ALGOMA PUBLIC HEALTH

BOARD OF HEALTH MEETING

JANUARY 25, 2017

Sault Ste. Marie Room A&B, 1st Floor

294 Willow Ave., Sault Ste. Marie, ON

www.algomapublichealth.com

January 25, 2017 - Board of Health Meeting Book

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ALGOMA PUBLIC HEALTH
BOARD OF HEALTH MEETING
JANUARY 25, 2017 @ 5:00PM
SAULT STE MARIE ROOM A&B, SSM
A*G*E*N*D*A

1.0 Meeting Called to Order — Dr. Marlene, Spruyt, MOH/CEO

a. Declaration of Conflict of Interest

2.0 Election of Officers

a. Appointment of Board of Health Chair — Dr. Marlene, Spruyt, MOH/CEO

Resolution
THAT the Algoma Public Health Board of Health appoints _____as Chair for the year 2017.

b. Appointment of the Board of Health First Vice-Chair — Board Chair

Resolution
THAT the Algoma Public Health Board of Health appoints _____as First Vice-Chair and Chair of the Finance and Audit Committee for the year 2017.

c. Appointment of the Board of Health Second Vice-Chair — Board Chair

Resolution
THAT the Algoma Public Health Board of Health appoints _____as Second Vice-Chair and Chair of the Governance Standing Committee for the year 2017.

d. Appointment to Finance and Audit Committee — Board Chair

Resolution
THAT the Algoma Public Health Board of Health appoints the following individuals to the Board's Finance and Audit Committee for the year 2017:_____.

e. Appointment to Governance Standing Committee — Board Chair

Resolution
THAT the Algoma Public Health Board of Health appoints the following individuals to the Board's Governance Standing Committee for the year 2017:_____.

3.0 Adoption of Agenda Items — Board Chair

Resolution
THAT the agenda items dated January 25, 2017 be adopted as circulated; and
THAT the Board accepts the items on the addendum.

4.0 Adoption of Minutes of Previous Meeting — Board Chair

Resolution
THAT the Board of Health minutes for the meeting dated November 23, 2016 be adopted as circulated.

5.0 Delegations/Presentations.

a. Food Safety — Mr. Jonathon Bouma, Program Manager

6.0 Business Arising from Minutes — Dr. Marlene, Spruyt, MOH/CEO

a. Pharmacy Flu Vaccine Reporting

7.0 Reports to the Board

a. Medical Officer of Health and Chief Executive Officer Report — Dr. Marlene, Spruyt, MOH/CEO

Resolution
THAT the report of the Medical Officer of Health and CEO for the month of January 2017 be accepted as presented.

b. Financial Report — Mr. Justin Pino, Chief Financial Officer

i. Draft Financial Statements for the Period Ending November 30, 2016

Resolution
THAT the Financial Statements for the Period Ending November 30, 2016 be accepted as presented.

ii. Community Accountability Planning Submission

Resolution
THAT the Board of Health reviewed and accepts the Community Accountability Planning Submission (CAPS) report as presented.

iii. 2016 *Financial Controls Checklist*

Resolution
THAT the Board of Health reviewed and accepts the 2016 Financial Controls Checklist for the Board of Health for the District of Algoma Health Unit.

8.0 New Business/General Business

a. 2017 Agency Insurance Renewal — Board Chair

Resolution
THAT the Board of Health approves the 2017 Insurance coverage for Algoma Public Health.

9.0 Correspondence — Board Chair

a. 2016 Ontario Public Health Standards Modernization/Review
- **i.** Letter to Ms. Wood from Grey Bruce Health Unit dated November 25, 2016

b. A Public Health Approach to the Legalization of Cannabis - *APH Resolution 2016-94*
- i. Resolution from Prince Township dated December 13, 2016

c. Alcohol Policy
- i. Letter to alPHa from Northwestern Health Unit dated November 1, 2016

d. Basic Income Guarantee
- i. Letter to Ministers Jaczek and Ballard from alPHa and OPHA dated January 17, 2017

e. Bill 178 – Smoke-Free Ontario Amendment Act
   i. Letter to Minister Hoskins from Simcoe Muskoka District Health Unit dated December 15, 2016

f. Bill S-228, An Act to amend the Food and Drugs Act
   i. Letter to Minister Philpott from Huron County dated December 8, 2016
   ii. Letter to Minister Philpott from Middlesex-London Health Unit dated December 13, 2016
   iii. Letter to Prime Minster Trudeau from Durham Region dated December 14, 2016

g. Bill 5 – the Greater Access to Hepatitis C Treatment Act, 2016
   i. Letter to Minister Hoskins from Peterborough Public Health dated November 28, 2016

h. Health Hazards of Gambling
   i. Letter to Minister Hoskins from North Bay Parry Sound District Health Unit dated December 5, 2016

i. HPV/Immunization Program Funding
   i. Letter to Minister Hoskins from Huron County dated January 5, 2017
   ii. Letter to Premier Wynne from Durham Region dated November 10, 2016

j. Lyme Disease
   i. Letter to Prime Minister Trudeau from Durham Region dated November 10, 2016

k. Nutritious Food Baskets
   i. Letter to Ministers from North Bay Parry Sound District dated November 25, 2016
   ii. Letter to Premier Wynne from Durham Region dated December 14, 2016
   iii. Letter to Premier Wynne from Sudbury & District Health Unit dated November 17, 2016

l. Opioid Addiction and Overdose
   i. Letter to the Registrar for College of Physicians and Surgeons of Ontario from Middlesex-London Health Unit Dated December 8, 2016

m. Oral Health Programs for Low-Income Adults and Seniors
   i. Letter to Minister Hoskins from County of Lambton dated December 8, 2016

n. Student Nutrition Programs
   i. Letter to Prime Minister Trudeau from Durham Region dated December 14, 2016

10.0 Items for Information Board Chair

a. alPHa Information Break – January 10, 2017
b. Public Health Expert Panel

11.0 Addendum

12.0 That The Board Go Into Committee Board Chair

Resolution
THAT the Board of Health goes into committee.

Agenda Items:

a. Adoption of previous in-committee minutes dated DATE
b. Litigation or Potential Litigation
c. Labour Relations and Employee Negotiations

13.0 That The Board Go Into Open Meeting Board Chair

Resolution
THAT the Board of Health goes into open meeting

14.0 Resolution(s) Resulting from In-Committee Session Board Chair

15.0 Announcements: Board Chair

Next Finance and Audit Committee Meeting
February 8, 2017 at 4:30
Prince Meeting Room

Next Governance Standing Committee Meeting
February 8, 2017 at 5:30
Prince Meeting Room

Next Board Meeting:
February 22, 2017 at 5:00pm
Sault Ste. Marie, Room A&B, Sault Ste. Marie

alPHa Winter Symposium
February 23-24, 2017
Toronto, TBA

16.0 That The Meeting Adjourn Board Chair

Resolution
THAT the Board of Health meeting adjourns

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FOOD SAFETY

Jon Bouma MSc; CPHI(C)
Manager, Environmental Health and Communicable Diseases
January 18, 2017

ONTARIO PUBLIC HEALTH STANDARDS (OPHS)

The goal is to prevent or reduce the burden of food-borne illness:

Disease prevention/health protection

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OPHS/PROTOCOL REQUIREMENTS

- **Assessment and Surveillance:**
  - Surveillance of suspected/confirmed food borne illness and food premises

- **Health promotion and policy development:**
  - Food handler training
  - Health promotion strategies

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HEALTH PROTECTION

- Annual site specific risk categorization process to determine frequency of inspection (high, medium and low risk)
- Inspect 1-3 times per year plus re-inspections if infractions are flagged
- Special events (Passport to Unity)

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INSPECTION

- 9 inspectors in Sault Ste. Marie
- 2 inspectors in Blind River
- 1 inspector in Elliot Lake
- 1 inspector in Wawa
- Food disclosure at: http://www.algomapublichealth.com/inspections-environment/food-safety/restaurant-inspection-reports

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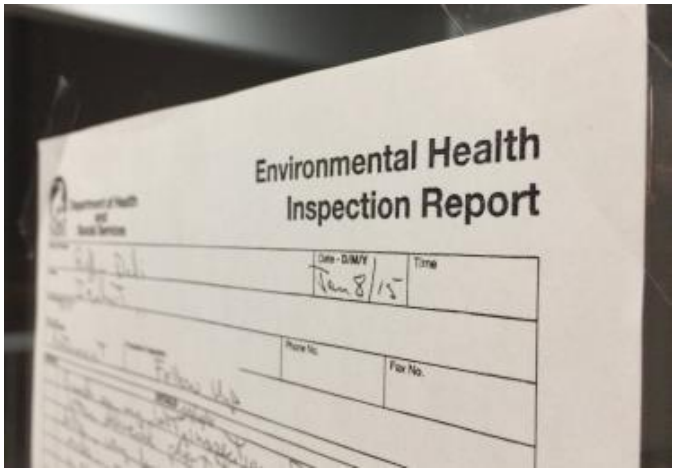
INSPECTION

- Critical items
- Design, Maintenance and Sanitation
- Inspector demo at:

https://www.youtube.com/watch?v=yncZkZbI3ms



RESULTS

	2015 inspections	Compliance %	2016 inspections	Compliance%
High	436	97	331	92
Medium	385	93	373	95
low	234	92	261	94
Seasonal	103		113	
Total inspections	1159		1073	

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FOOD HANDLER TRAINING

- Food handler training and certification is a priority to educate those who will be in direct contact with the public.
- 2015- 27 sessions hosted with 556 certified food handlers
- 2016-21 sessions with 425 certified food handlers

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COLLABORATIONS

- Sault College
- Ministry of Health and Long term Care
- Canadian Food Inspection Agency
- Farmers' Markets
- Schools, Daycares

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NEW THIS YEAR

- Healthy Menu Choices Act, 2015
- Sharing economy

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MEDICAL OFFICER OF HEALTH/CHIEF EXECUTIVE OFFICER
BOARD REPORT
JANUARY 2017

Prepared by Dr. Marlene Spruyt

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APH AT-A-GLANCE

I am pleased to provide you with my first report in my new position as MOH/CEO for Algoma Public Health. Most of my time has been spent getting oriented to the various programs here at APH, many of which I am familiar with and some that are new to me. Each health unit however is unique in its operating procedures for implementation of its specific programs. As most of you are aware there was a "meet and greet" session at APH-SSM with staff from district offices invited by teleconference and videoconference. I am currently scheduling mutually convenient meeting times for visits to each of the district offices.
As well there was a small send off for Tony Hanlon. I want to thank him for coming out of retirement to assist in keeping APH on track and providing support to me during my initial days.

As a follow up to the meeting Tony and Justin had with SSM City Council we are arranging to meet with any municipal council who are willing to have us attend. The presentation is focused on the role of public health and its relationship to the municipalities and an overview of our programs and budget.
To this end we are scheduled to present at council meetings for Plummer Additional on January 18, 2017, Spanish on April 5, 2017, MacDonald Meredith and Aberdeen Additional on February 7, 2017, Elliot Lake on February 13, 2017 and the Algoma District Municipal Association (ADMA) presentation at the April 22, 2017 meeting on St. Joe's Island.

We were advised that the City of SSM re-appointed Mr. Ian Frazier, Dr. Heather O'Brien and Dr. Lucas Castellani to the Board.

PROGRAM HIGHLIGHTS

ENVIRONMENTAL HEALTH

Director: Sherri Cleaves
Manager: Chris Spooney

Topic: Safe Water/Recreational Water

This report addresses the OPHS: Safe Water Requirement #1 under Assessment and Surveillance of the Safe Water OPHS: the board of health shall report Safe Water Program data elements in accordance with the Recreational Water Protocol, 2008 (or as current).

This report addresses the Strategic Direction: Be Accountable

Recreational Water Inventory Activity Report:
The Safe Water program contains three sections: Drinking water, Recreational water (beaches), and Constructed facilities that require inspections. This report addresses the Constructed facilities such as public swimming pools and spas. The goal of inspecting such facilities is to ensure the safety of the bathers while eliminating the potential of infectious transmission. Such inspections are mandated and linked to accountability agreements. The following table provides a brief summary of 2016.

Recreational Water Inventory Activity Report
As per Recreational Water Protocol, 2016

Board of Health: Algoma Public Health
Reporting Year: 2016 **Time Frame:** January 1st- December 31st

Number of Facilities and Camps

Class/Type*	Public Pools				Public Spas		Non-Regulated Recreational Water Facilities		
	Class A		Class B						
	Seasonal	Year-Round	Seasonal	Year-Round	Seasonal	Year-Round	Wading Pools	Splash Pads/ Spray Pads	Water Slide Receiving Basins
Total Number	2	6	4	13	2	13	1	0	0
Monitoring									
Routine Inspections **	4	24	8	52	4	52	4		
Re-Inspections				1		2	0		
Complaints									
Total Numbers	4	24	8	53	4	54	4	0	0
Closures				3		3			

As of December 31 of the reporting year (2016), there were a total of 33 year round premises which required a total of 112 inspections. There were 8 seasonal premises which resulted in 16 inspections. There were three Section 13 orders issued (an order set out to remedy an outstanding issue within a certain time frame) which resulted in pool closures. All inspections were completed and the Environmental Health program was 100% compliant in meeting ministry accountability agreements.

COMMUNITY MENTAL HEALTH PROGRAM & COMMUNITY ALCOHOL DRUG ASSESSMENT PROGRAM

Director: Sherri Cleaves
Manager: Jan Metheany

Topic: Collaboration through Service Contract

This report addresses the Program Guidelines/Deliverables: MOHLTC- Mental Health and Addictions

This report addresses the Strategic Directions:

- Improve Health Equity
- Collaborate Effectively

Addiction Support Initiative

Community Alcohol Drug Assessment Program (CADAP) partners with both Social Service Administration boards in Algoma, the ADSSAB (District) & DSSMSSAB (SSM) and their respective Ontario Works (OW) - Addiction Support Initiative(s) (ASI), through the utilization of service agreements. Since 2005, CADAP has been contracted by the above boards to provide specialized addiction counselling to participants of Ontario Works with addiction related barriers to employment that are living in the District of Algoma. With a health equity lens, CADAP staff use a holistic approach to help OW participants, who often have multiple needs, identify strengths and reach their treatment goals within the counselling milieu. Participants are screened by OW- ASI case managers and referred directly (no wait times) to a CADAP Counsellor for assessment, treatment planning and counselling. The problem substances most identified upon intake include: Alcohol, tobacco, cannabis, prescription opioids and cocaine. CADAP-ASI counsellors have strong collaborative connections with OW-ASI case managers and with client consent regularly share pertinent information regarding the client's participation, barriers to treatment and individualized progress reports. As part of these service contracts CADAP submits quarterly reports to both Social Service Administration Boards. As of the 2016 3rd quarter, CADAP-ASI reports show 114 participants throughout Algoma thus far this year. Both Ontario Works and CADAP staff continue to support the positive outcomes of the program.

Garden River Wellness Center

In 2015, APH and the Garden River Wellness Center (GRWC) entered a unique collaboration through service contract with a mutual aim to support members of the Garden River First Nations Community in achieving the best possible health outcomes, free from alcohol and/or other drug problems and to experience positive mental health. APH provides one CADAP Assessment/Counsellor and one APH-CMHP Psychiatric Case Manager dedicated full time to co-developing along with GRWC staff, culturally appropriate programing and in delivering specialized mental health and addiction services on site within the Garden River Community. As a team, they are also committed to assisting individuals in their recovery by incorporating physical, emotional and spiritual needs as part of cultural teaching. Using a health equity lens, the delivery of accessible specialized mental health & addiction services within the community, allows the integration of traditional and non-traditional knowledge in meeting community needs in this area. Monday, November 28th, 2016 GRWC held a "Grand Opening" of the new mental health and addictions building dedicated to the aim above, which has been named the "MeGe Zee Wuhsiswun" Centre. Elder Willard Pine performed the opening ceremony where several CADAP & CMHP staff along with Sherri Cleaves, APH Director of Health Protection and Prevention, participated in the event. Both GRWC and CADAP/CMHP staff are very proud of our collaborative role in the realization of this unique First Nations community mental health & addiction support initiative.

CHRONIC DISEASE PREVENTION

Director: Laurie Zeppa
Manager: Jennifer Flood

Program: Youth Engagement

Topic: Development in Tobacco Prevention

This report addresses the OPHS:

Chronic Disease Prevention (CDP) Health Promotion and Policy Development

- **Requirement 3**: the board of health shall work with schools boards and/or staff of elementary, secondary, and post-secondary educational settings, using a comprehensive health promotion approach, to influence the development of healthy policies, and the creation of supportive environments to address comprehensive tobacco control.
- **Requirement 7**: The board of health shall increase the capacity of community partners to coordinate and develop regional/local programs and services related to comprehensive tobacco control.
- **Requirement 11**: The board of health shall increase public awareness in comprehensive tobacco control and health inequities that contribute to chronic disease.

CDP Requirement Health Protection

- **Requirement 13:** The board of health shall implement and enforce the Smoke Free Ontario Act

This report addresses the Strategic Directions:

- Improve Health Equity
- Collaborate Effectively

The establishment of an agency adopted Youth Engagement and Development (YED) framework has demonstrated Algoma Public Health's commitment to incorporate YED as a method to achieve our strategic directions and goals of the Ontario Public Health Standards.

APH employs a Youth Engagement Coordinator to help build organizational YED capacity, cultivate community partnerships, and increase meaningful opportunities for young people. The coordinator offers consultations, resources and training to help identify opportunities to increase health outcomes through youth engagement principles and practices.

The Smoke-Free Ontario (SFO) Strategy's tobacco prevention pillar, funded through the Ministry of Health and Long term Care, has been foundational for youth engagement at APH. The SFO prevention pillar includes a number of programs, services, and policies focused on the prevention and reduction of tobacco use among youth and young adults.

Examples of some of the key agency tobacco prevention youth engagement programs, initiatives, and partnerships are summarized below.

Algoma Youth Engagement Network (AYEN): The AYEN is a Community of Practice designed to enhance capacity for youth engagement practices and assist in the development of partnerships amongst the diverse disciplines of network members. The goal is to create a synergistic approach to maximize positive youth outcomes. Monthly meetings offer professional development as well as opportunities for sharing best practices and networking amongst members. The AYEN has supported many community health promotion activities, youth forums and the creation of a youth portal which is now youth-driven and coordinated through the Sault Ste. Marie Innovation Center.

Algoma Youth Action Alliance (AYAA) Health Promotion Committees: To ensure diverse membership and equitable access to leadership opportunities amongst youth throughout the Algoma district, four health promotion committees of youth (ages 12 and up) have been created, one each in Wawa, Sault Ste. Marie, Blind River, and Elliot Lake.

Youth leaders identify health priorities that are important to them and design campaigns to create positive community change. In doing so, youth leaders improve or validate their own positive health practices as they reach out to other young people. Using an empowerment approach, public health staff and community partners (e.g., teachers, guidance counselors, Canadian Cancer Society volunteers, etc.) work together to serve as a supportive network of adult allies to foster positive youth outcomes. There are often training opportunities offered at local, regional and provincial levels to enhance the knowledge and skills sets of AYAA reps and community partners.

In October 2016, AYAA youth reps from Wawa and Sault Ste. Marie, as well as youth reps from Algoma Family Services' youth committee, received regional training to explore emerging tobacco prevention issues. This led the way for the development of follow-up campaigns and partnerships. In December, Algoma Family Services' youth group also worked with Algoma Public Health to support provincial efforts to promote Plain and Standardized tobacco packaging.

In December 2016, Wawa's AYAA committee hosted a Smoke Free Movie event at Michipicoten High School and Sault Ste. Marie's AYAA committee partnered with Algoma Family Services' youth group to host a Smoke Free Movie event at the Grand Theatre. The purpose of these Smoke Free Movies events was to generate awareness about the impact of smoking imagery in films on youth tobacco initiation rates, increase media literacy skills among youth to mitigate the impact, and promote policy changes to eliminate commercial tobacco use and images in youth rated films.

Collaborative Tobacco Prevention Projects with Indigenous Community Partners- Youth Focus
In Algoma, there is a high proportion of broad and diverse Indigenous communities. Smoking rates are significantly higher amongst Indigenous populations. There is a need to understand the historical context and focus on cultural connections using a strengths based approach, shifting the lens from at-risk youth to resilient youth. Effective Indigenous youth smoking prevention programs must involve Indigenous youth in the creative process as to support personal ownership that reduces dropout rates and increases the overall success of the program (McKennitt, D. First Peoples Child & Family Review, Volume 3, Number 2, 2007, Special Issue).

Examples of Activities:

1. **Movers and Shakers** is an annual culture-based youth gathering initiated by Maamwesying North Shore Community Health Services in partnership with First Nations communities along the North Shore, Algoma Public Health, Cancer Care Ontario, and Gen 7. Each year, the Movers and Shakers gathering rotates amongst our North Shore communities to foster healthy living skills and collaborative health promotion initiatives. Youth are connected with elders and knowledge carriers who share teachings that promote health and wellbeing. Youth are involved in the planning and preparation of the gathering, as well as with follow up youth engagement initiatives.

2. **Sacred Smoke** is a culture-based tobacco cessation program led by Maamwesying North Shore Community Health Services in partnership with Garden River First Nation, Cancer Care Ontario, and Algoma Public Health. From May-October 2016, culturally relevant group sessions were facilitated monthly at the Garden River Health Centre with individuals interested in changing their smoking behaviour and their support networks. Group sessions were supported by elders and knowledge carriers and involved discussions, strategy development, and skill building for changing smoking behaviours. They also involved cultural activities identified by participants that supported self-esteem, as well as, the opportunity to counter key psychological triggers for smoking.

Respectfully submitted,
Dr. Marlene Spruyt

Algoma Public Health
Financial Statements November 30, 2016

Algoma Public Health
Statement of Operations
November 2016

	Actual YTD 2016	Budget YTD 2016	Variance Act. to Bgt. 2016	Annual Budget 2016	Variance % Act. to Bgt. 2016	YTD Actual/ YTD Budget 2016
Public Health Programs						
Revenue						
Municipal Levy - Public Health	$ 3,399,791	$ 3,399,791	$ (0)	$ 3,399,791	0%	100%
Provincial Grants - Public Health 75% Prov. Funded	6,728,066	6,700,100	27,966	7,309,200	0%	100%
Provincial Grants - Public Health 100% Prov. Funded	2,408,917	2,411,883	(2,966)	2,652,500	0%	100%
Fees, other grants and recovery of expenditures	643,040	755,520	(112,481)	824,204	-15%	85%
Provincial Grants - Funding for Prior Yr Expenses	194,800	55,800	139,000	55,800		
Total Public Health Revenue	$ 13,374,614	$ 13,323,095	$ 51,519	$ 14,241,495	0%	100%
Expenditures						
Public Health 75% Prov. Funded Programs	$ 9,999,448	$ 10,604,439	$ 604,991	$ 11,533,195	-6%	94%
Public Health 100% Prov. Funded Programs	2,252,408	2,466,339	213,931	2,708,300	-9%	91%
Total Public Health Programs Expenditures	$ 12,251,856	$ 13,070,778	$ 818,922	$ 14,241,495	-6%	94%
Excess of Rev. over Exp. 75% Prov. Funded	$ 771,449	$ 250,972	$ 520,477	$ 0		
Excess of Rev. over Exp. 100% Prov. Funded	156,509	(54,455)	210,964	(55,800)		
Provincial Grants for Prior Yr Expenses	194,800	55,800	139,000	55,800		
Total Rev. over Exp. Public Health	$ 1,122,758	$ 252,317	$ 870,441	$ (0)		
Public Health Programs - Fiscal 16/17						
Provincial Grants	$ 95,664	37,370	(58,294)	143,500		
Expenditures	21,930	27,320	(5,390)	143,500		
Excess of Rev. over Fiscal Funded	73,734	10,050	63,684	-		
Community Health Programs						
Calendar Programs						
Revenue						
Provincial Grants - Community Health	$ 979,011	$ 979,010	$ 1	$ 1,068,011	0%	100%
Municipal, Federal, and Other Funding	251,543	239,250	12,292	266,455	5%	105%
Dental Benefits Ontario Works Recoveries	304,598		304,598			
Total Community Health Revenue	$ 1,535,151	$ 1,218,261	$ 316,891	$ 1,334,466	26%	126%
Expenditures						
Healthy Babies and Children	$ 975,545	$ 979,010	$ 3,465	$ 1,068,011	0%	100%
Child Benefits Ontario Works	20,700	22,128	1,428	24,135	-6%	94%
Dental Benefits Ontario Works	296,837		(296,837)			
Algoma CADAP programs	193,209	217,127	23,917	242,320	-11%	89%
Total Calendar Community Health Programs	$ 1,486,292	$ 1,218,265	$ (268,027)	$ 1,334,466	22%	122%
Total Rev. over Exp. Calendar Community Health	$ 48,860	$ (5)	$ 48,864	$ 0		
Fiscal Programs						
Revenue						
Provincial Grants - Community Health	$ 3,664,846	$ 3,731,533	$ (66,687)	$ 5,612,699	-2%	98%
Municipal, Federal, and Other Funding	509,780	511,605	(1,825)	800,253	0%	100%
Other Bill for Service Programs	27,246		27,246			
Total Community Health Revenue	$ 4,201,872	$ 4,243,138	$ (41,265)	$ 6,412,952	-1%	99%
Expenditures						
Northern Ontario Fruit & Vegetable Program	65,711	82,078	$ 16,367	117,400	-20%	80%
Brighter Futures for Children	67,936	76,149	8,213	114,447	-11%	89%
Infant Development	420,334	421,290	956	631,935	0%	100%
Preschool Speech and Languages	416,571	409,504	(7,067)	614,256	2%	102%
Nurse Practitioner	81,079	81,902	824	122,853	-1%	99%
Genetics Counseling	246,116	252,537	6,421	378,806	-3%	97%
Community Mental Health	2,181,575	2,263,532	81,957	3,426,098	-4%	96%
Community Alcohol and Drug Assessment	472,722	454,771	(17,951)	682,157	4%	104%
Healthy Kids Community Challenge	163,079	141,535	(21,544)	225,000	15%	115%
Stay on Your Feet	58,803	66,667	7,863	100,000	-12%	88%
Bill for Service Programs	34,130	-	(34,130)	-		
Misc Fiscal	0	-	-	-		
Total Fiscal Community Health Programs	$ 4,208,057	$ 4,249,965	$ 41,909	$ 6,412,953	-1%	99%
Total Rev. over Exp. Fiscal Community Health	$ (6,185)	$ (6,828)	$ 643	$ (1)		

Explanations will be provided for variances of 15% and $15,000 occurring in the first 6 months

and variances of 10% and $10,000 occurring in the final 6 months

Algoma Public Health
Revenue Statement
For the Eleven Months Ending November 30, 2016

	Actual YTD 2016	Budget YTD 2016	Variance Bgt. to Act. 2016	Annual Budget 2016	Variance % Act. to Bgt. 2016	YTD Actual/ YTD Budget 2016	Comparison Prior Year: YTD Actual 2015	YTD BGT 2015	Variance 2015
Levies Sault Ste Marie	2,362,846	2,362,846	0	2,362,846	0%	100%	2,301,476	1,805,337	496,140
Levies Sault Ste Marie Capital	0	0	0	0		0%	0	269,152	(269,152)
Levies Vector Bourne Disease and Safe Water	59,433	59,433	0	59,433	0%	100%	0	60,967	(60,967)
Levies District	977,512	977,512	0	977,512	0%	100%	1,070,285	737,391	332,894
Levies District Capital	0	0	0	0		0%	0	109,935	(109,935)
Total Levies	**3,399,791**	**3,399,791**	**0**	**3,399,791**	**0%**	**100%**	**3,371,761**	**2,982,781**	**388,980**
MOH Public Health Funding	6,564,627	6,536,658	27,969	7,130,900	0%	92%	6,872,889	6,892,508	(19,619)
MOH Funding Vector Bourne Disease	99,639	99,642	(3)	108,700	0%	92%	99,642	99,642	0
MOH One Time Funding Dental Health	0	0	0	0		0%	57,117	31,167	25,950
MOH Funding Safe Water	63,800	63,800	0	69,600	0%	92%	65,086	63,800	1,286
Total Public Health 75% Prov. Funded	**6,728,066**	**6,700,100**	**27,966**	**7,309,200**	**0%**	**92%**	**7,094,734**	**7,087,117**	**7,617**
MOH One Needle Exchange	46,483	46,475	8	50,700	0%	92%	46,464	46,475	(11)
MOH Funding Haines Food Safety	22,550	22,550	0	24,600	0%	92%	22,552	22,550	2
MOH Funding CINOT/Healthy Smiles	677,768	705,742	(27,974)	769,900	-4%	88%	376,380	376,383	(3)
MOH Funding - Social Determinants of Health	165,461	165,458	3	180,500	0%	92%	165,452	165,458	(6)
MOH Funding Chief Nursing Officer	111,383	111,375	8	121,500	0%	92%	111,368	111,375	(7)
MOH Enhanced Funding Safe Water	14,211	14,208	3	15,500	0%	92%	12,905	14,208	(1,303)
MOH Funding Unorganized	472,178	463,542	8,636	515,100	2%	92%	458,607	458,608	(1)
MOH Funding Infection Control	286,372	286,367	5	312,400	0%	92%	286,352	286,367	(15)
MOH Funding Diabetes	60,000	30,000	30,000	60,000	100%	100%			
Funding Ontario Tobacco Strategy	397,473	397,467	6	433,600	0%	92%	424,935	382,800	42,135
One Time Funding	155,038	168,700	(13,662)	168,700	-8%				
Total Public Health 100% Prov. Funded	**2,408,917**	**2,411,883**	**(2,966)**	**2,652,500**	**0%**	**91%**	**1,905,015**	**1,864,225**	**40,790**
Funding for Prior Yr Expenses	**194,800**	**55,800**	**139,000**	**55,800**		**349%**			
Recoveries from Programs	26,470	9,222	17,248	10,061	187%	263%	9,227	9,222	5
Program Fees	210,177	226,548	(16,371)	247,143	-7%	85%	188,815	226,548	(37,733)
Land Control Fees	121,080	146,667	(25,587)	160,000	-17%	76%	160,055	146,667	13,388
Program Fees Immunization	177,712	146,667	31,046	160,000	21%	111%	184,334	146,667	37,667
HPV Vaccine Program	5,729	9,167	(3,438)	10,000	-38%	57%	3,026	9,167	(6,141)
Influenza Program	1,525	55,000	(53,475)	60,000	-97%	3%	835	55,000	(54,165)
Meningococcal C Program	3,529	9,167	(5,638)	10,000	-62%	35%	714	9,167	(8,453)
Interest Revenue	10,284	1,833	8,451	2,000	461%	514%	10,746	1,833	8,913
Other Revenues	86,533	151,250	(64,717)	165,000	-43%	52%	19,992	151,250	(131,258)
Funding Holding		0	0	0		0%	0	0	0
Total Fees, Other Grants and Recoveries	**643,040**	**755,520**	**(112,480)**	**824,204**	**-15%**	**78%**	**577,744**	**755,520**	**(177,776)**
Total Public Health Revenue Annual	**$ 13,374,614**	**$ 13,323,095**	**$ 51,520**	**$ 14,241,495**	**0%**	**94%**	**$ 12,949,254**	**$ 12,689,643**	**$ 259,611**
Public Health Fiscal									
Panorama	49,728	14,920	34,808	74,600		67%	52,900	0	52,900
Rabies Software	19,264	14,450	4,814	28,900		67%			
Smoke Free Ontario NRT	20,000	6,000	14,000	30,000		67%			
Practicum	6,672	2,000	4,672	10,000		67%			
First Nations Inititative -One Time	0	0	0	0		0%	112,214	0	112,214
Total Provincial Grants Fiscal	**$ 95,664**	**$ 37,370**	**$ 58,294**	**$ 143,500**		**67%**	**$ 165,114**	**$ -**	**$ 165,114**

