2014).

The need for a public health approach to the management of cannabis is paramount. A balance between the health risks, social harms and legal ramifications is necessary.

7.0 A Public Health Approach…What Is It?

In May of 2014 the Canadian Public Health Association released a discussion paper entitled "A New Approach to Managing Illegal Psychoactive Substances in Canada", recommending a public health approach as the best alternative to prohibition and criminalization for the management of psychoactive substances.

A public heath approach addresses the public health concerns of cannabis use while aiming to eliminate or reduce the health and social harms resulting from its criminal prohibition.

A public health approach is "based on the principles of social justice, attention to human rights and equity, evidence informed policy and practice, and addressing the underlying determinants of health" (CPHA, 2014, p. 7).

The "Paradox of Prohibition" (Figure 1) provides a visual model demonstrating where a public health approach sits on a continuum of regulatory approaches. It proposes that supply and demand is best controlled and social and health problems are lowest when the extremes of complete prohibition and free market legalization and commercialization are avoided.

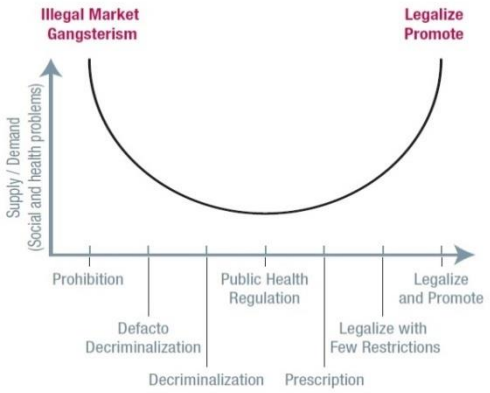

Figure 1: Paradox of Prohibition. Health Officers Council of British Columbia (2011). Reprinted with permission.

Public health approaches to tobacco and alcohol provide supporting evidence of effective strategies that could be applied toward a public health approach to cannabis.

Tobacco is a legal, but extremely harmful substance with no medical benefits, significant health harms, and is the focus of substantial public health efforts and government regulatory control aimed to dissuade consumption and reduce public harms. "Canada has been a world leader with regards to federal legislation about sponsorship restrictions, graphic packaging warnings and banning flavours" (Health Officers Council of BC, 2011, p.47). Provincially, the *Smoke-Free Ontario Act* puts in place many measures related to the sale, promotion and use of tobacco including prohibitions against the sale and supply of tobacco products to persons under the age 19, measures to control advertising such as banning displays, and indoor and outdoor smoking restrictions. Additionally, public health plays a role in tobacco use prevention, screening, brief intervention and cessation support for individuals that use tobacco products. The *Tobacco Tax Act* also provides substantial provincial control around the taxation and regulation of tobacco products from the production of raw leaf tobacco through to the sale of manufactured tobacco products.

Alcohol is legal and widely consumed but with clear evidence of health and social harms. Efforts to mitigate these harms include a combination of provincial and municipal regulatory approaches. These approaches include taxation, government based controls over production and distribution, minimum pricing, age restrictions for purchase, and restrictions retail outlet density and hours of sale. These are policies that have been shown to reduce alcohol related problems when implemented alongside targeted measures such as youth education, drinking and driving countermeasures, promotion of Canada's Low Risk Alcohol Drinking Guidelines, and screening and referral to treatment (Babor et al., 2010; CAMH et al., 2015).

Haden and Emerson (2014) have applied these public health based strategies to describe a public health model of cannabis regulation that incorporates evidence-based strategies from both tobacco and alcohol policy.

8.0 Trends Away From Prohibition

Evidence from other countries' experiences with cannabis policy approaches is incomplete. Furthermore, the policy and regulatory landscape within each jurisdiction is constantly evolving. When looking at the literature and reviewing related commentary, whether or not a certain cannabis policy is presented as a success or failure depends on the perspective of the writer. Outlined below are some of the key characteristics, differences and outcomes from countries that have moved away from a prohibition based approach.

8.1 The Netherlands

In the Netherlands a formal policy of non-enforcement has been in place since 1976 for the possession and sale of small amounts of cannabis. The intent of this policy was to separate cannabis from other hard drug use. Dutch policy and regulations continue to shift in response to emerging evidence related to cannabis, internal and external politics and lessons learned over time (MacCoun, 2011).

- Dutch 'coffeeshops' operate under strict licensing conditions, including age restrictions, limits on per person amounts, a ban on sales of alcohol and other drugs, and regulations related to shop appearance, signage and marketing.

- While purchase and use of cannabis is permitted, production is illegal. Thus, cannabis sold in coffeeshops comes from an illegal and unregulated production system (CCSA, 2014; Roles, 2014).

- There has been success in separating cannabis from the market for other illegal drugs (Room et al., 2010).

- During early commercialization, prior to advertising and age restrictions, there was evidence of more cannabis use by youth and an earlier age of first use. This trend reversed when increased regulations for coffeeshops were implemented in the mid-90's (Room et al., 2010).

- Evidence suggests that prevalence of cannabis use is lower in the Netherlands than in several neighboring countries as well as Canada and the US (MacCoun, 2011).

8.2 Portugal

Portugal decriminalized the possession of all drugs for personal use in 2001 at the same time as a national drug strategy was implemented aimed at providing a more comprehensive and evidence-based approach to drug use. This made possession and acquisition of personal amounts of drugs an administrative offence rather than a criminal offence.

- Offenders are referred to a Commission for the Dissuasion of Drug Addiction (CDT) who provide a range of sanctions ranging from a fines and community service to treatment (Hughes & Stevens, 2010).

- Early evidence suggests small increases in reported illicit substance use by adults, however reductions have been seen in problematic use, adolescent use, substance related harms, and criminal justice system burden (Hughes & Stevens, 2010).

8.3 Uruguay

In 2013 Uruguay became the first country to legalize the personal use and sale of cannabis. The law allows three ways to legally acquire marijuana: self-production of a limited number of plants by registered users, joining a cannabis club, or purchasing at a pharmacy. Households are permitted to grow up to six plants each. As written, the law states that to purchase from a pharmacy, people must be residents of Uruguay age 18 or over, and must be registered with a national database. Marijuana cannot be used in public places (CCSA, 2014). Change of Uruguay government since the law was initially passed has affected the extent and rate of implementation. Information on early outcomes is not readily available.

8.4 United States

While cannabis remains illegal for sale at the US federal level, there are significant differences in cannabis control policy across states. Fifteen states have decriminalized the possession of small amounts for personal use, with Oregon being the first state to do so. In 2012, Colorado and Washington State became the first two states to legalize recreational use of cannabis. Colorado began retail sales in January of 2014, while Washington State did so in July of 2014 (CCSA, Nov 2015). Since then, Alaska, Oregon and the District of Columbia have passed legislation allowing possession and personal use of cannabis for non-therapeutic purposes.

Colorado and Washington State are being looked to as a key source of information regarding legalization of cannabis and the resultant health, social, economic and public safety impacts. The early legalization experiences in these states will be highly informative to the development of Canadian policy. The Canadian Centre on Substance Abuse (CCSA) led a delegation in 2015 to both Colorado and Washington State with the aim to collect evidence to inform Canadian policy. Much of the data needed to evaluate the impact of legalization is not yet available. The CCSA will continue to monitor data from Colorado and Washington as it becomes available (CCSA, Nov 2015).

There are significant differences between how Colorado and Washington is implementing legalized cannabis, particularly related to the scope of government regulation. While Washington has a higher level of regulation, Colorado began with a more free-market approach.

8.4.1 Colorado

- Colorado took 1 year from voted legalization to implementation.

- Licensing body is Colorado Department of Revenue.

- Age restriction is 21 and over.

- Personal production of up to 6 plants permitted that must be in an enclosed locked space.

- Early legalization has been market driven, with new products and commercial branding.

- The extent of the edibles market was unanticipated and has become a large part of the market resulting in the need to address high potencies, child enticing packaging, and overconsumption.

- The Colorado Department of Public Health and the Environment (CDPHE) is responsible for monitoring changes in drug use patterns and health effects of marijuana. The CDPHE is also involved in the development of policies and regulations to protect public health and safety.

- Data on first year patterns of use and health outcomes is extremely limited. However, early data has shown increasing trends of poison centre calls, hospitalizations and emergency room visits possibly related to marijuana, and increase in hospitalization rates for children with possible marijuana exposure.

- The Rocky Mountain High Intensity Drug Trafficking Area (RMHIDTA) is concurrently tracking impact of marijuana legalization. While reported findings have been fairly widely quoted, this data should be interpreted with caution. RMHIDTA is a US Federally funded agency whose stance is to uphold US federal drug policy.

8.4.2 Washington State

- Washington took 18 months from voted legalization to implementation.

- Licensing body is Washington State Liquor and Cannabis Board.

- Age restriction is 21 and over.

- Personal production not permitted.

- In comparison to Colorado, Washington has stricter licensing laws: e.g. growers cannot sell and sellers cannot grow, limits on farm sizes, limited large corporate operations.

- Taxes are higher than in Colorado.

- The Washington State Institute for Public Policy (WSIPP) is responsible for evaluating legalization outcomes under the categories of public health, public safety, youth and adult rates of use and maladaptive use, economic impacts, criminal justice impacts and state and local administrative costs and revenues. While an evaluation plan is in place, initial outcome results are not expected until September 2017 (Darnell, 2015).

8.5 What are Canadians saying?

Canadian public opinion over the past several years has continued to shift away from a prohibitionist approach to cannabis. While there have been many polls, a recent poll conducted by Forum Research specifically surveyed Canadians about a model of cannabis legalization with regulation. According to this poll, 59 percent of Canadians support a change to law that would legalize tax and regulate recreational marijuana usage under some conditions. With regards to manufacturing and distribution if legalized, the largest proportion of respondents (40%) agreed with a model of corporations being licensed to grow marijuana, and sales controlled through government agencies where it could be restricted, regulated and taxed. However, 15% of respondents preferred an individual model where private consumers may grow their own product (Forum Research, 2015).

9.0 Policy Recommendation: A Public Health Approach

Legislative approaches to cannabis fall along a continuum, ranging from criminal prohibition at one end to unrestricted access and free market production at the other. Decriminalization and legalization (see definitions Appendix I) are approaches that have been used in other jurisdictions. The details within each legislative approach can vary widely. Limitations to the decriminalization approach have been previously described: Middlesex London Health Unit Report No. 047-15, July 2015.

The Center for Addiction and Mental Health's *Cannabis Policy Framework* (CAMH, 2014) provides a strong policy framework for cannabis, recommending legalization with strict regulation. The Canadian Centre on Substance Abuse's 2014 policy brief *Marijuana for Non-Therapeutic Purposes* as well as the

recommendations provided in the 2015 report *Cannabis Regulation: Lessons Learned in Colorado and Washington State* should also be considered key documents in the discussion of cannabis policy reform. Middlesex London Health Unit recommends an approach to cannabis policy that is consistent with many elements proposed by CAMH and CCSA. The positions of these organizations and others can be found in Appendix II.

Further, the Colorado Department of Public Health and Environment has developed a public health framework as a model to guide evidence based public health functions and activities including assessment, policy development and assurance (Ghosh et al., 2016).

The Ontario Public Health Standards mandates boards of health to reduce the frequency, severity and impact of substance misuse; with regards to cannabis, criminal prohibition is a barrier to effectively meet these objectives.

In the context of the coming legalization, strict regulation for the non-medical use of cannabis is recommended to best prevent and reduce health and social harms associated with cannabis use. A public health approach to cannabis would combine public education and awareness with regulations for production, distribution, product promotion and sale. This approach acknowledges that cannabis is not a benign substance and that policy built upon evidence is the recommended best approach to minimize the risks and harms associated with use.

9.1 Recommended considerations for public health focused regulations:

- Minimum age for access and use
- Regulations that address public consumption to the same extent as public smoking
- Regulations related to product formats, quality and THC potency
- Limits on marketing and advertising
- Labelling and packaging that clearly indicates dose and potential health harms
- Limit availability through measures including retail outlet density, business licencing, hours of sales
- Pricing and taxation at level that will curb demand while eliminating or minimizing black market access
- Public education about cannabis and potential health harms
- Targeted youth-focused prevention strategies aimed at preventing early use
- Drug –driving countermeasures that prevent and address cannabis impaired driving
- Access to treatment for problematic substance use that incorporates a harm reduction approach

9.2 Additional considerations:

- Sufficient time must be taken to develop regulations and build capacity to implement these regulations, ensure systems are in place to monitor patterns of use and health outcomes, and develop evidence based prevention and harm reduction messaging.
- Flexibility is paramount. Regulations must be responsive to new evidence as it becomes available.
- An incremental approach is warranted. It will take time to ensure that legalization is done well. Prior to full legalization, consideration should be given to the immediate decriminalization of possession of small amounts of cannabis as an interim step to mitigate the unintended health and social consequences of criminalization.
- Canada is a large and diverse country. Geographical, provincial, social, cultural, and other contextual factors must be taken into consideration in the development of Canadian policy.
- Sectors including but not limited to public health, enforcement, substance use, the medical marijuana industry as well as provincial and municipal levels of government should be consulted.
- Management of existing criminal records for cannabis possession should be a priority.
- Attention to unintended negative consequences is important. A health equity lens must be considered for any regulations that are put in place. For example, consequences of regulations that prohibit public consumption of cannabis will be disproportionately born by homeless or unstably housed populations.

- Investment in research and establishing an evidence base with ongoing data collection related to prevalence of use and health effects is paramount.

- Revenue gained through marijuana taxation should go towards education, prevention and treatment programs and relevant research.

In closing, despite prohibition, Canada has one of the highest rates of cannabis use in the world thus requiring a new approach to the issue. A public health approach is needed to minimize the health and social harms of cannabis. Moving forward in a proactive manner in the context of legalization of cannabis possession and use, strict regulations is the most promising approach to minimize harm.

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Appendix I - Glossary of Terms

Cannabis: Cannabis, more commonly called marijuana, is the dried flowers, fruiting tops and leaves of the cannabis plant, most frequently, Cannabis sativa (CCSA, 2015).

Criminalization: The production, distribution and possession of cannabis are subject to criminal justice sanctions ranging from fines to incarceration. Conviction results in a criminal record. (CCSA, Nov 2015)

Decriminalization: Non-criminal penalties, for example, civil sanctions such as tickets or fines, replace criminal penalties for personal possession. Individuals charged will not, in most cases, receive a criminal record. Most decriminalization models retain criminal sanctions for larger-scale production and distribution. (CCSA, Nov 2015). Decriminalization still leaves cannabis in an unregulated market of producers and sellers (Canadian Drug Policy Coalition, 2015).

Legalization: Criminal sanctions are removed. The substance is generally still subject to regulation that imposes guidelines and restrictions on use, production and distribution, similar to the regulation of alcohol and tobacco. (CCSA, Nov 2015)

Psychoactive Substance: A name given to a classification of substances that affect mental processes such as mood, sensations of pain and pleasure, motivation, cognition and other mental functions (CPHA, 2014).

