ALGOMA PUBLIC HEALTH

BOARD OF HEALTH MEETING

March 30, 2016

5:00 - 7:00 PM

SAULT STE MARIE ROOM, 1ST FLOOR, APH SSM

294 WILLOW AVE, SAULT STE MARIE, ON

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March 30, 2016 - Board of Health Meeting -

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2016 @ 4:30pm

b. Next Governance Standing Committee - April 13, 2016 @ 5:30pm

c. Next Board of Health Meeting - April 27, 2016 @ 5:00pm

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15. Adjournment

ALGOMA PUBLIC HEALTH
BOARD OF HEALTH MEETING
MARCH 30, 2016 @ 5:00 pm
SAULT STE MARIE ROOM A&B, 1ST FLOOR, APH SSM
A*G*E*N*D*A

1.0 Meeting Called to Order — Lee Mason, Board Chair

a. Declaration of Conflict of Interest

2.0 Adoption of Agenda Items — Lee Mason, Board Chair

Resolution
THAT the agenda items dated March 30, 2016 be adopted as circulated; and
THAT the Board accepts the items on the addendum.

3.0 Adoption of Minutes of Previous Meeting — Lee Mason, Board Chair

Resolution
THAT the minutes of the meeting dated February 14, 2016 be adopted as circulated.

4.0 Delegations/Presentations.

a. Nutritious Food Basket — Kristy Harper, Program Manager of Chronic Disease & Injury Prevention

5.0 Business Arising from Minutes

No business arising from previous minutes

6.0 Reports to the Board

a. Associate Medical Officer of Health and Chief Executive Officer Report — Tony Hanlon, Chief Executive Officer

Resolution
THAT the report of the Associate Medical Officer of Health and CEO for the month of March 2016 be adopted as presented.

b. Financial Report — Justin Pino, Chief Financial Officer

Resolution
THAT the Financial Statements for the Period Ending January 31, 2016 be approved as presented.

7.0 New Business/General Business

a. Performance Monitoring Quantitative Report — Tony Hanlon, Chief Executive Officer

8.0 Correspondence — Lee Mason, Board Chair

a. Basic Income Guarantee

i. Letter to Minister Duclos from Wellington-Dufferin-Guelph Public Health dated March 2, 2016

b. Enactment of Legislation to Enforce Infection Prevention and Control Practices within Invasive Personal Service Settings
   i. Letter to Premier Wynne from Sudbury District Health Unit dated March 7, 2016
   ii. Letter to Premier Wynne from Peterborough County-City Health Unit dated March 15, 2016

c. Environmental Health Program Funding
   i. Letter to Minister Hoskins from North Bay Parry Sound District Health Unit dated February 22, 2016

d. Herpes Zoster Vaccine
   i. Letter to Minister Hoskins from Peterborough County-City Health Unit dated February 25, 2016

e. Northern Ontario Evacuations of First Nations Communities
   i. Letter to Premier Wynne from Porcupine Health Unit dated March 21, 2016

f. Patients First: A Proposal to Strengthen Patient-Centred Health Care
   i. Letter to Minister Hoskins from the Association of Local Public Health Agencies (alPHa)
   ii. Letter to Ontario Boards of Health from Grey Bruce Health Unit dated March 7, 2016

g. Petition to Update Ontario Fluoridation Legislation
   i. Letter to Minister Hoskins from Windsor-Essex County Health Unit dated March 18, 2016

h. Some-Free Multi-Unit Housing
   i. Letter to Minister McMeekin from Porcupine Health Unit dated March 21, 2016

i. Smoke-Free Schools Act Bill 139
   i. Letter to Minister Hoskins from North Bay Parry Sound District Health Unit dated February 22, 2016

9.0 Items for Information

10.0 Addendum — Lee Mason, Board Chair

11.0 That The Board Go Into Committee — Lee Mason, Board Chair

Resolution
THAT the Board of Health goes into committee.

Agenda Items:
a. Adoption of previous in-committee minutes dated February 24, 2016
b. Litigation or Potential Litigation
c. Personal Matter about an identifiable individual

12.0 That The Board Go Into Open Meeting — Lee Mason, Board Chair

Resolution
THAT the Board of Health goes into open meeting

13.0 Resolution(s) Resulting from In-Committee Session Lee Mason, Board Chair

14.0 Announcements: Lee Mason, Board Chair

Next Board Meeting:
April 27, 2016
Sault Ste. Marie Room A&B, 1st Floor,
Algoma Public Health, Sault Ste. Marie

15.0 That The Meeting Adjourn Lee Mason, Board Chair

Resolution
THAT the Board of Health meeting adjourns

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The Cost of Eating Well in Algoma 2015

Kristy Harper
Public Health Program Manager
Chronic Disease & Injury Prevention Programs

What is a Nutritious Food Basket?

"A Nutritious Food Basket (NFB) is a survey tool that is a measure of the cost of basic healthy eating that represents current nutrition recommendations and average food purchasing patterns. Food costing is used to monitor both affordability and accessibility of foods by relating the cost of the food basket to individual/family incomes."

NFB Guidance Document 2010

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Nutritious Food Basket Survey

- Mandated by the Ontario Ministry of Health and Long-Term Care
- Conducted every May
- Visit 7 grocery stores across Algoma district
- Price 67 food items to determine an average price of a nutritious diet. Record lowest retail price.
- Reflects an eating pattern that meets Canada's Food Guide

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Understanding the NFB

What is NOT included?

- Highly processed foods and food with little or no nutritional value
- Any foods for special diets
- Personal and household care items such as toothpaste, cleaning supplies

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The NFB design assumes...

- Most people have the necessary time, food skills, and equipment to be able to prepare meals from scratch
- People have access to quality grocery stores

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Nutritious Food Basket Results

Year	Weekly Cost	Percent Change in Cost from Previous Year
2015	$211.07	↑ 7.0%
2014	$197.32	↑ 1.6%
2013	$194.12	↑ 0.8%
2012	$192.64	↑ 3.8%
2011	$185.50	↑ 6.8%
2010	$173.64	-

The family of four scenario is based on:

- Male 31-50
- Female 31-50
- Male 14-18
- Female 4-8

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Why can't people afford healthy food?

- People living on minimum wage, OW or ODSP find it hard to make ends meet. After paying rent they still have to pay for other necessities such as:
  - Heat and hydro
  - Transportation, car maintenance and gas
  - Child care
  - Phone
  - Clothing
  - Eye and dental care
  - Home maintenance
  - Costs for children in school
  - Household cleaners and personal hygiene products

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Why does the cost of food matter?

- When money is tight, people are forced to cut into their food budget to pay for other living expenses
- They skip meals, eat fewer vegetables and fruit, drink less milk and fill up on non-nutritious foods because they are cheap
- This can lead to an increase risk of chronic disease and poor growth and development in children

Position Statement on Responses to Food Insecurity (November 2015)

- Ontario Society of Nutrition Professionals in Public Health (OSNPPH) Food Security Workgroup
- Food charity is an ineffective response to food insecurity
- An income response is required to effectively address food insecurity

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Income-Related Policy Recommendations to Address Food Insecurity (November 2015)

- OSNPPH Paper: *Income-Related Policy Recommendations to Address Food Insecurity*
- 3 recommendations to address the root cause of food insecurity:
  - Prioritize and investigate a basic income guarantee
  - Increase social assistance rates and;
  - Provide basic minimum employment standards to reduce precarious employment

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Algoma Public Health

- Provide education around poverty and food insecurity
- Monitor and report on the Nutritious Food Basket data and other food insecurity indicators
- Work with community partners to address food insecurity
- Focusing on food literacy to provide families and individuals with knowledge and skills to make healthy food choices

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Future Considerations

- As we move forward to try to address food insecurity, there are other strategies that APH could consider, which include advocating for, policy change such as a basic income guarantee (BIG), improved social assistance and minimum wage rates, more affordable housing, improved employment insurance coverage and benefits and accessible and affordable childcare.

Thank you

Questions?

The Cost of Eating Well in Algoma 2015

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Eating a nutritious diet is important to help ensure optimal growth and development and to help prevent some chronic diseases. The health unit conducts a food cost survey every year in local grocery stores to calculate the **Cost of Eating Well in the district of Algoma** according to sex and age. These costs are based on a healthy diet including a variety of foods from *Canada's Food Guide*. Money for food is balanced with other household expenses, such as rent or mortgage payments, utilities and transportation. Budgeting money just for food is important so that it is not used to cover other expenses.

How can this information be used?

- To estimate what it might cost to feed individuals or a group of people (as in group homes, shelters, students sharing a house, and so on) and compare it to incomes.
- To make up case studies for discussion in budgeting or education programs.
- To discuss how difficult it can be for people with a limited income to afford a nutritious diet.

Weekly "Cost of Eating Well" in Algoma District

Sex and Age		Cost
Boy	2-3 years	$27.20
	4-8 years	$35.13
	9-13 years	$46.99
	14-18 years	$67.80
Girl	2-3 years	$26.66
	4-8 years	$34.05
	9-13 years	$40.07
	14-18 years	$48.20
Man	19–30 years	$65.66
	31–50 years	$59.19
	51–70 years	$57.12
	71+ years	$56.60
Woman	19–30 years	$50.64
	31–50 years	$50.03
	51–70 years	$43.84
	71+ years	$43.09

*Based on average prices from seven stores during May, 2015

Weekly "Cost of Eating Well" in Algoma District for Pregnant and Breastfeeding Women

Mother's Age at Pregnancy or Breastfeeding		Cost
Less than 18 years	Pregnancy	$54.14
	Breastfeeding	$56.17
19-30 years	Pregnancy	$54.79
	Breastfeeding	$58.55
31-50 years	Pregnancy	$53.53
	Breastfeeding	$57.29

*Based on average prices from seven stores during May, 2015

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Estimate Your Food Budget

Sample Weekly Household Food Cost Calculation		
Sex	**Age**	**Cost**
Man	41	$59.19
Woman	39	$50.03
Boy	14	$67.80
Girl	8	$34.05
	Subtotal =	$211.07
$211.07 x 1 = $211.07 (subtotal x adjustment) = Total		

Your Household Food Cost Calculation		
Sex	**Age**	**Cost**
		$
		$
		$
		$
		$
		$
	Subtotal =	$
$_____ x _____ = $_____ (subtotal x adjustment) = Total		

- Write down the sex and age for each person in your household.
- Write down the weekly food cost for each person according to the tables on the other page.
- Add up the food costs for your household to get a subtotal.
- Some studies have shown that it costs more to feed one person than to feed a small group of people. Therefore, multiply the subtotal for your household using the adjustment factor that is right for your household.
- The weekly cost can be changed to a monthly cost by multiplying the total by 4.33.

Adjustment Factor

If you are feeding:
1 person – multiply by 1.2
2 people – multiply by 1.10
3 people – multiply by 1.05
4 people – multiply by 1
5-6 people – multiply by 0.95
7+ people – multiply by 0.90

Caution!

- These calculations are a *guideline* of what you could be spending on food in order to stay healthy. It does not guarantee that you will be healthy by spending this amount. Eating a balanced diet based on *Canada's Food Guide* is the key to good nutrition.
- This food budget estimate does not include money for convenience foods, snack foods, eating out or for paper, personal hygiene and cleaning products. You need to budget extra money for these items.

Other Suggestions

- Try to keep the food budget money in a separate envelope or container so that it is available for food purchases during the month.
- If budgeting for food money is a problem, it may be helpful to look at all of your household incomes and expenses to see if money can be saved in other ways.
- For more information about healthy eating on a budget, contact Algoma Public Health or visit EatRight Ontario at www.eatrightontario.ca.

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MEDICAL OFFICER OF HEALTH/CHIEF EXECUTIVE OFFICER
BOARD REPORT
February 2016

Prepared by Tony Hanlon Ph.D., CEO and Dr. Alex Hukowich, Associate MOH

Elliot Lake staff officially moved into the new office space March 14, 2016

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APH AT-A-GLANCE

Each month we celebrate and promote different programs and professions in public health. This month we celebrate Nutrition Month and our dedicated dietitians! This year our Dietitians promoted the ***"Cook up Some Fun"*** campaign that emphasizes kids that plan, shop, cook and eat with their families enjoy benefits that go beyond nutrition.

During the week of March 6-12, 2016 we recognized the important contribution that our Dental Assistants provide to our clients and the community. We also celebrated Social Work Week on March 7-11, 2016. This year's theme is ***"Social Workers Help Turn Issues into Answers"***.

On March 10, 2016 our Elliot Lake office began their move to their new permanent location. The Elliot Lake team with support from IT and various staff from all offices made a smooth transition. The official first day of the office open to the public was March 15, 2016. A Grand Opening celebration is being planned for May.

Effective March 7, 2016 the Sault Ste. Marie front reception will now be open over the lunch hour.