Explanations will be provided for variances of 15% and $15,000 occurring in the first 6 months and variances of 10% and $10,000 occurring in the final 6 months

Algoma Public Health

Expense Statement- Public Health

For the Eleven Months Ending November 30, 2016

	Actual YTD 2016	Budget YTD 2016	Variance Act. to Bgt. 2016	Annual Budget 2016	Variance % Act. to Bgt. 2016	YTD Actual/ YTD Budget 2016	*Comparison Prior Year:* YTD Actual 2015	YTD BGT 2015	Variance 2015
Salaries & Wages	$ 7,272,652	$ 7,690,694	418,042	$ 8,392,979	-5%	87%	$ 7,159,036	$ 7,431,165	$ 272,129
Benefits	1,701,434	1,918,508	217,074	2,093,629	-11%	81%	1,648,569	1,860,881	212,312
Travel - Car Allowances	0	0	-			0%	39,664	56,797	17,133
Travel - Mileage	105,640	135,005	29,365	147,784	-22%	71%	133,198	114,993	(18,205)
Travel - Other	66,862	87,297	20,435	95,301	-23%	70%	59,679	115,782	56,104
Program	680,573	519,279	(161,294)	579,202	31%	118%	919,133	649,377	(269,756)
Office	105,167	84,833	(20,334)	92,750	24%	113%	50,806	120,954	70,148
Computer Services	570,213	821,249	251,036	861,936	-31%	66%	630,034	705,585	75,551
Telephone Charges	11,228	36,250	25,022	39,750	-69%	28%	27,212	44,241	17,029
Telecommunications	310,953	165,360	(145,593)	181,233	88%	172%	156,825	156,781	(44)
Program Promotion	91,000	206,245	115,245	229,085	-56%	40%	114,868	193,951	79,083
Facilities Expenses	712,820	751,097	38,277	821,424	-5%	87%	616,749	695,843	79,094
Fees & Insurance	322,583	366,105	43,522	391,305	-12%	82%	292,754	256,199	(36,555)
Debt Management	387,256	418,000	30,744	456,000	-7%	85%	417,868	418,000	132
Recoveries	(86,524)	(129,143)	(42,619)	(140,883)	-33%	61%	(74,860)	(130,907)	(56,047)
	$ 12,251,856	$ 13,070,778	$ 818,922	$ 14,241,495	**-6%**	**86%**	$ 12,191,535	$ 12,689,643	$ 498,108

	Current YTD	*2015*	*Total*	Total Budget	*Total % Spent*
Elliot Lake Renovations	405,588	277,890	683,478	724,960	94%

Explanations will be provided for variances of 15% and $15,000 occurring in the first 6 months and variances of 10% and $10,000 occurring in the final 6 months

Notes to Financial Statements – November 2016

Reporting Period

The November 2016 financial reports include eleven months of financial results for Public Health and the following calendar programs; Healthy Babies & Children, Child & Dental Benefits Ontario Works, and Algoma CADAP programs. All other programs are reporting eight month results from operations year ended March 2017.

Statement of Operations (see page 1)

Summary – Public Health and Non Public Health Programs

As of November 30th 2016, Public Health programs are reporting an $870k positive variance.

Total Public Health Revenues are indicating a positive $52k variance. Fees, Other Grants & Recoveries are indicating a negative $112k variance. In an effort to balance the budget, recognition of deferred revenue was planned for 2016. Management has determined this is not required which is impacting the negative variance related to Other Revenues. This negative variance is being offset with a positive $139k positive variance associated with Provincial Grants – Funding from prior years. This is associated with 2015 approved and settled one-time funding requests related to the Interim CEO Position and New Purpose-Built Vaccine Refrigerators. HST recoveries are also contributing to the positive variance noted.

There is a positive variance of $819k related to Total Public Health Expenses being less than budgeted. The $418k positive variance associated with Salary & Wages is driving this positive variance. This is a result of vacant positions which have been gapped in 2016. Management has recently posted for a part-time clerical in Wawa and a full-time Manger of Human Resources. In addition, the MOH position which was vacant in 2016 is contributing to the noted variance. In 2017, the size of the salary and wages positive variance should reduce. The Board of Health approved the purchase of IT network servers in November if the 2016 budget could support it. As noted in the November statements the budget can support the purchase of IT servers. The IT server purchase will reduce the noted positive variance.

Community Health Calendar programs are reporting a $49k positive variance.

On the revenue side, $305k positive variance is associated with Dental Benefits Ontario Works as these funds were not originally budgeted. This is being offset by the corresponding $297k negative variance related to expenses within the Dental Benefits Ontario Works program that have also not been budgeted. This represents an agreement between APH and Ontario Works where Ontario Works Compensates APH for Dental Service administration. Costs incurred are absorbed by the Revenues received.

On the expense side, a $24k positive variance is associated with the Algoma CADAP programs. APH Management was anticipating a surplus related to CADAP programs.

Community Health Fiscal programs are operating within budget.

Notes Continued...

On the Expense side, the Northern Ontario Fruit & Vegetable Program, Brighter Futures for Children and the Stay on Your Feet programs are indicating a positive variance as a result of timing of expenditures not yet incurred. The Healthy Kids Community Challenge is indicating a negative variance of $22k. This is a result timing of program purchases made within the program. As the year progresses, it is anticipated that all Community Health Fiscal programs will be within budget.

Public Health Revenue (see page 2 for details)

Public Health funding revenues are showing a positive $58k variance.

The municipal levies are operating within budget.

Provincial Funding Grants are operating within budget.

There is a negative variance of $112k associated with Fees, Other Grants & Recoveries. In an effort to balance the budget, recognition of deferred revenue was planned for 2016. Management has determined this is not required which is impacting the negative $65k variance related to Other Revenues. Most Program fee revenues are less than budgeted. Somewhat offsetting these negative variances are the positive $17k variance associated with Recoveries from Programs and the positive $31k variance associated with Program Fees Immunization. The positive variance associated with Recoveries from Programs is a result of HST recoveries.

Public Health Expenses (see page 3)

Benefits

Benefits are indicating a positive variance of $217k. The two vacant positions which have been gapped for most of the year and the MOH position which was vacant in 2016 are contributing to the positive variance noted. APH has posted for a part-time clerical position in Wawa and for a Manager of Human Resources. The MOH/CEO position has been filled. These actions should help to reduce the positive Benefits variance with regards to the 2017 operating budget.

Travel (Mileage, Other)

Travel (Mileage) is showing a positive $29k variance. Travel (Other) is showing a positive $20k variance. Management is anticipating actual expenses to be less than budgeted. The 2017 Operating Budget has been revised to more accurately reflect actual travel expenses.

Program

Program expense is indicating a negative $161k variance. The purchased services for the Acting MOH and Associate MOH roles are driving the noted variance. The positive variance associated with Salary & Wages is offsetting the added purchased service expenses. In addition, actual program material and supplies in the Sexual Health and VPD programs are greater than what was budgeted. The budget was reduced in 2016 but will be revised to more accurately reflect actual costs for 2017.

Notes Continued...

Office
Office expense is indicating a negative $20k variance. This is a result of Xerox expenses being budgeted in Facilities and Maintenance expenses and being charged to Office Expense. Management has revised the 2017 Operating Budget to ensure Xerox expenses are budgeted and charged to Office expense.

Computer Services
Computer Services is showing a positive variance of $251k. APH's 2016 Operating Budget was approved by the Board of Health in November of 2015 and included the buy-back of IT equipment. In December of 2015, the decision was made to buy-back leased IT equipment prior to 2016. This is driving the noted positive variance. In addition, the Cisco phone contract was budgeted in Computer Services but was charged to Telecommunications. Management has revised the 2017 Operating Budget to ensure the Cisco phone contract expenses are budgeted and charged to Telecommunications. The Board of Health has approved the purchase of IT servers which will reduce the noted positive variance related to Computer Services.

Telephone Charges
Telephone Charges are indicating a positive variance of $25k. This is a result of Management's decision to change cell phone providers.

Telecommunications
Telecommunications is indicating a negative variance of $146k. This is a result of the Cisco phone contract being budgeted in Computer Services but charged to Telecommunications. Management has revised the 2017 budget to ensure the Cisco phone contract expenses are budgeted and charged to Telecommunications. In addition, upgraded network technology related to APH's new Elliot Lake offices is contributing to this negative variance.

Program Promotion
Program Promotion is showing a positive variance of $115k. This is a result of budgeted Media dollars aligned to general agency needs that have historically been unspent. Revisions to the budgeted Program Promotion figure have been implemented in the 2017 APH Operating Budget.

Fees & Insurance
Fees & Insurance is indicating a positive variance of $44k. APH has incurred legal expenses regarding a Public Health policy matter. APH submitted a one-time funding request associated with these costs. Funds were received in November 2016. Excluding legal fees associated with the noted public health policy matter, agency legal fees are less than what was budgeted.

Recoveries
Recoveries are indicating a negative variance of $43k. This is a result of recoveries being less than budgeted. Revisions to the budgeted Recoveries figure have implemented in the 2017 Operating Budget.

Notes Continued...

Non Public Health Programs Revenue and Expenses (see page 1)

All Non Public Health 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 November 30th, 2016. Cash includes $324k in short-term investments.

Long-term debt of $5.875 million is held by TD Bank @ 1.95% for a 60 month term (amortization period of 180 months) and matures on September 1, 2021. $343k of the loan relates to the financing of the Elliot Lake office renovations with the balance related to the financing of the 294 Willow Avenue facility located in Sault Ste. Marie.

There are no collection concerns for accounts receivable.

Algoma Public Health
Statement of Financial Position

Date: As of November 2016	November 2016	December 2015
Assets		
Current		
Cash & Investments	$ **2,708,876**	$ 2,368,709
Accounts Receivable	**288,790**	658,510
Receivable from Municipalities	**229,198**	5,134
Receivable from Province of Ontario		
Subtotal Current Assets	**3,226,864**	3,032,353
Financial Liabilities:		
Accounts Payable & Accrued Liabilities	**1,409,341**	1,490,132
Payable to Gov't of Ont/Municipalities	**121,456**	641,766
Deferred Revenue	**758,616**	664,615
Employee Future Benefit Obligations	**2,453,960**	2,453,960
Capital Lease Obligation	**0**	107,264
Term Loan	**6,173,490**	6,173,490
Subtotal Current Liabilities	**10,916,862**	11,531,227
Net Debt	**-7,689,998**	-8,498,874
Non-Financial Assets:		
Building	**22,732,421**	22,732,421
Furniture & Fixtures	**1,914,772**	1,914,772
Leasehold Improvements	**1,169,635**	1,169,635
IT	**3,029,040**	3,029,040
Automobile	**40,113**	40,113
Accumulated Depreciation	**-6,880,999**	-6,880,999
Subtotal Non-Financial Assets	**22,004,981**	22,004,981
Accumulated Surplus	**14,314,982**	13,506,107

Community Accountability Planning Submission - LHIN Managed
HSP Name : Board Of Health For The District of Algoma Health Unit
Budget 2017-18
TOTAL LHIN MANAGED FUNDING
Return to Main Page

LHIN Program: Revenue & Expenses	2016/17 Budget	2017/18 Budget	Comments
Revenue			
LHIN Global Base Allocation	$3,483,459	$3,567,135	
HBAM Funding (CCAC only)	$0	$0	
Quality-Based Procedures (CCAC only)	$0	$0	
MOHLTC Base Allocation	$0	$0	
MOHLTC Other funding envelopes	$0	$0	
LHIN One Time	$0	$0	
MOHLTC One Time	$0	$0	
Paymaster Flow Through (Row 80)	$0	$0	
Service Recipient Revenue	$0	$0	
Subtotal Revenue LHIN/MOHLTC	$3,483,459	$3,567,135	
Recoveries from External/Internal Sources	$0	$0	
Donations	$0	$0	
Other Funding Sources & Other Revenue	$4,220	$4,220	
Subtotal Other Revenues	$4,220	$4,220	
TOTAL REVENUE FUND TYPE 2	$3,487,679	$3,571,355	
EXPENSES			
Compensation			
Salaries (Worked hours + Benefit hours cost) (Row 92+103)	$2,487,677	$2,589,690	
Benefit Contributions (Row 93+104)	$621,920	$589,015	
Employee Future Benefit Compensation	$0	$0	
Physician Compensation (Row 130)	$0	$0	
Physician Assistant Compensation (Row 131)	$0	$0	
Nurse Practitioner Compensation (Row 132)	$0	$0	
Physiotherapist Compensation (Row 133)	$0	$0	
Chiropractor Compensation (Row 134)	$0	$0	
All Other Medical Staff Compensation (Row 135)	$0	$0	
Sessional Fees	$19,764	$19,440	
Service Costs			
Med/Surgical Supplies & Drugs	$0	$0	
Supplies & Sundry Expenses	$204,731	$221,858	
Community One Time Expense	$0	$0	
Equipment Expenses	$9,500	$5,000	
Amortization on Major Equip, Software License & Fees	$0	$0	
Contracted Out Expense	$27,537	$29,802	
Buildings & Grounds Expenses	$116,550	$116,550	
Building Amortization	$0	$0	
TOTAL EXPENSES FUND TYPE 2	$3,487,679	$3,571,355	
NET SURPLUS/(DEFICIT) FROM OPERATIONS	$0	$0	
Amortization - Grants/Donations Revenue	$0	$0	
SURPLUS/DEFICIT Incl. Amortization of Grants/Donations	$0	$0	

Financial Controls Checklist

Board of Health:	Board of Health for the District of Algoma Health Unit	Period ended:	Dec. 31/16

Objective:

- The objective of the Financial Controls Checklist is to provide the Board of Health and the Public Health Unit with a tool for evaluating financial controls while also promoting effective and efficient business practices.

Responsibilities:

- This checklist is for the management of the public health unit to document that controls have been implemented. The controls listed in the checklist are not meant to be exhaustive. Management of the public health unit should outline other key controls in place for achieving the control objectives. One must note that no effective financial control is achieved by signing the checklist. The control is achieved through carrying out the key controls themselves.
- The following table outlines the responsibilities for completing and using this Financial Controls Checklist.

Description of Responsibilities	Board of Health	Management of the Public Health Unit
• Completion of Financial Controls Checklist		✓
• Review and assessment of the completed Financial Controls Checklist	✓	✓
• Ongoing design of financial controls		✓
• Ongoing preparation of policies related to financial controls		✓
• Ongoing testing of financial controls		✓
• Ongoing monitoring of financial controls testing results	✓	✓
• Approval of key financial controls and related policies	✓	✓
• Implementation of financial controls		✓

Financial controls support the integrity of the Board of Health's financial statements, support the safeguarding of assets, and assist with the prevention and/or detection of significant errors including fraud. Effective financial controls provide reasonable assurance that financial transactions will include the following attributes:

- **Completeness** – all financial records are captured and included in the board of health's financial reports;
- **Accuracy** – the correct amounts are posted in the correct accounts;
- **Authorization** – the correct levels of authority (i.e. delegation of authority) are in place to approve payments and corrections including data entry and computer access;
- **Validity** – invoices received and paid are for work performed or products received and the transactions properly recorded;
- **Existence** –assets and liabilities and adequate documentation exists to support the item;
- **Error Handling** – errors are identified and corrected by appropriate individuals;
- **Segregation of Duties** –certain functions are kept separate to support the integrity of transactions and the financial statements; and,
- **Presentation and Disclosure** – timely preparation of financial reports in line with the approved accounting method (e.g., Generally Accepted Accounting Principles (GAAP)).

Control Objective	Controls / Description	Control Deficiency (If Any) And Potential Impact
1. Controls are in place to ensure that financial information is accurately and completely collected, recorded and reported.	**Please select (☒) any following controls that are relevant to your board of health:** ☒ Documented policies and procedures to provide a sense of the organization's direction and address its objectives. ☒ Define approval limits to authorize appropriate individuals to perform appropriate activities. ☒ Segregation of duties (e.g., ensure the same person is not responsible for ordering, recording and paying for purchases). ☒ An authorized chart of accounts. ☒ All accounts reconciled on a regular and timely basis. ☒ Access to accounts is appropriately restricted. ☒ Regular comparison of budgeted versus actual dollar spending and variance analysis. ☒ Exception reports and the timeliness to clear transactions. ☒ Electronic system controls, such as access authorization, valid date range test, dollar value limits and batch totals, are in place to ensure data integrity. ☒ Use of a capital asset ledger. ☒ Delegate appropriate staff with authority to approve journal entries and credits. ☒ Trial balances including all asset accounts that are prepared and reviewed by supervisors on a monthly basis. ☐ Other – (*Please specify*)	*List control deficiencies and their potential impact.* *What is the action plan to correct the identified control deficiencies? Who is responsible to action the items? When will they be actioned?*
2. Controls are in place to ensure that revenue receipts are collected and recorded on a timely basis.	**Please select (☒) any following controls that are relevant to your board of health:** ☒ Independent review of an aging accounts receivable report to ensure timely clearance of accounts receivable balances. ☒ Separate accounts receivable function from the cash receipts function. ☒ Accounts receivable sub-ledger is reconciled to the general ledger control account on a regular and timely basis. ☒ Original source documents are maintained and secured to support all receipts and expenditures. ☐ Other – (*Please specify*)	*List control deficiencies and their potential impact.* *What is the action plan to correct the identified control deficiencies? Who is responsible to action the items? When will they be actioned?*

Control Objective	Controls / Description	Control Deficiency (If Any) And Potential Impact
3. Controls are in place to ensure that goods and services procurement, payroll and employee expenses are processed correctly and in accordance with applicable policies and directives.	**Please select (☒) any following controls that are relevant to your board of health:** ☒ Policies are implemented to govern procurement of goods and services and expense reimbursement for employees and board members. ☒ Use appropriate procurement method to acquire goods and services in accordance with applicable policies and directives. ☒ Segregation of duties is used to apply the three way matching process (i.e. matching 1) purchase orders, with 2) packing slips, and with 3) invoices). ☒ Separate roles for setting up a vendor, approving payment and receiving goods. ☒ Separate roles for approving purchases and approving payment for purchases. ☒ Processes in place to take advantage of offered discounts. ☒ Monitoring of breaking down large dollar purchases into smaller invoices in an attempt to bypass approval limits. ☒ Accounts payable sub-ledger is reconciled to the general ledger control account on a regular and timely basis. ☒ Employee and Board member expenses are approved by appropriate individuals for reimbursement and are supported by itemized receipts. ☒ Original source documents are maintained and secured to support all receipts and expenditures. ☒ Regular monitoring to ensure compliance with applicable directives. ☒ Establish controls to prevent and detect duplicate payments. ☒ Policies are in place to govern the issue and use of credit cards, such as corporate, purchasing or travel cards, to employees and board members. . ☒ All credit card expenses are supported by original receipts, reviewed and approved by appropriate individuals in a timely manner. ☒ Separate payroll preparation, disbursement and distribution functions. ☐ Other – (*Please specify*)	*List control deficiencies and their potential impact.* *What is the action plan to correct the identified control deficiencies? Who is responsible to action the items? When will they be actioned?*

Control Objective	Controls / Description	Control Deficiency (If Any) And Potential Impact
4. Controls are place in the fund disbursement process to prevent and detect errors, omissions or fraud.	**Please select (☒) any following controls that are relevant to your board of health:** ☒ Policy in place to define dollar limit for paying cash versus cheque. ☒ Cheques are sequentially numbered and access is restricted to those with authorization to issue payments. ☒ All cancelled or void cheques are accounted for along with explanation for cancellation. ☒ Process is in place for accruing liabilities. ☒ Stale-dated cheques are followed up on and cleared on a timely basis. ☒ Bank statements and cancelled cheques are reviewed on a regular and timely basis by a person other than the person processing the cheques / payments. ☒ Bank reconciliations occur monthly for all accounts and are independently reviewed by someone other than the person authorized to sign cheques. ☐ Other – (*Please specify*)	*List control deficiencies and their potential impact.* *What is the action plan to correct the identified control deficiencies? Who is responsible to action the items? When will they be actioned?*

Prepared by : *Justin Pino, CFO* — *Position Title* **Date:** *January 19, 2017*

Approved by : *Marlene Spruyt, MOH/CEO* — *Medical Officer of Health/ Chief Executive Officer* **Date:** *January 19, 2017*

Received by the Board of Health at the board meeting held on: **Date:** *January, 25, 2017*

Algoma PUBLIC HEALTH
Santé publique Algoma

Briefing Note

www.algomapublichealth.com

To: Algoma Public Health Board of Health

From: Dr. Marlene Spruyt, MOH/CEO
Justin Pino, CFO

Date: January 25th, 2017

Re: 2017 Insurance Renewal

☐ For Information ☐ For Discussion ☒ For a Decision

ISSUE:

Algoma Public Health's (APH) is in the process of renewing the agency's insurance coverage. The terms of reference of APH's Finance & Audit Committee state that one of the duties of the Committee is to "review and ensure that all risk management is complete with respect to all insurance coverage for the board". As the first Finance & Audit Committee meeting of the board is not scheduled until February 8th and where the agencies insurance coverage is set to expire on February 14th, management decided to include the 2017 Insurance Renewal briefing note for the board to ensure no disruption in coverage. Policy Coverage will be reviewed by the Finance & Audit Committee at its scheduled February meeting. If the committee recommends any changes to coverage, the board will be advised at the February board meeting.

RECOMMENDED ACTION:

It is recommended that the Board of Health approve the 2017 Insurance coverage for APH.

BACKGROUND:

The 2017 Insurance Coverage is similar to 2016 with regards to limits of insurance. The main change being recommended by the insurer is a recommendation to increase the Limit of Liability for Directors' & Officers to $5,000,000 (currently $3,000,000). The additional annual premium is $3,928. Management is in support of this recommendation.

FINANCIAL IMPLICATIONS:

The financial commitment to renew insurance coverage for 2017 is approximately $88,305 (compared to $84,162 in 2016) plus an additional $3,928 for additional coverage related to increasing the limit of Liability for Directors" & Officers. The 2017 Operating Budget included insurance coverage at $95,000.

CONTACT:

J. Pino, Chief Financial Officer

November 25, 2016

The Ontario Public Health Standards Modernization Committee
Executive Steering Committee
c/o Jackie Wood
Director, Planning and Performance Branch
College Park, 19th Floor
777 Bay Street, Suite 1903
Toronto ON M7A 1S5

Dear Jackie Wood:

Re: 2016 Ontario Public Health Standards Modernization/Review

The Board of Health for the Grey Bruce Health Unit strongly recommends that the Ministry of Health and Long-Term Care, Population Health and Public Health Division adopt a "Health in all Policy" approach when reviewing the current Ontario Public Health Standards. This evidence-based approach will assist public health leaders to work across sectors to integrate considerations of health, well-being and equity during the development, implementation and evaluation of policies and services (Adelaide 2000).

Modernizing the Ontario Public Health Standards using a population health and Health in all Policy framework will optimize public health resources by supporting a cross-sectoral approach to program and service delivery. As an example, we recommend that the Standards for Child Health, Chronic Disease and Injury Prevention be prepared together in order to facilitate a lifespan approach to these important issues. The Grey Bruce Health Unit have had success moving in this direction at the local level and would welcome the opportunity to share our experiences.

Complex issues such as childhood obesity, substance misuse and falls across the lifespan require unique and strategic partnerships to support system development within our communities. The modernization of the Ontario Public Health Standards allows the opportunity to place Public Health in a leadership role for this important work.

Sincerely,

Kevin Eccles

Kevin Eccles
Chair, Board of Health

Cc: Paulina Salamo, MOHLTC
Ontario Boards of Health
Association of Local Public Health Agencies

The Corporation of the Township of Prince
3042 Second Line West,
PRINCE TOWNSHIP, ON P6A 6K4
Phone: 705-779-2992 Fax: 705-779-2725

COUNCIL RESOLUTION

Date: December 13, 2016 **AGENDA ITEM** 13 a)

Resolution 2016 – 356	
Moved by: Councillor	Seconded by: Councillor

Moved by: Councillor I. Chambers **Seconded by: Councillor E. Palumbo**

Be it resolved that this Council hereby supports Resolution 2016-94 of Board of Health for the District of Algoma Health Unit regarding the legalization, enforcement and regulation of cannabis; and

Further be **it resolved that** a copy of this resolution be sent to the Chief Medical Officer of Health for the Algoma Health Unit, Board of Health for the District of Algoma Health Unit and MPP Michael Mantha.

RESOLUTION RESULT				
✓	CARRIED	Mayor & Council	YES	NO
	DEFEATED	**Ken Lamming**		
	DEFERRED	**David Amadio**		
	REFERRED	**Ian Chambers**		
	PECUNIARY INTEREST DECLARED	**Michael Matthews**		
	RECORDED VOTE (SEE RIGHT)	**Enzo Palumbo**		
	WITHDRAWN			

MAYOR – Ken Lamming

The above is a certified to be true copy of resolution number 2016 –

Peggy Greco
CAO/CLERK-TREASURER

Northwestern Health Unit
www.nwhu.on.ca

NORTHWESTERN HEALTH UNIT
BRIEFING NOTE

Date: November 1, 2016

Prepared by: Dr. Kit Young Hoon, Medical Officer of Health, Northwestern Health Unit

Prepared for: Association of Local Public Health Agencies (alPHa) Board Meeting

Title: Association of Municipalities of Ontario and Alcohol Policy

Background

The Burden of Disease on Ontario

In Ontario, alcohol consumption is the second leading cause of death, disease and disability. Alcohol consumption results in substantial health and social costs to individuals, families, communities, and society as a whole. Long-term or excessive consumption increases the risk of health harms including cancer, hypertension, stroke, and disease of the liver, pancreas, stomach, heart, and nervous system. According to Cancer Care Ontario, an estimated 1,000 to 3,000 new cancer cases in Ontario in 2010 were attributed to alcohol consumption (2016 Prevention System Quality Index).

Provincial Policy

Government decisions on alcohol should take into the account health and safety of a population. Provincial policy changes that move towards more access to alcohol, while maintaining a lower price, do not take into account the harms associated with increased consumption of alcohol. There is strong evidence to support that an increase in availability of alcohol in a community leads to increased consumption and increased alcohol-related harms Two of the most effective policy options for reducing alcohol-related harms are pricing (as alcohol prices increase, demand declines, even for heavy drinkers), and restrictions on physical availability (government monopoly of retail sales, restrictions on retail outlet density, and limits on hours and days of sale are all associated with reductions in alcohol consumption and alcohol-related harm). Ontario has moved recently toward wider and more liberal access to alcohol. Changes to the way alcohol is distributed, sold and available in Ontario have been made to increase revenue through alcohol taxation, and to increase consumer convenience and choice (Ontario Public Health Association, 2015). These changes are counter to what we know about reducing alcohol-related harms.

Costs of alcohol misuse

Government decisions are informed by the net costs of alcohol to society. This can be defined as alcohol revenues minus the economic and social costs to individuals, families, communities, and society. According to the Canadian Centre on Substance Abuse, the economic cost of alcohol related harm across Canada is $14.6 billion per year. These costs include $7.1 billion for lost productivity owing to illness and premature death, $3.3 billion for direct health care costs and $3.1 billion for enforcement costs (Canadian Centre on Substance Abuse, 2016). Currently, the province receives $3 billion in dividends and taxation from alcohol sales, but the cost to taxpayers is estimated to be $5.3 billion. This is a significant yearly loss due to a single substance. These costs are incurred at every level, including direct health care, law enforcement, our judiciary system, our social system, lost productivity, and premature deaths. In Canada this amounts to an estimated $473 per year in cost to each and every Canadian due to alcohol (OPHA, 2015).

Current situation

A number of municipalities under the Association of Municipalities of Ontario (AMO) are working towards an advocacy effort to request that a proportion of the provincial tax revenues from alcohol sales be reallocated to municipalities. Within Northwestern Ontario, a significant percentage of municipal budgets are dedicated to policing and emergency service costs. Billing practices for police services for some municipalities are partially based on the number of times that the police are required to respond to a call (Ministry of Community Safety and Correctional Services, 2014). The OPP servicing Northwestern Ontario have identified alcohol misuse as a contributor to most of the calls for service.

Discussion

There are some potential opportunities and risks from a public health perspective from this municipal advocacy effort.

The social and health harms from alcohol is a common message that can be supported by both municipalities and local public health agencies and an important message to be highlighted for the provincial government. For the provincial government there may be a disconnect in their understanding of the health harms of alcohol sales as they receive the tax revenues of alcohol sales but do not pay all the social costs associated with alcohol consumption i.e. enforcement costs and emergency services.

If municipalities are successful in their advocacy effort to receive funding, they will benefit financially from the tax revenues and, like the provincial government, may support efforts to increase alcohol sales through increased convenience and availability of alcohol.