Public Health Approach: "A public health approach ensures that a continuum of interventions, policies, and programs are implemented that are attentive to the potential benefits and harms of substances as well as the unintended effects of the policies and laws implemented to manage them…ensuring that the harms associated with interventions are not disproportionate to the harms of the substances themselves" (CPHA, 2014, p, 7).

Regulation: Regulation refers broadly to the legislative or regulatory controls in place with regard to the production, distribution and possession of cannabis. The term is, however, increasingly being used in reference to the guidelines and restrictions on use, production and distribution of cannabis under legalization approaches. (CCSA, Nov 2015)

Appendix II – Positions of Others

CAMH: CAMH recommends legalization with strict regulation, offering 10 basic principles to guide regulation of legal cannabis use.

CCSA: "CCSA promotes a national, evidence-informed, multi-sectoral dialogue to develop policy options that will reduce the negative criminal justice, social, and health impacts of marijuana use in Canada. Changes to marijuana policy should be made based on the principles of applying available evidence, reducing harms, promoting public health and equitable application of the law. Based on the evidence available, decriminalization provides an opportunity to reduce enforcement-related health and social harms without significantly increasing rates of marijuana use. This option also provides the opportunity to further investigate and learn from alternative models such as the legalization approaches being implemented internationally" (CCSA, Oct 2014).

CPHA: CPHA endorses a public health approach to the management of illegal psychoactive substances. They have no formal stance specific to cannabis, however endorse Low Risk Cannabis Use Guidelines and support "comprehensive approaches to addressing the use of psychoactive substance based on an accurate assessment and evaluation of the benefits and risks, with an appropriate balance and integration of the four pillars of prevention, harm reduction, treatment, and enforcement, and also needs to include adequate investments in health promotion, education, health protection, discrimination reduction, rehabilitation, research, and monitoring trends; and a public health approach to problematic substance use be central to the development and implementation of a proposed national framework for action on substance use and abuse in Canada."

Canadian Association of Chiefs of Police (CACP) Resolution #03-2013: Does not support the decriminalization or legalization of cannabis in Canada. Rather propose an amendment to the *Controlled Drug and Substances Act* and the *Contraventions Act* in order to provide officers with the discretionary option of issuing a ticket for simple possession (30 grams or less of cannabis marihuana or 1g or less of cannabis resin (CACP, 2013).

HALIBURTON, KAWARTHA, PINE RIDGE DISTRICT HEALTH UNIT
1-866-888-4577 • www.hkpr.on.ca • info@hkpr.on.ca

February 18, 2016

The Honourable Eric Hoskins
Minister of Health and Long-Term Care
Ministry of Health and Long-Term Care
10th Floor, Hepburn Block
80 Grosvenor Street
Toronto ON M7A 2C4

Dear Minister Hoskins

RE: *Patients First: A Proposal to Strengthen Patient-Centred Health Care in Ontario*

At its meeting held today, February 18, 2016, the Board of Health for the Haliburton, Kawartha, Pine Ridge District Health Unit considered a report from the Medical Officer of Health (copy attached) and endorsed the following recommendations:

THAT the Board of Health for the Haliburton, Kawartha, Pine Ridge District Health Unit request that the Minister of Health and Long-Term Care ensure that public health units continue to be directly funded by the Province;

THAT the Board of Health for the Haliburton, Kawartha, Pine Ridge District Health Unit request that the Minister of Health and Long-Term Care ensure that the Population and Public Health Division of the Ministry of Health and Long-Term Care maintain responsibility for accountability agreements with public health units;

THAT should the proposed changes for public health units as outlined in the Patients First Discussion paper be implemented then the Board of Health for the Haliburton, Kawartha, Pine Ridge District Health Unit endorse recommendations made to the Toronto Board of Health as follows:

HEAD OFFICE
200 Rose Glen Road
Port Hope, Ontario L1A 3V6
Phone · (905) 885-9100
Fax · (905) 885-9551

BRIGHTON OFFICE
Box 127
35 Alice Street
Brighton, Ontario K0K 1H0
Phone · (613) 475-0933
Fax · (613) 475-1455

HALIBURTON OFFICE
Box 570
191 Highland Street, Unit 301
Haliburton, Ontario K0M 1S0
Phone · (705) 457-1391
Fax · (705) 457-1336

LINDSAY OFFICE
108 Angeline Street South
Lindsay, Ontario K9V 3L5
Phone · (705) 324-3569
Fax · (705) 324-0455

…/2

1. The Board of Health request the Minister of Health and Long-Term Care to ensure a continued strong role for public health in keeping people healthy by:
    a. Maintaining independent governance of the local public health sector by boards of health;
    b. Strengthening comprehensive provincial standards for public health through the current review of the Ontario Public Health Standards, especially for healthy public policy and other programs that keep people healthy;
    c. Ensuring that any provincial funding directed to local boards of health by Local Health Integration Networks cannot be reallocated to other health services and that there is a transparent budget process;

2. The Board of Health request the Minister of Health and Long-Term Care to mandate a formal relationship between LHINs and senior representatives of the healthcare, municipal, education, social service and voluntary sectors as well as the Medical Officer of Health to support population health planning and service coordination in order to improve health equity and address social determinants of health; and

3. The Board of Health request the Minister of Health and Long-Term Care to provide the necessary resources to LHINs and Boards of Health to support collaboration on population health planning of health services;

4. The Board of Health request the Minister of Health and Long-Term Care to create transparent accountability indicators and targets for LHINs which include population health and health equity; and

THAT the Board of Health for the Haliburton, Kawartha, Pine Ridge District Health Unit request the Minister of Health and Long-Term Care to adjust LHIN boundaries to create geographic alignment with the boundaries of municipalities, school boards, and public health units.

…/3

The Board of Health for the Haliburton, Kawartha, Pine Ridge District Health therefore strongly urges the Ministry of Health and Long-Term Care to include these recommendations in any implementation of the *Patients First: Proposal to Strengthen Patient-Centred Health Care in Ontario.*

Sincerely

BOARD OF HEALTH FOR THE HALIBURTON, KAWARTHA,
PINE RIDGE DISTRICT HEALTH UNIT

Original signed by Mr. Lovshin

Mark Lovshin
Board of Health Chair

Attachment

HALIBURTON, KAWARTHA, PINE RIDGE DISTRICT HEALTH UNIT
1-866-888-4577 • www.hkpr.on.ca • info@hkpr.on.ca

DATE: February 18, 2016

TO: The Board of Health

FROM: Dr. A. Lynn Noseworthy
Medical Officer of Health

RE: Patients First: A Proposal to Strengthen Patient-Centred Health Care in Ontario

Background

On December 17, 2015, the Ontario Minister of Health and Long-Term Care released a discussion paper "Patients First: A Proposal to Strengthen Patient-Centred Health Care in Ontario", which outlined proposals to transform Ontario's health system. In his cover letter Minister Hoskins indicated that the Ministry is "committed to a meaningful engagement process that includes all health system partners……that this input will result in a plan that can successfully build a high-performing health system that is more responsive to local needs, is better connected and integrated, drives quality and performance, and enhances transparency for providers and patients, clients and their families."

Proposals related to Public Health in the Patients First Document included:

"Integrate local population and public health planning with other health services.

Formalize linkages between LHINs and public health units.

To better integrate population health within our health system, we propose that LHINs and public health units build on the collaborations already underway, and work more closely together to align their work and ensure that population and public health priorities inform health planning, funding and delivery.

To support this new formal relationship:

- The ministry would create a formal relationship between the Medical Officers of Health and each LHIN, empowering the Medical Officers of Health to work with LHIN leadership to plan population health services.

- The ministry would transfer the dedicated provincial funding for public health units to the LHINs for allocation to public health units. The LHINs would ensure that all transferred funds would be used for public health purposes.

- The LHINs would assume responsibility for the accountability agreements with public health units.

- Local boards of health would continue to set budgets.

- The respective boards of health, as well as land ambulance services, would continue to be managed at the municipal level. As part of a separate initiative to support more consistent public health services across the province, the ministry is modernizing the Ontario Public Health Standards and Organizational Standards to identify gaps and duplication in service delivery; determine capacity and resource needs; and develop options for greater effectiveness.

- The ministry would also appoint an Expert Panel to advise on opportunities to deepen the partnership between LHINs and public health units, and how to further improve public health capacity and delivery".

A brief report was prepared for the Board for its January meeting (Attachment 1).

Since January's report to the Board, the Association of Local Public Health Agencies (alPHa) sent a "Patients First Activity Update" (Attachment 2) to Board of Health members as well as Medical Officers of Health. The update included information about the preliminary results of a survey of alPHa's membership as well as plans by alPHa to develop its response to the discussion paper. The update also included links to a background paper (Attachment 3) written by Dr. Brent Moloughney for Toronto Public Health as well as recommendations made to Toronto's Board of Health (Attachment 4) and a link to a report to the Regional Municipality of Durham's Health & Social Services Committee (Attachment 5).

Toronto's Board of Health subsequently made recommendations to the Council of the City of Toronto and the City of Toronto's Council decision can be found via the following link: http://app.toronto.ca/tmmis/viewAgendaItemHistory.do?item=2016.HL9.3

The Association of Municipalities of Ontario is also preparing a response to the provincial consultation as outlined in the AMO Board Meeting Report January 2016: http://www.amo.on.ca/AMO-Content/Board/Report-to-Members/2016/AMO-Board-Meeting-Report-January-2016.aspx

Discussion

The roles and responsibilities of public health are primarily outlined in the *Health Protection and Promotion Act* and the Ontario Public Health Standards (OPHS), which were created under the Act. Public health's mandate is health protection, disease prevention and health promotion and its focus is primarily population health. While public health does have some programming that is focused on the individual, for example, clients in our sexual health and immunization clinics, most of our work addresses population health and is "invisible". Examples of such work include our work with municipalities around healthy public policy (official plans, food charters, access to recreation); work with our school boards regarding comprehensive school health; work with other community partners regarding child health; infection prevention and control activities including follow-up of over 400 reportable diseases and over 50 outbreaks annually, monitoring of immunization coverage in our school-aged population of over 28,000 children and investigating animal bites to prevent the transmission of rabies; enforcement activities such as inspection of food premises (over 1000), pools and spas, recreational camps as well as over 200 tobacco retailers; screening of the oral health of our school children ensuring that they access the dental care they need so that they are not in pain; and monitoring of chronic and communicable disease data as well as mortality data and risk factors for a variety of preventable diseases, so that public health programming can quickly address health issues as they arise and prevent others from occurring.

As of 2015, for 28 of the 36 Ontario boards of health, including the Board of Health for the Haliburton, Kawartha, Pine Ridge District Health Unit, the Ministry of Health and Long-Term Care's (MOHLTC) share of funding for the cost-shared Mandatory Programs was essentially frozen at the 2014 level due to the implementation of a new funding formula. These 28 health units were also advised that they would see a zero percent increase in their cost-shared budgets for the foreseeable future. The new funding model was based on 1. Service Cost Drivers – reflect variable cost of delivering public health services (geography and language) and 2. Drivers of Need – address demand and reflect utilization of public health services (Aboriginal, Ontario Marginalization Index and Preventable Mortality Rate). Only eight health units in Ontario were deemed to require additional funding when this formula was applied.

Every year, each board of health signs an Accountability Agreement with the MOHLTC, which outlines the requirements for each board of health including achieving targets for certain health protection and health promotion indicators. With the freeze in our cost-shared budget since

2014 and for the foreseeable future, it will become increasingly difficult to achieve compliance with the OPHS and Accountability Agreements as our costs increase on an annual basis.

In September 2015, the province announced that it would be "undertaking a review of the OPHS in an effort to ensure that the standards reflect current practice, are responsive to emerging evidence and priority issues in public health and aligned with the government's strategic vision and priorities for public health". In the Patients First discussion paper, the ministry reiterated that it "is modernizing the Ontario Public Health Standards and Organizational Standards to identify gaps and duplication in service delivery; determine capacity and resource needs; and develop options for greater effectiveness".

At this point we do not know if the review/modernization will be decreasing or increasing any of the requirements and standards contained within the OPHS.

As outlined in the Medical Officers of Health reports to the Toronto Board of Health and Durham Region's Health and Social Services Committee, a number of implications for public health in the Patients First discussion paper were identified as follows:

<u>Excerpt from Report to Toronto Board of Health (January 11, 2016)</u>

"The experience of other Canadian provinces with formal integration of public health and the larger health system suggests that opportunities for system improvement have often not been realized, and unintended risks to public health have arisen. This report reviews the implications of the MOHLTC proposals and recommends a response from the Board of Health (BOH) with particular attention to proposals with implications for local public health.

Public health plays a key role in population health and the sustainability of the health system by keeping people healthy. To minimize the risk of proposed changes compromising these contributions, the Medical Officer of Health (MOH) recommends that the BOH endorse maintaining independent governance of public health by local boards of health, protected and transparent funding for public health, and strengthened Ontario Public Health Standards.

Patients First also calls for local public health to play a formal role in planning of health care services to improve population health and health equity. Because health inequities are grounded in social determinants of health outside the health care system, the system must partner with non-health sectors beyond public health to realize this goal. The MOH recommends that the MOHLTC mandate formal local relationships between LHINs and the municipal, education, social service and voluntary sectors as well as public health.

Realignment of LHIN boundaries with the other sectors is necessary to enable intersectoral collaboration."

Excerpt from Report to Durham Region's Health and Social Services Committee (January 12, 2016)

"4. In general, Health staff **supports** LHINs working more closely together with MOHs and PHUs. That said, this work would be **in addition to** public health work already being done as prescribed by the MOHLTC. In addition, MOHs and PHUs have competing priorities, different capacities, skill sets, resource bases, etc. to name just a few **barriers**. Health staff has concerns about LHINs allocating funds to PHUs and administering accountability agreements because this may **open the door** to MOHs and PHUs and scarce public health resources being **drawn into** addressing acute, primary and long-term care issues and concerns of **questionable value** to the public health system (e.g., emergency room diversion strategies).

5. Health staff **supports** the modernization of the OPHS and OPHOS. That said, the current balance between local flexibility (e.g., health equity and promotion activities) and province-wide standardization (e.g., health protection activities) **needs to be maintained**. In addition, public health work should continue to be **evidence-based**, where possible, and **focus "upstream"** (e.g., disease and illness prevention) **rather than "downstream"** (e.g., acute, primary and long-term care). BOHs should continue to be held accountable for outcomes **attributable to their public health activities.** Finally, this process should **meaningfully improve** public health work and not be simply a **"slimming-down" exercise** to fit the MOHLTCs public health funding base. In fact, the MOHLTC should be encouraged to **expand** this base.

6. Finally Health staff recommends that attention be paid to the **Expert Panel**, including its **composition** and **mandate**. For example, will the Panel be empowered to advise on the **governance** and **number** of PHUs?"