Parent Child Services will be participating in the first Bumps, Babies, and Beyond Expo on April 24th 2016 at the Machine Shop in Sault Ste. Marie. Admission to this event is free for families. Vendors and agency representatives will be present to showcase prenatal, postpartum, baby and toddler services and products. It is a perfect opportunity for us to reach our target population. Parent Child Services will be promoting all the programs and services we offer to families with children ages 0-6. More specifically we will be highlighting car seat safety by having a live demonstration on site, offering giveaways of notepads and beach balls to promote our new website and showcasing the campaign 'First Dental Visit by First Birthday'. We look forward to this great opportunity to promote the great services and initiatives APH has to offer.

RISK MANAGEMENT

INFECTIOUS DISEASE

Topic: Rabies

This report addresses the following requirements of the Ontario Public Health Standards (2014) or Program Guidelines/Deliverables: Rabies Prevention and Control Requirement #7: The board of health shall ensure that the medical officer of health or designate is available on a 24/7 basis to receive reports of and respond to suspected rabies exposures in accordance with the Health Protection and Promotion Act; the Public Health Emergency Preparedness Protocol, 2008 (or as current); and the Rabies Prevention and Control Protocol, 2008 (or as current)

This report addresses the following Strategic Directions: Collaborate Effectively

Risk	Rabies is a fatal disease in humans thus considerable effort is made to identify the nature of the exposure by the animal and rule out infection by a normal ten day observation period of domestic cats and dogs.
Recommendations	With rabies still circulating in Southern Ontario, most recently fox variant cases detected in Perth County and raccoon variant in Hamilton area, it is important to remain vigilant in responding to potential exposures in Algoma.
Key Points	In 2014, APH received 193 potential rabies exposures (149 dogs, 40 cats, 4 livestock/wild animal). In 2015, APH received 221 rabies exposures (171 dogs, 46 cats, 4 wildlife). In addition we have worked with veterinarians and animal workers in the district and have been able to also get reports on when Q fever is in our district.
Analysis	Significant effort is made to locate the animal responsible for the exposure to institute requisite confinement period to rule out rabies. This may even involve media to find the domestic dog or cat. If unsuccessful, risk assessment with the physician is completed including consideration of post-exposure immunization.
Action	Public health inspectors begin investigating all cases within one day as per Ministry protocol and Ministry Accountability Agreement. The PHI work with the victim, owner, physician and occasionally Ontario Vet Techs and veterinarians in follow-up action including occasionally rabies immunization.
Financial Implications	Overtime is accrued in working on weekends and after normal business hours as public health is expected to be available to address significant events such as rabies exposures 24/7.
Staffing Implications	Overtime is accrued due to rabies exposure follow-up in the Algoma District.

PROGRAM HIGHLIGHTS

CHRONIC DISEASE PREVENTION

Topic: 2015 Nutritious Food Basket Results

This report addresses the following requirements of the Ontario Public Health Standards (2014) or Program Guidelines/ Deliverables: Chronic Disease Prevention Requirement #2: The board of health shall monitor food affordability in accordance with the *Nutritious Food Basket Protocol* and the *Population Health Assessment and Surveillance Protocol.*

This report addresses the following Strategic Directions: Improve Health Equity

Annually during the month of May, all Ontario public health units conduct the Nutritious Food Basket (NFB) survey in accordance with the requirements under the Ontario Public Health Standards. The survey provides a measure of the cost of basic healthy eating taking into consideration current nutrition recommendations and average food purchasing patterns of Canadians. The NFB results can be used to: estimate the basic cost for an individual or household to eat healthy; compare the basic costs of healthy eating with income and other basic living expenses; and inform policy decisions. In 2015, 7 grocery stores across Algoma were surveyed.

In May 2015, the estimated local monthly cost to feed a family of four was $913.93. This is a $59.53 or 7% increase from the estimated cost in May 2014. All of us have noticed that food costs are rising; however, those on a fixed income feel the effects the most. Households with limited incomes often consider food budgets to be “flexible” and redirect these funds to pay for housing, utilities and other essential “fixed” costs. From 2010 to 2015, the cost of the NFB has risen 20%.

The annual NFB results bring attention to the issue of food insecurity across Algoma. Food insecurity is associated with inadequate nutrient intakes as well as an increased risk of infectious and chronic diseases. It is also more difficult to manage these diseases and conditions for people who are food insecure. Algoma Public Health (APH) Registered Dietitians work with our Health Equity Public Health Nurses and community partners, such as Algoma Food Network and the Poverty Reduction Roundtable, to increase awareness of the issue of food insecurity and look for opportunities for community action to address it. GIS maps have been developed to highlight food access across Algoma. Food literacy is a priority for APH in order to provide families and individuals with the knowledge and skills to make healthy food choices. Examples include slow-cooker kitchens and the newly launched “Cook Up Some Fun” campaign.

The primary local response to food insecurity has been food banks and meal programs. While these programs can help fill the most urgent needs to a limited degree, there is a legitimate concern that community-based charitable food programs may unintentionally be enabling the retraction of social programs. These programs do not address poverty, which is the root cause of food insecurity and they do not provide an adequate or dignified solution to individuals and families facing food insecurity.

APH Public Health Dietitians are members of the Ontario Society of Nutrition Professionals in Public Health (OSNPPH) Food Security Workgroup. This workgroup has reviewed current evidence and developed a *Position Statement on Responses to Food Insecurity* which states that food charity is an ineffective response to food insecurity and an income response is required. This position statement has been endorsed by alPHa, OPHA, health units, numerous organizations, and individuals.

In addition, OSNPPH has developed income-related policy recommendations to address food insecurity. Based on research, OSNPPH proposes three recommendations to address the root cause of food insecurity as outlined in the paper *Income-Related Policy Recommendations to Address Food Insecurity.*

1. Prioritize and investigate a basic income guarantee;
2. Increase social assistance rates and;
3. Provide basic minimum employment standards to reduce precarious employment.

Currently, APH continues to strive to address food insecurity by:

- Providing education around poverty and food insecurity
- Monitoring and reporting on the Nutritious Food Basket data and other food insecurity indicators
- Working with community partners to address food insecurity
- Focusing on food literacy to provide families and individuals with knowledge and skills to make healthy food choices

As we move forward to try to influence and address food insecurity, there are other strategies that APH could consider, which includes advocating for, policy change such as a basic income guarantee (BIG), improved social assistance and minimum wage rates, more affordable housing, improved employment insurance coverage and benefits and accessible and affordable childcare.

COMMUNITY ALCOHOL DRUG ASSESSMENT PROGRAM

Topic: Enhancing the Reach of the Addiction Supportive Housing (ASH) Program

This report addresses the following requirements of the Ontario Public Standards (2014) or program guidelines/deliverables:

- Community Alcohol/Drug Assessment Program – Addiction Supportive Housing (ASH) Program
- Ontario Healthcare Reporting Standards (OHRS V9.0) Functional Center – MSAA Service Plan: Improve Access

This report addresses the following strategic directions: Improve Health Equity

Community Alcohol/Drug Assessment Program (CADAP) delivers a housing first model of care for individuals with substance use and misuse issues. The ASH program provides intensive case management and housing subsidy to people without requirements for abstinence. Stable housing is central to attaining treatment goals with housing being part of any comprehensive treatment program. The goal of the program, using a housing first model and harm reduction approach to services, is to increase the health and social outcomes of people with problematic substance use issues and difficulties in maintaining

housing. The main objectives of the program are to reduce frequency of re-admissions to addiction programs, reduce contact with criminal justice system, increase successful tenancy, and reduce emergency department visits. This program is client centered and is responsive to unique needs of the individual.

There has been a steady increase in the number of clients with addiction issues in need of the housing subsidy. Community partners have become more aware of the ASH services and have increased referrals for intensive case management without the housing subsidy. The case manager/client ratio is 1:8. Currently, the case managers are carrying a caseload of 1:18. ASH has a waitlist for the housing subsidy; however the case managers are meeting the demands of those individuals in most need.

Additional funds have been received to increase the housing subsidies from 16 to 20. The program is looking at options to increase the capacity of the case managers, to address the waitlist and to pilot the ASH program in the District. For the District programs, this additional support will expand the reach of the program, increase access to housing subsidy and case management support in Elliot Lake and Wawa, and creating opportunities for equitable health and social outcomes.

PARTNERSHIPS

Health Links
On March 11, 2016 APH attended the Sault Ste. Marie Health Links Project Engagement Session. The session served as a communication launch for the identified patients and providers involved in the project. The patient experience was at the centre of the session and there was opportunity for community stakeholders to provide input to the "guided care model" intended to drive the care planning process for the identified high needs/complex patients. The next steps of the project will involve a pilot of the care model with a sample of patients. It is anticipated that APH's Community Mental Health Transitional and Intensive Case Management program will align to this model.

Healthy Kids Community Challenge
Through the Healthy Kids Community Challenge initiative free public skating and swimming is being offered in Sault Ste. Marie throughout March and April.

STOP on the Road Workshops
Once again APH in partnership with Centre for Addition and Mental Health Centre (CAMH) hosted smoking cessation workshops for those looking to quit smoking cigarettes. The STOP program delivers research-based, cost-free smoking cessation workshops in local communities. Workshops were held in White River on March 11, 2016 and in Sault Ste. Marie on March 21, 2016. We offer community workshops that are open to the public; as well as, worksite workshops.

Respectfully submitted,
Tony Hanon, Ph.D., CEO and Dr. Alex Hukowich, Associate MOH

Algoma Public Health
Financial Statements
For the period ending: January 31, 2016

Algoma Public Health
Statement of Operations and Fund Balances
For the period ending: **January 2016**

	Actual YTD 2016	Budget YTD 2016	Variance Bgt to Actual 2016	Annual Budget 2016	2016 YTD Actual/ YTD Budget %
Revenue					
Municipal Levy -public health	$ 940,752	$ 283,316	$ 657,436	$ 3,399,791	332%
Provincial Grants -public health	$ 813,375	$ 813,942	$ (567)	$ 9,767,300	100%
Grants/Levies - Capital	$ -	-	$ -	-	
Provincial Grants - community health	5,280,714	5,177,901	$ 102,812	6,306,216	102%
Fees, other grants and recovery of expenditures	43,951	68,684	$ (24,733)	824,204	64%
	$ 7,078,791	$ 6,343,842	$ 734,949	$ 20,297,511	112%
Expenditures					
Public Health Programs					
Public Health	$ 1,100,667	$ 1,165,941	$ 65,274	$ 13,991,297	94%
Public Health (Capital)	0	-	-	-	
Community Health Programs					
Healthy Babies and Children	86,164	$ 89,000	2,836	1,068,000	97%
Child Benefits Ontario Works	0	$ -	-	-	#DIV/0!
Dental Benefits Ontario Works	32,042	$ -	(32,042)	-	#DIV/0!
Misc Calendar	23	$ -	(23)	-	#DIV/0!
Healthy Community Partnership	52	$ -	(52)	-	#DIV/0!
Northern Ontario Fruit & Vegetable Program	102,345	$ 97,451	(4,894)	117,400	105%
Brighter Futures for Children	78,325	$ 94,540	16,214	126,887	83%
Infant Development	533,114	$ 563,322	30,208	675,986	95%
Preschool Speech and Languages	491,821	$ 511,880	20,059	614,256	96%
Nurse Practitioner	97,930	$ 102,378	4,448	122,853	96%
Genetics Counseling	265,180	$ 306,505	41,325	367,806	87%
Community Mental Health	2,459,289	$ 2,614,832	155,542	3,164,598	94%
Community Alcohol and Drug Assessment	554,410	$ 565,165	10,755	683,210	98%
Remedial Measures	28,648	$ -	(28,648)	-	#DIV/0!
Diabetes	96,545	$ 125,000	28,455	150,000	77%
Healthy Kid Community Challenge	54,856	$ 92,410	37,554	169,669	59%
Stay on Your Feet	74,474	$ 83,333	8,860	113,550	89%
Misc Fiscal	32,735	$ -	(32,735)	-	#DIV/0!
	$ 6,088,620	$ 6,411,756	$ 323,137	$ 21,365,512	95%
Excess of revenues over expenses - CH	292,761				
Excess of revenues over exp. - Public Health	697,411				
Operating fund balance, beginning of year	3,009,266				
Operating fund & capital, end of month (Note 1)	$ 4,025,700				

Note 1:
The operating fund balance consists of a public health reserve and amounts owed to the Gov't of Ontario as of the report date.