Possible next steps to utilize this opportunity and reduce the potential risks could include:

- Working with AMO in the development of their argument for the request for funding. Ensure that the argument highlights the health and social harms and costs of alcohol, the health and social harms of provincial policies, and the benefits of alcohol policies that reduce availability.
- Educate municipalities on public health considerations with respect to alcohol policy.
- Request that alcohol sales tax revenues to the province be used to fund public health efforts to prevent the misuse of alcohol, social costs of alcohol, treatment of alcohol addiction and health protection and injury prevention activities related to alcohol.

- Request that alcohol sales tax revenues to municipalities be used to fund prevention programming, in addition to police and emergency services.

References

Canadian Centre on Substance Abuse (CCSA), 2016. Retrieved from: http://www.ccsa.ca/Eng/topics/alcohol/Pages/default.aspx

Cancer Care Ontario, 2016, Prevention System Quality Index. Retrieved from: https://www.cancercare.on.ca/pcs/prevention/psqi/

Ontario Public Health Association (OPHA), 2015. *Alcohol Availability Advocacy Package.* Retrieved from email June 15, 2015.

Ministry of Community Safety and Correctional Services, 2014. *Backgrounder. New OPP Billing Model.* Accessible at https://news.ontario.ca/mcscs/en/2014/08/new-opp-billing-model.html

simcoe muskoka
DISTRICT HEALTH UNIT

December 15, 2016

The Honourable Dr. Eric Hoskins
Minister – Minister's Office
Ministry of Health and Long-Term Care
Hepburn Block, 10th Floor
80 Grosvenor St
Toronto, Ontario
M7A 2C4

Dear Minister Hoskins:

Re: Marijuana controls under Bill 178, Smoke-Free Ontario Amendment Act, 2016

On behalf of the Board of Health at the Simcoe Muskoka District Health Unit, I am writing to recommend the inclusion of marijuana (medicinal and recreational) as a prescribed product or substance under the auspices of Bill 178, Smoke-Free Ontario Amendment Act, 2016.

If not regulated appropriately, the likely legalization of marijuana and its use in Canada will be accompanied by significant population health risks particularly as it relates to early and frequent use with a focus on high risk groups such as youth, drivers, those at risk for addiction and mental health disorders, and pregnant and lactating women. There are many lessons that have been learned from successful implementation of comprehensive tobacco control in Ontario which can be transferred to the emerging issue of legal marijuana. This includes the coordination of prevention, cessation and protection policies which are designed to support each other, leading consistently to minimized risk and improved population health outcomes.

Bill 178, Smoke-Free Ontario Amendment Act, 2016 has received Royal Assent but has yet to come into force. It will allow for the Ontario legislature to prohibit the use of certain products and substances under the regulatory framework of the Smoke-Free Ontario Act. In particular, it will allow the legislature to prohibit the smoking of prescribed products or substances in all places where smoking tobacco is prohibited, in addition to certain other protections and requirements.

This legislation as enacted presents an opportunity to manage the emerging issue of legal marijuana use both medicinal and recreational, in our communities. The legislature has an opportunity to act expediently in the interest of public health to list marijuana as a prescribed product or substance under this act. In doing so, Ontario will be better positioned to reduce the harm that may accompany the legalization of marijuana including exposure to second-hand marijuana smoke or vapor whether medicinal or recreational and the significant problem of increased youth uptake if marijuana use is normalized by public use. Research has confirmed the presence of known carcinogens and other chemicals implicated in respiratory and cardiovascular diseases in the second-hand smoke of marijuana cigarettes. [1, 2] By prohibiting the smoking of all marijuana in all places where the smoking of tobacco is prohibited, children, youth and adults in our communities will have a much lower public and second-hand exposure to the use of marijuana.

❑ **Barrie:** 15 Sperling Drive, Barrie, ON, L4M 6K9, 705-721-7520, FAX: 705-721-1495
❑ **Collingwood:** 280 Pretty River Pkwy., Collingwood, ON, L9Y 4J5, 705-445-0804, FAX: 705-445-6498
❑ **Cookstown:** 2-25 King Street S., Cookstown, ON, L0L 1L0, 705-458-1103, FAX: 705-458-0105
❑ **Gravenhurst:** 2-5 Pineridge Gate, Gravenhurst, ON, P1P 1Z3, 705-684-9090, FAX: 705-684-9887
❑ **Huntsville**: 34 Chaffey St., Huntsville, ON, P1H 1K1, 705-789-8813, FAX: 705-789-7245
❑ **Midland:** B-865 Hugel Ave., Midland, ON, L4R 1X8, 705-526-9324, FAX: 705-526-1513
❑ **Orillia:** 120-169 Front St. S., Orillia, ON, L3V 4S8, 705-325-9565, FAX: 705-325-2091

The Board of Health commends the provincial government on amending the Smoke-Free Ontario Act to allow for wider protections. Time is of the essence in positioning the protections available under this amendment.

The inclusion of all marijuana under the act will demonstrate the province's forward thinking on this emerging issue and will put in place one piece of the regulatory framework necessary to prevent population health harms from legalized marijuana in Ontario. Should enforcement of the amendment fall in part to health units, it is critical that long-term funding accompany the initiative to support comprehensive harm reduction, cessation, protection and prevention measures to give health units the opportunity to succeed.

In addition, the Board of Health strongly urges the commencement of workplace and public protections as enacted under the Electronic Cigarettes Act for all the above reasons. The vaping of marijuana will be effectively prohibited in all places where smoking of tobacco is prohibited once all provisions of the Electronic Cigarettes Act come into force.

Thank you for the opportunity to voice our support for the changes outlined and we look to your continued strong leadership to protect and promote the health of Ontario residents.

Sincerely,

ORIGINAL SIGNED BY

Barry Ward
Chair, Board of Health

BW:HM:mk

c. Chief Medical Officer of Health of Ontario
Ontario Boards of Health
Association of Local Public Health Agency
Ontario Public Health Association
Local Members of Provincial Parliament in Simcoe Muskoka
Municipal Councils in Simcoe Muskoka

1. Moir D, Rickert WS, Levasseur G, Larose Y, Maertens R, White P, Desjardins S. A Comparison of Mainstream and Sidestream Marijuana and Tobacco Cigarette Smoke Produced under Two Machine Smoking Conditions. Chem Res Toxicol [serial online]. 2008; 21: 494–502 [Last accessed 2016 Dec 6]. Available from: http://pubs.acs.org/doi/pdfplus/10.1021/tx700275p

2. Wang X, Derakhshandeh R, Liu J, Nabavizadeh P, Le S, Danforth OM, Pinnamaneni K, Rodriguex HJ, Luu E, Sievers RE, Schick SF, Glantz SA, Springer ML. One Minute of Marijua Secondhand Smoke Exposure Substantially Impairs Vascular Endothelial Function. J Am Heart Assoc [serial online]. 2016; Jul 27: 5(8) [Last accessed 2016 Dec 7]. Available from: https://www.ncbi.nlm.nih.gov/pubmed/27464788

HURON
COUNTY

COPY

December 8, 2016
The Honourable Dr. Jane Philpott
Health Canada
70 Colombine Driveway
Tunney's Pasture
Ottawa, ON K1A 0K9
Jane.Philpott@parl.gc.ca

Dear Minister Philpott:

Re: Children's marketing restrictions, federal Healthy Eating Strategy, and support for Bill S-228 and Bill C-313

Our Board of Health writes this letter expressing support for the federal government's plan to consider marketing restrictions as part of their recently announced Healthy Eating Strategy. This issue requires prompt attention to support the health and well-being of our population. We applaud and offer our express support for the two current private member bills seeking to address this issue: Senator Green-Raine's private member bill, Bill S-228, which if passed, would prohibit the advertisement of food and beverages to children under the age of 13 years; and Peter Julian's private member bill C-313, National Strategy on Advertising to Children Act, which focuses on strategy about advertising to children and amending the Broadcasting Act.

Over the last 5 years, it has become clear that restrictions on marketing to children are warranted. Protecting children from exposure to commercial marketing empowers parents to instill healthy habits in their children. Research in this intervention has shown that effective marketing restrictions help prevent chronic health conditions and allow children to grow up without the negative influences that powerfully shape food and beverage choices. National polling has revealed broad population support for such interventions.

Peterborough Public Health said it well:
Young children cannot distinguish between truth and the claims of advertisement. Young children are still developing their palate and food preferences. Parents often complain that they feel powerless to fend off the food industry's well-funded and well positioned campaign to create a demand for their products. Ontario's schools have policies promoting healthy choices in foods and beverages, but leaving the nutritional protection of children up to schools is too little and too late. Clearly we need to do more to protect vulnerable children from the onslaught of marketing to allow families, schools and community agencies like public health to support these children in making healthy choices.

Huron County Health Unit
77722B London Road, RR 5, Clinton, ON N0M 1L0 CANADA
Tel: 519.482.3416 Confidential Fax: 519.482.9014 www.huronhealthunit.ca

We know:

- Canada has one of the highest rates of advertising to children compared to many other developed countries. There are many different types of advertising to children including television, product packaging, branding, social media and digital technology.
- Advertisers actively target children and youth.
- Children are particularly vulnerable to advertising due to their underdeveloped cognitive and critical thinking skills. It influences preferences, perceptions, purchase requests and consumption patterns. Even adults are highly susceptible to advertising power, though we'd like to believe we're not.
- Advertising to children is essentially misleading. In 1989, the Supreme Court of Canada concluded that "advertising directed at young children is per se manipulative."
- Food and beverage advertising is a known contributor to poor food environments, purchasing and eating behaviours, and the development of chronic disease.
- Canadians diets are not meeting recommendations for nutrition and health.
- There is significant evidence that Canada's current approach to marketing to kids (voluntary regulation) is not working.
- It should be our highest priority to create an environment that supports children to grow up healthy.
- Most major health promotion and public health bodies agree that addressing advertising to children is a top priority.

The Huron County Health Unit is committed to protecting the health and well-being of our residents. We strongly believe that the implementation of federal marketing restrictions, similar to those imposed in Quebec, as part of your recently announced Healthy Eating Strategy, will help to do so.

The Huron County Health Unit can add its voice to the growing concern about the impact of advertising for children with a letter of support for Bill S-228 and Bill C-313.

Sincerely,

Tyler Hessel
Chair, Huron County Board of Health

cc:

Ben Lobb, MP, Huron-Bruce
Lisa Thompson, MPP, Huron-Bruce
Association of Local Public Health Agencies
Ontario Boards of Health

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December 13, 2016

The Honourable Dr. Jane Philpott
Health Canada
70 Colombine Driveway, Tunney's Pasture
Ottawa, ON N1A 0K9

Dear Minister Philpott,

Re: Bill S-228, *An Act to amend the Food and Drugs Act (prohibiting food and beverage marketing directed at children)*

At its December 8, 2016 meeting, under Correspondence item b), the Middlesex-London Board of Health voted to endorse the following:

b) Date: 2016 November 04 (Received 2016 November 07)
Topic: Bill S-228, *An Act to amend the Food and Drugs Act (prohibiting food and beverage marketing directed at children)*
From: Rosana Salvaterra, Medical Officer of Health, Peterborough Public Health
To: Dr. Jane Philpott, Health Canada

Background:
Creating supportive environments for healthy food choices makes the healthier choice the easier choice. Many public health advocacy groups have recommended limitations on marketing that is targeted at children. Peterborough Public Health echoes the recommendations identified by the Healthy Kids Panel and wrote the Federal Minister of Health to support their plan to consider marketing restrictions.

The Board of Health received a report in March 2016 regarding the Impact of Sugar Sweetened Beverage and Creating Supportive Environments. At this meeting the Board of Health endorsed the Heart and Stroke Foundation's position statement that includes a wide range of recommendations one of which is a reduction in marketing to children.

It was moved by Mr. Meyer, seconded by Ms. Vanderheyden *that the Board of Health endorse correspondence item b)* Bill S-228, *An Act to amend the Food and Drugs Act (prohibiting food and beverage marketing directed at children)*

Carried

The Middlesex-London Board of Health is pleased to support plans to consider marketing restrictions as part of a comprehensive Healthy Eating Strategy.

Sincerely,

Jesse Helmer, Chair
Middlesex-London Board of Health

cc: Bev Shipley, MP, Lambton-Kent-Middlesex
Irene Mathyssen, MP, London-Fanshawe
Karen Vecchio, MP, Elgin-Middlesex-London
Kate Young, MP, London West
Peter Fragiskatos, MP, London North Centre
Association of Local Public Health Agencies, Ontario Boards of Health

Peterborough Public Health

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peterboroughpublichealth.ca

November 4, 2016

The Honourable Dr. Jane Philpott
Health Canada
70 Colombine Driveway
Tunney's Pasture
Ottawa, ON K1A 0K9
Jane.Philpott@parl.gc.ca

Dear Minister Philpott:

Re: Bill S-228, *An Act to amend the Food and Drugs Act (prohibiting food and beverage marketing directed at children)*

Our board of health passed a motion three years ago (November 13, 2013) supporting marketing restrictions to children. As an Ontario physician, you will remember that in 2012, the Ministry of Health and Long-Term Care assembled a group of experts from many different sectors and walks of life to advise the government on how best to achieve its goal of reducing childhood obesity. The Healthy Kids Panel's recommendations identified "Changing the Food Environment" as one of the three pillars of a strategy and the restriction of marketing to children was identified as one of the steps. We were happy to see that Ontario was willing to consider taking action, but changes to marketing would be more effective if implemented at the federal level.

Young children cannot distinguish between truth and the claims of advertisement. Young children are still developing their palate and food preferences. Parents often complain that they feel powerless to fend off the food industry`s well-funded and well positioned campaign to create a demand for their products. Ontario`s schools have policies promoting healthy choices in foods and beverages, but leaving the nutritional protection of children up to schools is too little and too late. Clearly we need to do more to protect vulnerable children from the onslaught of marketing to allow families, schools and community agencies like public health to support these children in making healthy choices.

I am writing on behalf of my board of health, to express our support for your government's plan to consider marketing restrictions, similar to those imposed in Quebec, as part of your recently announced Healthy Eating Strategy. Protecting children from exposure to commercial marketing supports parents to instill healthy habits in their children. Research in this intervention has shown that effective marketing restrictions can prevent a substantial part of childhood obesity and allow children to grow up without the negative influences that powerfully shape food and beverage choices. We understand that national polling has revealed broad population support for interventions that would place limits on the advertising of unhealthy food and beverages to children.

I am also writing to express my gratitude for your government's openness to review Senator Greene-Raine's private member bill, Bill S-228, which, if passed by both Houses, would prohibit the advertisement of foods and beverages to children under the age of 13 years.

Peterborough Public Health is committed to protecting the health and wellbeing of the children who live in our communities. We commend you and your government for having the courage to think and act upstream, in order to create a healthier environment for families to raise these children.

We will eagerly follow the progress of your strategy, and will do everything within our power to support your efforts.

Sincerely,

Original signed by

Rosana Salvaterra, MD, MSc, CCFP, FRCPC
Medical Officer of Health

/ag

cc: Maryam Monsef, MP, Peterborough-Kawartha
Kim Rudd, MP, Northumberland-Peterborough South
Jamie Schmale, MP, Haliburton-Kawartha Lakes-Brock
Association of Local Public Health Agencies
Ontario Boards of Health

DURHAM REGION

December 14, 2016

COPY

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

The Regional Municipality of Durham

Corporate Services Department
Legislative Services

605 ROSSLAND ROAD EAST
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Matthew L. Gaskell
Commissioner of
Corporate Services

RE: Memorandum from Dr. R. Kyle, Commissioner and Medical Officer of Health, re: Marketing of Food and Beverages to Children
Our File: P00

Honourable Sir, please be advised that Committee of the Whole of Regional Council considered the above matter and at a meeting held on December 14, 2016, Council adopted the following recommendations of the Committee:

"A) That the correspondence from Peterborough Public Health dated November 4, 2016 supporting the Government of Canada's intent to restrict the marketing of food and beverages to children be endorsed, and to consider Bill S-228; and

B) That the Prime Minister of Canada, Minister of Health, Durham's MPs, Chief Public Health Officer and all Ontario boards of health be so advised."

Please find enclosed a copy of the Memorandum from Dr. R. Kyle, Commissioner and Medical Officer of Health, for your information.

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

DW/np

Attach.

c: The Honourable Jane Philpott, Minister of Health
Mark Holland, MP (Ajax)
Erin O'Toole, MP (Durham)

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

Jamie Schmale MP
Kim Rudd, MP
Dr. Colin Carrie MP (Oshawa)
Jennifer O'Connell, MP (Pickering/Uxbridge)
Celina Caesar-Chavannes MP (Whitby)
Dr. David Williams, Chief Medical Officer of Health
Ontario Boards of Health
Dr. R. Kyle, Commissioner and Medical Officer of Health

DURHAM REGION

The Regional Municipality of Durham

HEALTH DEPARTMENT

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An Accredited Public Health Agency

MEMORANDUM

To: Committee of the Whole

From: Dr. Robert Kyle

Date: December 7, 2016

Re: Marketing of Food and Beverages to Children

On November 4, 2016, Peterborough Public Health forwarded the attached correspondence to all Ontario boards of health for support.

In essence, the correspondence supports the Government of Canada's intent to restrict the marketing of food and beverages to children and to this end, to consider Bill S-228. Supporting this element of Health Canada's Healthy Eating Strategy, is consistent with Regional Council's mandate, as Durham's board of health, to promote healthy eating and healthy public policy.

Accordingly, I recommend that the Committee of the Whole recommends to Regional Council that:

a) The correspondence from Peterborough Public Health as regards restrictions on the marketing of food and beverages to children is endorsed; and

b) The Prime Minister of Canada, Minister of Health, Durham's MPs, Chief Public Health Officer and all Ontario boards of health are so advised.

Respectfully submitted,

Original signed by

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

Peterborough Public Health

Jackson Square, **185 King Street**, Peterborough, ON K9J 2R8
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November 4, 2016

The Honourable Dr. Jane Philpott
Health Canada
70 Colombine Driveway
Tunney's Pasture
Ottawa, ON K1A 0K9
Jane.Philpott@parl.gc.ca

Dear Minister Philpott:

Re: Bill S-228, *An Act to amend the Food and Drugs Act (prohibiting food and beverage marketing directed at children)*

Our board of health passed a motion three years ago (November 13, 2013) supporting marketing restrictions to children. As an Ontario physician, you will remember that in 2012, the Ministry of Health and Long-Term Care assembled a group of experts from many different sectors and walks of life to advise the government on how best to achieve its goal of reducing childhood obesity. The Healthy Kids Panel's recommendations identified "Changing the Food Environment" as one of the three pillars of a strategy and the restriction of marketing to children was identified as one of the steps. We were happy to see that Ontario was willing to consider taking action, but changes to marketing would be more effective if implemented at the federal level.

Young children cannot distinguish between truth and the claims of advertisement. Young children are still developing their palate and food preferences. Parents often complain that they feel powerless to fend off the food industry's well-funded and well positioned campaign to create a demand for their products. Ontario's schools have policies promoting healthy choices in foods and beverages, but leaving the nutritional protection of children up to schools is too little and too late. Clearly we need to do more to protect vulnerable children from the onslaught of marketing to allow families, schools and community agencies like public health to support these children in making healthy choices.

I am writing on behalf of my board of health, to express our support for your government's plan to consider marketing restrictions, similar to those imposed in Quebec, as part of your recently announced Healthy Eating Strategy. Protecting children from exposure to commercial marketing supports parents to instill healthy habits in their children. Research in this intervention has shown that effective marketing restrictions can prevent a substantial part of childhood obesity and allow children to grow up without the negative influences that powerfully shape food and beverage choices. We understand that national polling has revealed broad population support for interventions that would place limits on the advertising of unhealthy food and beverages to children.

I am also writing to express my gratitude for your government's openness to review Senator Greene-Raine's private member bill, Bill S-228, which, if passed by both Houses, would prohibit the advertisement of foods and beverages to children under the age of 13 years.

Peterborough Public Health is committed to protecting the health and wellbeing of the children who live in our communities. We commend you and your government for having the courage to think and act upstream, in order to create a healthier environment for families to raise these children.

We will eagerly follow the progress of your strategy, and will do everything within our power to support your efforts.

Sincerely,

Original signed by

Rosana Salvaterra, MD, MSc, CCFP, FRCPC
Medical Officer of Health

/ag

cc: Maryam Monsef, MP, Peterborough-Kawartha
Kim Rudd, MP, Northumberland-Peterborough South
Jamie Schmale, MP, Haliburton-Kawartha Lakes-Brock
Association of Local Public Health Agencies
Ontario Boards of Health

Peterborough Public Health

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November 28, 2016

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

Dear Minister Hoskins,

RE: Bill 5 – *the Greater Access to Hepatitis C Treatment Act, 2016*

As you are no doubt aware, approximately 110,000 Ontarians are living with hepatitis C. Individuals can live with hepatitis C for many years without experiencing any symptoms, even though the disease slowly damages their liver. If left untreated, hepatitis C can lead to cirrhosis, liver cancer, and ultimately premature death.

Fortunately there is a cure for hepatitis C, with new treatments having demonstrated a 95 percent effectiveness rate in restoring individuals to health. While new treatments have shown great promise in curing individuals with hepatitis C, many individuals cannot access these highly effective treatments until they meet restrictive clinical criteria that require that an individual's liver be substantially damaged.

The Board of Health for Peterborough Public Health was pleased to hear about and supports MPP Sylvia Jones' private Member's bill, Bill 5 – *the Greater Access to Hepatitis C Treatment Act, 2016.* If adopted, MPP Jones' private Member's bill would ensure every individual in Ontario with hepatitis C will receive treatment upon the recommendation from their physician, no matter what stage their disease is in. If Bill 5 is adopted, an individual will no longer have to wait and let their liver further deteriorate before receiving lifesaving treatment.

The board of health hopes that your government will support the principle of treating at risk individuals before evidence of harm exists. A universal program, where physicians are able to access curative treatment for their patients based on their own assessments of readiness and suitability, would be far better than the current limited access that exists. Thank you for considering this policy change.

Yours in health,

Original signed by

Mayor Mary Smith
Acting Chair, Board of Health

/ag

cc: MPP Sylvia Jones, Dufferin-Caledon
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

North Bay Parry Sound District Health Unit
Bureau de santé du district de North Bay-Parry Sound
in your community . . . here for your health
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70 Joseph Street, Unit 302, Parry Sound, ON P2A 2G5 TEL 705.746.5801 FAX 705.746.2711
myhealthunit.ca TOLL FREE 1 800 563 2808

December 5, 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: Health Hazards of Gambling – BOH Resolution #BOH/2016/11/10

On November 30, 2016, at a meeting of the Board of Health for the North Bay Parry Sound District Health Unit, the Board approved the following motion #BOH/2016/11/10:

Whereas, *a casino development is likely to occur within the Nipissing region due to provincial gambling expansion, and*

Whereas, *gambling expansion has been identified as a significant public health issue in Ontario and internationally due to its links to the prevalence of problem gambling, and*

Whereas, *increased availability and accessibility of gambling, including new casinos or slot machines, is strongly associated with increases in the prevalence of problem gambling, and*

Whereas, *problem gambling has serious adverse health impacts on individuals, families and communities, and*

Whereas, *the impacts of problem gambling are not evenly distributed in the community - males, youth, older adults, Aboriginal peoples, individuals and families with low income are disproportionately affected, and*

Whereas, *an estimated 35 percent of Ontario gambling revenue is derived from people with moderate and severe gambling problems, and*

Whereas, *a broad range of policies and strategies that focus on prevention are needed to minimize the probability of problem gambling occurring and to reduce health and social impacts for problem gamblers and their families, and*

Whereas, *healthy gambling builds on the World Health Organization (WHO) definition of health and involves informed choice on the probability of winning, a pleasurable gambling experience in low-risk situations, and wagering in sensible amounts of money for sensible amounts of time.*

Now Therefore Be It Resolved, *the Board of Health endorse a North Bay Parry Sound District Health Unit Position Statement that:*

- *gambling expansion has adverse health impacts on individuals, families and communities, and*

- *a public health strategy of prevention and harm reduction be recommended, and*

Furthermore Be It Resolved, *the Board of Health recommend to municipalities within our district implementing gambling expansion initiatives that municipalities:*

- *collaborate with the Health Unit to develop and employ strategies as outlined herein that prevent or mitigate gambling-related harm and protect vulnerable populations at risk of gambling addiction, those least able to recover from the consequences of problem gambling, and*
- *to set aside an adequate portion of gambling revenues to:*
    - *undertake a baseline study to determine the prevalence of problem gambling within our community, and*
    - *undertake a future study to determine the impact of a local casino on problem gambling, and*
    - *establish a responsible and problem gambling program to help prevent and reduce the harmful impacts of excessive or uncontrolled gambling and which provides education, free support and treatment services.*

Furthermore Be It Resolved*, that the Board of Health for the North Bay Parry Sound District Health Unit provide correspondence of this resolution to member municipalities, Premier Kathleen Wynne, Deputy Premier Deb Matthews, the Honourable Dr. Eric Hoskins (Minister of Health and Long-Term Care), the Association of Local Public Health Agencies (alPHa) 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: Hon. Kathleen Wynne, Premier of Ontario
Hon. Deb Matthews, Deputy Premier of Ontario
Linda Stewart, Executive Director, Association of Local Public Health Agencies
Ontario Boards of Health

HURON
COUNTY

January 5, 2017

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

Dear Minister Hoskins:

Re: HPV/Immunizations Program Funding

On December 8, 2016 at a regular meeting of the Board of Health for the Huron County Health Unit, the board considered the attached correspondence from the Boards of Health for Grey Bruce, Peterborough and Algoma Health Units regarding the annual funding for the Vaccine Preventable Disease Program and the following motion was passed:

MOTION:
Moved by: Member Rognvaldson and Seconded by: Member Gowing
THAT:
The Huron County Board of Health endorses correspondence from the Peterborough Public Health Board of Health and Algoma Public Health Board of Health regarding the HPV/Immunization Program Funding.

CARRIED

Sincerely,

Tyler Hessel
Chair, Huron County Board of Health

cc:
Hon. Dr. Bob Bell, Deputy Minister, MOHLTC
Roselle Martino, Executive Director, MOHLTC
Dr. David Williams, Chief Medical Officer of Health, MOHLTC
Ben Lobb, MP, Huron-Bruce
Lisa Thompson, MPP, Huron-Bruce
Association of Local Public Health Agencies
Ontario Boards of Health

Encl.

Huron County Health Unit
77722B London Road, RR 5, Clinton, ON N0M 1L0 CANADA
Tel: 519.482.3416 Confidential Fax: 519.482.9014 www.huronhealthunit.ca

November 8, 2016

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

Dear Minister Hoskins:

Re: HPV/Immunization Program Funding

On October 28, 2016 at a regular meeting of the Board for the Grey Bruce Health Unit, the Board considered the attached correspondence from the Board of Health for Peterborough Public Health regarding the annual funding for the Vaccine Preventable Disease Program. The following motion was passed:

Motion No: 2016-97

Moved by: Arlene Wright **Seconded by: Mitch Twolan**

"THAT, the Board of Health for the Grey Bruce Health Unit endorse the correspondence from the Peterborough Public Health Board of Health regarding the HPV/Immunization Program Funding."

Carried

Sincerely,

Christine Kennedy

Christine Kennedy, MSc, MS, DPhil, MD, CCFP, FRCPC
Medical Officer of Health & CEO

Cc: Hon. Dr. Bob Bell, Deputy Minister, MOHLTC
Roselle Martino, Executive Director, MOHLTC
Dr. David Williams, Chief Medical Officer of Health, MOHLTC
Lisa Thompson, MPP Huron-Bruce
Bill Walker, MPP Bruce-Grey-Owen Sound
Jim Wilson, MPP Simcoe-Grey
Association of Local Public Health Agencies
All Ontario Boards of Health

Encl.

Peterborough Public Health

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

October 6, 2016

Hon. Dr. Eric Hoskins, MPP
Minister of Health and Long-Term Care
ehoskins.mpp.co@liberal.ola.org

Dear Minister Hoskins:

At the September 14, 2016 meeting of the Board of Health for Peterborough Public Health, a motion was passed to endorse the resolution shared by Algoma Public Health regarding "Changes to the HPV Immunization Programs". As this resolution clearly articulates, while expansion of public health delivery of expanded immunizations is a positive move for public health, the funding model for these expanded programs is inadequate. We, therefore join the Board of Algoma Public Health in urging the Ministry of Health and Long-Term Care (MOHLTC) to increase the annual funding for the Vaccine Preventable Disease Program to levels necessary to meet the mandate.

Public Health is the most appropriate agency to deliver vaccination programs to school-aged children. The expansion of the publicly funded human papillomavirus (HPV) vaccination program to boys in grade 7 will see a potential 154,000 additional students in Ontario receiving the benefits of this vaccine. The current model of funding for this program however, at $8.50 per dose, does not reflect the real cost of programs delivery. Calculations based on experience at Peterborough Public Health is that the real cost of supplies, needle disposal, nursing and clerical staff time are approximately $14.25 per dose. We are concerned that as the immunization programs expand, it will inevitably lead to the erosion of other important public health programs.

The Board of Health commends the MOHLTC for its commitment to effective immunization programs and the recognition for the role of Public Health in delivering it to students across the province. Please take the proposed actions to ensure adequate funding for full delivery. Thank you for your consideration.

Yours in health,

Original signed by

Scott McDonald
Chair, Board of Health

/ag
Encl.

cc: Hon. Dr. Bob Bell, Deputy Minister, MOHLTC
Roselle Martino, Executive Director, MOHLTC
Dr. David Williams, Chief Medical Officer of Health, MOHLTC
Jeff Leal, MPP, Peterborough
Laurie Scott, MPP, Haliburton-Kawartha Lakes-Brock
Association of Local Public Health Agencies
Ontario Boards of Health

Algoma
PUBLIC HEALTH
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www.algomapublichealth.com

May 31, 2016

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

Dear Minister Hoskins:

RE: Changes to the HPV Immunization Progra.

At its meeting on May 25, 2016, The Board of Health for the District of Algoma Health Unit carried the following resolution #2016-50.