Recommendations:

That the Board of Health for the Haliburton, Kawartha, Pine Ridge District Health Unit request that the Minister of Health and Long-Term Care ensure that public health units continue to be directly funded by the Province;

That the Board of Health for the Haliburton, Kawartha, Pine Ridge District Health Unit request that the Minister of Health and Long-Term Care ensure that the Population and Public Health Division of the Ministry of Health and Long-Term Care maintain responsibility for accountability agreements with public health units;

THAT should the proposed changes for public health units as outlined in the Patients First Discussion paper be implemented then the Board of Health for the Haliburton, Kawartha, Pine Ridge District Health Unit endorses recommendations made to the Toronto Board of Health as follows:

1. **The Board of Health request the Minister of Health and Long-Term Care to ensure a continued strong role for public health in keeping people healthy by:**
    a. **Maintaining independent governance of the local public health sector by boards of health;**
    b. **Strengthening comprehensive provincial standards for public health through the current review of the Ontario Public Health Standards, especially for healthy public policy and other programs that keep people healthy;**
    c. **Ensuring that any provincial funding directed to local boards of health by Local Health Integration Networks cannot be reallocated to other health services and that there is a transparent budget process;**

2. **The Board of Health request the Minister of Health and Long-Term Care to mandate a formal relationship between LHINs and senior representatives of the healthcare, municipal, education, social service and voluntary sectors as well as the Medical Officer of Health to support population health planning and service coordination in order to improve health equity and address social determinants of health; and**

3. **The Board of Health request the Minister of Health and Long-Term Care to provide the necessary resources to LHINs and Boards of Health to support collaboration on population health planning of health services;**

4. **The Board of Health request the Minister of Health and Long-Term Care to create transparent accountability indicators and targets for LHINs which include population health and health equity;**

THAT the Board of Health for the Haliburton, Kawartha, Pine Ridge District Health Unit request the Minister of Health and Long-Term Care to adjust LHIN boundaries to create geographic alignment with the boundaries of municipalities, school boards, and public health units; and

THAT the Board of Health for the Haliburton, Kawartha, Pine Ridge District Health Unit forward this report to the Association of Local Public Health Agencies, the Council of Ontario Medical Officers of Health, the Ontario Public Health Association, the Association of Municipalities of Ontario, the City of Kawartha Lakes, the County of Northumberland, the County of Haliburton, all 14 LHINs, the 36 Ontario boards of health, the Kawartha Pine Ridge District School Board, Trillium Lakelands District School Board, Peterborough Victoria Northumberland and Clarington Catholic District School Board and the MPPs for Northumberland-Quinte West and Haliburton-Kawartha Lakes-Brock.

Respectfully submitted,

A. Lynn Noseworthy, MD, MHSc, FRCPC

ALN/MCM

Attachments: 5

HALIBURTON, KAWARTHA, PINE RIDGE DISTRICT HEALTH UNIT
1-866-888-4577 • www.hkpr.on.ca • info@hkpr.on.ca

DATE: January 13, 2016

TO: The Board of Health

FROM: Dr. A. Lynn Noseworthy
Medical Officer of Health

RE: Patients First: A Proposal to Strengthen Patient-Centred Health Care in Ontario

Background

On December 17, 2015, the Ontario Minister of Health and Long-Term Care (MOHLTC) released a discussion paper "Patients First: A Proposal to Strengthen Patient-Centred Health Care in Ontario", which outlined proposals to transform Ontario's health system. In his cover letter (Attachment 1), Minister Hoskins indicated that the Ministry is "committed to a meaningful engagement process that includes all health system partners……that this input will result in a plan that can successfully build a high-performing health system that is more responsive to local needs, is better connected and integrated, drives quality and performance, and enhances transparency for providers and patients, clients and their families."

I sent an e-mail to the Board on December 17, 2015, which provided a link to the discussion paper and highlighted the proposals pertaining to public health and questions for feedback. (Attachment 2)

<u>Proposals related to Public Health:</u>

Integrate local population and public health planning with other health services. Formalize linkages between LHINs and public health units.
To better integrate population health within our health system, we propose that LHINs and public health units build on the collaborations already underway, and work more closely together to align their work and ensure that population and public health priorities inform health planning, funding and delivery.

To support this new formal relationship:

• The ministry would create a formal relationship between the Medical Officers of Health and each LHIN, empowering the Medical Officers of Health to work with LHIN leadership to plan population health services.
• The ministry would transfer the dedicated provincial funding for public health units to the LHINs for allocation to public health units. The LHINs would ensure that all transferred funds would be used for public health purposes.
• The LHINs would assume responsibility for the accountability agreements with public health units.
• Local boards of health would continue to set budgets.
• The respective boards of health, as well as land ambulance services, would continue to be managed at the municipal level. As part of a separate initiative to support more consistent public health services across the province, the ministry is modernizing the Ontario Public Health Standards and Organizational Standards to identify gaps and duplication in service delivery; determine capacity and resource needs; and develop options for greater effectiveness.
• The ministry would also appoint an Expert Panel to advise on opportunities to deepen the partnership between LHINs and public health units, and how to further improve public health capacity and delivery.

<u>Questions for feedback include:</u>

1. How can public health be better integrated with the rest of the health system?
2. What connections does public health in your community already have?
3. What additional connections would be valuable?
4. What should the role of the Medical Officers of Health be in informing or influencing decisions across the health care system?

The Central East Local Health Integration Network (CELHIN) also sent correspondence related to the discussion paper. (Attachment 3)

Finally, the Association of Local Public Health Agencies (alPHa) sent out a news release (Attachment 4) and a survey to solicit input from its members regarding the discussion paper. The survey link was provided to Board of Health members and Management staff, with a January 8, 2016 deadline for response. I understand that the results of the survey are to be released in the next week or so.

Recommendation:

THAT the Board of Health receive the discussion paper "Patients First: A Proposal to Strengthen Patient-Centred Health Care in Ontario" for information.

THAT the Board of Health review the results of alPHa's recent survey of its members regarding the discussion paper once they are received; and

THAT Board of Health members consider having some of its members attend alPHa's Board of Health Section meeting scheduled for February 24, 2016 to discuss public health implications of the proposed changes outlined in the discussion paper with their Board of Health colleagues from across the province.

Respectfully submitted,

A. Lynn Noseworthy, MD, MHSc, FRCPC

ALN/MCM

Attachments: 4

Patients First Activity Update

January 22, 2016

It has been a busy couple of weeks at alPHa as we work on gathering input and developing a response to the Patients First discussion paper. The following summary and linked documents are intended to keep you up-to-date on alPHa's activities.

Summary of Activities - December 17 to January 22

December 17, 2015 - Attended a morning pre-release briefing meeting and an afternoon release meeting of the Patients First discussion paper.

December 17, 2015 - Issued a news release.

December 22, 2015 - Provided alPHa members with a survey through which to provide feedback to the proposals for local public health and to inform the development of alPHa's response. Organizations have been asked to provide responses by the end of February 2016.

January 8, 2016 - This was the response deadline for alPHa's membership survey. **The initial survey results have been compiled** and can be read by clicking here. The initial report focuses on the responses from board of health members, MOHs, AMOHs and senior management. The final report will add in responses from managers and front line staff.

January 11, 2016 - alPHa staff met with staff in Minister Hoskins' office to review the discussion paper and clarify the intent for proposals regarding public health.

January 12, 2016 - COMOH Executive Meeting

January 13, 2016 - alPHa Executive Meeting with COMOH Executive. The Executive groups developed a set of recommendations to alPHa's Board of Directors. alPHa's Board supported the recommendations via email over the next few days. The approval of the recommendations established that alPHa would:

- contract with a consultant to support the development of the alPHa response
- assign a sub-group of its Board of Directors members to work with the consultant and focus on the work forward
- put forward names for possible appointment to the Public Health Expert Panel discussed in *Patients First*
- develop a response to the discussion paper by the end of February deadline
- establish regular communications with its members regarding activities related to *Patients First*

January 14, 2016 - Meeting of alPHa's Conference Planning Committee. The theme of the June 2016 AGM and Annual Conference will focus on health system transformation and the role of local public health. The conference will reflect the need to develop further responses to evolving questions and information.

Week of February 18, 2016

- Boards of Health Section Executive teleconference
- alPHa released the initial report summarizing member survey responses - click here to access the report
- alPHa contracted consultants Brent Moloughney and Karen Singh to support the development of the Association's response to *Patients First*.
- alPHa Staff attended a LHIN System Strategy Council (SSC) Meeting that focused on the *Patients First* discussion paper. The LHIN SSC is made up of Associations the represent organizations that fall under the LHINs as well as key partners. alPHa has been part of the LHIN SSC for 2 years as a key partner. From the most recent meeting: all associations are working on their responses to *Patients First*; LHINs saw the discussion paper for the first time on December 17th along with everyone else and are also working on their responses; where possible, associations and LHINs will share their responses as they are completed and approved by Boards of Directors. The next meeting is in April.
- alPHa Staff attended an OPHA Board Meeting that included a discussion of *Patients First* with ADM Roselle Martino

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Coming Up

alPHa's President, Dr. Valerie Jaeger and Executive Director, Linda Stewart will be meeting with the consultants to plan the way ahead and to plan a face-to-face all-day meeting with alPHa's Board's Patients First Sub-Committee to take place in early February. At a high level the expected way forward is:

- identify alPHa's key messages at the early February Sub-Committee meeting
- draft response document by February 17
- review response with membership at the February 25th BOH Section and COMOH meetings

- finalize the response at the alPHa Board meeting on February 26th

Click here to register for the Boards of Health Section meeting

Click here to register for the COMOH Section meeting

IMPORTANT: A limited block of guestrooms at the Novotel Toronto Centre (45 The Esplanade, Toronto) have been reserved. Book today to avoid disappointment.

What Else is Happening?

alPHa staff is also working to stay on top of the activities related to *Patients First* among our members and the broader health sector. We will endeavour to keep our members up to date and share the most significant materials. Here's what we've collected so far:

Toronto Public Health's background paper written by Dr. Brent Moloughney and recommendations to their Board of Health

Durham Region's Recommendations

Ontario Primary Care Council (description of membership can be found in the first pages of the Framework for Primary Care document below)

- Framework for Primary Care (includes some thoughts on planning for primary care)
- Position on Primary Care Coordination

Northwest LHIN

- Blueprint for Patient Care Groups presentation - note that LHINs have been asked to start defining the sub-LHIN geography. Some are calling the geographical regions Patient Care Groups. Some LHINs have their initial thinking for sub-LHINs posted on their websites.

I hope you found this update helpful. alPHa will endeavour to keep its members informed on Association activities, opportunities for input and information as it becomes available.

Attachment 2

The Impacts on the Public Health Function with Integration with Regionalized Healthcare Systems

January 2016

Prepared for:
Toronto Public Health

Prepared by:
Brent Moloughney MD, MSc, FRCPC
Public Health Consultant

About the Author

Dr. Brent Moloughney is a Royal College certified specialist in Public Health and Preventive Medicine that has previously worked as a Medical Officer of Health in a Regional Health Authority (RHA), as well as a physician manager in the Public Health Branch of the Ontario Ministry of Health and Long-Term Care. He is an Adjunct Professor at the Dalla Lana School of Public Health at the University of Toronto.

Over the past 17 years, he has led numerous consulting projects involving public health organizations and systems across the country. These include: preparing national reports on the desired design features of public health systems;[1, 2] multiple rounds of key informant interviews with public health leaders regarding their experience with regionalization, which are summarized in a 2007 discussion paper for the Ontario Public Health Association;[3] the independent review of the public health systems of multiple provinces; and, a recent survey of the structure of all provincial public health systems.

Contact information:

Dr. Brent Moloughney
BWM Health Consultants Inc.

Highlights

- Ontario's 'Patients First' discussion paper proposes increasing the linkage between local public health agencies (LPHAs) and Local Health Integrated Networks (LHINs)
- The integration of public health into Regional Health Authorities (RHAs) elsewhere in the country provides insights into potential opportunities and risks of Ontario's proposed direction
- Conceptually, public health's formal involvement with the healthcare system could bring a population health perspective to the understanding of health issues and the planning of healthcare services. Where this has occurred best, RHAs have had strong and interested leadership combined with strong public health leadership and epidemiological capacity.
- However, the focus of healthcare systems is frequently on service provision and costs versus the overall health of the public. In general, a relatively small complement of public health professionals and their population health expertise cannot by themselves be expected to influence a much larger and more powerful set of illness care-oriented organizations and professionals. The result is often for the larger illness care culture to influence public health to a more clinical orientation.
- Integration of services is another potential opportunity. However, LPHAs have limited involvement in delivery of clinical services and these were often developed to address historical gaps in the availability of primary care services on a population-wide basis, particularly for more vulnerable populations. Nevertheless, there can be opportunities for greater coordination and collaboration with other service providers for specific services.
- While these potential opportunities for greater public health linkages with healthcare systems have been realized in some RHAs, adverse impacts on public health have frequently occurred including loss of funding, fragmentation of capacity, diversion of staff through re-orientation to clinical issues, and barriers to engagement with community and municipal partners. These adverse experiences may have been exacerbated by public health systems lacking a combination of comprehensive public health standards, protected public health budgets, dedicated governance and leadership, and accountability agreements.
- England has a longer experience with public health integration in a regional healthcare system. For public health, the experience has been similar with public health's budgets having been squeezed, staff disempowered and the system fragmented. The current plan is to realign public health to local municipalities.
- In summary, the opportunities provided by greater linkages between LPHAs and LHINs need to be actively supported to be realized and the repeatedly demonstrated risks need to be recognized and actively mitigated in a comprehensive fashion. The main body of this report provides specific recommendations for achievement of both of these intentions.

The Impacts on the Public Health Function with Integration with Regionalized Healthcare Systems

Introduction

Ontario's 'Patients First' discussion paper (December 17, 2015) identifies four proposed changes to strengthen patient-centred care including: i) more effective integration of services and greater equity; ii) timely access to primary care and seamless links with other services; iii) improved home care; and, iv) stronger links between population and public health and other health services. With respect to the latter, the relationship between Ontario's system of local public health agencies[i] (LPHA) and the rest of the healthcare system coordinated by the province's Local Health Integrated Networks (LHINs) would change in several ways including:

- Create a formal relationship between MOHs and each LHIN empowering the MOHs who work with LHIN leadership to plan population health services
- Transfer provincial funding for local public health agencies to the LHINs for allocation to these agencies. The LHINs would ensure that all transferred funds be used for public health purposes.
- LHINs would assume responsibility for the accountability agreements with LPHAs
- Local boards of health would continue to set budgets and continue to be managed at a municipal level.

The discussion paper identifies the following anticipated performance improvements:

- Health service delivery better reflects population needs
- Public health and health service delivery better integrated to address the health needs of populations and individuals
- Social determinants of health and health equity incorporated into health care planning
- Stronger linkages between disease prevention, health promotion and care.