Algoma Public Health
Revenue Statement
For the Month Ending January 31, 2016

	Current YTD	Budget YTD	Variance	YTD Actual to Annual Bgt %	Annual Budget
MOH Public Health Funding	618,328	624,817	(6,489)	8%	7,497,800
MOH One Time Funding	4,224	4,225	(1)	8%	50,700
MOH Funding Haines Food Safety	2,061	2,050	11	8%	24,600
MOH Funding CINOT/Healthy Smiles	34,216	34,217	(1)	8%	410,600
MOH Funding - Social Determinants of Health	15,049	15,042	7	8%	180,500
MOH Funding Vector Bourne Disease	9,072	9,058	14	8%	108,700
MOH Funding Chief Nursing Officer	10,139	10,125	14	8%	121,500
MOH Funding Safe Water	5,805	5,800	5	8%	69,600
MOH Enhanced Funding Safe Water	1,290	1,292	(2)	8%	15,500
MOH Funding Unorganized	41,692	41,692	0	8%	500,300
IC Prevention & Control Week	0	0	-	0%	0
MOH One Time Funding Dental Health	9,322	2,833	6,489	27%	34,000
MOH Funding Infection Control	26,047	26,033	14	8%	312,400
Levies Sault Ste Marie	601,261	196,904	404,357	25%	2,362,846
Levies Sault Ste Marie Capital	0	0	-	0%	0
Levies Vector Bourne Disease	0	4,953	(4,953)	0%	59,433
Levies District	339,491	81,459	258,032	35%	977,512
Levies District Capital	0	0	-	0%	0
Recoveries from Programs	891	838	53	9%	10,061
Program Fees	6,556	20,595	(14,039)	3%	247,143
Land Control Fees	900	13,333	(12,433)	1%	160,000
Program Fees Immunization	24,285	13,333	10,952	15%	160,000
HPV Vaccine Program	0	833	(833)	0%	10,000
Influenza Program	0	5,000	(5,000)	0%	60,000
Meningococcal C Program	0	833	(833)	0%	10,000
Interest Revenue	1,081	167	914	54%	2,000
Other Revenues	0	13,750	(13,750)	0%	165,000
Funding Holding	10,238	0	10,238	100%	0
Funding Ontario Tobacco Strategy	36,130	36,758	(628)	8%	441,100
Elliot Lake Office Relocation	0	0	-	0%	0
Panorama	0	0	-	0%	0
IT Platform Stabilization - One Time	0	0	-	0%	0
First Nations Inititative -One Time	0	0	-	0%	0
	$ 1,798,078	$ 1,165,941	$ 632,137		$ 13,991,295
Summary					
Levies	940,752	283,316	657,436	332%	3,399,791
Funding Grants	813,375	813,942	(567)	100%	9,767,300
Fees & Recoveries	43,951	68,684	(24,733)	64%	824,204
	$ 1,798,078	$ 1,165,941	632,137	154%	$ 13,991,295

Algoma Public Health

Expense Statement- Public Health

For the Month Ending January 31, 2016

	Current YTD	Budget YTD	Variance	YTD Actual to Annual Bgt %	Annual Budget	
Salaries & Wages	$ 647,382	$ 692,221	44,838	8%	$ 8,306,647	1
Benefits	181,719	173,055	(8,664)	9%	2,076,662	2
Travel - Mileage	6,596	12,138	5,542	5%	145,659	3
Travel - Other	3,210	7,817	4,607	3%	93,801	3
Program	33,885	47,484	13,599	6%	569,806	4
Office	2,453	7,667	5,213	3%	92,000	4
Computer Services	48,580	74,659	26,079	5%	895,908	4
Telephone Charges	651	3,250	2,599	2%	39,000	5
Telecommunications	6,233	15,624	9,391	3%	187,483	5
Program Promotion	4,039	17,840	13,802	2%	214,085	4
Facilities Expenses	35,287	67,827	32,540	4%	813,924	6
Fees & Insurance	91,692	20,100	(71,592)	38%	241,205	7
Special Projects	0	0	-	0%	0	
Debt Management	38,939	38,000	(939)	9%	456,000	
Recoveries	0	(11,740)	(11,740)	0%	(140,883)	8
Elliot Lake Relocation	0		-	0%		
	$ 1,100,667	$ 1,165,941	$ 65,274		$ 13,991,297	

	Current YTD	2015	Total	Total % Spent	Total Budget
Elliot Lake Renovations	179,742	277,890	457,632	63%	724,960

Notes to Financial Statements – January 2016

Reporting Period

The January 2016 financial reports include one month of financial results for Public Health and the following calendar programs, Healthy Babies, and Child and Dental Benefits Ontario Works All other programs are reporting ten month results from operations year ended March 2016.

Public Health – Statement of Operations (see page 1)

General Comments

As of January 31st, 2016, Public Health programs are reporting a surplus of approximately $697k. On the Revenue side, $657k positive variance is attributable to the timing of receipts of municipal levies from the City of Sault Ste. Marie and the District. Provincial Grants are operating within budget. Program Fees & Recoveries are indicating a negative $24k variance as a result of timing of fees recovered by APH.

There is a positive variance of $65k related to Public Health Expenses being greater than budgeted. This is due to the fact that APH is relatively early in its Public Health budget year with only one month of operations completed.

Community Health programs are reporting a surplus of $292k. There is a $155k positive variance associated with the Community Mental Health Program. The program received additional funding for positions related to transitional case management. The lag in time to fill these positions is driving the noted variance. APH has been working with the Northeast LHIN who has requested recovering any unspent dollars to help support local one-time funding requests related to patient safety issues.

There is a $30k positive variance related to Infant Development Program, a $20k variance related to the Preschool Speech and Language Program, and a $25k positive variance related to the Diabetes Program. Purchases related to these programs typically occur within the last quarter of the year (January – March). It is anticipated that these positive variances will be reduced by the end of the fiscal year.

There is a positive variance of $41k associated with the Genetics Program and a $37k related to the Healthy Kid Community Challenge. This is a result of the inherent time lag in filling positions within the agency.

Notes Continued…

Revenue (see page 2 for details)

Public Health funding revenues are indicating a positive variance of $632k. Driving this is a $657k positive variance related to the timing of the municipal levy receipts from the City of Sault Ste. Marie and the District. Funding Grants is within budget. There is a negative variance of $24k associated with Fees & Recoveries. APH typically captures the bulk of its fees between the spring and fall months.

Public Health Expenses Budget (see page 3)

Note 1/2– Salaries/Benefits

The positive variance of $44k is a result of two vacant positions which have been gapped and yet to be filled. In addition, the vacant permanent Medical Officer of Health (MOH) position is impacting the noted positive variance. The inherent time lag in filling positions within the agency also contributed to this variance.

Benefits is indicating a negative $8k variance. This is a result of employer contributions associated with Canada Pension and Employment Insurance. As the year progresses this negative variance is expected to reduce.

Note 3 –Travel (Mileage, Other)

Mileage is showing a positive $5k variance due to timing of employee claim submissions.

Travel - Other is showing a positive $4k variance. Staff travel typically occurs between the spring and fall months.

Note 4 - Program, Office, Computer Services, Program Promotion

Program expenses are indicating a positive variance of $13k. This is due to timing of expenditures not yet incurred.

Office expense is showing a positive $5k variance as a result of timing of expenditures not yet incurred.

Computer Services is showing a positive variance of $26k. This is a result of equipment purchases and software licensing renewals yet to be incurred.

Program Promotion is showing a positive variance of $13k due to timing of expenditures not yet incurred.

Notes Continued…

Note 5 – Telephone Charges/Telecommunications

Telephone Charges are indicating a positive variance of $2k. This is due to timing of expenditures not yet incurred.

Telecommunications is indicating a positive variance of $9k. This is due to timing of expenditures not yet incurred.

Note 6 – Facilities Expenses/Renovations

Facilities Expenses is showing a positive variance of $32k. This is a result of the timing of expenditures not yet incurred. As the year progresses, this positive variance is anticipated to reduce.

Note 7 – Fees & Insurance

Fees & Insurance is indicating a negative variance of $71k. This is a result of legal expenses incurred regarding a Public Health policy matter. APH has submitted a one-time funding request to the MOHLTC with the intention of recouping these costs.

Note 8 – Recoveries

Recoveries are indicating a negative variance of $11k. This is a result of entries not yet posted to the General Ledger as these entries typically occur quarterly.

Community Programs (see page 1)

All community programs are operating without budget issues.

Financial Position - Balance Sheet (see page 7)

Our cash flow position continues to be stable and the bank has been reconciled as of January 31st, 2016. Cash includes $.699 million in short-term investments. A portion of the short-term investments relates to insurance settlement funds associated with the Elliot Lake mall collapse and will be used to help finance renovations for the new Elliot Lake offices. In addition, APH has secured a $350,000 loan with interest only payments until September 1, 2016 to help with the financing of the Elliot Lake office renovations. The loan is open and can be repaid at any time without penalty.

Long term debt of $5.749 million is held by the Royal Bank @ 2.76% for a 20 year term. The loan matures on September 1, 2016. There are no collection concerns for accounts receivable.

NOTE: January 2016 Balance Sheet (page 7) not included as APH is currently completing 2015 year-end requirements. This will be provided next month with the 2015 Annual Audited financial statements.

PublicHealth
WELLINGTON-DUFFERIN-GUELPH
Stay Well.

March 2, 2016

The Honourable Jean-Yves Duclos
Minister of Families, Children and Social Development
House of Commons
Ottawa, Ontario K1A 0A6

Dear Minister Duclos:

I am writing today on behalf of Wellington-Dufferin-Guelph Public Health to request that the federal government study the merits of a basic income guarantee as a policy option for reducing poverty and as a measure to improve the health of all Canadians. Wellington-Dufferin-Guelph Public Health's Board of Health believes that health equity is an important part of building healthy communities which is why we urge you to give serious consideration to a basic income guarantee.

Income inequities are increasing in Canada as described in a number of recent reports, including a report released by Wellington-Dufferin-Guelph Public Health in 2011. The Low Income Measure (LIM) revealed that 11.4 percent of households in Wellington-Dufferin-Guelph (WDG) were low income. The rate of low-income households in WDG ranged widely among communities from 4.6 to 19.8 percent. Although just under 7 percent of children in WDG were living in households with low income, the rate in one Guelph neighbourhood was over 30 percent.

Another well-documented fact is that poverty has considerable negative impacts on health. Income may be the most important determinant of health as it influences health-related living conditions. A Wellesley Institute report presented compelling evidence that low income almost inevitably ensures poor health and significant health inequity in Canada. Canadians with the lowest incomes are more likely to suffer from chronic conditions such as diabetes, arthritis and heart disease, and to live with a disability. The report, *Poverty Is Making Us Sick* offered a comparison between the highest and lowest-income quintiles among Canadians and found that the lowest quintile had double the rates of diabetes and heart disease than those in the highest one. Those in the lowest quintile were 60 percent more likely to have two or more chronic conditions, four times more likely to live with disability, and three times less likely to have additional health and dental coverage.

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Telephone: 1-800-265-7293 | **Fax:** 519-836-7215 | **www.wdgpublichealth.ca**

Research conducted across multiple countries found that countries with higher rates of income inequality had higher levels of health and social problems across all income levels. This pattern was consistent and included health issues such as mental illness, higher levels of obesity and lower life expectancy, educational achievements such as math and literacy scores, and community issues such as violence.

There has been widespread support for an investigation into and consideration of a basic income guarantee for all Canadians. In the public health sector, resolutions have been passed by the Association of Local Public Health Agencies (alPHa) and the Ontario Public Health Association (OPHA). Prior to the last federal election, the Canadian Public Health Association released a fact sheet calling on the next federal government to take leadership in adopting a national strategy to provide all Canadians with a basic income guarantee.

Support for a basic income guarantee has also emerged from municipalities. In December of 2015, the City of Kingston passed a resolution advocating for the federal and provincial governments to consider, investigate and develop a basic income guarantee for all Canadians. The City of Kingston resolution was forwarded to all municipalities in Ontario with a request that they consider supporting the initiative. To date the resolution has been endorsed by the cities of Cornwall, Belleville, Pelham, Peterborough and Welland.

Wellington-Dufferin-Guelph Public Health's strategic directions include "health equity" and "building healthy communities." Both of these strategic directions are intended to support advocacy efforts for the investigation into and consideration of a basic income guarantee for all Canadians. We urge you to move the government's intentions from the well-documented evidence in a number of recent reports to action, by studying the merits of a basic income guarantee. Poverty results in poor health and a basic income guarantee is a cost-effective policy option that will impact the lives and health of the poorest Canadians.

Sincerely,

Doug Auld, Board of Health Chair
Wellington-Dufferin-Guelph Public Health

Attachment: Basic Income Guarantee Board of Health Report

cc. The Right Honourable Justin Trudeau, Prime Minister of Canada
The Honourable Kathleen Wynne, Premier of Ontario
Dr. David Williams, Ontario Chief Medical Officer of Health
Linda Stewart, Association of Local Public Health Agencies
Pegeen Walsh, Ontario Public Health Association
Ontario Boards of Health
Wellington-Dufferin-Guelph Members of Parliament
Wellington-Dufferin-Guelph Members of Provincial Parliament
Waterloo Wellington Local Health Integration Network
Central West Local Health Integration Network
Brock Carlton, Chief Executive Officer, Federation of Canadian Municipalities
Wellington-Dufferin-Guelph Municipalities

PublicHealth
WELLINGTON-DUFFERIN-GUELPH
Stay Well.