WHEREAS Ontario is expanding the publicly funded human papillomavirus (HPV) vaccination program to include boys in Grade 7; and

WHEREAS Algoma Public Health supports the immunization of boys to help prevent the spread of HPV and prevent cancer; and

WHEREAS the HPV vaccine will continue to be provided to girls in Grade 8 for the transition year until all grade 7 students receive the vaccination; and

WHEREAS the Ministry estimates about 154,000 students will be eligible to receive the vaccine each year; and

WHEREAS APH, similar to other PHUs, plans to deliver the vaccination program over the course of three school visits in order to avoid giving more than two doses of vaccine per student per visit, which will increase the number of school clinics by approximately 33% (previously two visits per year); and

WHEREAS the Ministry of Health and Long-Term Care's (MOHLTC) Immunization 2020 Strategy strives to "reduce health risks related to vaccine-preventable diseases in the province"; and

WHEREAS the MOHLTC has not increased funding to the Vaccine Preventable Disease (VPD) program despite adding responsibilities and new vaccines to the program.

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Wawa
18 Ganley Street
Wawa, ON P0S 1K0
Tel: 705-856-7208
TF: 1 (888) 211-8074
Fax: 705-856-1752

THEREFORE BE IT RESOLVED THAT the Board of Health for Algoma Public Health commends the Ministry of Health and Long- Term Care for its commitment to expand its HPV vaccination program to young males who are starting grade 7 this September; and

FURTHERMORE BE IT RESOLVED THAT the Board of Health for Algoma Public Health urges the MOHLTC to consider increasing the annual funding for the VPD program in order to provide the staff resources to meet the above mandate.

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, Executive Director, Ministry of Health and Long-Term Care, Dr. David Williams, 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,

Lee Mason
Board of Health Chair

cc: The Honourable Dr. Bob Bell, Deputy Minister of Health and Long-Term Care
Roselle Martino, Executive Director, Ministry of Health and Long-Term Care
Dr. David Williams, Chief Medical Officer of Health
The Association of Local Public Health Agencies
Ontario Medical Officers of Health
Ontario Boards of Health
Member municipalities.

DURHAM REGION

November 10, 2016

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

COPY

The Regional Municipality of Durham

Corporate Services
Department
Legislative Services

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Matthew L. Gaskell
Commissioner of
Corporate Services

RE: Memorandum from Dr. R. Kyle, Commissioner and Medical Officer of Health, re: HPV Immunization Program
Our File: P00

Honourable Premier, please be advised that Committee of the Whole of Regional Council considered the above matter and at a meeting held on November 9, 2016, Council adopted the following recommendations of the Committee:

"A) That the correspondence from the Peterborough Public Health dated October 6, 2016 with respect to funding for the enhanced HPV Immunization Program be endorsed; and

B) That the Premier of Ontario, Ministers of Finance and Health and Long-Term Care, Durham MPPs, Chief Medical Officer of Health and all Ontario Boards of Health be so advised."

Please find enclosed a copy of the Memorandum from Dr. R. Kyle, Commissioner and Medical Officer of Health, for your information.

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

DW/np

Attach.

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

c: The Honourable Charles Sousa, Minister of Finance
The Honourable Eric Hoskins, Minister of Health and Long-Term Care
Joe Dickson, MPP (Ajax/Pickering)
Lorne Coe, MPP (Whitby/Oshawa)
The Honourable Tracy MacCharles, MPP (Pickering/Scarborough East)
Granville Anderson, MPP (Durham)
Jennifer French, MPP (Oshawa)
Laurie Scott, MPP (Haliburton/Kawartha Lakes/Brock)
Dr. David Williams, Chief Medical Officer of Health
Ontario Boards of Health
Dr. R. Kyle, Commissioner and Medical Officer of Health

DURHAM REGION

The Regional Municipality of Durham

HEALTH DEPARTMENT

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Whitby ON
Canada

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Fax: 905-666-6214
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An Accredited Public Health Agency

MEMORANDUM

To: Committee of the Whole

From: Dr. Robert Kyle

Date: November 2, 2016

Re: HPV Immunization Program

On October 6, 2016, Peterborough Public Health forwarded the appended correspondence to all Ontario boards of health for support (Appendix A).

In essence, the correspondence urges the Government of Ontario to increase funding for boards of health to implement the enhanced human papillomavirus (HPV) immunization program.

Support for this correspondence is consistent with Council's role as Durham's Board of Health to implement the enhanced HPV immunization program locally.

Accordingly, I recommend that the Committee of the Whole recommends to Regional Council that:

a) The correspondence from Peterborough Public Health as regards funding for the enhanced HPV immunization program is endorsed; and

b) The Premier of Ontario, Ministers of Finance and Health and Long-Term Care, Durham's MPPs, Chief Medical Officer of Health and all Ontario boards of health are so advised.

Respectfully submitted,

Original signed by

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

Peterborough Public Health

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

October 6, 2016

Hon. Dr. Eric Hoskins, MPP
Minister of Health and Long-Term Care
ehoskins.mpp.co@liberal.ola.org

Dear Minister Hoskins:

At the September 14, 2016 meeting of the Board of Health for Peterborough Public Health, a motion was passed to endorse the resolution shared by Algoma Public Health regarding "Changes to the HPV Immunization Programs". As this resolution clearly articulates, while expansion of public health delivery of expanded immunizations is a positive move for public health, the funding model for these expanded programs is inadequate. We, therefore join the Board of Algoma Public Health in urging the Ministry of Health and Long-Term Care (MOHLTC) to increase the annual funding for the Vaccine Preventable Disease Program to levels necessary to meet the mandate.

Public Health is the most appropriate agency to deliver vaccination programs to school-aged children. The expansion of the publicly funded human papillomavirus (HPV) vaccination program to boys in grade 7 will see a potential 154,000 additional students in Ontario receiving the benefits of this vaccine. The current model of funding for this program however, at $8.50 per dose, does not reflect the real cost of programs delivery. Calculations based on experience at Peterborough Public Health is that the real cost of supplies, needle disposal, nursing and clerical staff time are approximately $14.25 per dose. We are concerned that as the immunization programs expand, it will inevitably lead to the erosion of other important public health programs.

The Board of Health commends the MOHLTC for its commitment to effective immunization programs and the recognition for the role of Public Health in delivering it to students across the province. Please take the proposed actions to ensure adequate funding for full delivery. Thank you for your consideration.

Yours in health,

Original signed by

Scott McDonald
Chair, Board of Health

/ag
ncl.

cc: Hon. Dr. Bob Bell, Deputy Minister, MOHLTC
Roselle Martino, Executive Director, MOHLTC
Dr. David Williams, Chief Medical Officer of Health, MOHLTC
Jeff Leal, MPP, Peterborough
Laurie Scott, MPP, Haliburton-Kawartha Lakes-Brock
Association of Local Public Health Agencies
Ontario Boards of Health

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May 31, 2016

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

Dear Minister Hoskins:

RE: Changes to the HPV Immunization Progra.

At its meeting on May 25, 2016, The Board of Health for the District of Algoma Health Unit carried the following resolution #2016-50.

WHEREAS Ontario is expanding the publicly funded human papillomavirus (HPV) vaccination program to include boys in Grade 7; and

WHEREAS Algoma Public Health supports the immunization of boys to help prevent the spread of HPV and prevent cancer; and

WHEREAS the HPV vaccine will continue to be provided to girls in Grade 8 for the transition year until all grade 7 students receive the vaccination; and

WHEREAS the Ministry estimates about 154,000 students will be eligible to receive the vaccine each year; and

WHEREAS APH, similar to other PHUs, plans to deliver the vaccination program over the course of three school visits in order to avoid giving more than two doses of vaccine per student per visit, which will increase the number of school clinics by approximately 33% (previously two visits per year); and

WHEREAS the Ministry of Health and Long-Term Care's (MOHLTC) Immunization 2020 Strategy strives to "reduce health risks related to vaccine-preventable diseases in the province"; and

WHEREAS the MOHLTC has not increased funding to the Vaccine Preventable Disease (VPD) program despite adding responsibilities and new vaccines to the program.

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Wawa, ON P0S 1K0
Tel: 705-856-7208
TF: 1 (888) 211-8074
Fax: 705-856-1752

THEREFORE BE IT RESOLVED THAT the Board of Health for Algoma Public Health commends the Ministry of Health and Long- Term Care for its commitment to expand its HPV vaccination program to young males who are starting grade 7 this September; and

FURTHERMORE BE IT RESOLVED THAT the Board of Health for Algoma Public Health urges the MOHLTC to consider increasing the annual funding for the VPD program in order to provide the staff resources to meet the above mandate.

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, Executive Director, Ministry of Health and Long-Term Care, Dr. David Williams, 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,

Lee Mason
Board of Health Chair

cc: The Honourable Dr. Bob Bell, Deputy Minister of Health and Long-Term Care
Roselle Martino, Executive Director, Ministry of Health and Long-Term Care
Dr. David Williams, Chief Medical Officer of Health
The Association of Local Public Health Agencies
Ontario Medical Officers of Health
Ontario Boards of Health
Member municipalities.

November 10, 2016

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

COPY

RE: Memorandum from Dr. R. Kyle, Commissioner and Medical Officer of Health, re: Lyme Disease Our File: P00

Honourable Sir, please be advised that Committee of the Whole of Regional Council considered the above matter and at a meeting held on November 9, 2016, Council adopted the following recommendations of the Committee:

"A) That the correspondence from the Peterborough Public Health dated September 20, 2016 with respect to Lyme Disease be endorsed; and

B) That the Prime Minister of Canada, Federal Ministers of Finance and Health, Chief Public Health Officer, Durham's MPs, Premier of Ontario, Provincial Ministers of Finance and Health and Long-Term Care, Durham's MPPs, Chief Medical Officer of Health and all Ontario Boards of Health be so advised."

Please find enclosed a copy of the Memorandum from Dr. R. Kyle, Commissioner and Medical Officer of Health, for your information.

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

DW/np

Attach.

c: The Honourable William Francis Morneau, Minister of Finance
The Honourable Jane Philpott, Minister of Health
Dr. Gregory W. Taylor, Chief Public Health Officer

The Regional Municipality of Durham

Corporate Services Department
Legislative Services

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Matthew L. Gaskell
Commissioner of
Corporate Services

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

"Service Excellence for our Communities"

Mark Holland, MP (Ajax)
Mr. Erin O'Toole, MP (Durham)
Jamie Schmale MP
Kim Rudd, MP
Dr. Colin Carrie MP (Oshawa)
Jennifer O'Connell, MP (Pickering/Uxbridge)
Celina Caesar-Chavannes MP (Whitby)
The Honourable Kathleen Wynne, Premier
The Honourable Charles Sousa, Minister of Finance
The Honourable Eric Hoskins, Minister of Health and Long-Term Care
Joe Dickson, MPP (Ajax/Pickering)
Lorne Coe, MPP (Whitby/Oshawa)
The Honourable Tracy MacCharles, MPP (Pickering/Scarborough East)
Granville Anderson, MPP (Durham)
Jennifer French, MPP (Oshawa)
Laurie Scott, MPP (Haliburton/Kawartha Lakes/Brock)
Dr. David Williams, Chief Medical Officer of Health
Ontario Boards of Health
Dr. R. Kyle, Commissioner and Medical Officer of Health

DURHAM REGION

The Regional Municipality of Durham

HEALTH DEPARTMENT

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An Accredited Public Health Agency

MEMORANDUM

To: Committee of the Whole

From: Dr. Robert Kyle

Date: November 2, 2016

Re: Lyme Disease

On September 20, 2016, Peterborough Public Health forwarded the appended correspondence to all Ontario boards of health for support (Appendix A).

In essence, the correspondence urges the Governments of Canada and Ontario to increase the funding for the education, surveillance, diagnosis, treatment and research of Lyme disease in Ontario and Canada.

Support for this correspondence is consistent with Council's role as Durham's Board of Health to develop a local vector-borne management strategy, including tick surveillance and Lyme disease education and awareness, in accordance with the *Infectious Disease Protocol.*

Accordingly, I recommend that the Committee of the Whole recommends to Regional Council that:

a) The correspondence from Peterborough Public Health as regards funding for Lyme disease is endorsed; and

b) The Prime Minister of Canada, Ministers of Finance and Health, Chief Public Health Officer, Durham's MPs, Premier of Ontario, Ministers of Finance and Health and Long-Term Care, Durham's MPPs, Chief Medical Officer of Health and all Ontario boards of health are so advised.

Respectfully submitted,

Original signed by

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

Peterborough Public Health

Jackson Square, **185 King Street**, Peterborough, ON K9J 2R8
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peterboroughpublichealth.ca

September 20, 2016

The Honourable Dr. Jane Philpott
Health Canada
70 Colombine Driveway
Tunney's Pasture
Ottawa, ON K1A 0K9

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

Dear Honourable Ministers:

Re: Lyme Disease

At its meeting held on September 14, 2016, the Board of Health for Peterborough Public Health considered correspondence from Grey Bruce Health Unit and Niagara Region regarding the above noted matter.

In the past few years, Lyme disease (LD) has surpassed West Nile virus as the predominant vector-borne disease of concern in the province of Ontario. In the past six years, in Peterborough County and City, we have seen an increase in the number of tick submissions, with a corresponding increase in ticks that have tested positive for LD.

However, the current financial and human resources to continue with the increased public consultations on tick submissions are inadequate, and therefore, we are requesting that the Government of Canada and the Province of Ontario increase funding in the areas of research, treatment, surveillance and education for LD. For this reason, our board has endorsed the attached motions from our Ontario board of health colleagues.

The Board appreciates your attention to this important public health issue.

Yours in health,

Original signed by

Scott McDonald
Chair, Board of Health

/at
Encl.

cc: Hon. Kathleen Wynne, Premier of Ontario
Dr. David Williams, Chief Medical Officer of Health, MOHLTC

Maryam Monsef, MP, Peterborough-Kawartha
Kim Rudd, MP, Northumberland-Peterborough South
Jamie Schmale, MP, Haliburton-Kawartha Lakes-Brock
Jeff Leal, MPP, Peterborough
Laurie Scott, MPP, Haliburton-Kawartha Lakes-Brock
Association of Local Public Health Agencies
Ontario Boards of Health

June 2, 2016

The Honourable Dr. Jane Philpotts
Health Canada
70 Colombine Driveway
Tunney's Pasture
Ottawa, ON K1A 0K9

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

Dear Ministers:

Re: Lyme Disease

On May 27, 2016, the Board of Health for the Grey Bruce Health Unit passed the following resolution.

Resolution No: 2016-52

Moved by: Gary Levine **Seconded by: David Shearman**

WHEREAS, the blacklegged tick, Ixodes scapularis, is expanding into new areas of Ontario, and can carry the bacteria, Borrelia bugdorferi, which causes Lyme disease; and

WHEREAS, people who are infected with Borrelia burgdorferi, may develop Lyme disease which can cause long-term consequences if not treated properly;

NOW THEREFORE BE IT RESOLVED THAT the Board of Health for the Grey Bruce Health Unit requests the Province of Ontario to increase funding to enhance environmental surveillance for the tick;

AND FURTHER THAT the Province of Ontario monitor the pattern of spread of the tick and the rate of tick infection in various areas of the province;

AND FURTHER THAT the Province of Ontario develop control measures for the tick;

AND FURTHER THAT the Province of Ontario increase the education to the population regarding personal protection, property management, testing and treatment.

Carried

Sincerely,

Hazel Lynn MD, FCFP, MHSc
Medical Officer of Health

Cc: Hon, Jody Wilson-Raybould, Minister of Justice and Attorney General of Canada
Hon. Jane Philpott, Minister of Health
Hon. Kathleen Wynne, Premier of Ontario
Hon, Madeleine Meilleur, Attorney General for Canada
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
Dr. David Williams, Chief Medical Officer of Health (Interim)
Linda Stewart, Executive Director, Association of Local Public Health Agencies
Pegeen Walsh, Executive Director, Ontario Public Health Association
Dr. Catherine Zahn, President and CEO, Centre for Addiction and Mental Health
All Ontario Boards of Health

Encl.

Niagara Region

Administration
Office of the Regional Clerk
1815 Sir Isaac Brock Way, PO Box 1042, Thorold, ON L2V 4T7
Telephone: 905-685-4225 Toll-free: 1-800-263-7215 Fax: 905-687-4977
www.niagararegion.ca

May 9, 2016

The Honourable Dr. Jane Philpotts
Health Canada
70 Colombine Driveway
Tunney's Pasture
Ottawa, ON K1A 0K9

Sent via email:
hon.jane.philpott@canada.ca

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

Sent via email:
ehoskins.mpp@liberal.ola.org

RE: Lyme Disease
Minute Item 9.3, CL 6-2016, April 28, 2016

Dear Ministers:

Regional Council at its meeting held on April 28, 2016, passed the following resolution:

Whereas the number of cases of ticks positive for Lyme disease is increasing throughout Ontario and specifically in Niagara Region;

Whereas the laboratory testing for and diagnosis of Lyme disease is sub-optimal; and

Whereas there are chronic sufferers of long term consequences of this disease.

NOW THEREFORE BE IT RESOLVED:

1. That Niagara Region **REQUEST** the Province of Ontario to increase funding for research aimed to enhance the testing for Lyme disease;

2. That Niagara Region **REQUEST** the Government of Canada to increase funding for research aimed to enhance the testing for Lyme disease and determine better treatment for long term outcomes of Lyme disease;

3. That this resolution **BE FORWARDED** to all Municipalities in Ontario for their endorsement; and

4. That this resolution **BE FORWARDED** to the Premier of Ontario, the Minister of Health and local Members of Provincial Parliament.

.../2

Please do not hesitate to contact me should you have any questions.

Yours truly,

Ralph Walton
Regional Clerk

cc: The Honourable K. Wynne, Premier of Ontario *Sent via email:* kwynne.mpp@liberal.ola.org
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The Honourable R. Nicholson, MP (Niagara Falls) *Sent via email:* rob.nicholson@parl.gc.ca
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All Ontario Municipalities *Sent via email*

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

681 Commercial Street, North Bay, ON P1B 4E7 TEL: 705 474 1400
70 Joseph Street, Unit 302, Parry Sound, ON P2A 2G5 TEL: 705 746 5801

myhealthunit.ca
TOLL FREE: 1 800 563 2808

November 25, 2016

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

Hon. Helena Jaczek, MPP
Minister of Community and Social Services
6th Floor, Hepburn Block
80 Grosvenor Street
Toronto, ON M7A 1E9

Hon. Christopher Ballard, MPP
Minister of Housing, Poverty Reduction Strategy
17th Floor
777 Bay Street
Toronto, ON M5G 2E5

Dear Ministers:

Subject: The Cost of Healthy Eating 2016 – BOH Resolution #BOH/2016/11/06

I am writing to inform you of the resolutions passed on November 23, 2016 at the North Bay Parry Sound District Health Unit (NBPSDHU) Board of Health meeting. These resolutions focus on increasing household incomes in order to reduce food insecurity in Ontario.

According to the 2016 Nutritious Food Basket data, the cost of healthy eating for a family of four in the North Bay Parry Sound District is approximately $885 per month. When this cost along with local rent costs are considered in several income scenarios, it is clear that many households relying on social assistance or earning minimum wage do not have enough money to pay for the basic costs of living, including nutritious food. Our 2016 Cost of Healthy Eating Report and associated infographic include more information on these income scenarios and are included in this package for your reference.

Household food insecurity is defined as inadequate or insecure access to food because of financial constraints. Food insecurity is a serious public health problem that affected 11.9% of Ontario households in 2014. Adults who experience food insecurity have poorer self-rated health and are more likely to suffer from chronic conditions such as diabetes, heart disease and depression. Children who live in food insecure households have an increased risk of developing asthma and depression in adolescence and early adulthood.

The NBPSDHU Board of Health commended the Ontario government's efforts to implement a Basic Income Pilot, as a way to investigate whether a Basic Income can reduce poverty and have positive outcomes on health, housing and employment in Ontario.

The NBPSDHU Board of Health also supported Bill 6 (An Act to amend the Ministry of Community and Social Services Act to establish the Social Assistance Research Commission). This bill would help ensure social assistance rates reflect regional costs of living including the cost of a Nutritious Food Basket and other basic necessities. The NBPSDHU Board of Health recognizes the importance of increasing social assistance rates, as 64% of Ontario households who rely on social assistance experienced food insecurity in 2014.

The NBPSDHU Board of Health understands the importance of the Nutritious Food Basket Protocol and supported keeping it in the modernized Ontario Public Health Standards.

Thank you in advance for taking the time to review this information and please consider the resolutions passed by the NBPSDHU Board of Health.

***Whereas**, the Nutritious Food Basket Survey results show that many low income individuals and families do not have enough money for nutritious food after paying for housing and other basic living expenses,*

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

***Whereas**, the provincial government announced a Basic Income Pilot in the 2016 budget and are hosting a public Basic Income Pilot consultation until January 31, 2017,*

***Whereas**, Bill 6 (An Act to amend the Ministry of Community and Social Services Act to establish the Social Assistance Research Commission) would help ensure social assistance rates reflect regional costs of living including the cost of a Nutritious Food Basket and other basic necessities, are indexed to inflation and reviewed on an annual basis,*

***Whereas**, the Ontario Public Health Standards are currently undergoing a modernization and public health stakeholders are invited to provide feedback,*

***Now Therefore Be It Resolved,** that the Board of Health for the North Bay Parry Sound District Health Unit commend the provincial government on taking steps to investigate the basic income guarantee as a policy option for reducing poverty and food insecurity,*

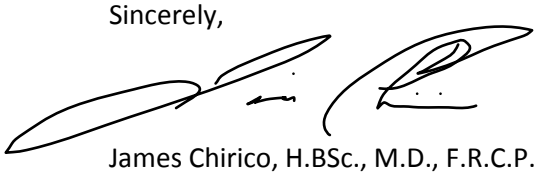
***Furthermore Be It Resolved,** that the Board of Health for the North Bay Parry Sound District Health Unit support Bill 6 (An Act to amend the Ministry of Community and Social Services Act to establish the Social Assistance Research Commission),*

***Furthermore Be It Resolved,** that the Board of Health for the North Bay Parry Sound District Health Unit support keeping the Nutritious Food Basket Protocol in the modernized Ontario Public Health Standards,*

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

***Furthermore Be It Resolved,** That the Board of Health for the North Bay Parry Sound District Health Unit provide correspondence of these resolutions to member municipalities, the Honourable Anthony Rota (Nipissing-Timiskaming), the Honourable Tony Clement (Parry Sound-Muskoka), Victor Fedeli, MPP (Nipissing), Norm Miller, MPP (Parry Sound-Muskoka), the Honourable Kathleen Wynne (Premier), the Honourable Deborah Matthews (Deputy Premier), the Honourable Helena Jaczek (Minister of Community and Social Services), the Honourable Dr. Eric Hoskins (Minister of Health and Long-Term Care) and the Honourable Christopher Ballard (Minister of Housing, Poverty Reduction Strategy), Ontario Boards of Health and the Association of Local Public Health Agencies (alPHa).*

Sincerely,



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

Attachments (2)

C: Hon. Anthony Rota, MP, Nipissing-Timiskaming
Hon. Tony Clement, MP, Parry Sound-Muskoka
Victor Fedeli, MPP, Nipissing
Norm Miller, MPP, Parry Sound-Muskoka
Hon. Kathleen Wynne, Premier of Ontario
Hon. Deb Matthews, Deputy Premier of Ontario
Ontario Boards of Health
Linda Stewart, Executive Director, Association of Local Public Health Agencies
Member Municipalities (31)

The 2016 Cost of Healthy Eating: North Bay Parry Sound District

What is the Nutritious Food Basket?

The Nutritious Food Basket is a provincial survey tool that is used to calculate the cost of a basic nutritious diet (Ministry of Health Promotion, 2010). Each year, the North Bay Parry Sound District Health Unit conducts the survey in 12 grocery stores across the district to price food items that represent a basic healthy diet according to Canada's Food Guide and Canadian purchasing patterns. The results of the Nutritious Food Basket survey are then compiled into the annual Cost of Healthy Eating Report.

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

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

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

In 2016, the cost for a family of four to eat a basic healthy diet for one week was $204.36 or $884.88 a month.

What is left after monthly rent and food costs?

- A 40 year old single man on Ontario Works with a total monthly income of $780.00 paying $550.00 per month in rent (which may or may not include heat and hydro) would need $297.42 to maintain the cost of a nutritious diet. This person would have no remaining income and would be in debt by $67.42 per month.
- A single man on Ontario disability support program with a total monthly income of $1,218.00 paying $720.00 per month in rent (which may or may not include heat and hydro) would need $297.42 to maintain the cost of a nutritious diet. This person would have $200.58 remaining per month.
- A family of four on Ontario Works with a total monthly income of $2,245.00 paying $1,131.00 per month in rent (which may or may not include heat and hydro) would need $884.88 to maintain the cost of a nutritious diet. This family would have $229.12 remaining per month.
- A single mother with a son and daughter on Ontario Works with a total monthly income of $2,034.00 paying $896.00 per month in rent (which may or may not include heat and hydro) would need $668.88 to maintain the cost of a nutritious diet. This family would have $469.12 remaining per month.
- A 75 year old single woman on an old age security/guaranteed annual income with a total monthly income of $1,574.00 paying $720.00 per month in rent (which may or may not include heat and hydro) would need $216.10 to maintain the cost of a nutritious diet. This person would have $637.90 remaining per month.

- A family of four with a full-time minimum wage earner with a total monthly income of $2,958.00 paying $1,131.00 per month in rent (which may or may not include heat and hydro) would need $884.88 to maintain the cost of a nutritious diet. This family would have $942.12 remaining per month.
- A family of four with the Ontario average income of $7,448.00 paying $1,131.00 per month in rent (which may or may not include heat and hydro) would need $884.88 to maintain the cost of a nutritious diet. This family would have $5,432.12 remaining per month.

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

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

Many costs including heat and hydro are much higher in Northern, rural communities. For instance, a recent report showed that Northern Ontario households spend 25% more on home energy costs than other regions of Ontario (Financial Accountability Office of Ontario, 2016). The burden is highest on rural households, who pay steep delivery charges (Hydro One, 2016).

Even with careful planning and budgeting, many low income families are unable to cover all of their necessary expenses and afford a basic healthy diet. When forced to decide, people pay for their fixed expenses like rent first and food becomes a 'flexible' part of the household budget and is compromised. People may worry about running out of food, fill up on less nutritious foods, or skip meals, resulting in poor diets (Tarasuk et al., 2016).

How does income impact health?

Household food insecurity is defined as inadequate or insecure access to food because of financial constraints (Tarasuk et al., 2016). Poverty is the root cause of food insecurity (OSNPPH, 2015).

Food insecurity greatly impacts health and wellbeing. Adults who are food insecure have poorer self-rated health and are more likely to suffer from chronic conditions such as diabetes, high blood pressure, heart disease, and depression. Children who experience food insecurity have an increased risk of developing asthma and depression in adolescence and early adulthood. In addition, being food insecure is strongly associated with being a high-cost health care user (Tarasuk et al., 2016).

Food insecurity in Ontario

In 2014, 11.9% of Ontario households were food insecure and 1 out of 6 children in Ontario experienced food insecurity (Tarasuk et al., 2016). Some households were at greater risk for food insecurity than the general population. These household characteristics include: having a low income, having children under the age of 18 (especially those headed by a lone parent), being an unattached individual, being Indigenous, being Black, being a newcomer to Canada, and renting rather than owning one's home (Dietitians of Canada, 2016).

The source of household income is also important. 58.9% of food insecure households in Ontario had income from employment. 64% of households reliant on social assistance experienced food insecurity (Tarasuk et al., 2016). These numbers show that current social assistance and minimum wage rates do not reflect the true costs of living.

What is the solution?

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

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

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

Encouraging News

In February 2016, the Ontario government announced their plan to implement a pilot of the basic income guarantee (Ministry of Finance, 2016). A basic income guarantee would ensure adequate income for all, regardless of work status (Basic Income Canada Network, 2016). In Canada, a successful example of a basic income guarantee is the Guaranteed Income Supplement for adults aged 65 years and older. Research shows that food insecurity rates drop by fifty per cent among low income people aged 65 to 69 compared to those 60 to 64 (OSNPPH Food Security Workgroup, 2015). In November 2016, the Honourable Hugh Segal submitted a discussion paper, *Finding a Better Way: A Basic Income Pilot for Ontario,* and the government announced a public Basic Income Pilot consultation (Ministry of Community and Social Services, 2016).

Bill 6, An Act to amend the Ministry of Community and Social Services Act to establish the Social Assistance Research Commission, was reintroduced in the Ontario legislature in September 2016 (Legislative Assembly of Ontario, 2016). This bill would establish an advisory group that would recommend social assistance rates each year for different regions of the province. The group's recommendation would be based on the actual costs of living including nutritious food, housing, utilities, transportation, telephone, internet access, and other basic necessities.

What can you do?

- Share these messages
    - Poverty is the root cause of food insecurity
    - Implement a basic income guarantee for all
    - Increase social assistance and minimum wage rates
    - Ensure health benefits for all
    - Strengthen employment standards to reduce unstable employment and improve working conditions
- Talk or write to your local MP and MPP
    - Share your support for the basic income guarantee and Bill 6
- Endorse your local food charter
    - Nipissing & Area Food Charter: www.nipissingareafood.ca
    - Parry Sound & Area Food Charter: https://parrysoundareafood.com

Additional Resources

- PROOF, Research to Identify Policy Options to Reduce Food Insecurity: http://proof.utoronto.ca/
- Basic Income Canada Network: http://www.basicincomecanada.org/about_basic_income
- Basic Income Pilot Consultation: https://www.ontario.ca/page/basic-income-pilot-consultation
- Ontario Society of Nutrition Professionals in Public Health – Position Statement on Responses to Food Insecurity: http://www.osnpph.on.ca/news/membership/news/osnpph-releases-position-statement-on-responses-to-food-insecurity
- Dietitians of Canada – www.dietitians.ca/foodinsecurity
- Call 705-474-1400 or 1-800-563-2808 and ask to speak with a Public Health Dietitian

References

Basic Income Canada Network. (2016). About basic income. Retrieved from http://www.basicincomecanada.org/about_basic_income

Dietitians of Canada. (2016). Executive summary addressing household food insecurity in Canada: Position statement and recommendations. Retrieved from http://www.dietitians.ca/Downloads/Public/HFI-Executive-Summary-Dietitians-of-Canada-FINAL.aspx

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The Cost of Healthy Eating

North Bay Parry Sound 2016

$885 Local monthly cost to feed a family of 4.