In addition, the discussion paper indicates that the ministry would appoint an Expert Panel to advise on opportunities to deepen the partnership between LHINs and LPHAs and how to further improve public health capacity and delivery.

The purpose of this report is to consider the experience of the public health function in regionalized health systems to inform the identification of potential opportunities and threats to transforming Ontario's current system.

[i] While local public health agencies (LPHAs) in Ontario are commonly referred to as 'public health units', under the *Health Protection and Promotion Act*, the 'health unit' is the geographic boundary within which the LPHA, specifically its Board of Health, has its mandated responsibilities.

Approach

There is limited information in the public domain on the design and functioning of the public health component of regionalized health systems in other provinces. This paper utilizes the author's 20 years of experience working for and consulting with the staff and leadership of regionalized health systems across the country. Where possible, examples and references are provided. While focussing primarily on the experience in Canada, additional information regarding recent reforms in England is also provided.

Public Health Experience with Regionalization in Canada

There is a more than 25-year experience with integrating public health into regionalized healthcare systems in other provinces. These systems have been comprised of several RHAs, each with the responsibility to plan and deliver a comprehensive range of healthcare and public health services. While the experience elsewhere is highly relevant to the analysis for Ontario, this province's LHIN model has key differences from regional models established elsewhere. These differences are summarized in Table 1.

Table 1: Comparison of RHAs and LHINs

Characteristic	Typical RHAs	LHINs
Governance structure	Single governance board for all health services	Boards of component organizations retained in addition to overall LHIN board.
Executive management	Single executive team to lead organization	Executive team retained in each component health organization
Range of services	Relatively comprehensive. Generally all health services except physician services	Has been less comprehensive. Patients First discussion paper has proposed inclusion of public health.
Funding	Global budget from province from which public health is funded.	Patients First discussion paper has proposed that provincial component of public health funding be routed through LHINs. Note that most public health programs funded 75/25 with municipalities.

These regionalized models have a fundamental difference with Ontario's LHINs in that as part of the regionalization process, the individual boards and executives of individual organizations have been eliminated resulting in a single healthcare system-wide executive team for the RHA accountable to one overall governance board. In contrast, many organizations within LHINs have maintained their own boards and executive teams. While the system designs vary among and within provinces, and over time, the experiences of other provinces provide important information regarding the potential opportunities and risks of public health becoming part of a regionalized health system. It is particularly important to distinguish potential, conceptual benefits from what has actually occurred on a wide scale basis.

Increased Health System Emphasis on Prevention and Promotion

At the time of healthcare reforms, provinces have emphasized that the changes would enable an increased emphasis on disease prevention and health promotion. However, depending upon the implementation context, there are a number of regionalization-related factors that could either increase or decrease the emphasis on disease prevention and health promotion (see Table 2).

Table 2: Regionalization Factors Influencing the Emphasis on Disease Prevention and Health Promotion

Factors Supporting Increased Emphasis	Factors Supporting Decreased Emphasis
• Provincial and RHA commitment to these activities • Explicit and high-profile mandate to pursue these activities • Strong RHA leadership and buy-in from significant constituencies • Accountability for performance in these areas • Mechanisms to ensure voices of the dispossessed are heard	• Public preoccupation with acute and medical care • Weak provincial commitment • Weak RHA commitment • Lack of provider interest • Impatience with long-term time frame for achievement of goals • Lack of public and media interest

Source: Lewis and Kouri, 2004.[4]

The challenge is that the items that favour a positive influence demand active leadership and management, whereas those that favour decreased emphasis tend to be the default state. While system transformation is accompanied with the rhetoric of increasing attention on prevention and promotion, the reality is that the primary driver of system reforms has generally been to address the financial pressures of illness care, which creates a focus on service provision and costs versus the health of the public. As such, organizational structures and their leadership are typically driven, dominated and rewarded for the delivery of timely illness care,[5] which is sometimes referred to as the 'tyranny of the acute'.[6] Even when a Board and executive have been particularly interested in population prevention and promotion, having approximately 97% of the budget focussed on individual-level care drives the organization's attention. By the end of the first decade of regionalization, a Federal/Provincial/Territorial (F/P/T) Committee's study that was prepared but not released concluded that reductions in province-wide programming had occurred as a result of the transfer of funding and responsibility to regional structures.[7]

Even the terms 'prevention and promotion' can create considerable misunderstanding. While public health will typically view such terms with respect to creating supportive environments and healthy public policy, as well as non-clinical individual and group interventions (e.g., support a community kitchen), clinical audiences will tend to focus on education, counselling and clinical preventive interventions. Similarly, public health's interest in how social determinants of health (SDOH) create health inequities considers not only their effect on access to services, but even more importantly, how these determinants affect the occurrence of ill health by increasing exposure to health risks, as well as increasing vulnerability to their effects.[8] Reflecting its

primary sphere of influence, healthcare services will predominantly focus on inequities in access to healthcare.

Viewed broadly, the public health and clinical perspectives are complementary. However, with a dominant clinical orientation in RHAs, the understanding and valuing of a broader population perspective to prevention and promotion can be limited. The result can often be a re-orientation towards clinical-type interventions of existing public health staff, as well as actual loss of public health positions. For example in recent consultations with health promoters in four other provinces, a common theme was that RHA managers of public health services and more senior decision-makers did not understand or value health promotion. To the frustration of the health promoters, expectations for practice were often limited to individual-level service delivery and a focus on education-type approaches versus addressing broader health determinants and public policy.[9] In one province, it was difficult to identify dedicated health promoters to consult with and in another, there was concern that individuals without any training in health promotion were being hired for these positions.[9]

In an earlier national consultation on public health action on health inequities, identified barriers to greater action included a continuing preoccupation with behaviour and lifestyle approaches; regionalization processes that had hindered traditional linkages between public health and municipalities; as well as a priority for individual service delivery and harder-type outcomes with less time and support for the development of strategic relationships with other organizations and the community.[10] Even in recent years, public health staff in some areas have been actively dissuaded from working with external community groups following broader healthcare system reforms.[11]

Conceptually, public health's formal involvement with the healthcare system could bring a population health perspective to the understanding of health issues and the planning of healthcare services. Reflecting the factors in Table 2, some RHAs with strong and interested leadership combined with strong public health leadership and capacity have made greater progress. Key features have included:

- Routine participation of public health leader (Medical Officer of Health) in RHA executive management team meetings and regular access to the Board
- Population data analysis capacity to provide health status outputs to inform decision making.

For example, the CEO of the former[ii] Capital Health Authority in Halifax describes how their Medical Officer of Health has helped their thinking and understanding of upstream prevention to prevent risk factors for disease ever existing, which requires targeting of the whole population and the use of comprehensive health promotion tools.[12] The result has been greater clarity

[ii] The current government is in the process of amalgamating the previous 9 District Health Authorities into a single province-wide health authority.

regarding the unique contribution of public health toward population health, the bulk of their work, and only a small contribution toward clinical care. Furthermore, the public health division's Understanding Communities Unit provides reports to assist the health authority to understand where and what needs attention.[12]

Similarly, in Saskatoon, the Medical Health Officer is a member of the RHA executive team and a Public Health Observatory has been established. The Observatory analyzes and integrates information on health status, determinants of health and health service utilization in order to provide analysis to inform health system decision-making and public health practice including reducing health inequalities.[13] The Observatory has been producing regular reports for several years on health status, health equity, determinants of health, and equity in healthcare services.

While these examples illustrate the favourable potential for positive public health involvement in regionalized systems, they are not typical. Despite the stated intent to increase emphasis on prevention and promotion, in most provinces, public health's involvement in providing a population health perspective was not achieved by design, but left to the discretion of individual RHAs. The result is to find many Medical Officers of Health with limited routine access to the RHA's executive team and Board, and little involvement in overall system planning.[3] Furthermore, with a change in RHA leadership, public health's structure and reporting relationship can change literally overnight.[3] As described in one province, in the absence of public health representation at the RHA executive table, and in some RHAs having Medical Health Officers with no direct influence on budgets, program implementation and staff deployment, "public health was marginalized and often invisible within the system and public health was unfairly targeted for cost cutting measures."[14]

An intrinsic problem is believing that a small complement of public health professionals and their population health expertise can influence a much larger and more powerful set of illness care-oriented organizations and professionals. Contrary to the intent for public health to bring a population health perspective to the healthcare system, the result is often for the larger illness care culture to influence public health to a more clinical orientation.[15]

Integration Among Services

The benefits of 'integration' are commonly emphasized during health system transformations with the intent to have services be more seamless and responsive to local needs. Considering the complexity of healthcare services and the challenges for patients to navigate the system this focus on integration makes sense. However, public health has a limited proportion of its services that deliver a clinical service to an individual. Examples include sexual health and dental health clinics, although in some other provinces, public health directly provides all childhood immunizations, provides well-baby clinical assessments, and conducts clinical post-partum follow-up visits. Many of the areas of public health involvement in the provision of clinical services reflect historical gaps in the availability of primary care services on a population-wide basis, particularly for more vulnerable populations.[16]

Being part of a regionalized system can allow for better collaboration among different service providers. Commonly identified examples of improvements include maternal-child programming such as post-partum follow-up, high-risk family follow-up, and breastfeeding support, as well as communication and coordination for follow-up of communicable diseases.[3, 17, 18] The challenge is that in pursuing integration as a measure of success mixed with an incomplete understanding of public health practice and a greater valuing of clinical approaches tends to drive a re-orienting of public health practice to a clinical perspective. For example, in many health authorities, a strategy for chronic disease prevention and management has been pursued with often a leadership role for public health in providing a comprehensive approach to assessment and planning in addition to supplying primary prevention expertise. The increased visibility however, was accompanied with a risk of diversion of public health efforts towards individual-level interventions.[3]

The Patients First discussion document emphasizes the intention for seamless links between primary care and other services. Generally, primary care has not been part of RHAs elsewhere and many of the examples of collaborative models between primary care and public health have occurred in smaller urban, rural and remote settings.[6] In many other provinces, public health organizations deliver a greater proportion of individual-level services than in Ontario providing greater opportunities for integration efforts such as co-location and/or transferring of service responsibilities. A practical challenge is how to establish linkages for a LPHA serving many hundreds of thousands of people to comprehensive primary care organizations, if they exist, serving several thousand people.[11]

An additional pragmatic challenge is that in those RHAs in which there has been active interest in having public health involvement in planning activities, this has created a significant participation burden since there is a potential prevention angle for every health condition. The result is having public health directors and managers involved in numerous integration and system-planning meetings, at the expense of working with community partners and focussing on their core programming.[3]

Adverse Consequences of Public Health Involvement

Overall, there have been several types of adverse consequences that have been widely but not universally experienced in public health's involvement in regionalized health systems:[3, 5, 6, 11, 15]

- Reductions in public health capacity and voice through a range of mechanisms:
    - Direct diversion of funding to other parts of health system
    - Indirect diversion by reorienting public health staff and programming to illness-related care
    - Fragmentation of public health capacity by:
        - Breaking up public health departments and distributing them to multiple, often non-public health managers within a RHA

        - Transferring public health inspectors to non-health government departments, which have been associated with adverse impacts on health protection services[19]
    - Limiting public health leaders' access to the RHA executive management team and Board
    - Creating too many health authorities in order to focus on individual care thereby limiting the covered population base and the support of a critical mass of public health expertise.
- Barriers to engagement with community and municipal partners for action on social determinants of health including:
    - Reorientation of focus to illness-related issues
    - Diversion of attention to planning healthcare services
    - Active discouragement of partnering with external agencies
    - Misalignment of RHA's service boundaries with municipal, education and social service agencies thereby impairing work on broader determinants.

While adverse consequences experienced elsewhere appear to have resulted from factors described in Table 2, they have also been exacerbated by aspects of the overall design of public health in most provinces. Based on the best available information, an F/P/T report identified the key design features for public health systems including the required structural elements.[2] Several of these have been missing from most provinces including a lack of explicit public health program standards; a lack of transparent, protected funding for public health; a lack of robust accountability mechanisms for fulfilment of the program standards; and, creating health authorities of too small a population base to support a critical mass of public health expertise.[3] In contrast, Ontario's existing public health system exhibits all of these elements, except for supporting a critical mass of expertise in some parts of the province.[20] Losing any of these design elements in Ontario's transformation efforts would be anticipated to increase the risk of adverse impacts on fulfilling public health's mandate.

England

England's experience with a regionalized health system pre-dates those in Canada. Public health's experience there provides further reason for caution with how to proceed with reforms in Ontario. Despite long-term integration efforts and public health's involvement in system planning, the result was that public health's budgets were squeezed, staff disempowered and the system fragmented.[21] Based on England's experience, it has been observed that public health's focus on upstream determinants of health and community-level prevention can be 'easily kidnapped and displaced' by a focus on the clinical care system.[15] The current plan has been to realign public health to local municipalities, although the implementation of this direction has been highly problematic.

Analysis and Implications

Based on the experience elsewhere to-date, there are two main arguments for public health's greater linkage with the healthcare system.

First, since healthcare is a determinant of health, it would be beneficial to achieve a re-orientation of healthcare services towards improving population health and reducing health inequities.

a. Public health can support change in the healthcare sector just as it strives to support the creation of supportive environments for health in other settings.
b. Public health's involvement alone will not achieve this re-orientation and too much unprotected exposure of public health to the healthcare system has been shown to pose a real risk of re-orienting public health to a clinical focus thereby losing action against social determinants of health
c. The change in orientation needs to occur primarily from within the healthcare system (population level goals, leadership, performance measures, accountability, training, pilot projects, etc.)

There is limited evidence of what specific approaches are effective to support a healthcare system's greater orientation to population health. Potential considerations include:[15, 16, 22, 23]

a. Public health senior level involvement in LHIN strategic planning and decision-making. This should be for the broad system and not limited to primary care. Possible examples include:
    i. Apply a population health lens to important/recurring problems
    ii. Relationship building – e.g., joint training/exercises between clinical care and public health
    iii. Use of healthcare system's voice to support broader advocacy efforts
b. Establish capacity/mechanisms to bring a population health perspective to clinical data. This might include:
    i. Identifying inequities in health status and service delivery (e.g., population coverage rates for preventive care interventions)
    ii. Adopt population health indicators
    iii. Linking social determinants, geography and healthcare delivery (e.g., high needs/service use -> partner with other agencies to resolve)
    iv. Use of simulation models to understand medium- and long-term impacts of investments.

The second main argument is that since public health provides some individual-level services, there may be opportunities for improving service coordination with other providers. Based on the experience elsewhere:[11, 16]

a. Collaborate on real mutual areas of individual-level clinical services
b. Avoid broad and vague intentions of 'integration' and 'strengthening prevention and promotion', which will tend to be defined inconsistently. Be clear what the goal is (e.g., address a specific need, service gap or overlap).
c. Apply a continuous improvement approach to make valuable change. In other words, the value add should be named, measured and demonstrated
d. Avoid responses to short-term service pressures that thwart long-term preventive intentions.