BOH Report – BH.01.MAR0216.R06
March 2, 2016

Report to:	**Board of Health**
Submitted by:	**Dr. Nicola Mercer, Medical Officer of Health & CEO**
Prepared by:	**Jennifer MacLeod, Manager, Health Analytics**
Approved by:	**Andrea Roberts, Director, Family Health & Health Analytics**
Subject:	**BASIC INCOME GUARANTEE**

RECOMMENDATION(S)

(a) That the Board of Health send a letter to the Minister of Families, Children and Social Development requesting that the federal government study the merits of a basic income guarantee as a policy option for reducing poverty and as a measure to improve the health of all Canadians.

Nicola J. Mercer, MD, MBA, MPH, FRCPC
Medical Officer of Health & CEO

EXECUTIVE SUMMARY

A Basic Income Guarantee is intended to ensure universal income security.[1] There are currently individuals and families who are living in poverty in Wellington County, Dufferin County and the City of Guelph.[2] There have been widespread advocacy efforts to support an investigation into and consideration of a Basic Income Guarantee for all Canadians. Pilot studies have demonstrated that Basic Income Guarantee initiatives can achieve intended outcomes.[3]

BACKGROUND

Basic Income Guarantee (BIG) is an income transfer from government to citizens that is not tied to labour market participation.[1] The objective of basic income guarantee is universal income security.[1] A basic income guarantee ensures that income for all individuals is at a level that is sufficient to meet basic needs and live with dignity, regardless of work status.[4] There are different models of basic income guarantee and it is known by other names such as Guaranteed Annual Income (GAI), Basic Annual Income, Guaranteed Liveable Income, and Citizen's Income.[4] A Basic Income Guarantee has the potential to alleviate or even eliminate poverty.[5]

One of the proposed models of Basic Income Guarantee is the negative income tax model (NIT). The NIT model depends on the tax system to administer income. Within this model there are three basic elements:

1. The benefit level – which delineates the maximum benefit payable to an individual
2. The reduction rate – which is the amount by which the benefit is decreased for additional income that exceeds the maximum allowable level
3. The break-even rate – which is the amount of income at which an individual will receive no benefit because the reduction rate has reached 100% [6]

Glen Hodgson, Chief Economist of the Conference Board of Canada stated that there are solid economic, fiscal and social reasons to give a guaranteed annual income serious consideration. He outlined three main advantages:

1. Its approach to addressing poverty would reduce public administration by streamlining existing social welfare programs into one universal system. The system used would be the already existing tax system.
2. Earned income for the working poor could be taxed at low marginal rates. This would provide a strong incentive for recipients to work to earn additional income.
3. Through reducing the prevalence of poverty, a guaranteed annual income could create better health outcomes and therefore reduce health care spending. [7]

Senator Hugh Segal has enumerated other compelling reasons to support a Basic Income Guarantee. He believes that it will result in supporting people to become productive, taxpaying, full participants in our economic mainstream. In contrast, continued societal poverty will result in "serious economic, stability and social cohesion costs that are not sustainable." In addition, he points out that a Basic Income Guarantee would result in

significant economic savings from reducing the administration costs of current systems.[8]

A Basic Income Guarantee has many advantages over minimum wage. It is financed through the tax and transfer system. Those who earn more money pay more for it. It is available whether an individual is working or not. In contrast the minimum wage is only of benefit to those who have a job and the cost of minimum wage is borne entirely by employers. As a result, employers may hire fewer workers or provide fewer hours of work. [9]

In 2011 it was estimated by the National Council of Welfare that it would cost $12.6-billion to top up the 3.5 million Canadians living under the poverty line. At that time the amount was less than five percent of the federal budget. It was also less than half the cost imposed on the economy by poverty and its effects. [10] Allowing poverty to continue is far more expensive than investing to improve the economic well-being of those who are impoverished.[4] The cost of poverty has been estimated at 5.5 to 6.6 percent of Canada's Gross Domestic Product (GDP). This is attributed to costs of health care, criminal justice and lost productivity. Canada's GDP is currently in the range of $1.5-$2.0 trillion a year. As a percentage of the current GDP, poverty costs are calculated to be in the range of $82-$132 billion per year.[4]

> *"Given that basic income is designed primarily to bring individuals out of poverty, it has the potential to reduce the substantial, long-term social consequences of poverty, including higher crime rates and fewer students achieving success in the educational system."*[4]

The Low Income Measure After Tax (LIM-AT) identifies individuals living in households with an income that is lower than 50% of the median adjusted income for all households of the same size in that year. The adjustment for household size reflects that fact that a household's needs increase as the number of household members increases, although not by the same proportion per additional member. For 2010, the LIM-AT threshold for a household of two people was $27,521. That same year, the LIM-AT threshold for a household of four people was $38,920.[11]

Living below this threshold is an indication of poverty. There are individuals and families who are living in poverty in Dufferin County, Wellington County, and the City of Guelph. The National Household Survey data shows that 10.5% percent of WDG residents live in low income circumstances as measured by the LIM-AT (10.1% in Dufferin County, 8.4% in Wellington County and 12.1% in the City of Guelph).[2] Since 2008, Ontario Works caseloads at the County of Wellington and Dufferin County have risen by approximately 60% and 42%, respectively.[12, 13]

Poverty has a negative and lasting impact on health and well-being. Income may be the most important determinant of health as it influences health related living conditions.[14] A Wellesley Institute report presented compelling evidence that low income almost inevitably ensures poor health and significant health inequity in Canada.[15] People living in poverty use health services more frequently and often are more seriously sick or injured. Low income results in poor health and is attributable to 20% of total health care spending in Canada.[16] Children who live in low income households are particularly affected. They are more likely to have a range of

health problems throughout their life, even if their socioeconomic status changes later in life.[16] Canadians with the lowest incomes are more likely to suffer from chronic conditions such as diabetes, arthritis, and heart disease, and to live with a disability. The Wellesley Institute study, *Poverty Is Making Us Sick* offered a comparison between the highest and lowest income quintiles among Canadians and found that the lowest quintile had double the rates of diabetes and heart disease than those in the highest one. Those in the lowest quintile were 60% more likely to have two or more chronic conditions, four times more likely to live with disability, and three times less likely to have additional health and dental coverage.[15]

Research conducted across multiple countries found that countries with higher rates of income inequality had higher levels of health and social problems across all income levels. This pattern was consistent and included health issues such as mental illness, higher levels of obesity and lower life expectancy, educational achievements such as math and literacy scores, and community issues such as violence.[17]

Politicians have acknowledged the benefits of a Basic Income Guarantee. The Senate of Canada in 2009 released a report on poverty which called for a study on the costs and benefits of a basic income supplement.[18] Conservative Senator Hugh Segal has long been a proponent of a Basic Income Guarantee. In 2012 he wrote that, "if the federal tax system topped up everyone who was beneath the poverty line to above it, there would be no Canadians eligible for provincial welfare." As a result the lowest income Canadians "would not occupy homeless shelters, prisons, court rooms and mental hospitals disproportionately to their percentage of the population, because they would be liberated from poverty-caused pathologies by having a basic income guarantee." [19]

At a 2014 convention, Liberal party members passed a policy resolution pledging to create a basic annual income. Priority Resolution 100: Creating a Basic Annual Income to be Designed and Implemented for a Fair Economy resolves "that a Federal Liberal Government work with the provinces and territories to design and implement a Basic Annual Income in such a way that differences are taken into consideration under the existing Canada Social Transfer System." [20]

Minister of Families, Children and Social Development, Jean-Yves Duclos, a veteran economist, has a mandate to come up with a poverty-reduction strategy for Canada. He stated that he appreciates the principles behind the idea of a guaranteed income, "greater simplicity for the government, greater transparency on the part of families, and greater equity for everyone." [21]

There have been widespread advocacy efforts to support an investigation into and consideration of a Basic Income Guarantee for all Canadians. Public Health agencies recognize that poverty and income inequality have well-established relationships with adverse health outcomes. In the Public Health sector, resolutions have been passed by the Association of Local Public Health Agencies (alPHa) and the Ontario Public Health Association (OPHA), calling for governments to "prioritize joint federal-provincial consideration and investigation into a basic income guarantee, as a policy option for reducing poverty and income insecurity and for providing opportunities for those in low income."[6] Prior to the last federal election the

Canadian Public Health Association released a fact sheet calling on the next federal government to take leadership in adopting a national strategy to provide all Canadians with a basic income guarantee.[22]

In a 2014 report the Canadian Association of Social Workers proposed the development of a basic income to encourage pan-Canadian income, social and health equity.[23] In August 2015, prior to the Federal election, members of the Canadian Medical Association passed a motion in support of a basic income guarantee.[24] The motion passed with a sizeable majority.

Support for a Basic Income Guarantee has also emerged from municipalities. In December of 2015 the City of Kingston passed a resolution advocating for the federal and provincial governments to consider, investigate and develop a basic income guarantee for all Canadians. The City of Kingston resolution was forwarded to all municipalities in Ontario with a request that they consider supporting the initiative. To date the resolution has been endorsed by the cities of Cornwall, Belleville, Pelham, Peterborough and Welland.[4]

ANALYSIS/RATIONALE

One of the only major studies on Basic Income Guarantee in a high-income country that examined outcomes beyond labour market effects was conducted in Canada in the 1970s. This study, "MINCOME", was conducted in the province of Manitoba between 1974 and 1979. The research design involved selecting families from two communities: the city of Winnipeg, and the small rural community of Dauphin, Manitoba. A unique design element in the study was that Dauphin was a saturation site; everyone was entitled to participate in the study. About a third of Dauphin families qualified for MINCOME stipends at any point in time. Families from other small, rural communities were selected as study controls for the Dauphin families.[3]

One of the advantages of the saturation site was that it reproduced the conditions that would be present in a universal program. It was believed that this would result in a greater ability to understand administrative and community outcomes in a less artificial environment. In addition, a saturation site can result in a "social multiplier effect" - outcomes that are stronger than one might expect because the broader community benefitted from changing social circumstances.[3] Details of the MINCOME stipend are described:

> *"The Dauphin cohort all received the same offer: a family with no income from other sources would receive 60% of Statistics Canada low-income cut-off (LICO), which varied by family size. Every dollar received from other sources would reduce benefits by fifty cents. All benefits were indexed to the cost of living. Families with no other income and who qualified for social assistance would see little difference in their level of support, but for people who did not qualify for welfare under traditional schemes – particularly the elderly, the working poor, and single, employable males – MINCOME meant a significant increase in income. Most important for an agriculturally dependent town with a lot of self-employment, MINCOME offered stability and predictability; families knew they could count on at least some support,*

no matter what happened to agricultural prices or the weather. They knew that sudden illness, disability or unpredictable economic events would not be financially devastating."[3]

At the end of the four-year study virtually no analysis was done by project staff, and a final report was not produced. This is attributed to a change in the intellectual and economic climate. There were also changes in both the federal and provincial governments.[3]

Dr. Evelyn Forget, an economist and professor at the University of Manitoba, conducted an analysis of the MINCOME study in 2009 and published her findings in 2011. She was interested in determining what impact MINCOME may have had on population health. The results were impressive. The MINCOME study demonstrated higher rates of school completion (Figure 1), and a reduction in hospitalizations (Figure 2).[25]