12% of Ontario households are food insecure

59% of food insecure households in Ontario have income from employment

Household food insecurity = Not enough money to buy healthy food

Higher rates of:

- Diabetes
- Heart disease
- Depression
- High blood pressure

In children, higher rates of:

- Asthma
- Depression later in life

What can you do?

Share these messages

- Poverty is the root cause of food insecurity
- Implement a basic income guarantee for all
- Increase social assistance and minimum wage rates
- Ensure health benefits for all
- Strengthen employment standards to reduce unstable employment and improve working conditions

Talk or write to your local MP and MPP

Sign your local food charter at:

www.nipissingareafood.ca
www.parrysoundareafood.com

What is left

after monthly rent and food costs?

Family of Four on Ontario Works	Individual on Ontario Works
$2,245 INCOME	$780 INCOME
- $1,131 RENT	- $550 RENT
- $885 FOOD	- $297 FOOD
+ $229 REMAINING	- $67 MINUS BALANCE

For heat, hydro, telephone, child care, transportation, clothing, out of pocket health costs etc.

Social assistance rates are inadequate

All people should have access to a nutritious, adequate and culturally appropriate diet

Learn more

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

North Bay Parry Sound District Health Unit

DURHAM REGION

The Regional Municipality of Durham

Corporate Services
Department
Legislative Services

605 ROSSLAND ROAD EAST
PO BOX 623
WHITBY, ON L1N 6A3
CANADA

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1-800-372-1102
Fax: 905-668-9963

www.durham.ca

Matthew L. Gaskell
Commissioner of
Corporate Services

December 14, 2016

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

COPY

RE: Memorandum from Dr. R. Kyle, Commissioner and Medical Officer of Health, re: Nutritious Food Basket
Our File: P00

Honourable Premier, please be advised that Committee of the Whole of Regional Council considered the above matter and at a meeting held on December 14, 2016, Council adopted the following recommendations of the Committee:

"A) That the correspondence from Peterborough Public Health urging the Government of Ontario to continue provincial monitoring of food insecurity rates, to participate in a pan-Canadian food security strategy as proposed by the Dietitians of Canada, and to use the costs of nutritious food basket (NFB) in setting social assistance rates be endorsed; and

B) That the Premier of Ontario, Ministers of Community and Social Services, Finance and Health and Long-Term Care, Durham's MPPs, Chief Medical Officer of Health and all Ontario boards of health be so advised."

Please find enclosed a copy of the Memorandum from Dr. R. Kyle, Commissioner and Medical Officer of Health, for your information.

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

DW/np

Attach.

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

c: The Honourable Helena Jaczek, Minister of Community and Social Services
The Honourable Charles Sousa, Minister of Finance
The Honourable Eric Hoskins, Minister of Health and Long-Term Care
Joe Dickson, MPP (Ajax/Pickering)
Lorne Coe, MPP (Whitby/Oshawa)
The Honourable Tracy MacCharles, MPP (Pickering/Scarborough East)
Granville Anderson, MPP (Durham)
Jennifer French, MPP (Oshawa)
Laurie Scott, MPP (Haliburton/Kawartha Lakes/Brock)
Dr. David Williams, Chief Medical Officer of Health
Ontario Boards of Health
Dr. R. Kyle, Commissioner and Medical Officer of Health

DURHAM REGION

The Regional Municipality of Durham

HEALTH DEPARTMENT

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An Accredited Public Health Agency

MEMORANDUM

To: Committee of the Whole

From: Dr. Robert Kyle

Date: December 7, 2016

Re: Nutritious Food Basket

On November 4, 2016, Peterborough Public Health forwarded the attached correspondence to all Ontario boards of health for support.

In essence, the correspondence urges the Government of Ontario to continue provincial monitoring of food insecurity rates, to participate in a pan-Canadian food security strategy as proposed by the Dietitians of Canada, and to use the costs of nutritious food basket (NFB) in setting social assistance rates.

Peterborough Public Health's 2016 NFB costing results mirror those in our *The Price of Eating Well in Durham Region 2016* (Council Information Package, Nov 18, 2016). Moreover, information on hunger in Durham Region has been posted on our YouTube channel: https://youtu.be/PrTBaVhhNCU. As a result, Regional Council, Durham's board of health, has endorsed similar resolutions in the past.

Accordingly, I recommend that the Committee of the Whole recommends to Regional Council that:

a) The correspondence from Peterborough Public Health as regards the nutritious food basket is endorsed; and

b) The Premier of Ontario, Ministers of Community and Social Services, Finance and Health and Long-Term Care, Durham's MPPs, Chief Medical Officer of Health and all Ontario boards of health are so advised.

The Commissioner of Social Services concurs with this recommendation.

Respectfully submitted,

Original signed by

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

Peterborough Public Health

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

November 4, 2016

Hon. Chris Ballard, MPP
Minister Responsible for the Poverty Reduction Strategy
cballard.mpp.co@liberal.ola.org

Hon. Dr. Eric Hoskins, MPP
Minister of Health and Long-Term Care
ehoskins.mpp.co@liberal.ola.org

Hon. Helena Jaczek, MPP
Minister of Community and Social Services
hjaczek.mpp@liberal.ola.org

Dear Honourable Ministers:

Re: Results of 2016 Nutritious Food Basket for Peterborough Public Health

We are writing to provide an update on food insecurity in our community. The results of the 2016 Nutritious Food Basket Costing for Peterborough Public Health was accepted at the October 12, 2016 Board of Health Meeting, and released to the public raising the concern that local poverty and food insecurity rates continue to rise. There is an urgent need to address the economic barriers that people living with low incomes experience in accessing nutritious food.

The cost of the Nutritious Food Basket in Peterborough City and County in May 2016 for a reference family of four (male between 31-50 years of age, female between 31-50 years of age, 14-year old boy, 8-year old girl) is $907 per month. This represents a 22% increase in food costs since 2010. Despite the increasing costs of food, the real issue is that incomes are too low and many individuals and families just do not have enough money to pay for their basic needs including shelter and healthy food. This issue poses serious health risks for our community. Of particular concern in our community are those who live on fixed incomes and the 23.6% of children under the age of 18 years who live in households reporting moderate and severe food insecurity.

A single mother with two children whose source of income is Ontario Works can expect 48% of her income to be required for rent. According to Canada Mortgage and Housing, housing is affordable when it costs 30% or less of monthly income. Based on the Nutritious Food Basket calculations, this family would need to spend 34% of total income to eat a nutritious diet. After this mother pays for shelter and a healthy diet, she has only $372 for all other monthly expenses. A single man receiving Ontario Works in Peterborough could expect 87% of their income to cover rental costs. In order to cover the costs of both shelter and a healthy diet, they would be in a deficit of $204 each month. It is clear that social assistance rates in Ontario do not reflect the actual costs of shelter and nutritious food. Access to a healthy diet can impact positively impact health.

We ask that you consider these real-life scenarios when considering decisions at the Cabinet table and within your Ministry that can impact food insecurity and the livelihoods and health of all Ontarians. In particular, we urge you to continue provincial monitoring of food insecurity rates through participation in the Canadian Community Health Survey Household Food Security Survey Module. We also request that the Ontario government participates in the development and implementation of a pan-Canadian government-led strategy that includes coordination of policies and programs to ensure all households have consistent and sufficient income to be able to pay for basic needs, including food. Both of these actions were proposed in the recent Dietitians of Canada Household Food Insecurity Reports.

We will be following the advancement of Bill 6: An Act to amend the Ministry of Community and Social Services Act to establish the Social Assistance Research Commission. We recommend that yearly Nutritious Food Costing, completed by Ontario's Public Health Agencies, be used to inform the process of determining Social Assistance Rates. We also look forward to seeing the Honourable Hugh Segal's discussion paper related to the design and implementation of a Basic Income Pilot for Ontario.

Yours in health,

Original signed by

Scott McDonald
Chair, Board of Health

/ag

cc: Dr. David Williams, Chief Medical Officer of Health, MOHLTC
Jeff Leal, MPP, Peterborough
Laurie Scott, MPP, Haliburton-Kawartha Lakes-Brock
Association of Local Public Health Agencies
Ontario Boards of Health

Sudbury & District
Health Unit
Service de santé publique

Make it a Healthy Day!

Visez Santé dès aujourd'hui!

Sudbury
1300 rue Paris Street
Sudbury ON P3E 3A3
☎ :705.522.9200
🖷 : 705.522.5182

Rainbow Centre
10 rue Elm Street
Unit / Unité 130
Sudbury ON P3C 5N3
☎ : 705.522.9200
🖷 : 705.677.9611

Chapleau
101 rue Pine Street E
Box / Boîte 485
Chapleau ON P0M 1K0
☎ : 705.860.9200
🖷 : 705.864.0820

Espanola
800 rue Centre Street
Unit / Unité 100 C
Espanola ON P5E 1J3
☎ : 705.222.9202
🖷 : 705.869.5583

Île Manitoulin Island
6163 Highway / Route 542
Box / Boîte 87
Mindemoya ON P0P 1S0
☎ : 705.370.9200
🖷 : 705.377.5580

Sudbury East / Sudbury-Est
1 rue King Street
Box / Boîte 58
St.-Charles ON P0M 2W0
☎ : 705.222.9201
🖷 : 705.867.0474

Toll-free / Sans frais
1.866.522.9200

www.sdhu.com

November 17, 2016

VIA ELECTRONIC MAIL

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

Dear Premier Wynne:

Re: Nutritious Food Basket 2016

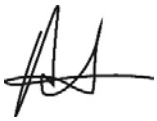
At its meeting on October 20, 2016, the Sudbury & District Board of Health carried the following resolution #50-16:

> *WHEREAS* the Sudbury & District Board of Health has monitored the cost of healthy eating on an annual basis in accordance with the Nutritious Food Basket Protocol and the Population Health Assessment and Surveillance Protocol per the 2008 Ontario Public Health Standards; and
>
> *WHEREAS* the 2016 costing results continue to demonstrate that individuals and families living on low incomes cannot afford food after paying for housing and other necessities and therefore may be at risk for food insecurity; and
>
> *WHEREAS*, within the 2016 Budget, the provincial government announced a Basic Income Pilot and has appointed the Honourable Hugh Segal to provide advice on the design and implementation of a Basic Income Pilot through a discussion paper to be delivered to the province by the fall;
>
> *THEREFORE BE IT RESOLVED THAT* the Sudbury & District Board of Health commend the provincial government on taking steps to investigate basic income guarantee as a policy option for reducing poverty; and
>
> *THAT* social assistance rates be increased to reflect the actual cost of nutritious food and adequate housing as informed by the current results of the Ministry of Health and Long-Term Care's Nutritious Food Basket and the Canada Mortgage and Housing Corporation Rental Income (Ontario) reports; and
>
> *FURTHER THAT* the Sudbury & District Board of Health share this motion and supporting materials with community agencies, boards, municipalities, elected representatives and others as appropriate throughout the SDHU catchment area.

Food insecurity is inadequate or insecure access to food because of financial constraints and has serious public health implications. It is well understood that health care costs increase as the severity of food insecurity increases. Health care costs for households experiencing severe food insecurity are 121% higher compared with total annual health care costs in food secure households[1]. Further, social assistance recipients are particularly vulnerable to food insecurity. In Ontario, 64.0% of the households reliant on social assistance experienced food insecurity[2]. A basic income guarantee has the potential to eliminate poverty and food insecurity.

The Board of Health commends the provincial government for pursuing the potential for a basic income guarantee in Ontario. We would note that an increase in social assistance rates in the meantime would be important to improve health equity across Ontario.

Thank you for your attention to this important health matter,



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

Enclosures: 2016 Nutritious Food Basket Scenarios (English and French)

cc: The Honourable Eric Hoskins, Minister of Health and Long-Term Care
The Honourable Helena Jaczek, Minister of Community and Social Services
Dr. David Williams, Chief Medical Officer of Health
Dr. Gregory Taylor, Chief Public Health Officer
Linda Stewart, Executive Director, Association of Local Public Health Agencies
Pegeen Walsh, Executive Director, Ontario Public Health Association
Louise Paquette, Chief Executive Officer, North East LHIN
Fern Dominelli, Chief Administrative Officer, Manitoulin-Sudbury District Services Board
Joseph Leblanc, Executive Director, Social Planning Council of Sudbury
Kristin Bickell, Child Poverty Task Force, Manitoulin Island

1. Tarasuk V, Cheng J, Oliveria C, Dachner N, Gundersen C, Kurdyak P. Association between household food insecurity and annual health care costs. Canadian Medical Association Journal. 2015; 1-8. Doi:10.1503/cmaj.150234

2. Tarasuk V, Mitchell A, Dachner N. (2016). Household food insecurity in Canada, 2014.Toronto: Research to identify policy options to reduce food insecurity (PROOF).Retrieved from http://proof.utoronto.ca/

2016 NUTRITIOUS FOOD BASKET SCENARIOS

	Households with children				Single person households		
	Scenario 1	Scenario 2	Scenario 3	Scenario 4	Scenario 5	Scenario 6	Scenario 7
Scenarios[a]	 Ontario Works	 Minimum Wage Earner	 Median Ontario Income	 Ontario Works	 Ontario Works	 ODSP	 Senior OAS / GIS
	Income						
Total Monthly Income (after tax)	$2,245	$2,958	$7,448	$2,034	$780	$1,218	$1,574
	Expenses						
	3 Bedroom			2 Bedroom	Bachelor	1 Bedroom	
Monthly Rent (may include heat/hydro)[b]	$1,114	$1,114	$1,114	$953	$610	$771	$771
Food[c]	$889	$889	$889	$672	$299	$299	$216
	Funds remaining for other basic needs						
	$242	**$955**	**$5,445**	**$409**	**($129)**	**$148**	**$587**
% of Income Required for Rent	50%	38%	15%	47%	78%	63%	49%
% of Income Required to Purchase Healthy Food	40%	30%	12%	33%	38%	25%	14%

a - As applicable, all scenarios are based on the following:
1 male adult, 1 female adult, 1 girl, 1 boy, 1 female older adult

b - Rental costs calculations are from the Rental Market Report: Ontario Highlights. Canada Mortgage and Housing Corporation, Fall 2015.
www.cmhc-schl.gc.ca/odpub/esub/64507/64507_2015_B02.pdf

c - Reference: Nutritious Food Basket Data Results 2016 for the Sudbury & District Health Unit – Includes Household Size Adjustment Factors.

For more information, please call 705.522.9200, ext. 257.

Ce document est disponible en français.

Make it a Healthy Day!
Sudbury & District Health Unit
Service de santé publique de Sudbury et du district

Attention: Registrar
College of Physicians and Surgeons of Ontario
80 College Street
Toronto, Ontario
M5G 2E2

December 8, 2016

Re: Opioid Addiction and Overdose

Dear Registrar,

I noted with interest your articles in the most recent issue of Dialogue Magazine. With the expanding availability of naloxone in Ontario, there seems to be an opportunity and perhaps an imperative for physicians to be speaking about the risks of opioids with their patients, and also ensuring that each patient who uses opioids has access to naloxone.

The risk of overdose is high and climbing, and is not limited to those who use opioids recreationally. People who are legally prescribed these medications and their families are at risk as well. Actions to address overdose should include focusing on better informing Canadians about the risks of opioids, supporting better prescription practices, reducing easy access to unnecessary opioids, supporting better treatment options, and improving the national evidence base. It is imperative to ensure that Ontario health care providers have the tools, resources and information necessary to provide the highest-quality care to patients.

As the Medical Officer of Health for Middlesex and London, I brought this issue to the November 17, 2016 meeting of the Middlesex-London Board of Health. The Board voted unanimously to endorse Report No. 062-16 re: "Opioid Addiction and Overdose" and the recommendations contained within this report, which included contacting CPSO to ask for guidance to enhance counselling around opioid risks and prescription of naloxone to each patient using opioids.

Patients look to their health care providers for leadership and guidance. Improved access to naloxone for all patients who are prescribed opioids will help decrease the life-threatening risks associated with overdose. Regulatory changes which include making naloxone more easily available will provide a greater opportunity to ensure that opioid users have access to it when needed.

Would you consider issuing guidance that Ontario physicians have a conversation with each patient that receives opioids about the risk of both addiction and overdose for themselves and their families, and also prescribing naloxone to have in the home of each such patient?

I look forward to a follow up meeting with you to further discuss this recommendation.

Sincerely,

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

cc: Dr. David Williams, Chief Medical Officer of Health, Ministry of Health and Long-Term Care
Association of Local Public Health Agencies, All Health Units

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 062-16

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2016 November 17

OPIOID ADDICTION AND OVERDOSE

Recommendation

It is recommended that the Board of Health

1. ***Endorse Report No. 062-16 Re: "Opioid Addiction and Overdose" and***
2. ***Recommend to The College of Physician and Surgeons of Ontario (CPSO) that when prescribing opiates, patients should also be prescribed and counselled on use of naloxone to help prevent potentially fatal complications associated with opioid overdose.***

Key Points

- Between 2010 and 2014, the number of prescription opioids legally dispensed in Canada climbed almost 24 percent. More than 21.7 million prescriptions for opioids were dispensed last year in Canada.
- Opioid misuse is the third leading cause of accidental death in Ontario.
- Improved access to naloxone for all patients prescribed opioids is recommended to decrease life-threatening risks associated with overdose. Regulatory changes making naloxone more easily available mean there is greater opportunity to ensure that opioid users have it available if needed.

Background

Narcotic pain medications, also known as opioids, are prescribed by physicians for the treatment of pain and their distribution is tightly regulated through the Controlled Drug and Substances Act. Between 2010 and 2014, the number of prescription opioids legally dispensed in Canada climbed almost 24 percent with more than 21.7 million prescriptions dispensed last year. However, opioid misuse is the third leading cause of accidental death in Ontario.

An overdose of opioid drugs - such as fentanyl, morphine, heroin, methadone or oxycodone - can cause a person's breathing to slow or stop. Naloxone is a medication that can temporarily reverse this effect so that the person can breathe more normally and potentially regain consciousness. Timely administration of naloxone can provide precious time to seek emergency medical attention and treat the overdose.

Beginning in June 2014, emergency naloxone kits and training have been made available to people who inject drugs in Middlesex-London as a harm-reduction response to overdoses occurring in the community attributed to the recreational use of opioids. To ensure accessibility, client training and naloxone kit distribution is provided through several locations including the Needle Syringe Program at the Health Unit, Needle Syringe Program at the Regional HIV / Aids Connection and Hepatitis C Program at the London Intercommunity Health Centre.

Since implementation, there have been 163 people trained and provided with naloxone kits. These kits have been used in 13 successful resuscitations. Further to the resuscitations associated with naloxone kit use, Emergency Medical Services (EMS) in London-Middlesex administered 47 doses of naloxone last year and 31 doses as of October this year when responding to 9-1-1 calls for overdoses.

Recent Regulatory Changes

Last month, in recognition that opioid addiction and overdose is a serious public health concern, the Ministry of Health lifted restrictions on who could be provided with naloxone kits and allowed for sites that provide naloxone kits to begin training and providing kits to friends and family members, as well. Previously, the kits were available only to those who were at risk for overdose and were also clients of the needle exchange or Hepatitis C programs.

In response to calls from Ontario and other provinces and territories for Health Canada to remove the prescription status of naloxone, the National Association of Pharmacy Regulatory Authorities (NAPRA) also recently reclassified naloxone as a Schedule II drug when used in an emergency opioid overdose situation outside of hospital settings. This change was effective immediately in Ontario. As a result, naloxone can now be kept behind the counter in Ontario pharmacies and dispensed without a prescription or charge to those who are at risk of an overdose (as well as their concerned family members or peers). Additionally, pharmacists are able to provide training on how to safely administer the drug. There are currently forty-nine pharmacies in Middlesex-London that can dispense naloxone.

Next Steps

The Minister of Health has announced a comprehensive strategy to address opioid misuse and addictions. Risk of overdose is not limited to those who use opioids recreationally, but the risk is also quite present to those who are legally prescribed these medications. Actions will be focused on better informing Canadians about the risks of opioids, supporting better prescribing practices, reducing easy access to unnecessary opioids, supporting better treatment options, and improving the national evidence base. Part of this strategy aims to ensure Ontario health care providers have the tools, resources and information needed to provide the highest-quality care to patients. Patients look to their health care providers for leadership and guidance.

As part of the strategy, we believe it would be helpful for the Board of Health to recommend to the CPSO that, as a matter of best practice when physicians are prescribing opiates, they also provide the patient with a prescription for and information about how to access and use naloxone.

This report was prepared by Shaya Dhinsa, Manager of Sexual Health.

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

Office of the County Warden
789 Broadway Street, Box 3000
Wyoming, ON N0N 1T0

Telephone: 519-845-0801
Toll-free: 1-866-324-6912
Fax: 519-845-3160

December 8, 2016

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

Dear Minister Hoskins:

Re: Access to Publicly Funded
Oral Health Programs for Low-Income Adults and Seniors

During its meeting on November 2, 2016, Lambton County Council (which serves as the County of Lambton Board of Health) accepted a report from Lambton Public Health regarding Access to Publicly Funded Oral Health Programs for Low-Income Adults and Seniors.

In January 2016, the Healthy Smiles Ontario public oral health program for children was expanded to help all low-income children, regardless of any coverage under employer-sponsored dental insurance. However, the expansion did not address the barriers to accessing dental care experienced by working poor adults and seniors. These cohorts are often ineligible for Ontario Works or the Ontario Disability Support Program and are without employer-sponsored dental benefits. These marginalized adults and seniors find they cannot afford to access dental care at the best of times. Often they must choose between paying for living expenses such as rent, utilities, or groceries, and paying for their oral health.

Lambton County Council recognizes the effects of poor oral health on general health as well as the impacts that extend beyond medical concerns. Unchecked, oral disease may lead to pain and infection which can spread throughout the body. Poor oral health can affect employability, work attendance and performance, self-esteem, and social relationships.

Oral health issues are not covered under universal healthcare through the Ontario Health Insurance Program. For low-income adults or seniors who are less likely to have employer-sponsored dental benefits and are more likely to report poor oral health, the cost of dental care is prohibitive. Typically when an adult or senior cannot afford to visit a dentist for pain and infection in their mouth they often end up visiting the emergency

room, or their family doctor instead. At these visits they will receive a course of antibiotics and pain medications which do not address the true cause of the problem. This only provides a temporary solution often resulting in repeat emergency room visits to defer the pain. In 2016, the Association of Ontario Health Centres reported over 60,000 visits to emergency rooms resulting in an estimated $31 million for costs directly related to oral health issues. In 2014, the Erie St. Clair Local Health Integration Network region had 3,160 emergency room visits due to oral health issues.

The Provincial Government has promised to extend oral health programs starting in 2025. However, nine years is too long to wait to address the current demand in low-income adults and seniors. In response to this delayed action, Lambton County Council calls on the Province to accelerate its promise to expand oral health programming for low-income adults and seniors starting within the next two years.

Sincerely,

Warden Bill Weber
County of Lambton (Board of Health)

cc: Bob Bailey, MPP, Sarnia-Lambton
Monte McNaughton, MPP, Lambton-Kent-Middlesex
Linda Stewart, Executive Director, Association of Local Public Health Agencies
Ontario Boards of Health
Dr. Sudit Ranade, Medical Officer of Health
Andrew Taylor, General Manager, Public Health Services Division

DURHAM REGION

December 14, 2016

COPY

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

The Regional Municipality of Durham

Corporate Services Department
Legislative Services

605 ROSSLAND ROAD EAST
PO BOX 623
WHITBY, ON L1N 6A3
CANADA

905-668-7711
1-800-372-1102
Fax: 905-668-9963

www.durham.ca

Matthew L. Gaskell
Commissioner of
Corporate Services

RE: Memorandum from Dr. R. Kyle, Commissioner and Medical Officer of Health, re: Student Nutrition Programs
Our File: P00

Honourable Sir, please be advised that Committee of the Whole of Regional Council considered the above matter and at a meeting held on December 14, 2016, Council adopted the following recommendations of the Committee:

"A) That the correspondence from Peterborough Public Health dated September 30, 2016 urging the Governments of Canada and Ontario to provide student nutrition programs with enhanced and stable funding to meet the needs of all elementary and secondary students in Ontario be endorsed; and

B) That the Prime Minister of Canada, Ministers of Families, Children and Social Development, Health and Finance, Durham's MPs, Premier of Ontario, Ministers of Children and Youth Services, Education, Finance and Health and Long-Term Care, Durham's MPPs, Chief Medical Officer of Health and all Ontario boards of health be so advised."

Please find enclosed a copy of the Memorandum from Dr. R. Kyle, Commissioner and Medical Officer of Health, for your information.

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

DW/np

Attach.

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

c: The Honourable Jean-Yves Duclos, Minister of Families, Children and Social Development
The Honourable Jane Philpott, Minister of Health
The Honourable William Francis Morneau, Minister of Finance
Mark Holland, MP (Ajax)
Erin O'Toole, MP (Durham)
Jamie Schmale MP
Kim Rudd, MP
Dr. Colin Carrie MP (Oshawa)
Jennifer O'Connell, MP (Pickering/Uxbridge)
Celina Caesar-Chavannes MP (Whitby)
The Honourable Kathleen Wynne, Premier
The Honourable Michael Coteau, Minister of Children and Youth Services
The Honourable Mitzie Hunter, Minister of Education
The Honourable Charles Sousa, Minister of Finance
The Honourable Eric Hoskins, Minister of Health and Long-Term Care
Joe Dickson, MPP (Ajax/Pickering)
Lorne Coe, MPP (Whitby/Oshawa)
The Honourable Tracy MacCharles, MPP (Pickering/Scarborough East)
Granville Anderson, MPP (Durham)
Jennifer French, MPP (Oshawa)
Laurie Scott, MPP (Haliburton/Kawartha Lakes/Brock)
Dr. David Williams, Chief Medical Officer of Health
Ontario Boards of Health
Dr. R. Kyle, Commissioner and Medical Officer of Health

DURHAM REGION

The Regional Municipality of Durham

HEALTH DEPARTMENT

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Canada

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Canada L1N 0B2

Tel: 905-668-7711
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An Accredited Public Health Agency

MEMORANDUM

To: Committee of the Whole

From: Dr. Robert Kyle

Date: December 7, 2016

Re: Student Nutrition Programs

On September 30, 2016, Peterborough Public Health forwarded the attached correspondence to all Ontario boards of health for support.

In essence, the correspondence urges the Governments of Canada and Ontario to provide student nutrition programs with enhanced and stable funding to meet the needs of all elementary and secondary students in Ontario.

Despite the Region's generous supports of Durham's Child Nutrition Program, the program would also benefit from enhanced provincial and new federal funding (attached). Support for this correspondence is consistent with Council's role as Durham's board of health to promote healthy eating and reduce food insecurity.

Accordingly, I recommend that the Committee of the Whole recommends to Regional Council that:

a) The correspondence from Peterborough Public Health as regards funding for student nutrition programs is endorsed; and

b) The Prime Minister of Canada, Ministers of Families, Children and Social Development, Health and Finance, Durham's MPs, Premier of Ontario, Ministers of Children and Youth Services, Education, Finance and Health and Long-Term Care, Durham's MPPs, Chief Medical Officer of Health and all Ontario boards of health are so advised.

The Commissioner of Social Services concurs with this recommendation.

Respectfully submitted,

Original signed by

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

Peterborough Public Health

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

September 30, 2016

Hon. Jane Philpott, MP
Minister of Health
Jane.Philpott@parl.gc.ca

Hon. Bill Morneau, MP
Minister of Finance
Bill.Morneau@parl.gc.ca

Hon. Scott Brison, MP
President of the Treasury Board
Scott.Brison@parl.gc.ca

Hon. Amarjeet Sohi, MP
Minister of Infrastructure and Communities
Amarjeet.Sohi@parl.gc.ca

Hon. Jean-Yves Duclos
Minister of Families, Children and
Social Development
Jean-Yves.Duclos@parl.gc.ca

Dear Honourable Ministers:

At the September 14, 2016 meeting of the Board of Health for Peterborough Public Health, correspondence from the Thunder Bay District Health Unit regarding food security and universal hot meal programs in schools was received.

Peterborough Public Health is one of the many partners of Food For Kids Peterborough and County who work to ensure that Student Nutrition Programs (SNPs) are offered and available in local elementary and secondary schools. In 2013, the Board of Health endorsed a local report entitled "Student Nutrition Programs: Best Practices, Actions for and Call to Action for Food for Kids Peterborough County".

In the 2015-16 school year, Food For Kids Peterborough and County served over 2.5 million breakfasts and snacks to over 17,000 local students with the dedication of 1,000 volunteers. The Board of Health has endorsed the vision of SNPs, delivered in Peterborough County and City schools by Food For Kids Peterborough and County, that all students who would benefit can achieve the positive health, learning and behavioural outcomes that result from this key nutrition strategy and sound public policy.

In December 1997, a "national school nutrition program" was recommended by the Standing Committee on Finance. Despite evidence supporting the need for universal SNPs and local programs meeting international best practices, funding for local programs is at a critical point. Increasing student need, expanding programs, increasing food costs and decreased funding from foundations traditionally supporting SNPs, means that Food For Kids Peterborough and County programs are currently vulnerable.

Currently local programs receive financial support in the form of grants from the Ministry of Children and Youth Services, administered for the Central East SNP through the Peterborough Family Resource Centre, along with additional funding and donations from grants, businesses, service clubs, school boards, community members and parents.

We request/urge that the Canadian government invest to leverage provincial efforts for student meal programs, through the development of a national Universal Healthy School Food Program. This partnership with provincial governments would allow funding to better reflect program costs of existing universal student nutrition programs in elementary and secondary schools across the country, while supporting student learning in regions currently lacking such programs.

In closing, we look forward to working with you, as well as our active community partners to address the need for increased funding for SNPs. Thank you for your immediate attention to this matter.