While pursuing perceived opportunities, the risk of adverse impacts experienced elsewhere must be managed. This includes:

a. Maintain the existing critical design features of Ontario's public health system:
    a. Dedicated governance through a Board of Health
    b. Structural integrity (i.e., not fragmented)
    c. Transparent, protected budget to fulfill the LPHA's function
    d. Accountability linked to fulfillment of Public Health Standards
b. Manage the risk of participation burden – the healthcare system is very large and complex. It is possible for public health's focus to be diverted through extensive engagement efforts of its management staff with healthcare planning and integration efforts. The healthcare system is but one determinant of health. Public health's involvement with the healthcare system needs to be balanced with broader complementary action to address the other health determinants.
c. If there are increased expectations for public health involvement, these should be identified and resourced – otherwise reflects diversion of public health resources to healthcare system.

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The Regional Municipality of Durham Report

To: Health & Social Services Committee
From: Dr. Robert Kyle
Report: 2016-MOH-03
Date: January 12, 2016

SUBJECT: Patients First Discussion Paper

RECOMMENDATION:

That the Health & Social Services Committee receives this report for information

REPORT:

1. The Patients First Discussion Paper was released by the Ontario Ministry of Health and Long-Term Care (MOHLTC) on December 17, 2015 (Appendix A).

2. The paper outlines proposed changes for the health system. In particular, Local Health Integration Networks (LHINs) would assume responsibility for home and community care and system integration, and have greater involvement with primary care, and improved linkages with population health planning.

3. Proposals related to Public Health:

   "Integrate local population and public health planning with other health services. Formalize linkages between and public health units [PHUs]."

   To better integrate population health within our health system, the paper proposes that LHINs and PHUs build on the collaborations already underway, and **work more closely together** to align their work and ensure that **population and public health priorities inform health planning, funding and delivery.**

   To support this new formal relationship:

   - The MOHLTC would create a **formal relationship between medical officers of health (MOHs)** and **each LHIN**, empowering the MOHs to work with LHIN leadership to plan population health services**.**

- The MOHLTC would transfer the **dedicated provincial funding** for PHUs to the LHINs for allocation to PHUs. The LHINs would ensure that **all transferred funds** would be used for **public health purposes**.

- The **LHINs** would assume **responsibility** for the **accountability agreements** with PHUs.

- **Local boards of health** (BOHs) would continue to **set budgets.**

- The respective **BOH,** as well as **land ambulance services,** would continue to be managed at the **municipal level.** As part of a separate initiative to support more consistent public health services across the province, the MOHLTC is **modernizing** the **Ontario Public Health Standards** (OPHS) and **Organizational Standards** (OPHOS) to identify gaps and duplications in service delivery; determine capacity and resource needs; and develop options for greater effectiveness.

- The MOHLTC would also appoint an **Expert Panel** to advise on **opportunities to deepen the partnership** between LHINs and PHUs**,** and how to further **improve public health capacity and delivery.**

4. In general, Health staff **supports** LHINs working more closely together with MOHs and PHUs. That said, this work would be **in addition to** public health work already being done as prescribed by the MOHLTC. In addition, MOHs and PHUs have competing priorities, different capacities, skill sets, resource bases, etc. to name just a few **barriers**. Health staff has concerns about LHINs allocating funds to PHUs and administering accountability agreements because this may **open the door** to MOHs and PHUs and scarce public health resources being **drawn into** addressing acute, primary and long-term care issues and concerns of **questionable value** to the public health system (e.g., emergency room diversion strategies).

5. Health staff **supports** the modernization of the OPHS and OPHOS. That said, the current balance between local flexibility (e.g., health equity and promotion activities) and province-wide standardization (e.g., health protection activities) **needs to be maintained**. In addition, public health work should continue to be **evidence-based**, where possible, and **focus "upstream"** (e.g., disease and illness prevention) **rather than "downstream"** (e.g., acute, primary and long-term care). BOHs should continue to be held accountable for outcomes **attributable to their public health activities.** Finally, this process should **meaningfully improve** public health work and not be simply a **"slimming-down" exercise** to fit the MOHLTCs public health funding base. In fact, the MOHLTC should be encouraged to **expand** this base.

6. Finally Health staff recommends that attention be paid to the **Expert Panel**, including its **composition** and **mandate**. For example, will the Panel be empowered to advise on the **governance** and **number** of PHUs?

Respectfully submitted,

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R.J. Kyle, BSc, MD, MHSc, CCFP, FRCPC, FACPM
Commissioner & Medical Officer of Health

TORONTO

STAFF REPORT FOR ACTION

Healthy People First: Opportunities and Risks in Health System Transformation in Ontario

Date:	January 11, 2016
To:	Board of Health
From:	Medical Officer of Health
Wards:	All
Reference Number:	

SUMMARY

The Ontario Ministry of Health and Long-Term Care (MOHLTC) released *Patients First: A proposal to strengthen patient-centred health care in Ontario* in December 2015 with the goal of addressing structural issues in the health care system that create inequities (Attachment 1). The *Patients First* discussion paper proposes expanding the role of the Local Health Integration Networks (LHINs) to include funding and accountability for public health.

The experience of other Canadian provinces with formal integration of public health and the larger health system suggests that opportunities for system improvement have often not been realized, and unintended risks to public health have arisen. This report reviews the implications of the MOHLTC proposals and recommends a response from the Board of Health (BOH) with particular attention to proposals with implications for local public health.

Public health plays a key role in population health and the sustainability of the health system by keeping people healthy. To minimize the risk of proposed changes compromising these contributions, the Medical Officer of Health (MOH) recommends that the BOH endorse maintaining independent governance of public health by local boards of health, protected and transparent funding for public health, and strengthened Ontario Public Health Standards.

Patients First also calls for local public health to play a formal role in planning of health care services to improve population health and health equity. Because health inequities are grounded in social determinants of health outside the health care system, the system must partner with non-health sectors beyond public health to realize this goal. The MOH

recommends that the MOHLTC mandate formal local relationships between LHINs and the municipal, education, social service and voluntary sectors as well as public health. Realignment of LHIN boundaries with the other sectors is necessary to enable intersectoral collaboration.

RECOMMENDATIONS

The Medical Officer of Health recommends that:

1. The Board of Health request the Minister of Health and Long-Term Care to ensure a continued strong role for public health in keeping people healthy by:
    a. Maintaining independent governance of the local public health sector by boards of health;
    b. Strengthening comprehensive provincial standards for public health through the current review of the Ontario Public Health Standards, especially for healthy public policy and other programs that keep people healthy;
    c. Ensuring that any provincial funding directed to local boards of health by Local Health Integration Networks cannot be reallocated to other health services and that there is a transparent budget process;

2. The Board of Health request the Minister of Health and Long-Term Care to mandate a formal relationship between LHINs and senior representatives of the healthcare, municipal, education, social service and voluntary sectors as well as the Medical Officer of Health to support population health planning and service coordination in order to improve health equity and address social determinants of health;

3. The Board of Health request the Minister of Health and Long Term Care to provide the necessary resources to LHINs and Boards of Health to support collaboration on population health planning of health services;

4. The Board of Health request the Minister of Health and Long Term Care to adjust LHIN boundaries to create geographic alignment with the boundaries of municipalities, school boards, and public health units, including creating one LHIN for the City of Toronto;

5. The Board of Health request the Minister of Health and Long Term Care to create transparent accountability indicators and targets for LHINs which include population health and health equity;

6. The Board of Health forward these recommendations to City Council for adoption; and

7. The Board of Health forward this report to the Association of Local Public Health Agencies, the Council of Ontario Medical Officers of Health, the Ontario Public Health Association, the Association of Municipalities of Ontario, the Toronto City Manager, all 14 LHINs, the 36 Ontario boards of health, the Toronto School Boards, and Dalla Lana Faculty of Public Health, University of Toronto.

Financial Impact
There are no financial implications arising from this report.

ISSUE BACKGROUND

On December 17, 2015 the Ontario Ministry of Health and Long-Term Care (MOHLTC) released *Patients First: A Proposal to Strengthen Patient-Centred Health Care in Ontario* (Attachment 1).[1] The *Patients First* discussion paper identifies four proposed changes to strengthen patient-centred care including:

i) More effective integration of services and greater equity;
ii) More timely access to primary care and seamless links between primary care and other services;
iii) More consistent and accessible home and community care;
iv) Stronger links between population and public health and other health services.

This report reviews the implications of the MOHLTC proposals and recommends a response from the Board of Health (BOH) with particular attention to Proposal Four, which most directly impacts local public health work. Proposal Four suggests:

- Create a formal relationship between Medical Officers of Health (MOHs) and each Local Health Integration Network (LHIN) to empower the MOH to work with LHIN leadership to plan population health services;
- Transfer dedicated provincial funding for public health units to the LHINs for allocation to public health units;
- LHINs would assume responsibility for the accountability agreements with public health units;
- Local boards of health would continue to set budgets and would continue to be managed at the municipal level.

The *Patients First* discussion paper anticipates that these proposed changes would lead to the following performance improvements:

- Health service delivery better reflects population needs;
- Public health and health service delivery will be better integrated to address the health needs of populations and individuals;
- The social determinants of health and healthy equity will be incorporated into health care planning;
- Stronger linkages between disease prevention, health promotion and care would be created.

In order to support the proposed changes, the *Patients First* discussion paper indicates the government would appoint an Expert Panel to advise on opportunities to deepen the partnerships between LHINs and public health units, and to advise on how to further improve public health capacity and delivery.[1]

In a separate but related process, the province is reviewing the Ontario Public Health Standards (OPHS) which are the guidelines for providing mandatory health programs and services by boards of health under the authority of the Health Protection and Promotion Act (HPPA).[2] The Ontario Public Health Organizational Standards (OPHOS), the management and governance requirements for boards of health are also undergoing review. [1]

COMMENTS

The *Patients First* discussion paper identifies that "[m]any aspects of the health care system are not able to properly benefit from public health expertise, including issues related to health equity, population health and the social determinants of health." These concepts are defined by the public health community as follows:

- **Health equity** ". . . means that all people can reach their full health potential and should not be disadvantaged from attaining it because of their race, ethnicity, religion, gender, age, social class, socioeconomic status or other socially determined circumstance."[3]
- A **population health approach** works to improve "the health of the entire population and to reduce health inequities among population groups. In order to reach these objectives, it looks at and acts upon the broad range of factors and conditions that have a strong influence on our health."[4]
- **Social determinants of health** include a range of factors mostly outside health services that influence our health including income, employment conditions, physical environment, education, housing and access to healthy foods, among others.[5]

Public Health in Ontario

Public health services are defined in the OPHS under the authority of the HPPA and delivered through boards of health in each of 36 geographic health units. The OPHS mandate some clinical services such as immunization, communicable disease case and contact management, and breastfeeding support, as well as a significant number of programs and services to keep people healthy, such as food safety, chronic disease and injury prevention, promoting healthy public policy, and emergency preparedness.

The OPHOS establish management, operational and governance requirements for all boards of health in Ontario including the assessment, planning, delivery, management and evaluation of public health programs and services that address local health needs.[2] Boards of health are held accountable for the implementation of the OPHS and the OPHOS through multi-year accountability agreements with the MOHLTC that set performance expectations and targets.

Boards of health consist of members appointed by the province and/or local municipalities, and are responsible for setting the budget for public health programs and services. The cost of public health services are shared between municipal and provincial governments, with some programs 100% provincially funded.[6]

While the details of board of health governance vary across Ontario depending on the structure of local government, all health units are geographically aligned with municipalities and school boards which greatly facilitates local partnerships necessary for delivery of public health services.

The OPHS incorporates a broad range of population-based activities designed to promote the health of the population. The importance of working with community partners to reduce health inequities is also explicitly stated in the OPHS.[2] Although it refers to population health, the main focus of the *Patients First* discussion paper is on services to patients - people already connected to the health care system for treatment. Keeping people healthy through health promotion and disease prevention is the primary focus of public health.

Public Health and the Health System

Patients First describes public health as disconnected from the larger health system due to the lack of a structural relationship at the local level. However, in practice local public health has a rich web of partnerships with the health system, often at the service delivery agency level, though not necessarily through the LHINs. Some examples of these partnerships, including service integration in Toronto include:

- Public health staff assigned to hospitals to support maternal child services and infection control;
- Dental clinics operated collaboratively with community health centers;
- Breastfeeding clinics operated jointly with hospitals;
- Daily connections between public health and primary care for communicable disease control; and
- Collaborating with Anishnawbe Health CHC and the Toronto Central LHIN to support development of an indigenous health strategy for Toronto.

Collaboration between local public health and LHINs is hampered by misalignment of boundaries. The City of Toronto Health Unit contains all or part of five different LHINs.

Public Health Planning

The OPHS require boards of health to conduct ongoing assessments of health unit residents and to use this information for population health planning. TPH uses data on mortality, hospitalization, reproductive outcomes, dental and oral health, behavioural risk factors, environmental health risks, demographic, socioeconomic and other social determinants measures, to fulfil these standards. The data comes from other agencies and from data collection carried out by TPH.

This data helps to increase understanding of the determinants of health, supports evidence informed decision-making and enables TPH to develop policies and services to keep people healthy and reduce health inequities.[7] This work has been shared with the health system, other sectors and the public through online data and widely-disseminated public reports that identify and characterize priority health issues in Toronto including, for example: *The Unequal City 2015: Income and Health Inequities in Toronto*; *Healthy Futures: 2014 Toronto Student Survey*; *Racialization and Health Inequities in Toronto* (2013);and *The Global City: Newcomer Health in Toronto* (2011).

The capacity of local public health agencies to collect and use population health data varies between health units, and is generally greater in larger agencies.

Public Health and Non-Health Sectors

Recognizing that the health of a population is determined to a significant extent by social, economic and environmental factors, the public health system has adopted and embedded a social determinants of health approach to public health program and service design and delivery. Social determinants of health are largely responsible for the health inequities which are referred to in the *Patients First* document. To address social determinants of health, public health works in partnership with the municipal, education, social services and voluntary sectors. These key partnerships are critical to ensure public health decisions are responsive to community needs, shape legislation, policies and programs that impact health, and address health inequities.

Some examples of local partnerships between public health and non-health sectors in Toronto include:

- Collaborating with Toronto school boards to conduct a school-based survey of youth health and develop a collaborative response to the issues identified;
- Working with City Planning and Transportation Services to create local programs and policies supportive of chronic disease and injury prevention;
- Delivering the Investing In Families program for high risk families jointly with Toronto Employment and Social Services, Toronto Parks Forestry and Recreation, Toronto Children's Services and the Toronto Public Library;
- Developing plans to respond to the health impacts of climate change with a number of municipal services;
- Working with the United Way of Toronto and community-based NGOs to implement programs to improve access to healthy food for low income neighbourhoods.

These partnerships are facilitated by the geographic alignment between public health and the municipal, education, social service and voluntary sectors.