Figure 1

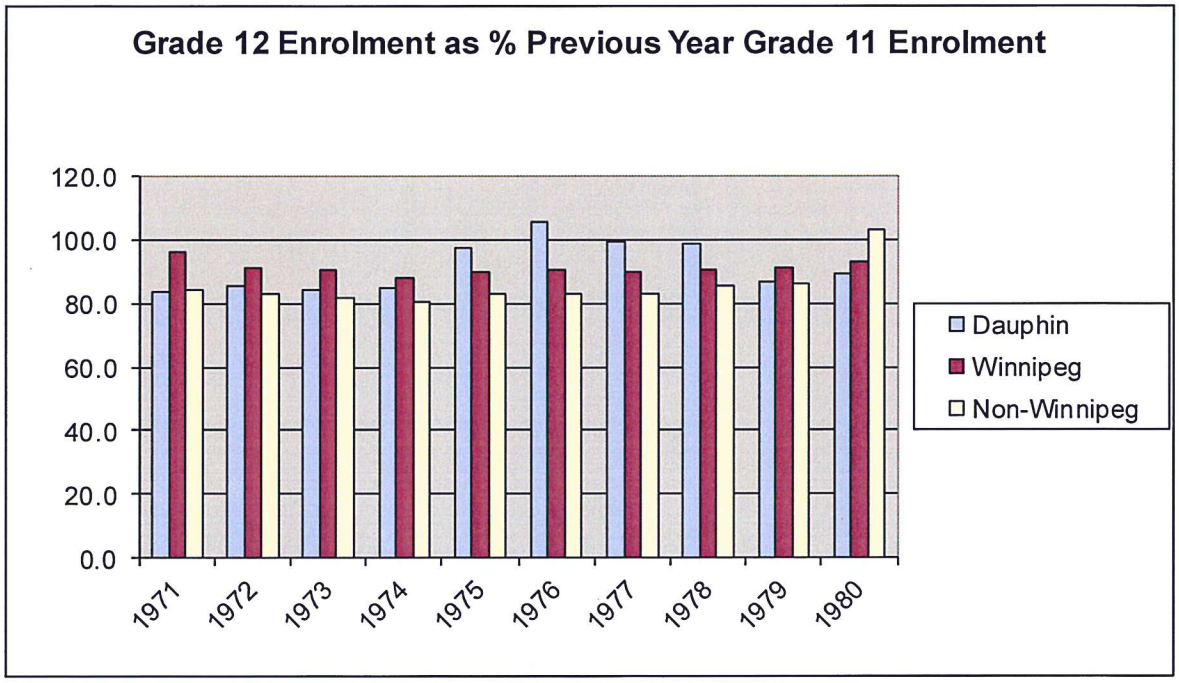
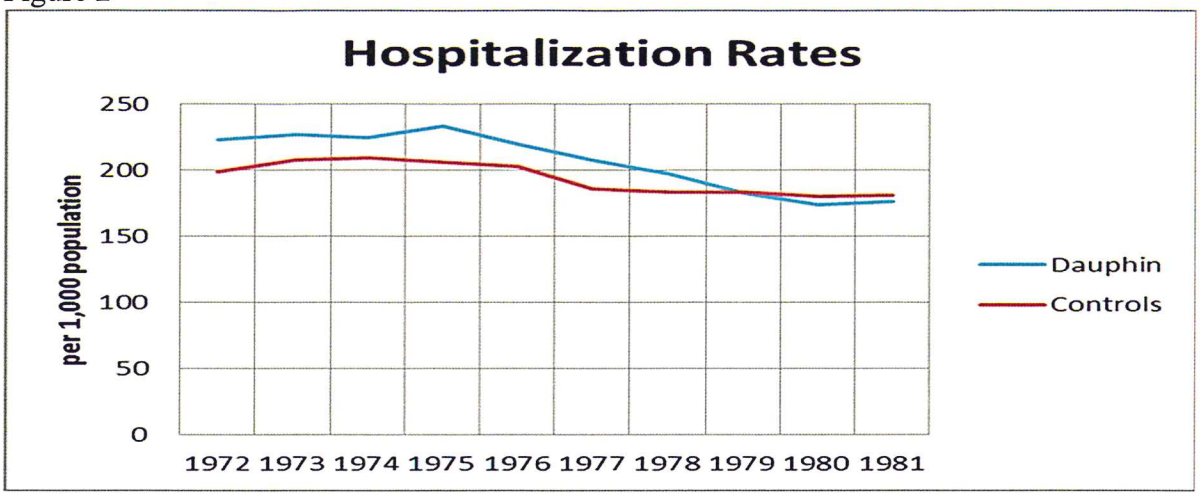


Figure 2



The results of Dr. Forget's analysis of the MINCOME study concluded that the findings suggest that a Guaranteed Annual Income, implemented broadly in society, may improve health and social outcomes at the community level.[3] Dr. Forget has been invited by the federal Liberals to review the findings of this Canadian study at pre-budget hearings. [26]

ONTARIO PUBLIC HEALTH STANDARD

"Addressing determinants of health and reducing health inequities are fundamental to the work of public health in Ontario. Effective public health programs and services consider the impact of the determinants of health on the achievement of intended health outcomes." (p.2)[27]

WDGPH STRATEGIC COMMITMENT

Health Equity
Our programs and services use health equity principles to reduce or eliminate health differences in our communities.

Building Healthy Communities
We will work with communities to support the health and well-being of everyone.

HEALTH EQUITY

A Basic Income Guarantee will ensure that all individuals living below an identified income threshold will be supported at a level that is sufficient to meet basic needs. There is strong evidence that reducing poverty will result in improved long term health outcomes.

APPENDICES

None.

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March 7, 2016

VIA ELECTRONIC MAIL

The Honourable Kathleen Wynne
Premier of Ontario
Legislative Building, Queen's Park
Toronto, ON M7A 1A1

Dear Premier Wynne:

Re: Enactment of Legislation to Enforce Infection Prevention and Control Practices within Invasive Personal Service Settings

At its meeting on February 18, 2016, the Sudbury & District Board of Health carried the following resolution #11-16:

WHEREAS adherence to Infection Prevention and Control (IPAC) best practices is essential in reducing the risk of infectious disease transmission through invasive procedures performed in personal services settings such as tattoo and body piercing establishment; and

WHEREAS the Ontario Public Health Standards requires that boards of health perform routine inspections of all personal services settings at least once per year to ensure adherence to best practices for IPAC; and

WHEREAS the Ontario Public Health Standards requires that boards of health investigate complaints regarding potential health hazards including IPAC lapses in personal services settings; and

WHEREAS provincial legislation does not currently exist outlining legal requirements for IPAC practices and operator responsibility and;

WHEREAS creation of provincial legislation governing invasive Personal Services Settings would support a consistent progressive enforcement model amongst Ontario's 36 public health units;

THEREFORE BE IT RESOLVED THAT the Sudbury & District Board of Health support the Haliburton, Kawartha, Pine Ridge District Health Unit motion recommending that the Government of Ontario enact legislation implementing IPAC requirements for invasive personal services settings under the Health Protection and Promotion Act with short-form wording under the Provincial Offences Act.

FURTHER BE IT RESOLVED THAT a copy of this motion be submitted to the Premiere of Ontario, the Minister of Health and Long-term Care, local members of Provincial Parliament, the Chief Medical Officer of Health, the Association of Local Public Health Agencies (alPHa), and all Ontario Boards of Health.

It is the Board's hope that the Government of Ontario will seriously consider enacting provincial legislation implementing IPAC requirements for invasive personal services settings under the *Health Protection and Promotion Act*, supported with short-form wording under the *Provincial Offenses Act*.

Sincerely,

Original signed by

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

cc: The Honorable Dr. Eric Hoskins, Minister of Health and Long-Term Care
France Gélinas, MPP, Nickel Belt
Michael Mantha, MPP, Algoma-Manitoulin
Glenn Thibeault, MPP, Sudbury
Dr. David Williams, Chief Medical Officer of Health
Linda Stewart, Executive Director, Association of Local Public Health Agencies
Ontario Boards of Health

March 15, 2016

The Honourable Kathleen Wynne
Premier of Ontario
Legislative Building, Queen's Park
Toronto, ON M7A 1A1
premier@ontario.ca

Dear Premier Wynne,

Re: Legislation to enforce infection prevention and control practices within invasive personal service settings under the Health Protection and Promotion Act

At its meeting held on March 9, 2016, the Board of Health for the Peterborough County-City Health Unit considered correspondence from the Haliburton, Kawartha, Pine Ridge District Health Unit regarding the above noted matter.

The Board echoes the recommendations outlined in their letter (attached) and it is our hope that you will consider enacting legislation for infection prevention and control requirements for invasive personal service settings under the *Health Protection and Promotion Act* with a suitable enforcement program such as short-form wording in the *Provincial Offences Act.*

Yours in health,

Original signed by

Scott McDonald
Chair, Board of Health

/at
Encl.

cc: Hon. Dr. Eric Hoskins, Minister of Health and Long-Term Care
MPP Jeff Leal, Peterborough
MPP Laurie Scott, Haliburton-Kawartha Lakes Brock
Dr. David Williams, Chief Medical Officer of Health
Association of Local Public Health Agencies
Ontario Boards of Health

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HALIBURTON, KAWARTHA,
PINE RIDGE DISTRICT
HEALTH UNIT

1-866-888-4577 • www.hkpr.on.ca • info@hkpr.on.ca

21 January 2016

The Hon. Kathleen Wynne
Premier of Ontario
Legislative Building - Queen's Park
Toronto ON M7A 1A1

Re: Legislation to Enforce Infection Prevention and Control Practices within Invasive Personal Service Settings under the *Health Protection and Promotion Act*

Dear Premier Wynne

Ontario has no legislation regulating infection prevention and control practices to minimize the risk of blood borne disease transmission from practices/procedures performed at invasive Personal Service Settings (PSS). The PSS Protocol under Ontario Public Health Standards (OPHS) govern the activities of Public Health Units regarding PSS infection control such as causing one inspection per year for invasive services which is the same frequency for non-invasive PSS such as a hair salon.

Public Health Inspectors (PHIs), in accordance with the OPHS and best practices, inspect invasive PSS without provincial legislation that outlines legal requirements for infection control needs and operator responsibilities. Infection prevention and control practices are a major component of assessing invasive PSS to minimize the transmission risks of blood-borne disease.

Invasive PSS such as tattoo/body modification establishments or other invasive PSS require extra attention and time for PHIs to mitigate risk to the public by ensuring operators have adequate infection prevention and control practices in place. The Board of Health for the Haliburton, Kawartha, Pine Ridge District Health Unit views the importance of public health regulations to minimize the risk of blood-borne disease transmission from invasive personal service settings.

The Haliburton, Kawartha, Pine Ridge District Board of Health therefore urges the Government of Ontario to enact legislation for infection prevention and control requirements for invasive PSS under the *Health Protection and Promotion Act* with a suitable enforcement program such as short-form wording under the *Provincial Offences Act*.

Sincerely

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

Mark Lovshin
Board of Health Chair

.../2

Encl. 2

Cc:

The Honourable Eric Hoskins, Minister of Health and Long-Term Care
Ms. Laurie Scott, MPP, Haliburton-Kawartha Lakes-Brock
Mr. Lou Rinaldi, MPP, Northumberland-Quinte West
Mr. Patrick Brown, MPP, Simcoe North – Leader of the Progressive Conservative Party of Ontario
Ms. Andrea Horwath, MPP, Hamilton Centre – Leader of the New Democratic Party of Ontario
Dr. David Williams, Chief Medical Officer of Health
Board of Health Chairs
Association of Local Public Health Agencies

HALIBURTON, KAWARTHA, PINE RIDGE DISTRICT BOARD OF HEALTH RESOLUTION

TITLE: Enactment of Legislation to enforce infection prevention and control practices within invasive Personal Service Settings (PSS) under the *Health Protection and Promotion Act.*

SPONSOR: Haliburton, Kawartha, Pine Ridge District Health Unit

WHEREAS Ontario has no legislation governing infection prevention and control practices to minimize the risk of blood borne disease transmission from practices/procedures performed at invasive Personal Service Settings (PSS); and

WHEREAS The Personal Service Setting Protocol under the *Ontario Public Health Standards* (OPHS) governs the activities of public health units regarding PSS infection control; and

WHEREAS The OPHS mandate one inspection per year for invasive personal service settings, which is the same frequency for non-invasive PSS such as a hair salon; and

WHEREAS Public Health Inspectors (PHIs), in accordance with the OPHS and best practices, inspect invasive PSS without provincial legislation that outlines legal requirements for infection control needs and operator responsibilities; and

WHEREAS Infection prevention and control practices are a major component of assessing invasive PSS to minimize the transmission risks of blood-borne disease; and

WHEREAS Invasive PSS such as tattoo/body modification establishments or other invasive PSS require extra attention and time for PHIs to mitigate risk to the public by ensuring operators have adequate infection prevention and control practices in place.

NOW THEREFORE BE IT RESOLVED that the Haliburton, Kawartha, Pine Ridge District Board of Health strongly recommends and urgently requests the Government of Ontario to enact legislation implementing infection prevention and control requirements for invasive personal service settings under the *Health Protection and Promotion Act* with a suitable enforcement program such as short-form wording under the *Provincial Offences Act* to allow for the enforcement of non-compliance with the legislation under the *Health Protection and Promotion Act*.

AND FURTHER that the Haliburton, Kawartha, Pine Ridge District Board of Health strongly recommends and urgently requests that the Association of Local Public Health Agencies advocate to the Premier of Ontario and the Minister of Health and Long-Term Care, to enact legislation implementing infection prevention and control requirements for invasive personal service settings under the *Health Protection and Promotion Act* with a suitable enforcement program such as short-form wording under the *Provincial Offences Act* to allow for the enforcement of non-compliance with the legislation under the *Health Protection and Promotion Act*.