Yours in health,

Original signed by

Scott McDonald
Chair, Board of Health

/at
Encl.

cc: Dr. David Williams, Chief Medical Officer of Health, MOHLTC
Maryam Monsef, MP, Peterborough-Kawartha
Kim Rudd, MP, Northumberland-Peterborough South
Jamie Schmale, MP, Haliburton-Kawartha Lakes-Brock
Association of Local Public Health Agencies
Ontario Boards of Health

Peterborough Public Health

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

September 30, 2016

Hon. Mitzie Hunter, MPP
Minister of Education
mhunter.mpp.co@liberal.ola.org

Hon. Helena Jaczek, MPP
Minister of Community and Social Services
hjaczek.mpp@liberal.ola.org

Hon. Michael Coteau, MPP
Minister of Children and Youth Services
mcoteau.mpp.co@liberal.ola.org

Dear Honourable Ministers:

At the September 14, 2016 meeting of the Board of Health for Peterborough Public Health, correspondence from the Thunder Bay District Health Unit regarding food security and universal hot meal programs in schools was received.

Peterborough Public Health is one of the many partners of Food For Kids Peterborough and County who work to ensure that Student Nutrition Programs (SNPs) are offered and available in local elementary and secondary schools. In 2013, the Board of Health endorsed a local report entitled "Student Nutrition Programs: Best Practices, Actions for and Call to Action for Food for Kids Peterborough County".

In the 2015-16 school year, Food For Kids Peterborough and County served over 2.5 million breakfasts and snacks to over 17,000 local students with the dedication of 1,000 volunteers. The Board of Health has endorsed the vision of SNPs, delivered in Peterborough County and City schools by Food For Kids Peterborough and County, that all students who would benefit can achieve the positive health, learning and behavioural outcomes that result from this key nutrition strategy and sound public policy.

Despite a decade of evidence supporting the need for universal SNPs and local programs meeting international best practices, funding for local programs is at a critical point. Increasing student need, expanding programs, increasing food costs and decreased funding from foundations traditionally supporting SNPs, means that Food For Kids Peterborough and County programs are currently vulnerable.

Currently local programs receive financial support in the form of grants from the Ministry of Children and Youth Services, administered for the Central East SNP through the Peterborough Family Resource Centre, along with additional funding and donations from grants, businesses, service clubs, school boards, community members and parents.

We request/urge that the Ontario government enhance funding to better reflect program costs of existing universal SNPs in elementary and secondary schools across the province. This is in line with recommendations of both the local report previously noted as well in the 2012 provincial report, No Time to Wait: The Healthy Kids Strategy.

In closing, we look forward to working with you, as well as our active community partners to address the need for increased funding for SNPs. Thank you for your immediate attention to this matter.

Yours in health,

Original signed by

Scott McDonald
Chair, Board of Health

/at
Encl.

cc: Dr. David Williams, Chief Medical Officer of Health, MOHLTC
Jeff Leal, MPP, Peterborough
Laurie Scott, MPP, Haliburton-Kawartha Lakes-Brock
Association of Local Public Health Agencies
Ontario Boards of Health

DCNP Program Overview

The Durham Child Nutrition Project (DCNP) oversees the day to day operations of school based nutrition programs across Durham. This role includes the management, allocation and distribution of program funds, volunteer support and appreciation, program development, and evaluation of outcomes.

There has been a huge increase in the number of participating schools in Durham Region. In 2005, we had 60 schools on board. Currently DCNP supports 172 nutrition programs in 140 schools across Durham. Each school program is managed and operated by volunteers, with the support of the DCNP Coordinator.

DCNP Data:

In the year 2015-2016:

- ***DCNP served 3, 000, 393 meals.***
- ***Nutritious food was made accessible to over 70, 585 students in Durham Region.***
- ***At present we have 140 school running nutrition programs at their facilities.***
- ***Currently there are nearly 1000 volunteers working to support local programs.***

DCNP Funders:

DCNP's main funding comes from Ministry of Children and Youth Services. That is the seed money to get the SNPs (Student Nutrition Programs) running.
DCNP is fortunate enough to be receiving Regional funding for the past decade through the Social Investment Fund. This Regional funding of $103 000 allows DCNP to operate and sustain our local nutrition programs.
Despite of our two main funders, our schools run short of funds for their SNPs.
DCNP has many partnerships at the local level to help fund the SNPs over the school year. As programs proceed through the year, local programs report budget shortfalls.

Importance of a Student Nutrition Program

- Healthy foods increase a child's ability to learn and retain information during the school day and decrease classroom disruption and higher attendance.
- Supports and promotes healthy living for the future.
- Encourages students to adopt healthy eating habits which has a positive impact on their home, school or community environment.
- Increases the consumption of fruits and vegetables among young people.
- Many students come to school hungry or without a snack/ lunch.

- Decreases the consumption of junk food during snack time and replaces it with a serving of vegetables or fruits.
- Studies show youth perform the best when they eat around 10 a.m. which our morning meals help with
- Our grassroots model engages community members, disabled, senior citizens and the school community.
- Healthy eating in the school has a trickle down effect to the student's home.
- The peer aspect of the program encourages healthy eating.
- Our program teaches life skills to children and youth- meal planning, budgeting, grocery shopping and preparation.

Consequences of a Budget Shortfall

- Volunteers will have to spend more time fundraising.
- The equipment funding will not be there for schools
- No honorarium for our volunteers
- It is believed that as potential shortfalls loom, programs do not fully meet the Nutrition Standard i.e.
    - Decrease the number of food groups offered;
    - decrease the number of servings;
    - decrease the serving size;
    - trade off more costly items such as milk for less costly items such as crackers);
    - decrease the number of operating days (i.e., start later in the year, stop earlier in the year, or reduce the number of days per week);
    - and/or reduce the number of program participants.

In the 2010/11 school year, TPH dietitians visited 627 of the 684 municipally funded programs. Over the course of the year they found that 50% of programs met the TPSN Nutrition Standard in all categories (food group, number of servings, serving size).

However, looking more closely, it was revealed that 80% of programs actually met the TPSN Nutrition Standard in 2 of the 3 categories, but offered smaller serving sizes than required. By offering smaller serving sizes, programs were able to stretch their budget, while still providing some of the key nutrients required. In 2009/10, using the TPH dietitian visit to programs as a 'snap shot in time': 16 programs (3%) were not running (although these visits may have been early in the school year, when programs had not yet started), 62 programs (12%) expressed financial concerns, 110 programs (21%) were feeding fewer students than reported on the original application, 37 programs (7%) were operating for fewer days per week (could be due to budget or volunteer availability), 30 programs (6%) were offering a different program (e.g. different meal type) than funded for. The TPH dietitian data revealed that overall, 37% were not operating their programs as outlined in their original applications.

However, one must exercise caution when interpreting this data since it is based on single day site visits and may not necessarily reflect ongoing trends or exclusively link to budget

==========

Submission to the Social Investment Fund from Rose of Durham to Support the Durham's Child Nutrition Project

31st March 2016

Rose of Durham is submitting this request to the Social Investment Fund on behalf of the Durham Child Nutrition Project (DCNP). The Rose of Durham oversees the implementation of aspects of this project and has held SIF resources on behalf of the DCNP for several years.

Program Overview

The Durham Child Nutrition Project (DCNP) oversees the day to day operations of school based nutrition programs across Durham. This role includes the management, allocation and distribution of program funds, volunteer support and appreciation, program development, and evaluation of outcomes.

Currently DCNP supports 133 nutrition programs in schools across Durham. In the 2015/ 2016 school year, supported nutrition programs have offered nutritious breakfast and snack programs to over 70, 585 local students of Durham Region schools, serving over 1 million meals. The schools are from all 6 school boards currently operating in Durham Region. Each school program is managed and operated by volunteers, with the support of the DCNP Coordinator, and currently there are nearly 1000 volunteers working to support local programs.

Best Practices Manual

In support of local nutrition programs, DCNP has developed various resource materials for school based nutrition programs. Last year we developed a Nutrition Standards Guideline for the SNPs. The resource is for participating schools and is available to others who may be interested in developing school based nutrition programs. Volunteers and school administrators have expressed appreciation for the guideline, indicating that is a useful tool as they develop and manage their local programs.

Partnerships

The DCNP is built on partnerships between local government, community organizations, private enterprise, schools and communities. All programs rely on strong and collaborative relationships to ensure that they function properly and are well resourced.

The DCNP Coordinator works to develop community partnerships that can support the school based programs. In 2015 the following partnerships were developed:

- DCNP partnered with the Rotary Club of Oshawa who contributed $7000 to support school based nutrition programs.
- DCNP worked with the Lions Club of Bowmanville who adopted 4 local nutrition programs and will provide support to these programs through the school year.
- DCNP brokered several relationships across the community to ensure that local nutrition programs received the equipment required to functions effectively and efficiently.
- Partnerships have been developed over the past years with the local French District School Board and the local French Catholic District School board and nutrition programs are now running with DCNP support in all 6 local school boards in Durham.
- DCNP has built partnerships with BFL (Breakfast for Learning) and BCC (Breakfast Clubs of Canada) who has supported more than 20 schools in 2015/16, with cash funding, gift vouchers as well as equipment.
- DCNP has made a significant partnership with SKYC who donated over $4500 in 2015/2016 school year.
- Grocery Foundation partnered with our lead agency in the last school year and have supported Durham, schools with over $30 000.
- DCNP supported schools to apply for Metroland grant and succeeded in getting grant money for Durham Student nutrition programs

Although, DCNP has great support from the community and local business, we are growing every year and funds are insufficient. Our schools struggle to provide minimum, required food groups to the children. Inflation rates have risen in the past years but the allocation amount from the Region and other funders has stayed the same.

For the last two years, DCNP has received $103 250 from of Region of Durham. This is $8, 750 less than what we received in 2012. As we are a growing program with new schools coming on board every year, the decrease in funding had a significant impact on our allocation to schools.

DCNP also provides emergency funding to schools that are unable to continue the program through the school year due to insufficient funds. We usually have to cut down our equipment budget to provide for that funding.

Further, DCNP is currently using its reserved funds to pay for website domain and webhosting and any other printing and other office expenses. We have no source for funding our office/ marketing expenses.

The breakdown of the expenses is as follows:

Book keeping fee (Rose of Durham): $6000 ($500 X 12)

Allocation/ distribution/ collection of year end reports admin fee: $ 850

Equipment for school nutrition programs: $ 4105

Funding for School Nutrition programs: $ 92, 295

Total: $103, 250

The breakdown of funding provided to the schools is as follows:

School Name	Meal	Total Funding
Ajax High School	Breakfast	$ 943.50
All Saints Catholic Secondary School	Breakfast	$ 377.40
Altona Forest Public School	Breakfast	$ 801.98
Anderson C.V.I	Breakfast	
Archbishop Denis O'Connor C.H.S.	Breakfast	$ 452.88
Bayview Heights Public School	Snack	$ 3,019.20
Beau Valley Public School	Snack	$ 1,065.93
Beaverton Public School	Snack	$ 390.72
Beaverton Public School	Breakfast	$ 43.96
Bolton C. Falby Public School	Morning Meal	$ 122.10
Bowmanville High School	Breakfast	$ 305.25
Brock High School-Cannington	Breakfast	$ 660.45
Cartwright Central Public School	Morning Meal	$ 2,830.50
Cartwright Central Public School	Snack	$ 152.63
Central P.S. (Bowmanville)	Breakfast	$ 424.58
Clarington C.I.S.	Breakfast	$ 1,132.20

Clarington C.I.S.	Snack	$ 885.23
Clarington Central Secondary School	Breakfast	$ 235.88
Clarke High School	Breakfast	$ 235.88
College Hill P.S.	Morning Meal	$ 943.50
College Hill P.S.	Snack	$ 1,495.73
College Hill P.S.	lunch	$ 339.66
Courtice North Public School	Morning Meal	$ 152.63
Courtice Secondary Public School	Breakfast	$ 377.40
Courtice Secondary Public School	Snack	$ 152.63
Dr. Ross Tilly Public School	Breakfast	$ 1,556.78
Dunbarton Highschool	Breakfast	$ 226.44
East dale C.V.I	Breakfast	$ 613.28
East dale C.V.I	Snack	$ 91.58
École Antonine Maillet	Snack	$ 1,123.32
École Catholique Corpus-Christi	Snack	
Epsom Public School	Snack	$ 140.42
Fairport Beach Public School	Snack	$ 1,434.68
Father Fenelon Catholic School	Snack	$ 1,355.31
Father Joseph Venini Catholic School	Breakfast	$ 735.93
Father Leo J Austin	Breakfast	$ 415.14
Forest View Publi School	Snack	$ 2,503.05
Glengrove P.S.	Breakfast	$ 377.40
Glengrove P.S.	Snack	$ 952.38
Goodwood Public School	Breakfast	$ 471.75
Goodwood Public School	Lunch	$ 305.25
Greenbank Public School	Morning Meal	$ 854.70
Henry Street High School	Breakfast	
Holy Family Catholic Elementary School-Bowmanville	Snack	$ 1,678.88
Holy Family Catholic School- Beaverton	Snack	$ 278.39
J. Clarke Richardson Collegiate	Breakfast	$ 943.50
John M. James	Breakfast	$ 283.05
Lord Elgin Public School	Morning Meal	$ 1,312.58
Maxwell Heights Secondary School	Breakfast	
McCaskills Mills Public School	Morning Meal	$ 377.40
Monsignot Leo Cleary C.E.S.	Snack	$ -

Mon. Paul Dwyer C.H.S.	Breakfast	$	226.44
Mons. Paul Dwayer C.H.S.	Snack	$	91.58
Mons. John Pereyma Catholic School	Breakfast	$	566.10
Mons. John Pereyma Catholic School	lunch	$	226.44
Mother Theresa Catholic School	Breakfast		
Newcastle Public School	Snack	$	3,663.00
Notre Dame C.S.S.	Breakfast	$	452.88
Notre-Dame-de-la-Jeunesse	Snack	$	457.88
O'Neill Collegiate and Vocational Institiute	Breakfast		
Orono Public School	Breakfast	$	1,283.16
Oshawa Central Collegiate Institute	Breakfast	$	801.98
Pickering High School	Breakfast	$	2,358.75
Pine Ridge Secondary School	Breakfast	$	943.50
Port Perry High School	Breakfast	$	566.10
Prince Albert Public School	Morning Meal	$	152.63
R.S. Mc laughlin C.V.I	Breakfast	$	377.40
Roland Michener Public School	Snack	$	720.39
S. T. Worden Public School	Snack	$	717.95
S.A. Cawker Public School	Snack	$	943.50
Scott Central Public School	Snack	$	396.83
Sinclair Secondary School	Breakfast	$	1,415.25
Sir John A. McDonald Public School	Snack	$	940.17
Sir Samuel Steele Public School	Snack	$	152.63
Sir William Stephenson	Snack	$	1,098.90
St. Bernadette C.S.	Breakfast	$	1,887.00
St. Bernard Catholic School	Breakfast		
St. Christopher Catholic School	Snack	$	396.83
St. Francis of Assisi Catholic Elementery School	Snack	$	2,747.25
St. Joseph Catholic FIC (French Imm Centre)	Snack	$	1,892.55

St. Joseph Catholic School	Snack	$ 1,721.61
St. Jude Catholic School	Breakfast	$ 150.96
St. Marguerite d'youville Catholic School	Breakfast	$ 518.93
St. Marys Catholic Secondary, Pickering	Breakfast	
St. Stephen's Secondary	Breakfast	$ 1,320.90
St. Theresa Catholic School	Snack	
St. Thomas Acquinas Catholic School	Breakfast	$ 283.05
St. Thomas Acquinas Catholic School	Snack	$ 457.88
St. Wilfrid Public School	Snack	$ 1,343.10
The Pines Senior Public School	Breakfast	$ 613.28
Thora Central Public School	Snack	$ 376.07
Uxbridge Secondary School	Breakfast	$ 566.10
Valley farm Public School	Breakfast	$ 226.44
Vimy Ridge Public School	Breakfast	$ 566.10
Vincent Massey Public School- Bowmanville	Morning Meal	$ 2,442.00
Vincent Massey Public School- Oshawa	Snack	$ 488.40
Waverly Public School- Bowmanville	Breakfast	$ 613.28
Waverley Public School-Oshawa	Morning Meal	$ 424.58
West Creek Public School	Breakfast	$ 311.36
St Marks	Breakfast	

Archbishop Anthony Meagher Catholic Continuing Education Centre	Morning Meal	$ 1,002.47
Durham Family Court Clinic	Breakfast	$ 178.06
Durham Family Court Clinic	[redacted]	$ 275.19
Durham Family Court Clinic	Snack	$ 178.06
Durham Alternative Secondary School- Oshawa	[redacted]	$ 540.55
Durham Alternative Secondary School- Oshawa	Snack	$ 508.75
Durham Alternative Secondary School- Oshawa	Breakfast	$ 982.81
Durham Alternative Secondary School- North	Morning Meal	$ 373.47

Durham Alternative Secondary School- North	Lunch	$	241.66
Durham Alternative Secondary School- Pickering	Breakfast	$	638.83
Durham Alternative Secondary School- Pickering	Snack	$	393.13
Rose of Durham, Section 20 High School (Alternative) Program		$	129.73
Rose of Durham, Section 20 High School (Alternative) Program	Breakfast	$	86.49
TEAM Clarington	Breakfast	$	98.28
TEAM Clarington	Snack	$	95.39
Father Donald McLellanCatholic Secondary School-Ajax- Return Ticket	Breakfast	$	849.15
Father Donald McLellanCatholic Secondary School-Ajax- Return Ticket	Snack	$	305.25
Father Donald McLellanCatholic Secondary School-Oshawa- Re engagement	Morning Meal	$	141.53
Father Donald McLellanCatholic Secondary School- Whitby-Reconnect	Breakfast	$	330.23
Father Donald McLellanCatholic Secondary School- Whitby-Reconnect	Lunch	$	471.75
Father Donald McLellanCatholic Secondary School- Whitby-Reconnect	Snack	$	427.35
Father Donald McLellanCatholic Secondary School-Oshawa- Centre for Success	Breakfast	$	283.05
Father Donald McLellanCatholic Secondary School-Oshawa- Centre for Success	Snack	$	183.15
Glenholm and Grove School	Morning Meal	$	927.96
		$	**7,245.64**

	$	82,188.32

DURHAM 2-			
Bellwood P.S	Snack	$	305.25

Donald A. Wilson Secondary School	Breakfast	$	943.50
Dr Emily Stowe P.S.	Morning Meal	$	1,887.00
Duffin's Bay P.S	Snack	$	183.15
Immaculate Conception C.S.	Snack	$	366.30
Lester B. Pearson P.S.	Morning Meal	$	188.70
Lincoln Alexander P.S.	Snack	$	1,831.50
Mother Teresa C.S.	Breakfast	$	943.50
Norman G. Powers p.S.	Snack	$	317.46
Seneca Trail Public School	Snack	$	366.30
Seneca Trail Public School	Morning Meal	$	943.50
St. Catherine Siena C.S.	Snack	$	903.54

Durham 1	**$ 83,115.32**
Durham 2	**$ 9,179.70**
Total Allocation	**$ 92,295.02**

Plans for 2015/2016

In 2015/2016, DCNP has plans to achieve the following:

- Work with schools to initiate breakfast programs in schools with snack programs.
- Complying with new Program policy of MCYS, DCNP will be working with schools on Safe Food Handling and data management for better food traceability.
- Expand and develop the "Adopt a school program", brokering new relationships between local organizations and businesses and school based nutrition programs.

- Expand and enhance the volunteer training program, ensuring that all local volunteers receive training in the areas of safe food handling, program budgeting and financial record keeping, fundraising, volunteer recruitment and retention, and program sustainability.
- Working with local partners to ensure that all new and existing programs have equipment required to run nutrition programs safely, effectively and efficiently.
- Continuing our program outreach activities, presenting to service organizations to bring awareness about the student nutrition programs and the benefits of good nutrition.
- Expand DCNP reach with social media management of the program

The Durham Region schools get their core funding from The Ministry of Children and Youth Services. However this funding serves only as seed money and is inevitably insufficient for the nutrition programs.

Regional funding provides Durham Region Nutrition Programs a life line. To be able to operate and sustain theses nutrition programs through the school year, the Regional funds play a significant role.

You are also very welcome to visit a student nutrition program in your community and see for yourself the benefits of the program.

Continued financial support from the Region's Social Investment Fund would greatly assist DCNP in supporting the management and development of these important local programs. Funds from the program are used to directly support school based programs. Good nutrition is strongly linked to healthy physical and mental development and children who eat well are more successful at school. We thank that SIF Committee for its consideration and look forward to ongoing partnership with the Region.

Contact:

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Durham Child Nutrition Program

Breakdown of funding for years 2012-2016

2012- $112,000

2013- $103,250

2014- $103,250

2015- $103,250

2016- $103,250

Is the breakdown per school on pp 278-283 also available on a per pupil basis?

No a breakdown per pupil is not available. Schools provide an estimated number of students that they believe they will service for the year; if the school plans to offer snacks to each classroom then the entire school population is used.

The emphasis is on the $ value of a meal vs what they are spending per child. $1 is allocated per breakfast and $0.85 is allocated per snack. Funding to each school is based on the following,

- (Cost of meal) x (# of potential students) x (# of days program is to be offered)
- Each school is then allotted a percentage of the funding; this percentage changes each year depending on number of schools. For the 2015/2016 school year, each school was allotted 4.5% of our budgeted funds.
- It is never based on what the school actually needs; it's based on what they can get.
- For example, a school of 400 students wants to run a breakfast program only.....
  ($1) x (400)x(184 school days)=$73,600 x 4.5%=$3312.00 for the year.
- It is up to the school to then manage that budget which often includes bulk purchases and coupon buying.
- The school is then allowed a honorarium to cover costs associated with the volunteers; up to a maximum of $500 for a school year.
- Based on a conference attended by Ana recently the dollar values on breakfasts and snacks will be increased.

It is difficult to track numbers of students as program is run by volunteers. Ana advised that support from the DDSB and DCDSB has a long way to go for the program to run more smoothly. She has difficulty getting the monthly stats as it is, these stats track numbers of meals served each month and numbers of new students only.

Ana does not believe that she would be allowed to collect statistical information on students.

In 2015/2016 130 meal programs were offered to 70, 585 students which amounted to 1,000,000 meals being served by 1000 volunteers.

Do we know the # of schools that ran out of funding last year?

No school runs out of funding. Ana's role is to manage the many funding bases to ensure that the food programs make it through the school year. Community development is a large part of what she does.

School meal programs receive funding from numerous sources including the Ministry of Children and Youth Services, Region of Durham funding, the Grocery Foundation, the Peterborough Family Resource Centre as well as local businesses and service clubs. Should a school be at jeopardy of running out of money it is Ana's job to reach out to community service clubs and businesses to make presentations in support of securing emergency funding to keep the programs running. These can include Canadian Tire, Gerdau, the Rotary Club, Lions Club; they are encouraged to make donations or adopt schools.

Ana did note that sometimes quality of food is compromised near the end of school year to avoid programs collapsing before the end of the school year.

Do we know what messaging the program/school board provides to pupils/parents to try to ensure that the program is not abused?

The Durham Child Nutrition Program is a universal program designed to support not only feeding hungry children but to encourage healthy eating habits for all students; every student gets equal opportunity. For example, having healthy breakfast options available in high schools means that teenagers are more likely to grab an apple in the morning before class.

Letters are either sent out to parents or included in the school newsletter to advise parents that the healthy food will be available to all of the students at that school and students can chose whether to participate or not. Programs that were designed to address only the needs of a particular population were not successful as students felt stigmatized. An example of this was Ajax High School where program was run out of guidance; no one came in for food, it wasn't readily available to all.

Sent by email at: basicincome@ontario.ca

January 17, 2017

Honourable Helena Jaczek
Minister of Community and Social Services
Hepburn Block 6th Floor
80 Grosvenor St.
Toronto, ON M7A 1E9

Honourable Chris Ballard
Minister of Housing
College Park
777 Bay St.
Toronto, ON M5G 2E5

Dear Minister Jaczek and Minister Ballard,

On behalf of the Association of Local Public Health Agencies (alPHa) and the Ontario Public Health Association (OPHA), we are writing to reiterate our strong support for the Ontario basic income pilot and to convey our high-level feedback as part of the current consultations. Both of our organizations passed resolutions in support of basic income in 2015[1,2]. As such, we were pleased to see that the recommendations made in the Honourable Hugh Segal's discussion paper, *Finding a Better Way: A Basic Income Pilot Project for Ontario*, are consistent with piloting a strong, health-promoting basic income. Our support for basic income is informed by overwhelming evidence of the powerful link between income and health. People living with a lower income are at far greater risk of preventable medical conditions across the lifespan, including cancer, diabetes, heart disease, mental illness, and their associated health care costs, compared with those living with higher incomes. Children are particularly vulnerable to the impacts of growing up in low income, due to its attenuating effect on early childhood development. The experience of childhood poverty leads to vulnerability, both to negative health outcomes and social outcomes, including reduced educational attainment and greater risk of involvement with the justice system. Our members feel strongly that ensuring everyone has an income sufficient to meet basic needs and live with dignity would be one of the most important initiatives the provincial government could pursue to promote health, well-being and equity amongst Ontarians.

The Hon. Hugh Segal's discussion paper provides important considerations for designing the pilot. **We have prepared detailed feedback in collaboration with Public Health Ontario (PHO) on these considerations in a separate technical submission, in accordance with your *Consultation Guide for the Basic Income Pilot Project.***

To complement that detailed feedback, this letter serves to outline the views of alPHa and OPHA on key, high level aspects of the basic income pilot.

We believe that a set of principles should guide the design of a basic income program, including the type of basic income to be piloted in Ontario. A principle-based approach is consistent with the recommendations of Basic Income Canada Network[3], the Basic Income Initiative (a multi-faith, indigenous and multi-sector collaboration)[4], and the resolutions passed by our respective organizations[1,2]:

- the pursuit of equity, both health and social;
- income security for all, across the lifespan and regardless of employment status;
- universality, leaving no one behind;
- non-conditionality, other than based on income level and family composition;
- dignity, creating a process for receiving basic income that is comparable to other well-accepted income security programs in Canada, such as child and seniors' benefits; and
- autonomy, ensuring that recipients of basic income have the ability to spend money as they see fit to support the wellbeing of themselves and their family.

Additionally, we feel that key elements should guide the design of the pilot itself, consistent with scientifically rigorous public health research methods:

- designed to produce valid and reliable results, including the ability to detect outcomes of basic income; this will require an adequate benefit level, and sufficient length and sample size of the pilot, amongst other considerations;
- designed to produce generalizable results; this will require pilot sites and participants that reflect Ontario's demographic and geographic diversity, including indigenous communities;
- emphasis on health and social outcomes;
- overseen by those with research expertise, and by an advisory body of diverse stakeholders and those with lived experience of poverty and precarious employment; and
- long-term commitment to implementing, evaluating and sharing the results of the pilot.

These elements are described in more detail in our collaborative technical submission with PHO.

The Hon. Hugh Segal made several key recommendations in his discussion paper, which we support as in keeping with the above principles and elements:

- Much better alignment of income amounts with the cost of living and improved health outcomes, than current Ontario Works (OW) and Ontario Disability Support Program (ODSP) rates
- Replacement of OW and ODSP with basic income
- Use of the negative income tax model
- The testing of two benefit amounts, 100% and 75% of the Low Income Measure, over a period of, minimally, three years
- The testing of a higher and lower tax back rate to earned income
- The stipulation that no one be worse off than before the basic income program

We would emphasize, however, that basic income is an important form of income security not only for those on OW and ODSP - who are the primary targets of the discussion paper proposal - but also for those who are employed yet still living in poverty, including the precariously employed. Accordingly, the pilot methods and results should reflect this range of relevant recipients. This would require that pilot eligibility be based on income level, and not on current receipt of OW or ODSP.

While we clearly see a great deal of promise in a basic income pilot and program, we also believe that basic income can only have a strong impact on the health-damaging conditions of poverty and precarious employment if it is part of, and not a replacement for, a comprehensive approach that includes progress on other key policies and programs. This includes affordable high quality child care, affordable housing, expanded health benefits, and labour law reform, amongst others. In the immediate future, we also strongly urge the Province not to delay increasing social assistance rates to sufficient levels to meet the basic needs of all Ontarians in the short-term, while the basic income pilot is in progress.

Thank you for this opportunity to comment, and for your ongoing and internationally-recognized leadership on this pivotal health and social matter. We would welcome the opportunity to further support the design, implementation and evaluation of the basic income pilot.

Yours Sincerely,

Jaeger

Dr. Valerie Jaeger
alPHa President

Ellen Wodchis

Ellen Wodchis
OPHA President

c. Dr. David Williams, Chief Medical Officer of Health
Hon. Eric Hoskins, Minister of Health and Long-Term Care
Hon. Michael Coteau, Minister of Children and Youth Services
Hon. Indira Naidoo-Harris, Associate Minister of Education (Early Years and Child Care)
Roselle Martino, ADM Population and Public Health Division
Paul Miller, NDP Critic, Poverty Reduction
Julie Munro, PC Critic, Poverty Reduction Strategy
Board of Health Chairs
Medical Officers of Health

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Collaborative Public Health Technical Submission to Ontario's Basic Income Pilot Project Consultation

Prepared by The Association of Local Public Health Agencies (alPHa), The Ontario Public Health Association (OPHA), and Public Health Ontario (PHO); January 17, 2017

Response to Consultation Guide Discussion Questions

Section 1: Determine eligibility for the Pilot

1.1 Are there specific groups of people or populations who should be targeted in the Pilot, such as the under-employed, social assistance recipients, or newcomers? Why?

The Pilot should include a cross-section of people living with insecure income, so that the experience and outcomes of Basic Income for different such groups of people can be assessed. All individuals whose income falls below the pre-determined threshold, regardless of their source of income, should be potentially eligible. In particular, however, the Pilot should target:

- **Social assistance recipients**. This will allow the Pilot to determine the impact of a change from a traditional welfare approach to a Basic Income approach, as well as a change (increase) in the income amount. The Honourable Hugh Segal's discussion paper clearly outlines the rationale to emphasize this population (1).