Local Health Integration Networks

Local Health Integration Networks (LHINs) are governed by the Local Health Systems Integration Act, 2006, and were established a decade ago in Ontario with the purpose of

planning and managing health system performance in the acute care, long-term care, community services and mental health and addictions sectors. There are 14 LHINs in Ontario serving geographic populations based on hospital catchment areas, which do not align with municipal, education or public health jurisdictions.

The *Patients First* discussion paper identifies LHINs as the focus for improved service quality and accountability, and further integration of planning and funding of health services, including public health, with the caveat that in order to be successful in a new model they would require some adjustments and additional tools.[1]

Regional Integration of Public Health and Healthcare - the Experience of Other Jurisdictions

In contrast to Ontario's strong municipal involvement in public health governance and funding, in every other province public health has been integrated over the past 25 years into Regional Health Authorities (RHAs). These RHAs are 100% provincially funded and are responsible for planning and delivering a comprehensive range of healthcare and public health services for a defined geographic area. While there is variation in the design of RHAs within and among provinces, these entities differ from Ontario's LHINs in that in their formation, the executives and boards of individual health organizations were eliminated. Each RHA has a single health system-wide executive team and governance board. Despite this difference, public health's experience of being integrated into these regionalized models is highly relevant for considering the proposed provincial direction outlined in *Patients First*. A summary of the experience of other jurisdictions is provided in the attached report *The Impacts on the Public Health Function with Integration with Regionalized Healthcare Systems* by Dr. Brent Moloughney [Attachment 2].[8] The following sections discuss potential opportunities and risks associated with the changes to public health proposed for Ontario in *Patients First,* drawing on the experiences of other provinces which have made similar changes, and makes recommendations to maximize the potential opportunities and minimize the risks that have been experienced elsewhere.

Opportunities

Patients First echoes two main arguments which have been made in other jurisdictions for strengthening the connections between public health and the healthcare system. First, public health's greater involvement with the healthcare system could bring a population health perspective to the understanding of health issues and the planning of healthcare services. In doing so, social determinants of health and healthy equity would be better incorporated into health system planning. Second, public health provides some clinically focused services which could be strengthened by improving service coordination (i.e., integration) with other health service providers.[8]

a) Health System Planning

Public health's expertise in understanding and applying population health assessment, including social determinants of health, to service planning could be advantageous for the

broader health system. The OPHS require that boards of health analyse surveillance data, including monitoring trends over time, emerging trends and priority populations.[2] The Population Health and Surveillance Protocol, 2008, specifies that the determinants of health have to be considered when identifying priority populations and using population health data to contribute to the maintenance and improvement of the health and well-being of the population, including a reduction of health inequities.[9] Public health has experience in using a broad range of data to assess the effectiveness of health interventions in the local population.

Increased connection to the healthcare system could increase access to shared data systems or electronic medical records that would further increase public health's contribution to health system planning and could be a key benefit of integration.

While achieving a greater population health perspective to health system planning and a greater emphasis on prevention and health promotion have been common themes of health system integration elsewhere, their achievement has been uneven. The expectation for public health to provide a population health perspective to broader health system planning has generally not been explicit nor have the structural mechanisms to achieve it been mandated. For example, it has been left to the discretion of individual RHAs to decide on public health's structure and the extent of its involvement in health system decisions. As a result, Medical Officers of Health and public health staff in many RHAs have limited opportunity for involvement in overall system planning. RHAs' public health capacity to analyze population health information is also variable and is a requirement in order to contribute to system planning. The RHAs that have achieved active involvement of public health with system planning have had strong and interested RHA leadership combined with strong public health leadership and epidemiologic capacity.

b) Health Service Integration

Health service integration is a key component of the MOHLTC's proposed plans outlined in *Patients First.* The potential opportunity is to focus on streamlining services and creating stronger linkages between various health care services. Public health has a primary focus on prevention and health promotion work. However, some public health programs and services also provide clinical service to communities and individuals that are responsive to local needs and fill service gaps, particularly for vulnerable populations. For example, at TPH the tuberculosis (TB) program works with health professionals and the community to reduce the incidence and impact of TB in Toronto, while also providing support for individuals with TB and their families. The sexual health program provides consultation, support, resources, programming and clinical services to clients who are not well served by other health service providers.

RHAs in other provinces have placed particular emphasis on the integration of clinical health services. Commonly identified examples of improvements from better integration of public health services with the healthcare system include maternal-child programming such as post-partum follow-up, high-risk family follow-up, and breastfeeding support, as well as communication and coordination for follow-up of communicable diseases. The

opportunities for integration tend to be greater in provinces where public health has historically had a greater role in clinical service delivery than in Ontario. However, while integration has made sense for clinical services, in pursuing the goal of integration, a common adverse effect has been the re-orienting of public health's vital prevention and promotion work to a more clinical treatment focus.

Service integration plans also need to consider the broader social determinants of health which are often outside the immediate scope of healthcare services. In order to begin to address health inequities and social determinants of health, a more formal relationship between LHINs and public health is not enough. LHINs should also develop formal relationships with the municipal, social services, education, and voluntary sectors to support regional planning. This type of work has been taking place through the Toronto Central LHIN and should be considered a best practice for supporting service integration.

Risks

There are significant potential opportunities for improvements to the health system by integrating public health. However, the experience of other jurisdictions indicated there are also risks to public health of moving into an integrated model. Two types of adverse effects of public health integration into regional health structures have been seen in other jurisdictions which have hampered public health's role in keeping people healthy.

a) *Reductions in Public Health Capacity*

Concerns about reductions in public health capacity associated with regionalization processes emerged in the late 1990s. This included direct diversion of public health funding to other parts of the health system; fragmentation of public health capacity by breaking up public health departments and distributing them to multiple, often non-public health managers; and re-orienting public health services to illness care. Achieving a critical mass of public health capacity with a population health focus has also been undermined by provinces creating too many RHAs with small populations in order to focus on individual level care. In addition, as noted earlier, public health leadership has not consistently been included in health system decision making.

Regionalization plans have often emphasized prevention and health promotion. However the financial pressures of illness care (the "tyranny of the acute") have led to organizational structures and leadership that are typically driven and rewarded for the timely delivery of illness care, rather than for improvements in the population's health. It has been reported that approximately 97% of the RHAs budget is focused on individual-level care.[8] The Canadian public health experience in a RHA model is echoed in England where it has been recognized that public health's involvement in regional health structures has resulted in fragmentation of public health, reduced community prevention activities and a reduced focus on the social determinants of health.

b) *Barriers to Partnership with Non-health Sectors*

Upstream prevention requires inter-sectoral collaboration with municipalities, education, social services and other partners, as discussed earlier. Public health staff in many RHAs have experienced a series of barriers to engaging potential partners as a result of re-

orientation of efforts to focus on illness-related issues, diversion of attention to planning healthcare services, and active discouragement of partnering with external agencies. Despite the original intent for public health to bring a population health perspective to the healthcare system, often the much larger mandate for illness care influences public health to a more clinical orientation. Misalignment of RHA service boundaries with municipal, education and social services agencies is an added barrier to collaboration across sectors on social determinants of health and health inequities.

How Ontario Can Maximize Opportunities and Minimize Risks

As the provincial government considers how to move forward on the proposals in *Patients First*, there are steps it should take to maximize hoped-for opportunities for health system improvement and mitigate potential risks experienced in other provinces of undermining public health's primary mandate to keep people healthy.

1. Maintain independent public health governance

As outlined in *Patients First*, boards of health should continue to be accountable for implementing OPHS and OPHOS and determining public health budgets to support them. This would enable an independent voice for local healthy public policy and would be consistent with the current structure of independent governance for other health service provider organizations.

2. Protect provincial funding for public health services

Keeping people healthy should be a mainstay of health system sustainability, but the experience of other jurisdictions indicates that short term pressing needs and the "tyranny of the acute" may make funding for longer term health improvement programs vulnerable. As indicated in *Patients First*, any public health funding directed through the LHINs should be transparent and should not be available for reallocation to other health services.

3. Strengthen the Ontario Public Health Standards

The review of OPHS and OPHOS should strengthen standards for effective and accountable local public health services especially for upstream disease prevention, health promotion and healthy public policy programs. Standards should mandate critical partnerships with non-health sectors.

4. Formalize local relationships between LHINs, public health and the municipal, education, social service and voluntary sectors.

If LHINs are to play a meaningful role in addressing health equity and social determinants of health, strengthening their relationship with Medical Officers of Health is not enough. A formal relationship between LHINs, public health, and non-health sectors

which play a key role in social determinants of health would enable coordination of cross sector efforts to address health equity. Local multi-sectoral engagement could be implemented through a formal structure, such as a Local Health Council with a clear provincial mandate, supported by the LHIN with senior membership from the health care sector (acute care, long term care, primary care and community care) public health, and non-health sectors (municipal, social services, education and voluntary). A model of this type is currently in place in the Toronto Central LHIN.

5. Ensure capacity for population health planning

Both LHINs and local public health agencies have fully committed their resources to their current mandates. To enable an enhanced focus on population health planning of health services in an integrated model, both LHINs and local public health must have the capacity to collaborate. To ensure success, the MOHLTC should provide the resources necessary to support these new roles. Capacity needs may be greater for smaller LHINs and public health units.

6. Align LHIN boundaries with public health, municipal and education jurisdictions

The misalignment of LHIN and health unit boundaries is a barrier to greater integration. The current alignment of health units with municipal and education service boundaries is critical for the essential partnerships with those sectors which enable public health to deliver on its mandate. If LHINs are to achieve closer integration with public health and play a meaningful role in addressing health equity through social determinants of health, alignment of healthcare planning with the geography of other non-health sectors is essential. Boundary alignment may mean that there will continue to be LHINs which contain more than one municipality (though in their entirety). In some parts of the province amalgamation of small health units may be helpful in achieving geographic alignment and sufficient capacity for integration as well as compliance with strengthened public health standards. However, the situation in Toronto where one health unit and municipality has five LHINs should be resolved by creating a single LHIN for the City of Toronto.

7. Implement accountability measures for population health and health equity.

As the health system enhances its efforts to improve population health and health equity, system accountability measures should follow suit. LHINs should have indicators and targets for the health of the population they serve rather than just the patients they serve. Population indicators should measure and track the equity of distribution of health within the population, rather than just access to health services.

CONCLUSION

If the provincial government proceeds in the direction outlined in *Patients First* for public health, experience from other jurisdictions indicates that care must be taken in order to realize the potential opportunities for improved population health planning and

service integration. Furthermore, steps must be taken to avoid the risk of compromising the key public health contribution to health system sustainability by keeping people healthy. If the Ontario health system is truly to play a greater role in creating health equity by addressing social determinants of health, it must create formal partnerships with sectors beyond health and be held accountable for this aspect of its performance.

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SIGNATURE

_____

Dr. David McKeown
Medical Officer of Health

ATTACHMENTS

Attachment 1: Ministry of Health and Long-Term Care. (2015). *Patients first: A proposal to strengthen patient-centred health care in Ontario.* Discussion Paper December, 2015.

Attachment 2: *The Impacts on the Public Health Function with Integration with Regionalized Healthcare Systems*. Moloughney, B. (2016)

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February 18th, 2016

The Honourable Dr. Eric Hoskins, M.P.P.
Minister of Health and Long-Term Care
10th floor, Hepburn Block
80 Grosvenor Street
Toronto, Ontario M7A 2C4

Dear Minister:

RE: Ontario Minister of Health and Long-Term Care's discussion paper*: Patients First: A Proposal to Strengthen Patient-Centred Health Care in Ontario*

At its regular meeting on February 8, 2016, the Board of Health for the City of Ottawa Health Unit approved the recommendations included in *Towards Better Outcomes for Communities and Patients: Protecting and Leveraging Public Health in Ontario's Proposed Health System Transformation* report, a copy of which is attached. This report is in response to your discussion paper, *Patients First: A Proposal to Strengthen Patient-Centred Health Care in Ontario* discussion paper. The Board approved the following motion, as amended:

That the Board of Health for the City of Ottawa Health Unit:

1. **Receive for information the Ministry of Health and Long-Term Care's discussion paper entitled: Patients First: A Proposal to Strengthen Patient-Centred Health Care in Ontario (Document 1);**
2. **Approve that the Chair of the Board of Health submit this report to the Minister of Health and Long-Term Care and write a letter to the Minister of Health and Long-Term Care outlining the key considerations for successful health system transformation, as outlined in the report:**
    a) **Leverage the Role of Public Health**
    b) **Maintain Independent Governance and Accountability**
    c) **Protect Public Health Funding**
    d) **Strategically Integrate Population Health Priorities, Assessment, and Surveillance; and**
    e) **Enhance Public Health Capacity**

Ottawa Board of Health / Conseil de santé Ottawa
100 Constellation Drive / 100, promenade Constellation
Ottawa, Ontario K2G 6J8
Mail Code 26-50

3. **Approve that the Chair of the Board of Health include in the letter, referenced in Recommendation 2, a recommendation that Boards of Health be afforded ex-officio representation on Local Health Integration Networks (LHIN) Boards in order to effectively influence priority setting, and also recommend that public health representation from Boards of Health be included on the Expert Panel outlined in the Ministry's *Patients First* report;**
4. **Approve that the Chair of the Board of Health, subject to the approval of Recommendations 2 and 3, forward the letter referenced in recommendations 2 and 3 and this report to all Ontario Boards of Health, Ottawa City Council, the Association of Municipalities of Ontario (AMO), Association of Local Public Health Agencies (alPHa), the Champlain LHIN, and local Members of Provincial Parliament, as part of the Ministry's consultations on their proposals included in the Patients First: A Proposal to Strengthen Patient-Centred Health Care in Ontario report;**
5. **Recommend that the Chair of the Board of Health, and the Medical Officer of Health consult with the Ottawa City Council representative for AMO, regarding municipal perspectives around the proposed changes in governance and funding; and,**
6. **Direct staff to contribute to the Ministry's consultations, as required.**

The Ottawa Board of Health welcomes and supports enhanced integration of population and public health planning into local health system decision making. However, there are potential risks, including the diversion of prevention and health promotion resources, the erosion of important local partnerships, and the loss of the municipal share of funding, which must be considered and, ideally, mitigated, as the government moves towards implementation of these proposals.

The *Towards Better Outcomes for Communities and Patients: Protecting and Leveraging Public Health in Ontario's Proposed Health System Transformation* report provides an overview of the key principles that we hold must be considered and addressed in order to ensure that proposed changes to Ontario's healthcare system lead to an improvement in population health and patient outcomes.

In addition, as the Ministry of Health and Long-Term Care advances its health transformation agenda, the Ottawa Board of Health proposes that a whole of government approach, at the municipal, provincial and federal level, be enhanced to

advance policies and programs that address the social determinants of health and to address inequities in health outcomes.

We appreciate the importance of transforming the health care system in Ontario to achieve better outcomes for communities and patients, and we welcome the engagement you have initiated with Boards of Health.