North Bay Parry Sound District Health Unit
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February 22, 2016

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

Dear Minister Hoskins:

Subject: Environmental Health Program Funding – BOH Resolution #BOH/2016/01/13

On January 27, 2016, at a regular meeting of the Board of Health for the North Bay Parry Sound District Health Unit, the Board unanimously approved the following motion #BOH/2016/01/13:

Whereas, *the Board of Health is responsible to oversee the implementation of the Ontario Public Health Standards (OPHS), related protocols/guidelines and Health Protection and Promotion Act (HPPA) and related regulations, and*

Whereas, *the Board of Health works towards improvement of the overall health of the population through surveillance, health promotion, disease prevention, health protection and enforcement of provincial public health policy, and legislation, and*

Whereas, *the Board of Health supports the Province of Ontario enacting new policy and legislation which will improve the health of the population, and*

Whereas, *recent changes to provincial policy and new legislation has resulted in the expansion of the Environmental Health program mandate in recent years, and*

Whereas, *in 2014 the Skin Cancer Prevention Act (Tanning Beds) went into effect and public health inspectors (PHIs) were required to complete education visits of tanning bed establishments and respond to future public complaints with these facilities, and*

Whereas, *the Recreational Water Protocol was updated by the Ministry of Health and Long-Term Care in 2014 and included a broadening of the definition of a public beach which resulted in doubling the number of municipal public beaches that require annual water sampling, and*

Whereas, *in 2015, the Ministry of Health and Long-Term Care released the new Infection Prevention and Control Lapse Disclosure Guidance document requiring the Health Unit to actively investigate public complaints related to infection prevention and control (IPAC) in regulated health care settings where previously the Health Unit was not mandated, and*

Whereas, *in 2017, the Ministry of Health and Long-Term Care advises that menu labelling requirements will come into force for certain restaurants and will require PHIs to enforce, and*

Whereas, *recent amended environmental health protocols require the disclosure of public facility inspection reports to the public on request and resulting in increased workload for Health Unit staff, and*

Whereas, *the challenge is implementing new policy and legislation that comes often without any additional resources and where current Environmental Health program staff are already at full capacity implementing existing mandated programs, and*

Whereas, *the challenge is implementing new policy and legislation that comes often without any support for staff training,*

Now Therefore Be It Resolved, *that the Board of Health for the North Bay Parry Sound District Health Unit endorse the following actions to support the Environmental Health program in implementing new provincial public health policy and legislation:*

1) *Encourage the Ontario Ministry of Health and Long-Term Care to provide dedicated, predictable recurring funding to public health units for the purpose to enhance Environmental Health program field staff and management capacity to implement new provincial public health policy and legislation;*

2) *Encourage the Ontario Ministry of Health and Long-Term Care to fund an additional 2.0 full-time equivalent (FTE) public health inspectors in the Environmental Health program;*

3) *Encourage the Ontario Ministry of Health and Long-Term Care to adopt as standard policy for providing of training to public health staff whenever new provincial public health policy and legislation is implemented; and*

4) *Encourage the Ministry of Health and Long-Term Care to develop a staffing model for health units to use to determine adequate levels of environmental health staffing which include field staff, supervisory staff and management staff necessary to fully implement provincial environmental health policy and legislation.*

Furthermore Be It Resolved, *that a copy of this resolution be forwarded to the Honourable Dr. Eric Hoskins, Minister of Health and Long-Term Care, Dr. Bob Bell, Deputy Minister of Health and Long-Term Care, Roselle Martino, Assistant Deputy Minister of Health and Long-Term Care, Dr. David Williams, Interim Chief Medical Officer of Health for the Ministry of Health and Long-Term Care, the Association of Local Public Health Agencies, Ontario Medical Officers of Health, and Ontario Boards of Health, and member municipalities.*

Sincerely,

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

C: Hon. Dr. Bob Bell, Deputy Minister of Health and Long-Term Care (MOHLTC)
Roselle Martino, Assistant Deputy Minister, Population and Public Health Division, MOHLTC
Dr. David Williams, Chief Medical Officer of Health, MOHLTC
Linda Stewart, Executive Director, Association of Local Public Health agencies
Ontario Medical Officers of Health
Ontario Boards of Health
Member Municipalities (31)

Peterborough County-City
HEALTH UNIT
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February 25, 2016

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

Dear Minister Hoskins:

The board of health for Peterborough County-City Health Unit recently received a staff report on the Herpes Zoster Vaccine, at our request. As individual board members, we are aware of both the serious complications of Herpes Zoster reactivation, or "Shingles", and the significant cost of the vaccine. We are also aware that the currently available vaccine, Zostavax II™, produced by Merck Canada Inc., appears to have a limited length of time where it is considered protective.

The burden of illness associated with Herpes Zoster reactivation is considerable, with a lifetime risk of 30%. For persons over 80 years of age, the incidence has been estimated to be 8.4/1,000. The debilitating neurogenic pain syndrome that can occur following shingles, called post-herpetic neuralgia, occurs in 20% of all cases, but increases to more than a third of octogenarians.

The Provincial Infectious Diseases Advisory Committee (PIDAC) for Ontario released a report in 2013 which examined several options for a publicly funded vaccine program for herpes zoster. PIDAC found that the vaccine was cost-effective under a wide range of assumptions, particularly for adults aged 65-70 years of age. PIDAC recommended that the provision of the vaccine for 65 year olds, as this is also the age eligibility for the pneumococcal polysaccharide vaccine. Providing the vaccine to 60 year olds, as currently recommended by the National Advisory Committee on Immunization (NACI) would be more expensive but also more equitable, as all persons for whom the vaccine is recommended by NACI would be eligible.

We understand that there is a new vaccine currently in development that may present a much more effective and longer lasting option. The availability of this promising vaccine would only enhance the economic evaluations that have already been done.

We call upon you and your government to seriously consider adding the herpes zoster vaccine to the list of publicly funded vaccines available to Ontario's adults. Immunization continues to be one of our most effective tools in the prevention of disease and promotion of health, and this remains true through-out the life cycle, including into our later years.

Jackson Square, 185 King Street, Peterborough, ON K9J 2R8 P: (705) 743-1000 or 1-877-743-0101 F: (705) 743-2897 www.pcchu.ca

We appreciate your consideration of this important addition as you move forward with Vision 20/20, the modernization of our provincial immunization system.

Yours in health,

Original signed by

Scott McDonald
Chair, Board of Health

/at

cc: Hon. Dipika Damerla, Associate Minister of Health and Long-Term Care
Dr. David Williams, Ontario Chief Medical Officer of Health
M.P.P. Jeff Leal, Peterborough
M.P.P. Laurie Scott, Haliburton-Kawartha Lakes-Brock
Ontario Boards of Health
Association of Local Public Health Agencies

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Porcupine
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March 21, 2016

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The Honourable Kathleen Wynne
Premier of Ontario
Room 281, Main Legislative Building
Queen's Park
Toronto, ON
M7A 1A1

Dear Premier Wynne,

On March 18, 2016, the Porcupine Health Unit Board of Health passed the following resolution:

THAT the Board of Health for the Porcupine Health Unit support Thunder Bay District Health Unit's resolution # 50-2015, and The Corporation of the Town of Iroquois Falls resolution # 2015-307, requesting that the provincial government address the ongoing lack of resources and infrastructure to ensure the safe, efficient and effective temporary relocation of First Nations communities in Northwestern Ontario and the James Bay coast when they face environmental and weather related threats in the form of seasonal flooding and forest fires;

AND THAT this resolution be forwarded to the Premier of Ontario, Ministers responsible for Health and Long-Term Care, Community Safety and Correctional Services, Aboriginal Affairs, Northern Development and Mines, Natural Resources and Forestry, the Association of Local Public Health Agencies (alPHa), local area Members of Provincial Parliament and Ontario Boards of Health.

Thank you for your attention to this important public health issue.

Yours very truly,

Donald W West BMath, CPA, CA
Chief Administrative Officer

DW:mc

Branch Offices: Cochrane, Hearst, Hornepayne, Iroquois Falls, Kapuskasing, Matheson, Moosonee, Smooth Rock Falls

alPHa
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February 29, 2016

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

Dear Minister Hoskins:

On behalf of member Medical Officers of Health, Boards of Health and Affiliate organizations, the Association of Local Public Health Agencies (alPHa) is pleased to provide comment on the Ministry of Health and Long-Term Care discussion paper, *Patients First: A Proposal to Strengthen Patient-Centred Health Care in Ontario*. We received and reviewed the paper with much interest and anticipation. There is much to consider from a local public health perspective. We offer our preliminary comments herein and will be very pleased to engage further as the government's work progresses to strengthen patient-centred health care in Ontario.

We note the fact that how a "problem" is defined will greatly inform the solutions that are considered.

Patients First conceptualizes the problem as that of reducing gaps and inequities in care and strengthening patient-centred care. One solution to this problem is to better integrate population health within the health system, specifically through establishing closer linkages between LHINs and public health units. We are aware of recent work exploring the use of the population health approach in health system planning (CIHI 2014) and appreciate the merits of this work in contributing to health system sustainability. Further, we believe that local public health has valuable expertise to offer in this area. Indeed this approach is one of the five actions for health promotion as set out in the 1986 Ottawa Charter for Health Promotion.

A wider problem is improving and supporting the health and health equity of Ontarians which is effectively the mandate of the Ontario public health system. A solution to this problem would be to support and strengthen the public health system which works on all five Ottawa Charter actions for health promotion. The public health system understands that although access to a quality health care system is a determinant of individual and population health, it is a relatively minor determinant as compared with social and economic circumstances that create opportunities for health, mediated by factors such as education, food security, physical activity opportunities, social networks, effective coping strategies, etc. The public health system is that part of the overall health system that is specifically mandated to work with both health and non-health sector partners to act on these determinants and create opportunities for health for all.

We are concerned that some of the *Patients First* proposals regarding public health may have the unintended consequence of eroding the capacity of the public health system to improve the health of Ontarians through our intersectoral work on the determinants of health.

At the same time, we firmly hold that public health can assist in reorienting the health care system and see this as a valuable contribution of public health to the problems of health care system sustainability as set out in *Patients First*. We also hold that health care system sustainability is achieved by ensuring a strong public health system that can stem the tide of need; focusing on healthy people first.

In the recommendations that follow, we list and briefly describe what we present are the conditions necessary to achieve both. That is, to ensure that public health is able to contribute to the reorientation of the health care system so that population and public health priorities inform health care planning, funding and delivery, while at the same time protecting public health's ability to work upstream to promote and protect the health of all Ontarians.

Recommendations

1. **Funding and Accountability** – Provincial Public Health Funding and Accountability Agreements (PHFAA) must continue to be directly negotiated between local boards of health and the MOHLTC.
   a. A direct relationship mitigates against the threat of resource reallocation (financial and functional) to the acute care system as has been evidenced in the experience of other regions with integrated health systems.
   b. The direct relationship ensures that common Ministry principles and standards are upheld and implemented for all boards, further ensuring that all Ontarians benefit equitably from the public health system.
   c. The direct relationship with the Ministry is needed to maintain the independent voice of public health at LHIN tables; otherwise public health would be advising on health resource allocation and also be a resource recipient.

2. **Independent Voice of Boards of Health –** Boards of health must be maintained as defined in the Health Protection and Promotion Act, directly accountable to the Minister of Health.
   a. Boards of health must continue as entities with an independent voice with roles and responsibilities as set out in statute, standards and accountability agreements.
   b. Municipal representation on boards of health ensures invaluable connections with decision makers and staff in non-health sectors where there is scope of authority over key determinants of health (e.g. bylaws, built environment, social services, child care, planning, long term care, drinking water, recreational facilities, first responders, etc.).
   c. For certain boards of health (e.g. single tier and regional boards), local government is the de facto board of health, creating governance issues if required to report to an appointed LHIN board.
   d. Ways to strengthen boards of health should be explored; this should form part of the work of the Expert Panel following the report of the Institute on Governance (IOG).

3. **Integration of Local Population and Public Health Planning with Other Health Services –** The Ontario Public Health Standards and Ontario Organizational Standards, as required, should be modified to require boards of health to align their work and ensure that population and public health priorities inform LHIN health planning, funding and delivery. Reciprocal amendments should be made to the LHIN legislation (or other mandate documents as appropriate) to require LHIN boards to ensure that population and public health priorities inform LHIN health planning, funding and delivery. alPHa looks forward to participating in the following activities.
    a. Identification of the enabling policies and structures to ensure an effective relationship between the medical officer of health and LHIN leadership.
    b. The identification of the resources and funding required for public health to effectively engage in this work.