  The working poor, including those precariously employed and under-employed. The poor health consequences of precarious employment have been well demonstrated (2, 3). As Lewchuk and colleagues note, precarious workers have the potential to "face more difficult working conditions, experience higher levels of job insecurity, have lower levels of control over their working conditions and arrangements, experience poorer quality social interactions, or be exposed to particular demands associated with their employment arrangements." (4) The working poor do not currently qualify for substantive benefits, and the precariously employed often fall through the cracks of current income security programs. Rates of precarious employment are already considerable and are anticipated to increase in the coming years (4, 5). In Ontario, the trend continues to shift towards a low-wage economy with substantial increases in part-time and temporary employment and fewer gains made in full-time employment opportunities (6). It is therefore imperative that the Pilot explore the implications of Basic Income for this population and phenomenon. Further, attention should be paid to the employment experience of populations over-represented as precarious workers, including women, racialized persons, indigenous persons, immigrants, people with disabilities, and youth (7, 8).

- **Young adults transitioning from school to the labour market.** According to Forget and colleagues, young adults transitioning from education into the labour market are very likely to experience precarity in the job market and, therefore, their labour market participation is more likely to be affected by a basic income than most other age groups (9). While a Basic Income allows them to gain valuable experience and train further as appropriate, it also makes it possible for them to delay committing to a full-time paying job. Forget and colleagues note the potential concern from this delay, as reduced attachment to the workplace at a young age has long-term negative impacts on wage and career outcomes (9). Therefore, they recommend that young adults be closely examined by the Basic Income (BI) Pilot, to understand how to achieve the most positive outcomes for this population (9). Given the known health impacts of future income level and employment conditions (10, 11), we support this recommendation.

In addition to these target populations, we recommend that the Pilot also include:

- **Youth between the ages of 16 and 17 years old living independently of a parent or guardian.** The Honourable Hugh Segal's discussion paper suggests restricting the age for Pilot participation to 18-64 year olds (1). However, at the age of 16 years old, young people are legally able to move out of the residence of their parent/guardian but are no longer eligible to receive the Canada Child Benefit, and are not yet eligible to receive benefits through OW or ODSP until they reach the age of 18 unless they are able to identify a trustee[i]. Youth is a critical transitional stage in the lifecourse between childhood and adulthood. Opportunities and experiences that occur in youth can set lifelong trajectories and can have long-term impacts on health and development in areas including employment and health (12). Youth who are forced to flee from unsafe family or domestic living arrangements (e.g., domestic violence, child abuse) are at heightened risk of adverse financial, educational, socio-emotional and health outcomes stemming from lack of familial, social and economic supports. These vulnerable youth should have access to a secure income source to provide them with the financial supports to live independently from adverse home environments, without facing homelessness. Therefore, it would be appropriate to include them in the Basic Income Pilot, in order to understand the implications of basic income for them as part of the eligible 16-64 year old population.

1.2 What should the Pilot use to determine eligibility? Should eligibility be based on an individual's income, or should eligibility be determined by total family income? Why?

We agree with Hugh Segal's recommendation that eligibility be based on family income level, while also respecting the need for individual income autonomy (1). He has suggested that the amount of benefits received by participants would be a function of both their net family income and their family composition, but that Basic Income payments would be equally divided and paid to all adults in the family in order to provide each adult with financial autonomy (1). He also suggests that mechanisms

[i] Note: If the Child, Youth and Family Services Act that was introduced by Minister Coteau in December 2016 is passed before Basic Income is piloted, this age recommendation may be reconsidered. If the Bill is passed, the age of eligibility for protection services would be raised from 16 to 18, which may address this gap in supports for this vulnerable population (Ministry of Children and Youth Services, 2016).

should be in place to allow for changes in family income and composition to be reflected in the payments within a given year, including circumstances such as divorce (1). Together, these recommendations would provide the ability for individuals to leave unhealthy relationships if necessary, without the fear of being without a source of income.

Section 2: Select the sites

2.1 What are the most important things to think of when selecting a Pilot location? Why?

The most important consideration is selecting a Pilot location that enables the primary research question(s) of the BI Pilot to be answered. The choice of BI Pilot location will have a significant impact on important factors related to the experiment, such as: the study population, project budget, hypothesized outcomes, etc. The context of the Basic Income experiment will impact the hypothesized outcomes across potential sites. Therefore, it is important to select a site that most appropriately allows the primary research questions to be investigated while maximizing BI Pilot efficiencies (e.g., costs, sample size).

2.2 How do you think Pilot sites should be selected?

As stated above, the BI Pilot site should be selected to most effectively and efficiently answer the primary research questions, prioritizing scientific principles. The population demographics of a proposed site will be critical to selecting an appropriate study population. The study population should be representative of the group of individuals to which the BI Pilot results should be generalizable to (i.e., the target population). For example, this may be those who would be eligible to receive a basic income should the Pilot be adopted for the whole province. Ideally, the BI Pilot should be designed to assess whether the impact of receiving a Basic Income is consistent across specific sub-populations of interest (e.g. social assistance recipients or the working poor) and geographic contexts (such as rural, small urban, large urban, and First Nations communities). This decision should be made prior to the initiation of the BI Pilot as these sub-populations will need to be oversampled within an RCT, or prevalent within a saturation site community, to ensure there is enough sample size to properly investigate the impact of the Basic Income within these groups. For example, to study the impact of receiving a Basic Income on perinatal outcomes, which have been shown to be positive(13, 14), a sufficient number of expectant mothers would have to be included in the BI Pilot to investigate this potential outcome. Similarly, sufficient low-income families with school-age children would need to be sampled to examine whether increased income through a Basic Income would translate into the hypothesized improvements in child test scores (15, 16) or Readiness to Learn (or Early Development Vulnerabilities) based on the Early Developmental Instrument (EDI)(17). Therefore, special consideration should be given to ensure that the study population from any proposed Pilot site is representative of the target population, to ensure the generalizability of the BI Pilot findings to the intended groups.

Community characteristics should also be considered in selecting a site. The degree to which a community is geographically isolated may also be important if a saturation site approach is selected, to reduce contamination of intervention effects across geographical borders. Additionally, available infrastructure, the working relationships between different sectors (e.g., housing, children's services,

social assistance) and available data resources may also be considered to improve efficiency in administration and management of the BI Pilot.

Finally, a community's willingness to participate in the BI Pilot should also be considered.

2.3 Do you think it's important to have saturation and RCT sites? Why?

The choice of main research questions and outcomes should drive the design of the BI Pilot. It should be emphasized that there is no "best" study design for the BI Pilot without a specific research question. Different study designs will be more or less effective for answering specific research and policy questions. For example, an RCT design may be more effective in answering questions related to the optimal parameters of the negative income tax model, whereas a saturation site would be necessary to measure the community level impact, or social multiplier effect, resulting from the interactions between individuals receiving a Basic Income. Not measuring the social multiplier would result in an underestimation of the impacts of receiving a Basic Income. Forget hypothesized a social multiplier was at work during the MINCOME experiments, helping to explain why high school students in Dauphin were more likely to complete high school than their rural or urban counterparts (16). Therefore, the BI Pilot study design should be closely linked to research questions to enable the impacts of receiving a Basic Income to be detected, and to causally link Basic Income to the main study outcomes.

Independent of the choice of study design, the comparability of the selected control group is an important factor for consideration. Selecting control participants or community(s) (i.e., those that do not receive the Basic Income intervention) that are as similar as possible to the intervention community (e.g., in demographic characteristics and health status) is essential for minimizing potential confounding effects (both measured and unmeasured) and therefore ensuring that any observed effects are caused by the Basic Income intervention. For example, concerns have previously arisen around the comparability of the intervention and control groups when examining the effects of unconditional income transfers on birth outcomes (18). Methodologically, there are a number of approaches that should be considered for deriving control groups, such as: collecting primary data from controls, propensity score matching and synthetic control groups.

2.4 Should the government consider phases for sites e.g. starting with RCT and doing saturation sites later?

No. There is sufficient evidence to proceed with investigating the benefits of the BI Pilot for both the RCT and saturation sites simultaneously. Delaying the experiment in phases will only delay the evidence to move forward with policy-options informed by the BI Pilot.

However, it would be advised that the distribution method of the intervention (i.e., getting the income to the participants), regardless of the Pilot design, be tested before initiation of the main BI Pilot. This will reduce any complications associated with the delivery of the intervention that would have an impact on potential outcomes. This may require committing additional resources to help participants navigate delivery of the intervention.

Section 3: Design the benefits

3.1 Should the Basic Income amount be enough to significantly raise incomes and reduce poverty, or should it provide a base level of financial modest income floor to provide a certain level of stability? Should the benefit amount alone get people out of poverty or should it be a combination of benefits and earnings that accomplish this goal? Why?

The Basic Income amount should provide enough money to meet basic needs, and to live with dignity and the opportunity for societal participation (i.e. reduce many aspects of the poverty experience). The benefit amount alone should be sufficient to raise people out of poverty, as that is the intention of Basic Income: to ensure that, regardless of circumstance, all individuals have enough money to meet their basic needs. There will always be people who cannot participate in paid work or are unable to find a job for a range of reasons. The Basic Income amount should be sufficient to ensure that these individuals are not living in poverty, and that the health consequences of poverty are prevented.

It is difficult to suggest a Basic Income amount that would be 'sufficient' from a health perspective, as there is a gradient in health improvement with each level up the income ladder (11). Simulation modelling could be undertaken prior to the Pilot commencement to better estimate health improvements at different levels of the LIM. However, 100% of the low income measure (LIM) is a reasonable estimate to achieve the intended purpose of Basic Income and to anticipate health improvements. Using the Nutritious Food Basket Survey approach required of all Ontario Boards of Health within an example health unit area (19), data suggests that 100% of LIM would have the benefit of allowing a family of four to purchase healthy food and to sit below the threshold for spending 30% or more of their total household income on shelter expenses – a marker of housing affordability (data available upon request). For one-person households receiving 100% of LIM, after purchasing healthy food one would still need to spend over 30% of income on shelter, but a considerably lower proportion of income than current OW and ODSP recipients do (data available upon request). Therefore, these calculations indicate that a Basic Income amount of 100% of LIM would lead to greater likelihood of all Ontarians being able to afford adequate food and housing – key determinants of health - regardless of personal financial circumstances. Furthermore, it is known that Canadians in the lowest income quintile experience a disproportionately high burden of morbidity and mortality; a recent report from the Public Health Agency of Canada estimates that socio-economic health inequalities cost the health care system $6.2 billion annually, with the lowest income quintile accounting for 60% (or $3.7 billion) of those costs (20). At 100% of LIM for individuals ($19,460 after-tax) (21), people would be brought above the current upper threshold for the lowest income quintile ($16,000 after-tax in 2010)(22), holding promise for improved health.

With that said, it has been calculated that guaranteeing 100% of the LIM or the LICO to all individuals would represent a very large increase in public expenditure(23, 24), even though it is likely in the short, medium, and long-term to lead to progressive savings in health care spending and many other areas of public spending. If there is potential that this expenditure will not achieve the necessary public and political will for long-term implementation, it is prudent to also pilot a lesser amount that is still a substantial improvement from current social assistance rates. As such, we support the piloting of 75% and 100% of LIM as recommended by Hugh Segal, in order to compare the outcomes of these

approaches. Either way, if a Basic Income program were to be fully implemented in future, it would be imperative that it be indexed to inflation so that benefits rise with costs of living.

Beyond the health impacts of individual income levels, evidence strongly suggests that the extent of income inequality in society is an important determinant of population rates of a range of poor health and social outcomes (25). While the Basic Income amount itself may only go a moderate distance in addressing the large income inequalities that currently exist in Canadian society, the choice of taxation approach through which it is funded has strong potential to help address this important issue.

3.2 Beyond money, what other services and supports (e.g. employment, mental health, housing, etc.) are needed to accompany the Basic Income? Which are most important? AND

3.3 What elements of Ontario Works and ODSP should Basic Income replace? What about other benefits outside of Ontario Works and ODSP, such as help with childcare, employment start-up benefits to help cover the costs of trade tools, uniforms, etc., or drug and dental benefits? Why or Why not?

Response to 3.2 and 3.3:

We recommend that Basic Income should replace direct money payments to current OW and ODSP recipients, and should also provide these payments to others in low income who are not currently receiving OW or ODSP (as per our response to Section 1.1). Basic Income should not, however, replace other benefits currently provided to OW and ODSP recipients, such as medical and dental coverage, employment and housing assistance benefits and other mandatory and discretionary benefits as indicated by the Ministry of Community and Social Services (26). These benefits should continue to be provided to OW and ODSP recipients as well as to anyone else receiving Basic Income, as many of these benefits are otherwise unaffordable on a modest income and people may be faced with having to make a choice to purchase them or purchase other essential goods and services. In turn, foregoing benefits that are vital for adequate prevention or early treatment could lead to detrimental health and social outcomes.

We strongly support and see a great deal of promise in a BI Pilot and program in Ontario. We would like to emphasize, however, that a Basic Income can only have a strong impact on the health-damaging conditions of poverty and precarious employment if it is part of a comprehensive approach that includes progress on other key policies and programs. These include an affordable high quality child care system, affordable housing, labour law reform, and expanded health benefits, amongst others, as has been advocated for by public health organizations (27-29).

3.4 What other factors should be considered when determining the Basic Income level. Why?

We support Hugh Segal's recommendation to provide more income to people with disabilities, due to the additional barriers faced to paid employment and the extra costs of living with certain disabilities (1). We also suggest that it may be warranted to provide additional income to lone parents, given the unique barriers they also face to paid employment, their considerable over-representation amongst low income families, and the substantial health and social consequences faced by children raised in poverty

(30). Rates of food insecurity are also higher among lone parent households than non-lone parent households (31).

Section 4: Deliver the Basic Income Pilot project

4.1 The Discussion Paper recommended a NIT model for the Basic Income. Do you agree with this recommendation? Why or why not? If not, what model would you prefer?

Both a universal demogrant or a negative income tax (NIT) model would inherently increase incomes for those in low income groups. While the demogrant model has the potential of eliminating the stigma of income benefits due to its universal nature (32) , the NIT model used in the MINCOME experiment has also been demonstrated to reduce stigma (33). An NIT is considerably less costly to fund at the outset, and therefore it has been suggested that it is the more feasible model in the Canadian setting and (34), as such, may be the most appropriate model to pilot.

4.2 Should the Pilot consider delivering payments in an alternative method to the Canada Revenue Agency delivery system proposed in the Discussion Paper, if they are available?

Whichever method is selected should be simple, reliable, and work smoothly in conjunction with other benefit payments. One advantage of using the Canada Revenue Agency is that it would build infrastructure for other basic income experiments to take place in other provinces, and also test a more sustainable model should the policy be scaled up to the full populations of Ontario or all of Canada.

4.3 How should the Basic Income respond to changes in income circumstances?

An important feature of Basic Income is its ability to respond to changes in income circumstances, so that it provides income security (with its associated health implications) to people with anticipated and unanticipated fluctuations in income. This may include job loss, personal illness, need to care for a young child or aging parent, changes in marital status, etc. The ability for income level and Basic Income payments to be assessed and change on a frequent basis if required, as recommended in Hugh Segal's discussion paper, is a necessary element (1).

Section 5: Evaluate the Pilot's outcomes

As outlined in Hugh Segal's Discussion Paper, the receipt of Basic Income is hypothesized to impact a number of potential outcomes (1). How to incorporate the required complexity into an evaluation framework presents an important challenge and should not be underestimated. For both Basic Income advocates and sceptics alike, the selection and measurement of appropriate outcomes on which to base the success of the BI Pilot will be essential to the evaluation of this important social experiment.

With this in mind, we support two recommended actions articulated in Hugh Segal's Discussion Paper to evaluate the outcomes of the BI Pilot (1). **First, the establishment of both a Basic Income Pilot Advisory Council (AC) and a Research Operations Group (ROG) is essential to oversee the planning and execution of the BI Pilot's evaluation**. With a function of advising on and overseeing the operations of the Pilot, the AC should be representative of the perspectives of community members, community agencies as well as public health organizations such as the Association of Local Public Health Agencies

and the Ontario Public Health Association. The ROG should bring together a group of experts from the proposed outcome areas who will assist in selecting primary research questions to test regarding the impacts of the BI Pilot, identify outcomes and advise on evaluation methodology. For example, Public Health Ontario is ideally situated to provide scientific and technical advice on population/public health outcomes. Ideally, the ROG would also inform the study design, participant selection, availability of data and data collection procedures including how best to measure the proposed outcomes. **Second that the proposed phased implementation for the BI Pilot be adopted to ensure that appropriate infrastructure (e.g., data sharing agreements, data infrastructure and standardized measurement tools) are in place prior to rolling out the BI Pilot.** Collecting data from pre-baseline (if possible), baseline, during the experiment as well as longitudinal follow-up (either directly or through administrative data) would be advantageous to evaluate the impact of the BI Pilot. An organized approach will maximize synergies to allow for efficient data collection and analyses to evaluate the impact of the BI Pilot.

5.1 The discussion paper recommends measuring ten outcome areas. Rank these outcome areas in order of importance:

The time horizon of the BI Pilot is an important factor when considering which outcomes are likely to be impacted. With this in mind, it is necessary to specify whether a meaningful change in a potential outcome from receiving a Basic Income would be expected over the short-, medium- or long-term. Outcomes that are highly sensitive to short-term income relief are most likely to show meaningful change during the time horizon of the BI Pilot. For example, in the short-term receiving a Basic Income is hypothesized to alleviate **poverty and food insecurity** (i.e., lack of access to adequate food because of financial constraints) (35-37), **reduce psychosocial risk factors** such as life stress (i.e., worrying less about money) (38), and **increase mental bandwidth** (resulting from decreased participation in social assistance system) (39).

Moreover, significant health impacts over the short term that have been associated with providing increased incomes or rent-geared-to-income housing include those related to mental health, psychological distress, and pain (38, 40, 41). In the BI Pilot it will be important to collect data regarding the impact of receiving a Basic Income on acute measures of mental and physical health. Where possible, this information should be collected using validated measurement tools similar to existing population-level data sources to allow for comparability across other study populations in Ontario and Canada, such as the Canadian Community Health Survey (CCHS). This will facilitate the comparison of BI Pilot participants with the Ontario population and sub-populations of interest. Further, oversampling of the CCHS or other Statistics Canada surveys could possibly be done in areas where the basic income is implemented as an efficient and cost effective way to build on existing data collection infrastructure using validated survey tools.

In addition to health outcomes, the impact of receiving a Basic Income could impact health-care utilization and costs, which are also indirect measures of health outcomes. Both low socioeconomic status (i.e., low income) and food insecurity are highly associated with high-cost health care users in Ontario (42, 43). In addition, *future* high cost health care utilization has been shown to be associated with income, education, food security and housing in Ontario (44). In the MINCOME experiments, Forget

highlighted the impact of receiving a Basic Income on decreasing the gap between intervention and control communities for hospitalizations related to “accidents and injuries”, hypothesizing that influencing factors may be that individuals with more income security would not need to work in dangerous jobs, would be less likely to consume alcohol and other substances that put them at risk for injuries, and children may have greater parental supervision (16). Further, hospitalization due to mental health diagnoses followed a pattern very similar to that of accidents and injuries (16).

Where possible the BI Pilot should collect information on outcomes that have been questioned by some as potential unintended consequences of receiving a Basic Income; for example reduction in labour force participation or increased prevalence of negative health behaviours (e.g. smoking, alcohol and drug use). While there is often no or little evidence to support these claims, it is important to understand, anticipate and measure potential unintended consequences of interventions.

It is necessary to consider more than solely which outcomes to evaluate in the BI Pilot. **A detailed theory of change describing the complex mechanisms through which receiving a Basic Income is hypothesized to change the primary outcomes should be developed before the BI Pilot is initiated** (45). By clearly articulating the proposed mechanisms, and resulting data collection, a more complete understanding of how outcomes were changed can be used to possibly explain circumstances when the hypothesized change did not occur.

Within the proposed time horizon in Hugh Segal’s Discussion paper (1), it will be challenging to assess the impact of the Basic Income on mid- to long-term outcomes. It is important that consent to be followed up for research and evaluation purposes be sought from all participants in the BI Pilot. This will enable secondary research and evaluation, not part of the original BI Pilot timetable, and thereby enhance the potential learning opportunities from this important social experiment. For example, consent to follow-up would enable Basic Income recipients to be invited to participate in focus groups or key informant interviews to better understand for whom, how and in what contexts the intervention works. In addition, permission and the necessary information to link BI Pilot participant data to administrative and health databases will greatly enhance research and evaluation efforts to understand the impact of the BI Pilot on both primary and secondary outcomes over longer time horizons. The benefit of administrative health data in evaluating population health interventions were observed in evaluating the health impacts of the MINCOME experiment (16).

More details are provided in the alPHa-OPHA discussion paper on “Measuring Community Health Outcomes for a BI Pilot” submitted to the Honourable Hugh Segal as part of his consultations for the Basic Income Discussion paper.

We have commented primarily on health outcomes including food insecurity, though we see value in measuring many of the other listed outcome areas as well, particularly to establish a theory of change. Some of these are essential in order to understand the operational aspects of basic income (i.e. administrative efficiency, and functionality for users), and many others are themselves important determinants of health (i.e. social inclusion, housing, education, etc.). We would suggest that ‘work behaviour’ be replaced by or supplemented with ‘time use’, so that non-market forms of work and

caregiving and time for personal health are also captured (e.g. volunteer work, child care, parental care, personal sick leave in absence of other benefits, etc.).

To facilitate research and evaluation operations a number of considerations should be taken into account to evaluate the BI Pilot:

1. Build a flexible research infrastructure, similar to the Social Data Research Initiative described by Hugh Segal in his Discussion Paper (1), and make it available to independent researchers. This will greatly increase opportunities for research and evaluation outside of the main objectives of the BI Pilot, and therefore enable the Pilot itself to have more focused objectives. For example, adding income information collected for tax purposes to administrative datasets will provide a more objective measure of income and wealth in study participants. The data infrastructure should aim to enhance data collected as part of the BI Pilot through linkage with routinely collected administrative data. This process would leverage existing data routinely collected by the government to build a rich new data resource while reducing administrative costs and complexity of collecting data on all potential outcomes of the BI Pilot (9). Ideally, the effort would result in the creation of harmonized datasets including information on income, health, health care utilization, education, employment, interactions with the judicial system and other relevant public organizations, including municipalities and regions. Making this resource available to independent researchers, whether through Statistics Canada Research Data Centre Networks or other means such as the Institute for Clinical Evaluative Sciences (ICES), would greatly increase the utility of this resource to produce policy-relevant evidence regarding the effectiveness of the BI Pilot.

2. Identify areas of potential synergy between research infrastructure and the administration of the BI Pilot more generally during pilot development phase. For example, cooperation between Provincial and Federal Government could be used as a model for Basic Income experiments across Canada (of which there is great interest). In addition, it is also worth considering how any infrastructure used to evaluate the BI Pilot could be used if a universal Basic Income policy was scaled up.

3. Dedicated funding should be specifically allocated to support research and evaluation of the BI Pilot, including the proper research and evaluation infrastructure. Moreover, providing funding opportunities to support independent researcher projects, for example in collaboration with the Canadian Institutes for Health Research (CIHR), will greatly enhance the evidence generated from the BI Pilot.

5.2 Do you think that data and evaluation results should be made public in an ongoing basis?

Yes. A robust knowledge translation (KT) strategy will be essential to explain to the public the BI Pilot findings and their implications, including recommendations on why a Basic Income policy should or should not be undertaken. Critically, public awareness needs to be built over the course of the Pilot, and not only at the end.

5.3 What changes in behavior would you expect to see with a BI? What kind of results should we see from the Pilot to call it a success? Why?

Much of this question has been discussed above. However, one additional point is that success should not be determined based on cost-effectiveness of the BI Pilot alone. Regardless of the study design, it will be impossible to truly measure the impact (on any outcome including costs) of receiving a Basic Income. The degree to which the BI Pilot helps support the values related to the alleviation of poverty (e.g., respect for human dignity) and the improvement of social assistance programs (e.g., ease of receiving benefits and reduction of stigma) are important outcomes.

5.4 What strategies can we use to encourage people to participate in the Pilot?

For participants who are offered a Basic Income, it will be necessary to provide assurance that payments will be secure, sufficient, and adaptable to their changing circumstances. Also, they should be assured that no one will be worse off as a result of their participation.

For those selected as controls, if they are required to dedicate time for their participation, then a small additional amount of income could be given to respect their time spent answering questions, to potentially improve their willingness to participate, and to reduce attrition.

5.5 To measure outcomes, we would need people to share their personal information, including linking administrative data together. What concerns would you have about using this information to see how people use benefits and services differently after getting a BI? How can we make you feel that your information is secure?

Any data collected as part of the Pilot should be governed by the highest standard of research ethics and privacy, for example those set out in the *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans* (46).

5.6 So that we can compare the outcomes of BI to the status quo, we would need people to share their personal information, even if they didn't receive the BI. Would you be comfortable with this so that we can understand these differences?

Yes, as long as any data collected as part of the Pilot should be governed by the highest standard of research ethics and privacy, for example those set out in the *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans* (46).

5.7 If you are a Pilot participant, should you receive results prior to any public report release?

Yes. BI Pilot participants should receive aggregate level results prior to the release of any public report. This is consistent with standard research ethics.

Additional comments

Two additional points raised in a Mowat Centre report by Forget and colleagues warrant emphasis (9). First, the experience of MINCOME made clear that it is essential that a proactive approach be taken to

ensure the complete implementation of the BI Pilot, along with its full analysis and reporting, regardless of economic or political circumstances. Consideration should be given to legislating this (9).

Second, a robust community engagement strategy will be critical as the Pilot is planned, implemented, and evaluated, to ensure that the public is well informed and engaged throughout, as the notion of a Basic Income is a considerable shift in social policy that most of the Ontario public is likely not yet familiar with. This engagement strategy should be deliberate and inclusive, in order to begin to address frustration and mistrust that exists among some individuals and organizations across the province on the issue of social assistance and poverty, and to help overcome this potential barrier to successful implementation of the BI Pilot.

Thank you for this opportunity to provide feedback into the design of Ontario's Basic Income Pilot.

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Measuring Community Health Outcomes for a Basic Income Pilot

Submission to Special Advisor on Basic Income Hugh Segal, August 17, 2016

Overview

The Association of Local Public Health Agencies (alPHa) – Ontario Public Health Association (OPHA) Health Equity Workgroup is pleased to have this opportunity to provide additional input into the basic income pilot discussion paper being prepared by Special Advisor Hugh Segal. Following our consultation meeting with Hugh Segal and Maripier Isabelle on July 14, 2016, further advice was requested on the measurement of community health outcomes. The Table on page 4 provides the specific community health indicators and data sources we recommend, and the remainder of the submission provides rationale for these recommendations, as well as related recommendations on study design, individual-level data collection, and the potential role of the public health sector.

The Complex Relationship between Income and Health

Understanding the complex relationships between income and health can inform the design of Basic Income Pilot study. Income is related to health in three ways: through the gross national product of countries, the income inequalities that exist within a country/province, and the actual income of individuals (Marmot, 2002). The latter two are the most important when considering health inequalities in a high income country such as Canada. While providing a Basic Income (BI) may have some influence on income inequalities - especially if provided widely at a provincial level - it is most likely the influence on recipients' income levels and income security that will be associated with the most significant health outcomes in a community.

Beyond individual income levels and income security, neighbourhood level effects also contribute to health status and can mitigate or exacerbate the impacts of individual income. Considering this, the BI pilot must impact a sufficient number of individuals within a community and provide a sufficient enough increase in income to actually impact the health of a community. Taking into account both individual and community level impacts of a basic income, two approaches to measurement of health outcomes are required. First, an overall estimate of the community level change in a health outcome, and second, disaggregating (i.e. breaking down) each health outcome by income level to determine if there is more of a change in those in the lowest income group. We would anticipate that the improvement in health for those in low income (and who, therefore, may receive BI) would be greater than the improvement for those in high income, contributing to lessening health inequalities, which is an important outcome to demonstrate. This "income gradient" is usually examined by comparing the health of the highest income quintile (top fifth) in a community versus the health of the lowest income quintile (lowest fifth) in a community, either by dividing their rates (a relative measure of inequality) and/or by subtracting them (an absolute measure of inequality) (CIHI, 2015).

It is also important that the changes in the income gradients for health outcomes are examined within the context of the overall change to income inequalities in the community as a result of the BI provided to residents of the pilot community. For example, one might expect to see a reduction in health inequities between income groupings that mirrors the reduction of income inequalities themselves.

While the relationship is complex between income and health, it is worth considering the key mechanisms through which income is thought to impact the measured outcomes, i.e., through a direct effect on material needs (e.g. healthy food, safe housing, affordable prescription drugs and dental care), or through an effect on social connectedness and the opportunity to control life circumstances (e.g. ability to make choices, reduced stress). Both aspects should be considered in the selection of community level health outcomes.

The Basic Income Pilot and Community Level Health Outcomes

Receiving a basic income is hypothesized to impact health outcomes through a number of complex mechanisms. The most well-known and documented health outcomes associated with income are: smoking, chronic diseases, all-cause mortality, and life expectancy. These health outcomes and their associated inequities are slow to change over time, and may not be the best ones to select when the time horizon to examine outcomes is relatively short, as in the case of a BI Pilot. A number of studies that have examined the health impacts of providing income and/or housing supports have found limited improvements in health outcomes, often because follow up periods are too short (Larrimore, 2011; Pickett & Wilkinson, 2015). Therefore to understand changes in community level health outcomes, indicators need to be selected which are highly associated with income but also where a meaningful change would be expected in a short period of time.

Some of the shorter term significant health impacts that have been associated with providing increased incomes or rent geared to income housing include those related to mental health, psychological distress, and pain (Costello, 2003; Dunn, 2015; Gibson et al, 2014). In addition, there have been improvements in outcomes that are more closely related to income itself, such as food insecurity (i.e. affording nutritious food) and life stress (i.e. worrying less about money) (Emery et al, 2013; Dunn, 2015). As well, Tarasuk et al (2015) has shown that household food insecurity is, in turn, a robust predictor of health care utilization independent of other social determinants of health.