We have initiated discussions with local Members of Provincial Parliament to this affect and I would be delighted to continue this discussion with you at any time.

Sincerely,

Councillor Shad Qadri
Chair, Board of Health for the City of Ottawa Health Unit

Encl.

Cc: The Honourable Bob Chiarelli, M.P.P., Ottawa West-Nepean
The Honourable Madeleine Meilleur, M.P.P., Ottawa-Vanier
The Honourable Yasir Naqvi, M.P.P., Ottawa Centre
Mr. Grant Crack, M.P.P., Glengarry-Prescott-Russell
Mr. John Fraser, M.P.P., Ottawa South
Ms. Marie-France Lalonde, M.P.P., Ottawa-Orléans
Mr. Jack MacLaren, M.P.P., Carleton-Mississippi Mills
Ms. Lisa MacLeod, M.P.P., Nepean-Carleton

Dr. Isra Levy, Medical Officer of Health for the City of Ottawa Health Unit
Ms. Gillian Connelly, Secretary, Board of Health for the City of Ottawa Health Unit
Ottawa City Council
Ottawa Board of Health
Association of Municipalities of Ontario
Association of Local Public Health Agencies
Champlain Local Health Integration Network
Ontario Boards of Health

Report to
Rapport au:

Ottawa Board of Health
Conseil de santé d'Ottawa
8 February 2016 / 8 février 2016

Submitted on February 1, 2016
Soumis le 1 février 2016

Submitted by
Soumis par:
Dr./ Dr Isra Levy,
Medical Officer of Health / Médecin chef en santé publique

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Ward: CITY WIDE / À L'ÉCHELLE DE LA VILLE

File Number: ACS2016-OPH-SSB-0002

SUBJECT: TOWARDS BETTER OUTCOMES FOR COMMUNITIES AND PATIENTS: PROTECTING AND LEVERAGING PUBLIC HEALTH IN ONTARIO'S PROPOSED HEALTH SYSTEM TRANSFORMATION

OBJET: VERS DE MEILLEURS RÉSULTATS POUR LES COMMUNAUTÉS ET LES PATIENTS : PROTÉGER ET METTRE À CONTRIBUTION LES SERVICES DE SANTÉ PUBLIQUE DANS LE REMANIEMENT PROPOSÉ DU SYSTÈME DE SANTÉ DE L'ONTARIO

REPORT RECOMMENDATIONS

That the Board of Health for the City of Ottawa Health Unit:

1. **Receive for information the Ministry of Health and Long-Term Care's discussion paper entitled: *Patients First: A Proposal to Strengthen Patient-Centred Health Care in Ontario* (Document 1);**

2. **Approve that the Chair of the Board of Health submit this report to the Minister of Health and Long-Term Care and write a letter to the Minister of Health and Long-Term Care outlining the key considerations for successful health system transformation, as outlined in the report:**

    a) **Leverage the Role of Public Health**

    b) **Maintain Independent Governance and Accountability**

    c) **Protect Public Health Funding**

    d) **Strategically Integrate Population Health Priorities, Assessment, and Surveillance; and**

    e) **Enhance Public Health Capacity**

3. **Approve that the Chair of the Board of Health include in the letter, referenced in Recommendation 2, a recommendation that Boards of Health be afforded ex-officio representation on Local Health Integration Networks (LHIN) Boards in order to effectively influence priority setting;**

4. **Approve that the Chair of the Board of Health, subject to the approval of Recommendations 2 and 3, forward the letter referenced in recommendations 2 and 3 and this report to all Ontario Boards of Health, Ottawa City Council, the Association of Municipalities of Ontario (AMO), Association of Local Public Health Agencies (alPHa), the Champlain LHIN, and local Members of Provincial Parliament, as part of the Ministry's consultations on their proposals included in the *Patients First: A Proposal to Strengthen Patient-Centred Health Care in Ontario* report;**

5. **Recommend that the Chair of the Board of Health, and the Medical Officer of Health consult with the Ottawa City Council representative for AMO, regarding municipal perspectives around the proposed changes in governance and funding; and,**

6. **Direct staff to contribute to the Ministry's consultations, as required.**

RECOMMANDATIONS DU RAPPORT

Que le Conseil de santé de la circonscription sanitaire de la Ville d'Ottawa :

1. **Reçoive à titre d'information le document de discussion du ministère de la Santé et des Soins de longue durée intitulé : *Priorité aux patients : Une proposition pour renforcer les soins de santé axés sur les patients en Ontario* (Document 1);**

2. **Approuve que le président du Conseil de santé soumette le présent rapport au ministre de la Santé et des Soins de longue durée et écrive une lettre au ministre de la Santé et des Soins de longue durée exposant les principales considérations pour assurer le succès du remaniement du système de santé, comme il est décrit dans le rapport :**

   a) **Mettre à contribution le rôle de la santé publique;**

   b) **Préserver une gouvernance indépendante et renforcer la responsabilisation;**

   c) **Protéger le financement des services de santé publique;**

   d) **Intégrer de manière stratégique les priorités, l'évaluation et la surveillance en matière de santé de la population;**

   e) **Améliorer la capacité des services de santé publique.**

3. **Approuve que le président du Conseil de santé inclue dans la lettre, mentionnée dans la recommandation 2, une recommandation voulant que les conseils de santé se voient donner une représentation d'office aux conseils des réseaux locaux d'intégration des services de santé (RLISS), afin de pouvoir influencer efficacement l'établissement des priorités.**

4. **Approuve que le président du Conseil de santé, sous réserve de l'approbation des recommandations 2 et 3, fasse parvenir la lettre mentionnée dans les recommandations 2 et 3 ainsi que le présent rapport à tous les conseils de santé de l'Ontario, au Conseil municipal d'Ottawa, à l'Association des municipalités de l'Ontario, à l'Association des agences locales de santé publique (alPHa), au RLISS de Champlain et aux membres locaux du parlement provincial, dans le cadre des consultations du Ministère au sujet des propositions avancées dans le rapport *Priorité aux patients : Une proposition pour renforcer les soins de santé axés sur les patients en Ontario*.**

5. **Recommande que le président du Conseil de santé et le médecin chef en santé publique consultent le représentant du Conseil municipal d'Ottawa auprès de l'AMO, en ce qui concerne les perspectives municipales relatives aux changements proposés en matière de gouvernance et de financement;**

6. **Enjoint le personnel à contribuer aux consultations du ministère, le cas échéant.**

EXECUTIVE SUMMARY

In December 2015, the Ministry of Health and Long-Term Care (MOHLTC) released the discussion paper, “Patients First, a Proposal to Strengthen Patient-Centred Health Care in Ontario.” The proposal focuses on population health and integration at the local level, and seeks to improve access to primary care, standardize and strengthen home and community care, and strengthen population and public health.

Some of the proposals in this paper have substantive potential impacts on the public health sector and the relationships of local Public Health Units with municipalities and the Local Health Integration Networks (LHINs). It proposes expanding the role of the LHIN to include accountability and funding of local Public Health Units.

Ottawa Public Health (OPH) staff welcomes and supports enhanced integration of population and public health planning into local health system decision making. However, there are potential risks, including the diversion of prevention and health promotion resources, the erosion of important local partnerships, and the loss of the municipal share of funding, which must be considered and, ideally, mitigated, as the government moves towards implementation of these proposals.

This report provides an overview of the discussion paper and the key principles that should be considered as health system transformation evolves. The following principles should be considered and addressed in order to ensure that changes lead to an improvement in population health and patient outcomes:

1. Leverage the Role of Public Health:

Public Health Units contribute to the sustainability of the health care sector by working across sectors to focus on broader populations and keeping people healthy.

Local Public Health Units differ from other health agencies and services in Ontario by virtue of their focus on populations, not individuals. Public health’s focus on keeping

people healthy is critical in the overall sustainability of the health care system. Public health uniquely addresses primary prevention of disease and injury through advancing health promotion, health protection, disease and injury prevention, as well as epidemiological monitoring of health events and risks. Public health's strength is its capacity for, and focus on, cross-sectoral planning and programming, which rely heavily on partnerships, such as local government and allied health agencies. In addition, Public Health Units are embedded in municipal or regional entities, and receive core funding from multiple levels of governments, including municipalities.

2. **Maintain Independent Governance and Accountability:**

Boards of Health would need to be afforded ex-officio representation on LHIN Boards in order to effectively influence priority setting.

Governance roles and accountabilities of different governing entities should be clarified. The ability of Boards of Health to influence priority setting and resource allocation within the health sector should be enhanced by affording ex-officio representation of Boards of Health to LHIN Boards. Due to the inter-sectoral nature of population health, the effectiveness of Local Public Health Units is enhanced by being closely aligned with the municipal sector, and erosion of such alignment should be guarded against.

3. **Protect Public Health Funding:**

Mechanisms would need to be in place to ensure that both provincial and municipal public health funding is protected.

In order to prevent an inadvertent erosion of the public health sector's effectiveness in influencing population health outcomes, public health funding and resources should be protected from being redirected to acute, primary and long-term care. Funding and resources should be enhanced to address growing needs, and improve population health outcomes, in order to relieve the burden on other health sector services. The municipal contribution of public health funding, and in-kind municipal support, should be protected. In addition, provincial commitment to ongoing implementation of the 2015 provincial public health funding model needs to be fulfilled, in order to address existing inequities between Public Health Units.

4. **Strategically Integrate Population Health Priorities, Assessment, and Surveillance:**

While population health assessment and surveillance could be more strategically integrated, public health's role in upstream prevention should be explicitly acknowledged and supported.

Public Health Units should be supported to ensure the primary focus of their work remains on prevention and addressing non-health system social determinants of health. Population health assessment and surveillance should strategically inform health system planning and priority setting. New roles in acute care and primary care planning and evaluation, should be supported by enhanced capacity to undertake these roles.

5. Enhance Public Health Capacity:

Deeper participation of public health across the health system will require enhanced resources that should not be diverted to other health sectors from existing mandates or cross-sectoral collaboration efforts.

Public Health Units have different skill sets, capacities and resources. Implications for labour within the public health workforce must be explicitly considered; most notably, the implications of Public Health Units' new role in population health planning at a systems level. Proposed changes should address risks of weakening or diverting public health capacity from existing roles and responsibilities.

RESUMÉ

En décembre 2015, le ministère de la Santé et des Soins de longue durée a publié le document de discussion Priorité aux patients : Une proposition pour renforcer les soins de santé axés sur les patients en Ontario. Cette proposition est axée autour de la santé de la population et de l'intégration à l'échelle locale, dans le but d'améliorer l'accès aux soins primaires, de renforcer et d'uniformiser les soins à domicile et en milieu communautaire, et de consolider la santé publique et celle de la population.

Certaines des propositions de ce document pourraient avoirdes répercussions majeures sur le secteur de la santé publique, de même que sur les relations des bureaux de santé publique avec les municipalités et les réseaux locaux d'intégration des services de santé (RLISS). Elles entendent étendre le rôle des RLISS de manière à englober la responsabilisation et le financement des bureaux de santé publique.

Le personnel de Santé publique Ottawa (SPO) voit d'un bon œil une meilleure intégration de la planification de la santé de la population et de la santé publique dans le cadre du processus de décision du système de santé local. Cependant, cette intégration présente des risques potentiels, notamment la réorientation des ressources

allouées à la prévention et à la promotion de la santé, l'érosion de partenariats locaux importants et la perte de la part de financement municipal. Ces risques doivent être considérés et, idéalement, atténués, lors de la mise en place de ces propositions par le gouvernement.

Le présent rapport propose un aperçu du document de discussion et des principes clés qui doivent être pris en compte au fur et à mesure de l'avancement du remaniement du système de santé. Les principes suivants devraient être examinés et abordés pour veiller à ce que les changements entraînent une amélioration de la santé de la population et de l'évolution de l'état de santé des patients.

1. Mettre à contribution le rôle de la santé publique :

Les bureaux de santé publique contribuent à la viabilité du secteur des soins de santé par leur travail intersectoriel portant sur des populations plus larges, dans le but de garder la population en santé.

Les bureaux de santé publique se distinguent des autres agences et services de santé en Ontario en raison du fait que leur action est axée sur les populations, et non sur les personnes. L'orientation des services de santé publique, consistant à garder la population en santé, est cruciale dans la viabilité d'ensemble du système de soins de santé. Les services de santé publique s'intéressent uniquement à la prévention primaire des maladies et blessures au moyen de la promotion et de la protection de la santé, de la prévention des maladies et blessures, de même que d'une surveillance épidémiologique des événements et risques liés à la santé. La force des services de santé publique réside dans leur capacité de planification et d'établissement de programmes intersectoriels, lesquels misent grandement sur les partenariats, notamment avec l'administration municipale et les agences de santé associées, et dans l'attention qu'ils y portent. En outre, les bureaux de santé publique sont intégrés dans les entités municipales et régionales, et reçoivent leur financement de base des divers paliers gouvernementaux et des municipalités.

2. Préserver une gouvernance indépendante et renforcer la responsabilisation :

Les conseils de santé auraient besoin de se voir attribuer une représentation d'office aux conseils des RLISS, afin de pouvoir influencer efficacement l'établissement des priorités.

Les rôles et responsabilités de gouvernance des différentes entités dirigeantes doivent être précisés. La capacité des conseils de santé d'influencer l'établissement des priorités et l'affectation des ressources au sein du secteur de la santé doit être accrue en accordant une représentation d'office aux conseils de santé et aux conseils des RLISS. Compte tenu de la nature intersectorielle de la santé de la population, l'efficacité des bureaux de santé publique locaux est renforcée par son harmonisation avec le secteur municipal, et il faut se prémunir contre l'érosion de cette harmonisation.

3. Protéger le financement des services de santé publique :

Des mécanismes devraient être en place pour veiller à la protection du financement provincial et municipal des services de santé publique.

Afin de prévenir une érosion, par mégarde, de l'efficacité du secteur de la santé publique dans l'influence des résultats en matière de santé de la population, le financement et les ressources des services de santé publique doivent être protégés de manière à ce qu'ils ne soient pas redirigés vers les soins de courte durée, primaires et de longue durée. Le financement et les ressources devraient être accrus pour répondre aux besoins croissants et améliorer les résultats en matière de santé de la population, afin de réduire le fardeau imposé aux services des autres secteurs de la santé. La contribution municipale au financement des services de santé publique, de même que l'appui non financier des municipalités doivent être protégés. En outre, l'engagement provincial à mettre en place le modèle provincial de financement des services de santé publique 2015 doit être concrétisé, afin de répondre aux inégalités existantes entre les bureaux de santé publique.

4. Intégrer de manière stratégique les priorités, l'évaluation et la surveillance en matière de santé de la population:

Alors que l'évaluation et la surveillance de la santé de la population pourraient être intégrées de manière plus stratégique, le rôle en amont des services de santé publique en matière de prévention doit être reconnu et appuyé de manière explicite.