4. **Process for Determining Respective Roles –** The respective roles of local public health and LHINs (and other system players involved with population and public health including the Population and Public Health Division, MOHLTC, the Capacity Planning and LHIN Support, Health Analytics Branch, MOHLTC and Public Health Ontario) must be determined through a transparent, inclusive and deliberative process that is informed by evidence. We maintain that this is a key role of the proposed Expert Panel.
    a. It must be recognized that the work for public health as described in *Patients First* is additional to public health's core functions and mandate and the related resources must be identified to accommodate this work to ensure that public health capacity to promote and protect health and improve health equity is not eroded.
    b. There is an important distinction between providing population health information and translating this information into planning, funding and delivery decisions for acute care and other downstream services. It should not be assumed that the latter is a public health competency.

5. **Geographic Boundaries –** LHIN boundaries should be re-configured to align with municipal, local public health, education and social service boundaries to support their relationships with local public health and population health and health care system planning.

Local public health appreciates that a population health approach to health system planning is an emerging paradigm that may contribute to the sustainability of the health care system. Local public health also agrees with the *Patients First* discussion document that the public health system has expertise that may support such a reorientation of the health care system. Simply put, however, we must ensure that this "fix" to the health care system does not "break" the public health system.

We are committed to engaging in a thoughtful change management process with you that minimizes system disruption, mitigates risks associated with system instability and fosters balance between the systems intended to treat illness and the systems intended to prevent disease and promote health. To this end, we look forward to ongoing dialogue with government on the issues addressed in this letter. We trust that this will take place in many ways, including our participation in the proposed Expert Panel. We remain available for further consultation and are eager to pursue next steps.

In closing, I would reiterate that we are committed to finding win-wins so that Ontarians can continue to benefit from a strong and effective public health system while knowing that a quality health care system is there for them when they need it.

Sincerely,

Dr. Valerie Jaeger,
President

Copy: Dr. David Williams, Chief Medical Officer of Health
Dr. Bob Bell, Deputy Minister of Health and Long-Term Care
Sharon Lee Smith, Associate Deputy Minister of Health and Long-Term Care
Nancy Naylor, Associate Deputy Minister of Health and Long-Term Care
Roselle Martino, Assistant Deputy Minister, Population and Public Health Division
Board of Health Chairs
Medical Officers of Health

March 7, 2016

Association of Local Public Health Agencies
Suite 1306
2 Carlton Street
TORONTO, ON M5B 1J3

Dear Ontario Boards of Health:

Re: Grey Bruce Health Unit Brief in Response to *Patients First* Discussion Document

On February 26, 2016 at a regular meeting of the Board for the Grey Bruce Health Unit, the Board considered the attached 'Grey Bruce Health Unit Brief in Response to *Patients First* Discussion Document'. The following motion was passed:

Motion No: 2016-19

Moved by: David Shearman Seconded by: Laurie Laporte

"That the Grey Bruce Board of Health does endorse the Grey Bruce Health Unit Brief in Response to *Patients First* Discussion Document."

Carried.

Sincerely,

Hazel Lynn MD, FCFP, MHSc
Medical Officer of Health

Cc: Larry Miller, MP Bruce-Grey-Owen Sound
Benn Lobb, MP Huron-Bruce
Kellie Leitch, MP Simcoe-Grey
Bill Walker, MPP Bruce-Grey-Owen Sound
Lisa Thompson, MPP Huron-Bruce
Jim Wilson, MPP Simcoe-Grey

Encl.

Grey Bruce Health Unit Brief in Response to *Patients First* Discussion Document

February 2016

For More Information:
Drew Ferguson
Public/Media Relations Coordinator
Grey Bruce Health Unit
101 17th Street East Owen Sound ON N4K 0A5
519-376-9420 ext. 1269
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Grey Bruce Health Unit Brief in Response to Patients First Discussion Document

This brief specifically addresses Section Four of the *Patients First* discussion document, titled *Stronger Links Between Public Health and Other Health Services.*

This brief is comprised of two components. The first looks at the population health approach taken by Public Health and issues that arise. The second section provides a Grey Bruce Health Unit perspective to the specific question for discussion contained within Section Four.

THE ISSUE

The initial statement ***Public health has historically been relatively disconnected from the rest of the health care system*** is at the core of this discussion.

The focus of the LHIN-based health care is on individual patient care, service provision and costs. In essence, it is sickness care.

Public Health has a different role than the sickness care system. Our focus is “upstream” through prevention of disease and illness, staying well.

Public Health’s population health approach aims to improve the health of the entire population. It considers the things that influence our health both inside and outside the health care system. It recognizes that at every stage of life, our health is affected by complex interwoven fabric of factors referred to as 'determinants of health'. These include Housing; Income; Social Status; Social Support Networks; Education and Literacy; Employment/Working Conditions; Social Environments; Physical Environments; Personal Health Practices and Coping Skills; Healthy Child Development; Biology and Genetics; Health Services; Gender; and Culture. These factors do not exist in isolation. Rather, the combined influence of these factors determines our health.

This is profoundly different from the health care system’s view of population health. The health care system’s approach to population health is to provide interventions to specific, identifiable groups whose needs are greatest and it is taken that, by extension, this will improve overall population health.

A Public Health-based, population health strategy addresses the factors contributing to dis-ease in the population as a whole. That goes beyond behaviour and lifestyle approaches. Working at the population health level does not translate well to the individual. Using alcohol misuse as an example, greater societal gain is achieved from a small change within the larger population than by addressing the problem on an individual basis. Referred to as the ‘prevention paradox’; preventive measures, through strategies such as policy development, that address health equity or social determinants of health, that bring benefit at the population level, offers little to the individual. Public Health is virtually invisible to the public. In the population health model, success is marked by a non-event.

Public Health is the ounce of prevention. In terms of health funding, Public Health is small potatoes accounting for about 1.4 per cent of the province's over-all health budget. When limited funding for population health initiatives is balanced again individual care, the scale invariable tips to individual care. Referred to as the, "tyranny of the acute", when limited resources are in play, the demands of sick person will always take precedent over the need to better the health of the larger population. The public have a preoccupation with acute and medical care, as that affects them directly.

In identifying the current situation, Section Four states that ***Many 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.***

Given that reality, it would be unrealistic to expect a relatively small Public Health sector to have much influence on the larger and more powerful set of illness care-oriented priorities. As seen in other jurisdictions, the larger culture of illness care will steer Public Health to a more clinical orientation and away from population health. As a result, the already scarce Public Health resources are diverted to acute, primary and long-term care issues (e.g., emergency room diversion strategies).

The role with respect to the regulatory functions performed by Public Health is not addressed in the *Patients First* discussion. These roles do not align well with health care and speak to the "disconnect from the rest of the health care system" as. Areas including safe drinking water, beach water testing, food premise inspections, personal service setting inspections (aesthetic/tattoo etc.), tobacco by-law enforcement, environmental hazards, and emergency preparedness are all significant components of the Public Heath portfolio. The transfer and monitoring of accountability and performance in these regulatory areas is a substantial undertaking for LHINs. Additionally, it would seem redundant to require 14 independent LHINs to provide universal regulatory and performance oversight in these non-healthcare areas.

Further to this discussion of accountability and performance, it should be noted that population health does not lend itself easily to quick measurements as compared to acute care. It is easy to count ER visits, but as we have seen with the shift towards tobacco de-normalization, results are often incremental and can take decades.

The LHINs are defined by health-care referral patterns where the patient goes. Owen Sound patients go to London, Blue Mountains patients go to Collingwood and Barrie, Dundalk patients go to Shelburne and Orangeville. Public Health is defined by municipal boundaries. The two do not align. The current proposal puts the Grey Bruce Health Unit in three LHINs; the majority in the South West LHIN, Southgate in the Waterloo Wellington LHIN and Town of Blue Mountains the North Simcoe Muskoka LHIN. The implications of these over-lapping alignments require clarification.

QUESTIONS FOR DISCUSSION

The following provides the Grey Bruce Health Unit perspective to the specific question for discussion contained within Section Four.

How can public health be better integrated with the rest of the health system?

Should it be? As described, the healthcare system is sickness care, the system comes into play once you become ill; Public Health is all about maintain and extending wellness. That question could well be reversed to ask how the rest of the health system can better integrate with Public Health. This would have the health care system acknowledge and adopt a population health approach as fundamental to all significant health issues. By necessity, this is a long-term approach re-directing the focus towards health and not just health care.

What connections does public health in your community already have?

Grey Bruce Health Unit has filaments that thread throughout our community. The list is extensive; these connections can be characterized as being with:

- upper and lower tier municipal partnerships and working groups. We perform regulatory roles but also focus on planning and policy for healthy communities
- health care, primary care/health care and a wide range of health professionals, providing materials, knowledge and resources
- community and community groups supporting capacity in the community around specific issues
- school boards, from frontline services such as dental screening and immunization, to issue specific initiatives such as youth mental health, to broader healthy school initiatives
- post-secondary institutions
- First Nations communities
- Plains Communities, also known as Amish and Mennonite communities
- federal and provincial ministries
- agriculture and veterinary, producer and consumer groups, industry, and
- the community at large.

What additional connections would be valuable?

Many of the areas of public health involvement, including the provision of clinical services, reflect ongoing or historic gaps on a population-wide basis. This has been particularly true for the more vulnerable populations. One of the emerging roles for the Grey Bruce Health Unit is to

identify capacity within a community and seek out the resources and links that can help empower populations or communities to take steps to improve their own health and wellbeing. These types of partnerships may provide examples of collaborative models between primary care and Public Health.

As noted, health inequities and the broader social determinants of health are often outside the immediate scope of healthcare services. In this regard, LHINs not only need to work with Public Health but they should also develop formal relationships with the municipal, social services, housing, education, and voluntary sectors to support service integration. As the Ottawa Charter for Health Promotion suggests, health services should be expanded to include building healthy public policy, creating supportive environments, strengthening community action and supporting development of personal skills.

What should the role of the Medical Officers of Health be in informing or influencing decisions across the health care system?

The Ministry plan 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.***

A direct role by the Medical Officers of Health in informing or influencing decisions would provide a public health link to healthcare systems. Offering the potential to bring a population health view to health issues and the planning of healthcare services. This can only be achieved with the Medical Officer of Health's routine participation in the executive management team and at the Board level. Experience from other jurisdiction has shown that success requires a strong and interested health sector leadership combined with strong public health leadership and epidemiological capacity. Public health's involvement in providing a population health perspective can only be achieved by design and cannot be left to the discretion of individual LHINs or their Boards.

Without a formal or direct influence on budgets, programs and staffing, it might fall to the Medical Officers of Health to be the lone voice for Public Health. The challenge being to mitigate adverse impacts on Public Health 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.

March 18, 2016

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

Dear Minister Hoskins:

Re: Petition to Update Ontario Fluoridation Legislation

I am writing as Chair of the Windsor-Essex County Board of Health in support of changes to Ontario fluoridation legislation-amendments to the Fluoridation Act and the Ontario Municipal Act to make the fluoridation of municipal drinking water mandatory in all municipal water systems across Ontario (see attached petition).

On December 18, 2014 our Board of Health passed a resolution (see attached) recommending the Province of Ontario amend the regulations of the Safe Drinking Water Act to require community water fluoridation for all municipal water systems (when source-water levels are below the Health Canada-recommended Level of 0.7 mg/L) to prevent dental caries .

Because fluoridation is a safe, equitable, effective and cost-effective way to improve the oral health of everyone in our community, and water fluoridation is effective against dental cavities even when other sources of fluoride, such as toothpastes and topical fluorides are used, I urge you to support mandatory community water fluoridation that will extend this protection to all Ontario residents.

I thank you in advance for your consideration of this significant public health issue.

Sincerely,

Gary McNamara, Chairperson
Windsor-Essex County Board of Health

F:\Gary Kirk\Letters\2016\CWF Letter to Min Hoskins -2016 March 18-final.docx

Attachments: Community Water Fluoridation Petition
Windsor-Essex County Board of Health Community Water Fluoridation Resolution

Continued to page 2

cc: The Honourable Bob Delaney, Member, Standing Committee on Justice Policy
Ted McMeekin, Ministry of Municipal Affairs and Housing
Dr. Bob Bell, Deputy Minister, Ministry of Health and Long-Term Care
Hon. Dipika Damerla, Associate Minister of Health and Long-Term Care
Martha Greenberg, Assistant Deputy Minister (A), Ministry of Health and Long-Term Care
Sharon Lee Smith, Associate Deputy Minister, Policy and Transformation
Roselle Martino, Executive Director, Ministry of Health and Long-Term Care
Paulina Salamo, Director (A), Public Health Standards, Practice & Accountability Branch
Laura Pisko, Director, Health Promotion Implementation Branch
Dr. David Williams, Chief Medical Officer of Health of Ontario
The Honourable Tracy MacCharles, Minister of Children and Youth Services
Pat Vanini, Executive Director, Association of Municipalities of Ontario (AMO)
Monika Turner, Director of Policy, AMO
Dr. Vic Kutcher, President, Ontario Dental Association
Dr. Charles Frank and Dr. Lesli Hapak, Board Members, Ontario Dental Association
Dr. Edward Socilotto, President, Essex County Dental Society
Dr. Peter Cooney, Canadian Oral Health Advisor, Public Health Agency of Canada
Tracey Ramsey, NDP MP for Essex
Cheryl Hardcastle, NDP MP for Windsor-Tecumseh
Brian Masse, NDP MP for Windsor-West
Dave Van Kesteren, MP for Chatham-Kent-Leamington
France Gelinas, MPP, NDP Critic, Health and Long-Term Care
Lisa Gretzky, MPP, Windsor West
Taras Natyshak, MPP, Essex
Percy Hatfield, MPP. Windsor-Tecumseh
Rick Nicholls, MPP, Chatham-Kent-Essex
Ontario Boards of Health
Windsor-Essex County Board of Health
Dr. Gary Kirk, Medical Officer of Health and CEO, Windsor-Essex County Health Unit

Petition to the Ontario Legislative Assembly

Update Ontario Fluoridation Legislation

WHEREAS scientific studies conducted during the past 70 years have consistently shown that community water fluoridation is a safe and effective means of preventing dental decay, and is a public health measure endorsed by more than 90 national and international health organizations, including the Ontario Chief Medical Officer of Health, and the Ontario Dental Association, **and**

WHEREAS recent experience in Canadian cities that have removed fluoride from drinking water has led directly to a dramatic increase in tooth decay, **and**

WHEREAS the Ontario Ministry of Health and Long-Term Care urges support for amending the *Fluoridation Act* to ensure community water fluoridation is mandatory, **and**

WHEREAS the Ontario Ministry of Municipal Affairs and Housing urges support for the removal of provisions allowing Ontario municipalities to cease drinking water fluoridation, or fail to start drinking water fluoridation, from the *Ontario Municipal Act*,

WE the undersigned, petition the Legislative Assembly of Ontario as follows:

THAT the **Premier of Ontario** direct the Ministries of Municipal Affairs and Housing, and Health and Long-Term Care to amend all applicable legislation and regulations to make the fluoridation of municipal drinking water mandatory in *all* municipal water systems across the Province of Ontario before the end of the first session of the current Ontario Parliament.

Name (Printed)	**Home Address and E-Mail Address**	**Signature**

Please mail or deliver *(do not fax)* the **original** signed petition *(no copies)* to your Member of Provincial Parliament, or

Bob Delaney
Member of Provincial Parliament
Mississauga-Streetsville
2000 Argentia Road; Plaza 4, Suite 220
Mississauga ON L5N 1W1

WINDSOR-ESSEX COUNTY
BOARD OF HEALTH

Resolution Recommendation

December 18, 2014

Issue:

Community water fluoridation promotes good (oral) health, and the optimal concentration of fluoride in drinking water is essential to the health of Ontarians by minimizing tooth decay, and helping restore tooth enamel.

Background:

Dental caries, also known as tooth decay or cavities, is one of the most prevalent chronic diseases in humans. Dental caries affect 60 to 90 per cent of school children and the vast majority of adults in most industrialized countries (World Health Organization, 2003). Among five to seventeen year olds, dental decay is five times as common as asthma and seven times as common as hay fever (U.S. Public Health Service, 2000). In Canada, 57 per cent of children, and 59 per cent of adolescents and 96 per cent of adults have been affected by tooth decay (Health Canada, 2010). In children, early tooth loss caused by dental decay can result in failure to thrive, impaired speech development, absence from and inability to concentrate in school, and reduced self-esteem (Office of Disease Prevention and Health Promotion, 2000).

Oral health care is a critical component of health care and must be included in the design of community programs. The World Health Organization states that oral health is an important part of overall health, and a determinant of quality of life (World Health Organization, 2003). Prevention is critical to good oral health, and tooth decay is almost always easily preventable.

Community water fluoridation is recognized as the single most effective public health measure to prevent tooth decay and was listed by the Centres for Disease Control in the top ten greatest public health achievements of the 20th century. In her report, Oral Health, More than just Cavities, A Report by Ontario's Chief Medical Officer of Health, April 2012, Dr Arlene King, states that all Ontarians should have access to optimally fluoridated drinking water. "It is my view that the improvements to oral health in Ontario as a result of our publicly funded oral health programs would be undermined by the removal of fluoridation from the water supply" (King, 2012).

From a public health perspective, an advantage of providing fluoride at a population level is that it benefits all residents served by community water supplies (Petersen, 2003). As well water fluoridation does not rely on individual compliance with health recommendations and therefore removes barriers around poor compliance or limited access. Population level intervention ensures all socioeconomic sectors of the population can be reached, notably those with limited access to preventive dentistry. There is mounting evidence for the role of fluoridation in reducing disparities in dental caries (cavities) that are related to the social determinants of health. Fluoridation is highly effective and can reach and benefit large populations. Other preventive services such as fluoridated toothpaste, fluoride mouth rinses, fluoride varnish, and sealants may be less accessible to those without private dental insurance, or those living on low incomes (King, 2012).

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Fluoridation of Ontario's drinking water supplies is a safe and cost-effective and efficient population health intervention. Studies have shown that fluoridated drinking water reduces the number of cavities in children's teeth by up to 60 per cent and in their permanent teeth by up to 35 per cent (American Dental Association, 2005). As well, a number of studies have shown a positive cost-benefit analysis for community water fluoridation (National Collaborating Centre for Environmental Health, 2014).

Many major health organizations support community water fluoridation including the WHO, the CDC, Health Canada, the Public Health Agency of Canada, the Canadian Dental Association and the Canadian Medical Association. An expert panel convened by Health Canada in 2007 recommended adopting a level of 0.7 mg/L as the optimal target concentration for fluoride in drinking water, which prevent excessive intake of fluoride through multiple sources of exposure. In 2010 Health Canada recommended an optimal concentration of fluoride in drinking water of 0.7 mg/L to promote dental health.
Opponents to fluoridation claim it causes harm to individuals. A known health consequence is fluorosis (an alteration of the appearance of the tooth enamel). Other health outcomes suspected to be associated with community water fluoridation have not been supported by the scientific literature. Anti-fluoridation advocacy efforts targeting various Ontario communities are costly in terms of time and resources to city and municipal councils, Boards of Health, MOH's, public health professionals as well as other dental professionals.

Therefore, let it be moved that:

WHEREAS the relationship between poor oral health and poor physical and mental health is clear; and

WHEREAS the relationship between poor oral health and risks associated with childhood development are known; and

WHEREAS individuals in the community of lower socio-economic status suffer a more significant burden of poor health; and

WHEREAS Windsor-Essex has a higher than average number of individuals living in low income compared to the province; and

WHEREAS providing fluoride via community water offers the positive benefits equally for everyone in the community; and

WHEREAS global health experts and evidence support community water fluoridation to prevent tooth decay;

THEREFORE BE IT RESOLVED that the Windsor Essex County Health Unit recommends that the Province of Ontario amend the regulations of the Safe Drinking Water Act to require community water fluoridation for all municipal water systems (when source-water levels are below the Health Canada-recommended level of 0.7 mg/L) to prevent dental caries.

March 21, 2016

Porcupine
Health Unit • Bureau de santé

The Honourable Ted McMeekin
Ontario Minister of Municipal Affairs and Housing
777 Bay Street, 17th Floor
Toronto, ON
M5G 2E5

Head Office:
169 Pine Street South
Postal Bag 2012
Timmins, ON P4N 8B7

Phone: 705 267 1181
Fax: 705 264 3980
Toll Free: 800 461 1818

email: info4you@porcupinehu.on.ca
Website: www.porcupinehu.on.ca

Dear Minister McMeekin,

On March 18, 2016, the Porcupine Health Unit Board of Health passed the following resolution:

WHEREAS smoking in multi-unit housing results in significant exposure to the health harming effects of tobacco smoke; and

WHEREAS area municipalities and service boards that are landlords of multi-unit housing can adopt no-smoking policies that set an example and protect health;

NOW THEREFORE BE IT RESOLVED THAT the Board of Health for the Porcupine Health Unit support the efforts of the Smoke-Free Housing Ontario Coalition, and others, in the following actions and policies to reduce the exposure of second-hand smoke in multi-unit housing:

(1) Encourage all landlords and property owners of multi-unit housing to voluntarily adopt no-smoking policies in their rental units or properties;

(2) Advocate that all future private sector rental properties and buildings developed in Ontario should be smoke-free from the onset;

(3) Encourage public/social housing providers to voluntarily adopt no-smoking policies in their units and/or properties;

(4) Advocate that all future public/social housing developments in Ontario should be smoke-free from the onset;

(5) Encourage the Ontario Ministry of Housing to develop government policy and programs to facilitate the provision of smoke-free housing.

FURTHER BE IT RESOLVED THAT a copy of this motion be submitted to the Smoke-Free Housing Ontario Coalition, the Ontario Minister of Municipal Affairs and Housing, local members of Provincial Parliament (MPP), the Chief Medical Officer of Health, the Association of Local Public Health Agencies (alPHa), all Ontario Boards of Health, the Association of Municipalities of Ontario (AMO), the Federation of Northern Ontario Municipalities (FNOM) and Porcupine Health Unit municipalities for their information and support.

Thank you for your attention to this important public health issue.

Yours very truly,

Donald W West BMath, CPA, CA
Chief Administrative Officer

DW:mc

Branch Offices: Cochrane, Hearst, Hornepayne, Iroquois Falls, Kapuskasing, Matheson, Moosonee, Smooth Rock Falls

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
70 Joseph Street, Unit 302, Parry Sound, ON P2A 2G5 TEL 705.746.5801 FAX 705.746.2711
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February 22, 2016

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

Dear Minister Hoskins:

Subject: Bill 139: Smoke-Free Schools Act – BOH Resolution #BOH/2016/01/11

On January 27, 2016, at a regular meeting of the Board of Health for the North Bay Parry Sound District Health Unit, the Board unanimously approved the following motion #BOH/2016/01/11:

***Whereas**, tobacco use is the leading cause of preventable death and disability in Canada (Ministry of Health and Long-Term Care, 2010), and*

***Whereas**, the number of daily and occasional cigarette smokers in the North Bay Parry Sound District Health Unit is 7% higher than the provincial average (25.8% vs. 18.7%; NBPSDHU, 2014), and*

***Whereas**, Bill 139: Smoke-Free Schools Act introduced by MPP Todd Smith is slated for third reading in the Ontario Legislature this year, and*

***Whereas**, Bill 139: Smoke-Free Schools Act includes a prohibition on the sale of any tobacco products in schools, increased fines for offenders caught selling illegal tobacco, and increased suspension periods of driver's licenses for people convicted of using a vehicle for unauthorized delivery/transportation of illegal tobacco, sharing the proceeds of disposition of forfeited property with police forces if they were involved in the investigation, a requirement that the Government establish a public education program about the health risks associated with the use of tobacco, and*

***Whereas**, the illegal sale of contraband cigarettes undermines public health's efforts to reduce smoking rates and protect children and youth from the dangers of smoking, and*

***Whereas**, higher tobacco taxes have been identified as the most effective strategy to reduce smoking prevalence and Ontario has one of the lowest tobacco tax rates in Canada (Smoke-Free Ontario Scientific Advisory Committee, 2010; Ontario Tobacco Research Unit, 2015), and*

***Whereas**, plain and standardized packaging is an effective counter measure to the tobacco industry's use of packaging as an important part of tobacco promotion, and*

***Whereas**, Bill 139: Smoke-Free Schools Act has been endorsed by the Canadian Cancer Society, the Heart & Stroke Foundation, and the Ontario Campaign Against Tobacco (OCAT),*

***Now Therefore Be It Resolved**, that the Board of Health for the North Bay Parry Sound District Health Unit support Bill 139: Smoke-Free Schools Act and that legislation for plain and standardized cigarette packaging and higher tobacco taxes be considered by all levels of government, and*

***Furthermore Be It Resolved,** that a copy of this resolution be forwarded to the Honourable Dr. Eric Hoskins, Minister of Health and Long-Term Care, the Association of Local Public Health Agencies (alpha), MPP Todd Smith (Prince Edward-Hastings), MPP Victor Fedeli (Nipissing), MPP Norm Miller (Parry Sound-Muskoka), Premier Kathleen Wynne, and Ontario Boards of Health.*

Sincerely,

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

C: Todd Smith, MPP, Prince Edward-Hastings
Victor Fedeli, MPP, Nipissing
Norm Miller, MPP, Parry Sound-Muskoka
Hon. Kathleen Wynne, Premier of Ontario
Linda Stewart, Executive Director, Association of Local Public Health Agencies
Ontario Boards of Health