Les bureaux de santé publique doivent être appuyés pour faire en sorte que l'orientation principale de leur travail demeure la prévention et l'étude des déterminants sociaux de la santé non liés au système de santé. L'évaluation et la surveillance de la santé de la population doivent être intégrées de façon stratégique à la planification et à l'établissement des priorités du système de santé. De nouveaux rôles dans la

planification et l'évaluation des soins de courte durée et des soins primaires doivent être soutenus par une capacité accrue à assumer ces rôles.

5. Améliorer la capacité des services de santé publique :

Une participation de plus grande ampleur des services de santé publique au sein du système de santé nécessitera un accroissement des ressources qui ne devront pas être redirigées de mandats actuels ou d'efforts de collaboration intersectorielle vers d'autres secteurs de la santé.

Les bureaux de santé publique disposent de différentes compétences, capacités et ressources. Les répercussions en matière de main-d'œuvre au sein du personnel des services de santé publique doivent être considérées de manière explicite; plus précisément, les répercussions du nouveau rôle des bureaux de santé publique dans la planification de la santé de la population au niveau du système. Les changements proposés devraient tenir compte du risque d'affaiblissement ou de détournement de la capacité des services de santé publique de ses rôles et responsabilités actuels.

BACKGROUND

As part of the Province's transformation and health care reform agenda, the Minister of Health and Long-Term Care (MOHLTC), in February 2015, released the report Patients First: Action Plan for Health Care. This report outlines a vision for faster and more efficient connections to services, more integration of services, and more effective support for the public to make better decisions about their health.

Continuing the provincial government's work to transform Ontario's health care system, the Minister released, in December 2015, a follow-up discussion paper, Patients First, A proposal to Strengthen Patient-Centred Health Care in Ontario. The discussion paper includes proposals to significantly transform Ontario's health system. The four principle proposals include:

1. More effective integration of services and greater equity
2. Timely access to primary care, and seamless links between primary care and other services
3. More consistent and accessible home and community care
4. Stronger links between population and public health and other health services.

An underlying theme of these proposals is to expand the role of the 14 Local Health Integration Networks (LHIN) and create geographical sub-LHINs. Ottawa could,

theoretically, be a sub-LHIN region within the Champlain LHIN. LHINs would become responsible for home and community care, primary care planning and system integration, as well as strengthening population and public health integration at the local level. The transformations would have substantive impacts on the roles and responsibilities of Public Health Units, including the relationship between Boards of Health, Medical Officers of Health, the LHINs, and contractual relationships with the Province of Ontario. More specifically the discussion paper outlines the following recommendations, which would have impacts on Public Health Units:

> The Ministry would create a formal relationship between the Medical Officers of Health and each LHIN, empowering the Medical Officers of Health to work with LHIN leadership to plan population health services (i.e. public health would have an increased role in health service planning and an enhanced opportunity to bring issues of population and health equity to the table).
>
> The Ministry would transfer the dedicated provincial funding for public health units to the LHINs for allocation to public health units. The LHINs would ensure that all transferred funds would be used for public health purposes.
>
> The LHINs would assume responsibility for the accountability agreements with public health units.
>
> Local boards of health would continue to set budgets.
>
> The respective boards of health, as well as land ambulance services, would continue to be managed at the municipal level.
>
> The Ministry would also appoint an Expert Panel to advise on opportunities to deepen the partnership between LHINs and Public Health Units, and how to further improve public health capacity and delivery.

The discussion paper states that the proposal seeks to reduce gaps, including better integration of public health into the rest of the health care system, while strengthening patient-centred care. Currently, in Ottawa, OPH works closely with the Champlain LHIN, primary care physicians, long-term care facilities and many other entities in the health care system. Further work could strengthen integration of public health expertise into the local health care system.

OPH senior management reviewed the proposal, consulted with other health units, and provided input to the evolving work of the Association of Local Public Health Agencies' (alPHa) assessment of the implications of these proposed changes, which are

described in the Discussion section of this report. Other Ontario Public Health Units have released reports and statements related to the discussion paper, including Toronto Public Health's (TPH) "Healthy People First: Opportunities and Risks in Health System Transformation in Ontario." TPH notes that "the experience of other Canadian provinces with formal integration of public health and the larger health system suggests that opportunities for system improvement have often not been realized, and unintended risks to public health have arisen" (1).

Local Public Health Context:

To contextualize the considerations required for any realignment of Public Health Units, it is necessary to understand the types of activities and outputs generated by the public health sector. From a local perspective, through inter-sectoral, population-health based approaches, OPH has achieved a significant range of outcomes to make our community healthier. As examples, these include the following:

- Working with the local municipality and the child care sector to develop Healthy Eating and Active Living guidelines for child care centres.
- Providing information to parents and caregivers through the OPH Parenting in Ottawa website, which includes common issues faced by parents in Ottawa to help them ensure children stay healthy.
- Contributing to healthier public policies that guide the built environment and support chronic disease and injury prevention through influencing the City's Official Plan, Transportation Master Plan, and Community Design Plans.
- Improving infection prevention and control in personal service settings through online, interactive education modules.
- Collaborating with municipal and community agencies that provide services to at-risk populations to alert for extreme heat, cold, and air quality events, and provide direction and assistance in the event of a public health emergency.
- Launching a *Sex It Smart* campaign to reduce rates of Chlamydia and gonorrhea among teens in Ottawa.

The outcomes by Public Health Units need to be recognized, resourced and further enabled in order to continue advancing population health.

DISCUSSION

OPH, as one of 36 local Public Health Units in Ontario, welcomes the Ministry's discussion paper on improving integration and effectiveness in Ontario's health sector, and commends the commitment within the Ontario government's transformation agenda to including public health services in future plans to improve population health and patient outcomes. Public health has a role in supporting integration of the health care system through working with the LHINs. The proposals, if implemented, create opportunities for Public Health Units, as outlined below. Also outlined are potential risks, which must be considered and, ideally, mitigated, as the government moves towards implementation of these proposals.

KEY CONSIDERATIONS

The following principles and considerations are offered for successful health system transformation, which includes integration of current local Public Health Units and functions:

1. Leverage the Role of Public Health:

Local Public Health Units differ from other health agencies in Ontario by virtue of:

- Being responsible for programs and services that, in the main, focus on populations not individuals.
- Being responsible for programs and services that mainly focus on primary prevention of disease and injury, broad concepts of health promotion, conventional health protection, and epidemiological disease surveillance.
- Being accountable for advancing healthy public policy and health equity agendas, including those that cut across such sectors as municipal, workplaces, education, social services, child and youth, older adults and health.
- Being accountable for epidemiological disease surveillance, monitoring, and supporting the health status of groups within a geographically defined jurisdiction.
- Being accountable for conventional health protection including education, inspection and enforcement under authority of the *Health Protection and Promotion Act*.
- Being integrated with local agencies and partners such as municipal, educational and community agencies to ensure local programs and resources are relevant, tailored, appropriate, available and accessible to subpopulations.

- Often being embedded in municipal or regional administrative entities.
- Receiving core funding from multiple levels of government and government agencies, and in the absence of a transparent or consistent funding formula.

Given Public Health Units' unique role both in the health care system and municipal government, future changes should ensure that:

- Public Health Units maintain their primary focus on prevention (i.e. upstream) and on mechanisms inclusive of non health system social determinants of health.
- Public Health Units provide a local leadership role in providing primary prevention and population health expertise.
- Public Health Units' proposed 'new role' – of contributing population health expertise to inform the local health care system – should not impede on or divert from public health's core work outlined above.

2. Maintain Independent Governance and Accountability:

- The ability of Boards of Health to effectively influence priority setting and resource allocation within the health sector should be enhanced by Boards of Health being afforded ex-officio representation with LHIN Boards. Boards of Health should remain independent entities of local public health governance to ensure for a strong, local voice for community wide population health initiatives. Boards of Health should continue to be held accountable for outcomes attributable to their public health activities.
- Governance roles and accountabilities of different governing entities should be clarified.
- Due to the inter-sectoral nature of population health, the effectiveness of Local Public Health Units is enhanced by being closely aligned with the municipal sector, and erosion of such alignment should be guarded against.
- The existing protections for the independence of statutory officers to protect communities from health hazards should be retained.
- There should be local public health representation on the Expert Panel to be established by the Ministry.

3. Protect Public Health Funding:

- Public health resources need to be protected from potential diversion to the rest of the health care system. Funding levels for public health programs should be protected and enhanced to address growing needs, as well as improve population health outcomes, in order to relieve the burden on other health sector services. In addition, the municipal funding envelope, and its unallocated funding levels, should also be protected and/or guaranteed.
- Potential impacts of any transformation on municipal funding allocations to local Public Health Units should be explicitly considered and addressed.
- To address inequities between Public Health Units, provincial commitment to ongoing implementation of the 2015-2016 public health funding model needs to be fulfilled.

4. **Strategically Integrate Population Health Priorities, Assessment, and Surveillance:**
    - Population health assessment and surveillance should be more integrated into broader health system planning and priority setting, including interpretation of public health indicators, and identification of local population health issues.
    - Public Health Units should be supported to integrate population health assessment and health system surveillance into non-health sector planning (e.g. housing, planning, social services, education), to ensure that communities are designed and built to reduce injuries and promote physical and mental health.
    - Broader use and application of public health data across the health care system will require enhanced system-level data collection, and enhanced resources for Public Health Units. Opportunities to integrate health equity data into health systems planning should also be considered.
5. **Enhance Public Health Capacity:**
    - Proposed changes should explicitly address the risk of weakening or diverting capacity within local Public Health Units from existing authorities, roles and responsibilities of Boards of Health, Medical/Associate Medical Officers of Health and Public Health Inspectors.
    - Public health units' resources are fully committed to meeting their current mandates. Resource implications and needs of integration must be addressed. Implications for labour within the public health workforce must be calibrated to support unique skills including population health assessment, policy development and implementation, risk communication, emergency response, and

enforcement. The opportunity costs of enhanced integration of public health without additional resources must be considered, as this would be an added participation burden. Public health's engagement with the health care system needs to be balanced with its work on addressing the broader social determinants of health.

- Timelines and mechanisms for periodic evaluation of changes and needed adjustment of activities must be developed prior to implementation of changes.
- Integration of public health should be followed by appropriate system accountability measures that reflect population health; this includes indicators for the whole population, rather than solely on patients served and health services accessed.
- Modernization of the Ontario Public Health Standards should enhance standards for upstream disease prevention and promotion, and healthy public policy, as well as increase the requirements for inter-sectoral collaboration that address the determinants of health. The review should also maintain the current balance between flexibility at the local level (i.e. health promotion) and provincially standardized activities (i.e. health protection).
- Public Health Units' strength is their reliance on partnerships, not only within the health system, but even more so in the broader community. Public Health focuses on creating social and physical environments that promote health and prevent harms through healthy public policy, multi-sectoral planning and service integration that cut across sectors, such as municipal, business, education, social services, environment, recreation, child and youth, older adults and health. Influencing the determinants of health requires strong collaboration with multiple sectors. Mechanisms must be developed to ensure that existing working partnerships with other sectors and agencies are protected and enhanced.
- The interests of local Public Health Units for achieving their population health objectives are well served through close alignment with the municipal sector. This "whole of government" approach is especially critical for supporting and enabling cross-sectoral and cross municipal department collaboration to advance healthy public policy (i.e. social services, planning and public works, environmental services, etc.). Public health Units are positioned such that critical relationships with the municipal sector can develop and flourish. Future population health impacts will require collaboration on inter-sectoral policy development and partnership with municipalities having the critical infrastructure

and political mechanisms to promote health and prevent disease in populations at the local level.

In summary, the sustainability of the health care system will be significantly influenced by improving our capacity to keep people healthy. This includes preventing diseases and injuries, and positively affecting the determinants of health. The *Patients First* discussion paper seeks to better integrate public health with health system planning in order to improve overall health and health equity. However, shifting health outcomes and reducing health disparities through affecting the social determinants of health requires partnering with non-health sectors, which is a key function of public health.

The public health sector needs to be further enabled to play this critical role in our overall health care system. Should the *Patients First* discussion paper recommendations be implemented, the integration of population health would need to be assured and enhanced within the health system. Formal relationships between Public Health Units, Boards of Health and the LHINs would need to be established through a system design that leverages the benefits and mitigates the potential risks. Provincial, municipal and unallocated municipal funding levels for public health programs should be protected and enhanced. And finally, public health's collaborative work with the local municipalities must be protected.

Staff recommend that the Chair of the Board of Health submit this report to the Minister of Health and Long-Term Care, and write a letter to the Minister of Health and Long-Term Care outlining the key considerations for successful health system transformation, as outlined in this report. It is recommended that the Chair of the Board of Health include in the letter a recommendation that Boards of Health be afforded ex-officio representation with LHIN Boards in order to effectively assist in priority setting, with copies sent to all Ontario Boards of Health, Ottawa City Council, the Association of Municipalities of Ontario, alPHa, the Champlain LHIN, and local Members of Provincial Parliament, as part of the Ministry's consultations. In addition, staff recommend that the Chair of the Board of Health and the Medical Office of Health consult with the Ottawa City Council representative for the Association of Municipalities of Ontario (AMO), regarding municipal perspectives around the proposed changes in governance and funding These recommendations aim to ensure that public health meaningfully contributes to the consultation process and that the considerations outlined in this report are shared with relevant stakeholders.

Next Steps

OPH staff will continue to monitor and assess developments and to work closely with partners, including the LHIN, alPHa and AMO.

RURAL IMPLICATIONS

There are no rural implications associated with this report.

CONSULTATION

OPH has consulted with other Public Health Units in Ontario as well as the Association of Local Public Health Units to inform its assessments of the discussion paper impacts.

LEGAL IMPLICATIONS

There are no legal impediments to implementing the recommendations in this report.

RISK MANAGEMENT IMPLICATIONS

There are no risk management implications associated with this report.

FINANCIAL IMPLICATIONS

The financial implications are unknown at this time. There are concerns that an increased role for public health within the LHIN will not be accompanied by additional resources.

ACCESSIBILITY IMPACTS

There are no accessibility impacts associated with this report.

TERM OF COUNCIL PRIORITIES

This report addresses the City of Ottawa's Healthy & Caring Communities Term of Council Priority.

SUPPORTING DOCUMENTATION

Document 1: Ministry of Health and Long-Term Care's Discussion Paper: Patients First, A proposal to Strengthen Patient-Centred Health Care in Ontario

DISPOSITION

The Board of Health secretary will prepare a letter to be sent on behalf of the Chair to the Minister of Health and Long-Term Care as detailed in the report recommendations.

Staff will also continue to participate in Ministry consultation process, as required, and finally staff will support the Chair and the Medical Officer of Health in their consultations with the City of Ottawa's AMO representative.

REFERENCE

1. McKeown, D. Healthy People First: Opportunities and Risks in Health System Transformation in Ontario. Toronto: Toronto Public Health: 2015