The most direct health evidence we have of possible health outcomes related to BI comes from Forget (2011) and Brownell (2016). Forget (2011) highlighted the impact of increased incomes on decreasing the gap between intervention and control communities for hospitalizations related to “accidents and injuries”, hypothesizing that influencing factors may be that individuals with more income security would not need to work in dangerous jobs, would be less likely to consume alcohol and other substances that put them at risk for injuries, and children may have greater parental supervision. In addition, hospitalization due to mental health diagnoses followed a pattern very similar to that of accidents and injuries. Another source of direct evidence is from Brownell et al (2016). This research examined the impact of receipt of an unconditional prenatal income supplement over six years in Manitoba. Health impacts included a 21% reduction in low birth weight and an 18% reduction in preterm births, along with improvements in small for gestational age births, breastfeeding and large for gestational age births. Shankardass (2014) showed similar relationships in perinatal outcomes with income in Nova Scotia.

The perinatal period and early childhood experiences can change one’s health trajectory over an entire life course. These two critical stages along with other times of vulnerability and dependence such as the transition to adulthood (“emerging adult” years) and older age, is where the impact of the social determinants of health can have more influence (Davies, 2011). Therefore health outcomes associated with these specific vulnerable life stages may be more likely to show a shift as a result of BI. Examples of perinatal outcomes have been mentioned previously (Brownell, 2016) and support this hypothesis. In addition, studies have reported on improvements in child test scores associated with increased incomes (Milligan & Stabile, 2011; Forget, 2011). Importantly, there have been consistent associations between Readiness to Learn (or Early Development Vulnerabilities) based on the Early Developmental Instrument (EDI) and income levels (CIHI, 2014).

Beyond health outcomes specifically, there are a number of social outcomes that are closely related to health (i.e. social determinants of health) which are very important to measure. We have not included substantial content on these outcomes in this submission as were asked to focus on community health outcomes, however we would be happy to comment on these further in future. Examples include prevalence of housing affordability (those spending 30 percent or more of their income on housing costs) and unemployment, which could be monitored with the long form census, and Ontario's Poverty Reduction Indicators, specifically high school graduation rates, education progress (grade 3 and 6 EQAO results) and the prevalence of youth not in education/ employment/ training, which are valuable indicators that are related to an individual's health trajectory and may be available at a community level.

When examining prevalence of a health outcome, statistical power is maximized when the prevalence occurs in about one-half of the population. For a very low prevalence (e.g. <10%, such as for certain perinatal outcomes), it is worth noting that a larger sample size will be required to detect significant differences when the effect of an intervention actually exists. This was considered when making recommendations on potential indicators, generally suggesting outcomes that are of relevance to most of the population and not so rare that too few cases will be found in the community under study.

Disaggregation of the Outcomes by Sex and Income:

It is also worth noting that a couple of studies that were reviewed indicated that examining the changes in health outcomes by sex is important, as some outcomes may be more likely to occur in males versus females (such as emotional problems and pain) or in females versus males (such as improvements in food security) (Milligan & Stabile, 2011; Dunn, 2015).

As described earlier, it is not only the absolute change in health outcomes at a community level that should be considered over the duration of the pilot, but also the change in the gap in each outcome between the richest and poorest members of the community. Outcomes need to be disaggregated by income groups, so that the change in health for each group and the change in health inequality (or gap) between groups can be detected.

Association of Public Health Epidemiologists in Ontario (APHEO) Core Indicators:

Based on the considerations above, the table on the following page summarizes the community health indicators and data sources that may be most appropriate for consideration for Ontario's BI pilot.

APHEO has collaborated with partners to develop over 120 standardized public health indicators. Many of these indicators are already being reported at a local level by public health units and baseline values may be available for larger communities. Wherever possible, the use of standardized indicators is recommended and consultation with local public health unit epidemiologists is advised.

Table: Community Level Health Indicators to Measure for a Basic Income Pilot

Category	Indicator	Data Source(s)**
Shorter Term Outcomes (< 3-5 years) ***– most appropriate for a Basic Income Pilot***		
Mental Health & Addictions	Self-Rated Mental Health Life stress* Sense of Community Belonging* Emergency department visits for a mental illness or an addiction (Health Quality Ontario, 2016)	CCHS or RRFSS CCHS CCHS IntelliHEALTH
Household Food Insecurity	Household Food Insecurity* Vegetable and Fruit Consumption* (may be improved as a consequence of improved food security)	CCHS CCHS or RRFSS
Healthcare Utilization	All-cause Emergency Department Visits All-cause Hospitalizations Primary Care Visits	IntelliHEALTH IntelliHEALTH ICES (special data request)
Injury	Injury-related Emergency Department Visits* Injury-related Hospitalizations*	IntelliHEALTH IntelliHEALTH
Intentional Self-harm	Intentional Self-Harm Related Hospitalizations*	IntelliHEALTH
Perinatal Outcomes	Low birth weight* Pre-term birth rate* Small for gestational age*	IntelliHEALTH or Better Outcomes Registry & Network (BORN)
Medium Term Outcomes		
School Readiness	Children Vulnerable in Areas of Early Development (see CIHI, 2014)	The Early Development Instrument (EDI)
Self-Rated Health	Self-Rated Health*	CCHS or RRFSS
Smoking	Adult Current Smokers*	CCHS or RRFSS
Longer Term Outcomes (10+ years)		
Chronic Diseases	Chronic Disease Hospitalization* Prevalence of Chronic Diseases	IntelliHEALTH CCHS or RRFSS or a special request from ICES
Diabetes	Prevalence of Diabetes (special data request from ICES)	Ontario Diabetes Database
Mortality	Potentially Avoidable Mortality* All-cause Mortality* Life Expectancy*	IntelliHEALTH (Vital Statistics) IntelliHEALTH (Vital Statistics) IntelliHEALTH (Vital Statistics)

**** indicates an APHEO core indicator***

***** a description of each data source can be found here:*** http://core.apheo.ca/index.php?pid=261#Data%20Sources

Finding the Signal in the Noise: Evaluating the Impact of the Basic Income Pilot on Community Health Outcomes

While selecting appropriate health outcomes is critical, this cannot be done without considering the methodological challenges that exist when attempting to attribute the impact of receiving a basic income on changes in health outcomes at the community level. Essential to disentangling these complex mechanisms is an appropriate study design and data collection plan.

Study Design

The design of the Basic Income Pilot will have a significant impact on the ability to measure resulting impacts on community health outcomes. Important features include:

1) Consideration should be given to the **benefit level (basic income) provided to participants in the intervention group** to ensure that it is at a level that is hypothesized to improve health outcomes. In addition, there may be consideration given to the value of randomly varying levels of the minimum basic income assigned to participants to be able to study the potential dose-response relationship related to changes in the basic income level on health.

2) **The size and number of communities that receive the basic income intervention.** Of particular concern is **to ensure sufficient statistical power to detect differences in health outcomes** that may result from BI, there needs to be a large enough sample size of people whose incomes have been enhanced/supplemented as part of the Basic Income Pilot. This can be achieved by (i) picking a large community to pilot, (ii) ensuring a saturation model is used as the intervention, and (iii) sampling sufficient respondents from the community to measure health outcomes. A statistician can be consulted to assist with both sample size as well as study design characteristics.

3) **The comparability of the selected control community(s) is an important factor for consideration**. Selecting control participants or community(s) (i.e. those that do not receive the basic income intervention) that are as similar as possible to the intervention community (e.g.in demographic characteristics and health status) is essential for minimizing potential confounding (both measured and unmeasured) and therefore ensuring that any observed effects are caused by the basic income intervention. For example, concerns have previously arisen around the comparability of the intervention and control groups when examining the effects of unconditional income transfers on birth outcomes (Racine, 2016).

4) **The time horizon of both the Basic Income Pilot and the follow-up for changes in health outcomes**. Extending the Basic Income Pilot over several years is essential for examining the potential cumulative effects of receiving the intervention. This approach would enable the study of whether the impacts of receiving a basic income go beyond protection against short-term income shocks and help shape life course trajectories for educational achievement, employment and health. In addition, the **study follow-up** for such a pilot needs to be long enough for health effects to be able to be seen. For some conditions and diseases, such as cancer, the impacts are not felt until many years later. Changes in eating behaviours and physical activity are compounded over time and lifelong changes may be necessary to see health impacts. As mentioned previously, shorter term health outcomes related to income are often most highly related to those with a direct tie to income, such as food insecurity, psychological distress, and self-rated mental health.

Therefore, to assess the impact of basic income on community health outcomes, careful consideration must be given to the benefit level assigned in the intervention, the population receiving the intervention, the comparability of the control population to the intervention population and time horizon of the Basic Income Pilot and study follow-up. To help ensure the strongest statistical power to detect changes in

community health outcomes from BI, one would want to consider a larger community, with a saturation site, over a prolonged period of time (as long as possible given this is a pilot project). If no improved health outcomes are found, it may not be an indication that BI is not achieving such outcomes, but that the initiative is too small and has not been in place long enough to see the delayed health impacts in the population. Short follow up periods have been noted as a challenge in previous studies that examined income interventions and their association to health outcomes.

Data Collection

To evaluate the impact of the basic income intervention on health outcomes, high quality data from before, during and after the intervention will be necessary. In parallel with the Basic Income Pilot and the measurement of community health outcomes as described above, it would be extremely valuable if individual level health outcomes were also measured by setting up a cohort study. The study population should include all participants receiving the basic income intervention and a control arm of comparable participants from Ontario receiving the current social assistance and benefits available to all Ontarians. The cohort study should encompass data collection on demographic factors, social determinants of health (e.g. food insecurity, housing), sources of income, aspects of the intervention (e.g. barriers to participation, what the money was used for, stigma), social assistance participation, health behaviours and mental health, social networks and other primary and secondary outcomes of interest. In addition, the survey should encompass other areas impacted by the Basic Income Pilot, including information on educational achievement, employment and economic outcomes. Where possible, this information should be collected using standardized measurement tools similar to existing data sources to allow for comparability across other study populations in Ontario and Canada. Moreover, collected data should be enhanced through routinely collected administrative data through data linkage. For example, adding income information collected for tax purposes for a more objective measure of income and wealth in study participants.

It is important that consent to be followed up for research and evaluation purposes be sought from all participants in the Basic Income Pilot study cohort. This will enable secondary research and evaluation, not part of the original Basic Income Pilot timetable, thereby enhancing the potential learning opportunities from this important social experiment. For example, consent to follow-up would enable BI recipients to be invited to participate in focus groups or key informant interviews to better understand for whom and how the intervention works. In addition, to enhance the health data collected as part of the cohort, permission and the necessary information to link project data to administrative and health databases will greatly enhance research and evaluation efforts, particularly the impact of basic income on health over longer time horizons. The benefit of administrative health data in evaluating population health interventions were observed in evaluating the health impacts of the MINCOME experiment (Forget, 2011).

Is a Basic Income Pilot Cohort Study necessary?

While there are existing data sources that can provide some of the information described above, primary data collection will be necessary to fully disentangle the impact of the Basic Income Pilot. A number of challenges can occur when trying to measure the health status at a community level, especially in smaller towns or rural locations. Consideration should be given to the following:

- **Individual Level Data:** There is no existing data source that will have individual level information on the intervention, outcomes of interest and potential confounders (e.g. demographic information) necessary to evaluate the community level health impacts of the Basic Income Pilot.
- **Administrative Data:** In the absence of including tax information into administrative data, it will likely not be possible to identify participants who received the intervention in the Basic Income Pilot. Data is also limited to information routinely collected by the health system. Information is often lacking at

individual level on socio-demographic factors and health behaviours. Using area-level indicators derived from the census will not be specific enough to evaluate an individual level BI intervention.

- **Survey Methodology:** Surveys such as the Canadian Community Health Survey may not be designed for analysis at the community level of geography and the predefined weights may not be appropriate to use. This is an important consideration for community level health outcomes comparisons, if for example CCHS participants were to be targeted as a potential control group. In order to effectively use CCHS data to measure outcomes of the pilot, the geographical area selected for the pilot needs to be defined in a way that is compatible with Statistics Canada's sampling methods. For instance, selecting Census Metropolitan Areas would ensure the CCHS sampling frame aligns with the pilot. In addition, changes to survey methodology are also important to consider for trends over time or combining multiple years of data. The CCHS underwent a major redesign for the 2015 cycle. As a result, Statistics Canada is recommending that data from 2015 onwards not be compared to data prior to 2015 (Statistics Canada, 2015).

- **Risk Factor Surveillance System (RRFSS):** Data collection could be enhanced through established collections of community level survey data such as the Rapid Risk Factor Surveillance System (http://www.rrfss.ca). In order to have sufficient sample size for the health outcomes associated with a Basic Income pilot, a customized survey available through RRFSS may be a solution. The purpose of RRFSS is to provide timely data relevant to local community needs where a specific sample size for a specific geography can be purchased with results available within 2 months. There are over 250 different modules to choose from, and additional modules can be added at request. Fourteen of the 36 public health units in Ontario are currently using RRFSS and may be producing population health estimates at the municipal level.

- **Small Sample Sizes and Large Confidence Intervals:** There may appear to be changes in health outcomes over time, but because of small sample sizes there may be large confidence intervals (i.e. uncertainty about the exact size of the health effect). This, along with the many statistical comparisons to be made for various health indicators, may result in health differences that are not statistically significant. Sample sizes also need to be large enough to be able to disaggregate the community level health outcome into income groups (often quintiles), essentially increasing the required sample size five-fold.

Role of the public health sector in the BI pilot

Measuring the impact of the Basic Income Pilot on community health outcomes in Ontario will require an extensive multidisciplinary study. The public health community in Ontario has invaluable experience in this regard. The Association of Local Public Health Agencies (alPHa) - Ontario Public Health Association (OPHA) Health Equity Workgroup, in collaboration with the Association of Public Health Epidemiologists in Ontario (APHEO), can provide important perspectives as to current community level health inequities in Ontario and which community health indicators should be assessed, in addition to supporting community-level conversations on basic income. We welcome the opportunity to provide advice on the planning and implementation of a Basic Income Pilot in these regards. In addition, a provincial-wide organization with extensive experience evaluating the impact of population-level interventions on population health and health inequities in Ontario would be ideal for conducting the proposed study. Public Health Ontario is one potential organization with the appropriate expertise, among others. Funding an independent study of the Basic Income Pilot can help avoid the MINCOME experience, where the pilot was ended without much analysis or a final report (Forget, 2011). Planning for and executing a proper study will be key to translating any findings from this experiment into knowledge and practice.

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Information Break

January 10, 2017

This semi-monthly update is a tool to keep alPHa's members apprised of the latest news in public health including provincial announcements, legislation, alPHa correspondence and events.

Save the Date: Feb. 23 & 24 alPHa Winter Symposium

Even though it seems alPHa's fall membership event just wrapped up yesterday, planning is underway for the **2017 Winter Symposium**, which will take place on February 23 at the DoubleTree by Hilton in downtown Toronto. On the following day, February 24, alPHa will be holding concurrent Section meetings for board of health members and medical officers of health at the same venue. Details on registration and program coming soon.

TOPHC 2017: Global challenges. Local solutions.

The 7th annual The Ontario Public Health Convention (TOPHC) will be held March 29-31, 2017 at the Allstream Centre in Toronto. A collaboration of Public Health Ontario, alPHa and the Ontario Public Health Association, TOPHC is an opportunity for public health professionals to learn from each other, provoke thought, and get motivated to make a difference in the practice of public health. This year's theme, ***Global challenges. Local solutions.*** will highlight solutions to the global challenges facing public health every day. Emerging infectious diseases, the effects of the social determinants of health, the impacts of climate change, and rising chronic diseases will all be a focus. Come and learn about solutions to these pressing challenges and how to apply them to your work. Registration is now open; early bird deadline is **February 12**.
Register here for TOPHC 2017
Learn more about TOPHC 2017

Updated alPHa Records Retention Guidelines

alPHa has updated its *Guidelines on Minimum Retentions for Health Unit Records*. While retention periods have not changed, citations of legislation have been updated, where applicable, in the appendix, and links to legislation have also been added. Many thanks to the working group members from the following health units who assisted with the review: Haliburton, Kawartha Pine Ridge District; Leeds, Grenville & Lanark District; Niagara Region; and Wellington-Dufferin-Guelph. For a copy of the Guidelines, please send an email to alPHa.

Public Health Reports of Interest

Health Status of Canadians 2016: Report of the Chief Public Health Officer (released Dec. 15, 2016)

A Framework for the Legalization and Regulation of Cannabis in Canada -- The Final Report of the Task Force on Cannabis Legalization and Regulation (released Dec. 13, 2016)

alPHaWeb Feature: Current Consultations

Health units and members of the public are often invited by government to provide their input on legislation and initiatives of interest. alPHa has compiled a list of consultation opportunities for members on its website. Click below to view.
Go to alPHa's list of Current Consultations

alPHa Group Insurance Offer

alPHa members and all health unit staff are eligible to receive an exclusive group discount of 12.5% on home and auto insurance from Aviva Insurance. Request a quote today by visiting www.alphagroupinsurance.ca or by calling 1-877-787-7021. Other benefits include: additional savings available through other discounts, free access to personal legal, home and health information service (included with home insurance policies), and professional claims handling backed by Claims Service Satisfaction Guarantee.

Upcoming Events - Mark your calendars!

February 23 & 24, 2017 - alPHa Winter Symposium, DoubleTree Hilton Hotel, Toronto, Ontario. Registration and program details coming soon!

March 29-31, 2017 - TOPHC 2017: Global challenges. Local solutions. Allstream Centre, Toronto.

June 11, 12 & 13, 2017 - 2017 alPHa Annual General Meeting and Conference: *Driving the Future of Public Health*, Chatham-Kent John D. Bradley Convention Centre, Chatham, Ontario.

alPHa is the provincial association for Ontario's public health units. You are receiving this update because you are a member of a board of health or an employee of a health unit.

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Ontario

January 18, 2017

Dear Colleague,

I am pleased to announce the establishment of a Public Health Expert Panel to advise on structural and organizational factors that will improve the integration of population and public health into the health system, deepen the partnerships between local boards of health and LHINs, and improve public health capacity and delivery within a transformed and integrated health system.

The *Patients First: Action Plan for Health Care*, December 2015, and the *Patients First: Reporting Back on the Proposal to Strengthen Patient-Centred Health Care in Ontario*, June 2016, made commitments to engage with our indigenous partners and to four key proposals intended to reduce gaps and strengthen patient-centred care in Ontario. These proposals included strengthening connections between population and public health and the rest of our health system, and establishing the expert panel on public health.

On December 7, 2016 Ontario passed Bill 41: the *Patients First Act, 2016* and we are now moving forward with our commitment to transform and truly integrate our health system, using a population heath and health equity approach to health system planning and delivery across the continuum of care.

The panel that has been established includes experts that have been appointed from several sectors (see attached list) and will be chaired by Dr. David Williams, Ontario's Chief Medical Officer of Health. Roselle Martino, Assistant Deputy Minister, Population and Public Health Division, will serve as the ministry's Executive Sponsor.

The Expert Panel has been given a mandate to provide their strategic and confidential advice to me by Spring, 2017. The work of the Panel will include a review of various operational models for the integration of public health into the broader health system and the development of options and recommendations that will best align with the principles of health system transformation, enhance relationships between public health, LHINs and other public sector entities and improve public health capacity and delivery.

I look forward to the continued participation of the public health sector in our system transformation and working with you to ensure that population and public health expertise is used to build a better health system that serves the needs of all Ontarians.

Yours sincerely,

Dr. Eric Hoskins
Minister

c: Dr. Robert Bell, Deputy Minister
Dr. David C. Williams, Chief Medical Officer of Health
Roselle Martino, Assistant Deputy Minister, Population and Public Health Division

Public Health Expert Panel

Chair:
Dr. David Williams, Chief Medical Officer of Health

Executive Sponsor:
Roselle Martino, Assistant Deputy Minister, Population and Public Health Division, MOHLTC

Members:
Dr. Laura Rosella, University of Toronto
Solomon Mamakwa, Sioux Lookout First Nations Health Authority, Health Advisor for NAN
Susan Fitzpatrick, Toronto Central Local Health Integration Network (LHIN)
Carol Timmings, Registered Nurses Association of Ontario, Toronto Public Health
Dr. Valerie Jaeger, Niagara Region Public Health Unit, alPHa
Dr. Nicola Mercer, Wellington-Dufferin-Guelph Public Health Unit
Gary McNamara, Mayor of the Town of Tecumseh, Association of Municipalities of Ontario
Dr. Jeffrey Turnbull, The Ottawa Hospital, Health Quality Ontario

Minister's Expert Panel on Public Health

Mandate

The main objective of the Expert Panel is to recommend changes to the local public health sector that would support the realization of the Minister's vision for an integrated health sector as outlined in *Patients First: A Proposal to Strengthen Patient-Centred Health Care in Ontario*.

The mandate of the Expert Panel will be to provide advice to the Minister on structural, organizational and governance changes for public health. The work of the Expert Panel will include a review of various operational models for the integration of public health into the broader health system, the development of options and considerations for implementation.

As part of its deliberations, the Expert Panel will consider:

- How the organization and structure of public health can best align with the principles of health system transformation, with a focus on health equity, access, meeting the needs of patients, population-focused and integration at the local level.
- A clearly defined role for public health units in the broader health system. It will ensure the population health planning and equity expertise and functions of public health are informing needs assessment, planning and resource allocation decisions. The modernization of the Ontario Public Health Standards and the Ontario Public Health Organizational Standards (Standards Modernization) will provide key inputs.
- Potential opportunities for and impacts of structural, organizational and governance changes to public health units.
- That funding for public health programs and services is to be protected.

The following is an outline of in-scope and out-of-scope considerations for the work of the Expert Panel:

In Scope:	Out of Scope:
Recommendations on the structure and organization of Ontario's public health system.	Recommendations on overall structure and organization of health care system.
Recommendations on governance models within recommended system structure.	Recommendations on funding and funding models.
Relationships between public health and other public sector entities.	Definition of the scope of public health programming and services (being addressed through the Standards Modernization process).
System-wide public health capacity considerations.	Capacity considerations at a regional/local or organizational level.
	Implementation of recommendations.

Expert Panel on Public Health: Panel Member Biographies

Date: January 18, 2017

Confidential

Ontario

Expert Panel on Public Health

Panel Members

Panel Chair:
David Williams, MD, MHSc, FRCPC
Chief Medical Officer of Health Ministry of Health and Long-Term Care

Dr. David Williams was appointed as the province's Chief Medical Officer of Health, effective February 16, 2016.

Since July 1, 2015, Dr. Williams served as the Interim Chief Medical Officer of Health for the province of Ontario, having been the Medical Officer of Health for the Thunder Bay District Board of Health from October 2011 to June 30, 2015.

Dr. Williams held the position of Associate Chief Medical Officer of Health, Infectious Disease and Environmental Health Branch Director at the Ministry of Health and Long-Term Care from 2005 to 2011. During this time he was also the Acting Chief Medical Officer of Health for Ontario from November 2007 to June of 2009. Prior to working at the province, Dr. Williams was the Medical Officer of Health and CEO for the Thunder Bay District Health Unit from 1991 to 2005.

Dr. Williams is a four time graduate of the University of Toronto receiving his BSc., MD, Masters in Community Health and Epidemiology (MHSc) and Fellowships in Community Medicine/Public Health and Preventive Medicine (FRCPS).

Prior to entering public health, Dr. Williams practiced hospital-based clinical practice as a GP and GP Anesthetist at the Sioux Lookout Zone Hospital and also in International Health at the United Mission to Nepal Mission Hospital, Tansen, Nepal.

Susan Fitzpatrick
Chief Executive Officer
Toronto Central Local Health Integration Network (LHIN)

Susan Fitzpatrick is the Chief Executive Officer of the Toronto Central Local Health Integration Network (LHIN) in 2015, following a career in the Ontario Public Service that spanned more than three decades.

In this role, Susan leads an organization with a mandate to plan and integrate local health services, engage with the central Toronto community, and allocate 4.7 billion dollars to over 170 local health service providers. Susan is also accountable for strengthening the local health care system through leading the implementation of the Toronto Central LHIN's Strategic Plan for 2015 to 2018, which focuses on three goals: A Healthier Toronto, Positive Patient Experiences, and System Sustainability.

Prior to joining the LHIN, Susan was Associate Deputy Minister, Health System Delivery and Implementation, Ministry of Health and Long-Term Care. As Associate Deputy Minister, Susan was responsible for bringing together health programs in LHINs, CCACs, Long-term Care and Physician Services, and creating alignment opportunities in order to deliver quality health services to patients.

Susan is a results-oriented leader, strategic planner and a skilled negotiator with a capacity to engage stakeholders and build consensus across the broader health sector and within government.

Valerie Jaeger, MD, PhD, MPH
Medical Officer of Health
Niagara Region Public Health

Dr. Valerie Jaeger has been Medical Officer of Health for Niagara Region for the past five years. In this capacity she is responsible for protecting the health of Niagara's 450,000 residents and 15 million visitors through Public Health programs, Land Ambulance and Dispatch Services and Emergency Planning. Dr. Jaeger also currently holds part-time appointments in Community Health Sciences at Brock University and in the Department of Health Research Methods, Evidence, and Impact, McMaster University

Dr. Jaeger's eclectic view of the world was shaped by life in fourteen cities and three continents. Many universities have been like home to her; including Cambridge and Edinburgh in the UK and, in Canada, the University of New Brunswick (Bachelor of Science), McGill University (PhD and MD) and University of Waterloo (Master of Public Health). Twenty-five years in private family practice and university student health contributed to her being named Family Physician of the Year for Southern Ontario in 2006.

Dr. Jaeger is President of alPHa (Association of Local Public Health Agencies), a former Chair of the Council of Ontario Medical Officers of Health and the founder of the Niagara Health Trust. She served for eleven years on the Brock University Board of Trustees and has also been Chair of successful local United Way Campaigns.

Being convinced that progress best occurs when new perspectives are sought, Dr. Jaeger aims to bring the knowledge of other disciplines such as physics, economics and psychology to Public Health. She has the privilege of enabling her over 600 staff to do great work that they are passionate about.

Gary McNamara
Mayor of the Town of Tecumseh

Gary McNamara was born and raised in Cornwall, Ontario and moved to Tecumseh 35 years ago. He was employed at Hiram Walkers and Sons Ltd. as a Power Engineer until his retirement in 2011. He has been married to Heather for 41 years, and is the father of two grown sons and proud grandfather of three grandchildren.

Gary was first elected to Tecumseh Town Council in November of 1991. In 1998, Gary was elected as Deputy Mayor and in November 2003, he was elected Mayor for the Town of Tecumseh. Gary was re-elected as Mayor in 2006, acclaimed in 2010, and re-elected in 2014. His County Council colleagues entrusted Gary with the responsibilities of Deputy Warden for 2000-2003 and again for 2010-2014. He has been a strong community leader for over 30 years.

As part of the restructuring of the electricity sector in Ontario in June 2000, four municipalities joined to form Essex Power Corporation. Gary has been elected as Chair since its incorporation, and has been instrumental in its strategic planning.

Gary has served as Tecumseh's representative on the Windsor-Essex County Health Unit since 1999. He was elected as Chair for 2006-2009 and again since January 2011.

Gary was first elected in 2004 as a Director for the Association of Municipalities of Ontario (AMO), Small Urban Caucus. In 2006 he was elected Chairman of Ontario Small Urban Municipalities (OSUM). In 2011 and again in 2014, Gary was acclaimed as President of the Association of Municipalities of Ontario, a position he has held until August 2016, now currently serving as AMO's Past President until August 2018. Gary also serves as Chair of AMO's Local Authority Services.

Solomon Mamakwa
Health Advisor
Nishnawbe Aski Nation

Solomon Mamakwa is Oji-Cree and band member of Kingfisher Lake First Nation located in northwestern Ontario. Currently, he is the Health Advisor for Nishnawbe Aski Nation (NAN). Previously, he was the Health Director for Shibogama First Nations Council in Sioux Lookout for 9 years.

He is active on several boards, including Board Member for Sioux Lookout First Nation Health Authority, Sioux Lookout Regional Physicians Services Inc., Northern Ontario School of Medicine and is also the Co-chairman and Board Member for Sioux Lookout Meno Ya Win Health Centre.

Nicola J. Mercer, MD, MBA, MPH, FRCPC
Medical Officer of Health and CEO
Wellington-Dufferin-Guelph Public Health

Dr. Nicola Mercer was appointed as the Medical Officer of Health and CEO for Wellington-Dufferin-Guelph Public Health in 2007.

A prior anesthesiologist with 15 years of direct patient care in teaching and community hospitals, Dr. Mercer also served as the chief of anesthesiology at Guelph General Hospital. Her experience as a physician, MOH and CEO has given her working relationships with senior hospital leadership, community agencies and municipal and provincial leaders.

Dr. Mercer serves as a member of the Cardiac Care Council of the Waterloo Wellington LHIN and she is a member of the Provincial Infectious Diseases Advisory Committee Tuberculosis Working Group. She has served as the Secretary of the Ontario Medical Association Section of Anesthesiology and as a Royal College of Physicians and Surgeons of Canada Examiner for 5 years.

In her community, Dr. Mercer is past president of the Wellington County Medical Association and currently sits as a member of the University of Guelph, Board of Trustees. She also holds the position of Special Graduate Faculty in support of the Department of Pathobiology, University of Guelph.

Having received medical training including her residency as an anesthesiologist at the University of Toronto, Dr. Mercer also received a Master of Business Administration from Wilfrid Laurier University and a Masters of Public Health from the University of Waterloo. She has had several publications in the Canadian Veterinary Journal and the Canadian Journal of Public Health.

Dr. Mercer has lived in Guelph for more than 20 years and met her husband, a Guelph family physician, in the operating room of the old St. Joseph's Hospital. Nicola and her husband have two children.

Laura Rosella, PhD, MHSc
Canada Research Chair in Population Health Analytics
Assistant Professor, Dalla Lana School of Public Health, University of Toronto,
Scientist, Public Health Ontario

Dr. Rosella has formal training in public health, epidemiology, biostatistics and public health policy. Her primary role is a full-time tenure-track faculty position in the Dalla Lana School of Public Health at the University of Toronto.

Dr. Rosella currently holds a Tier 2 Canada Research Chair in Population Health Analytics (2015-2020) and appointments at the Institute for Clinical Evaluative Sciences and Public Health Ontario. She has authored 80 peer-reviewed publications in the area of public health, public health policy, and health services research. Her expertise in population health, health system research and strong methodological background uniquely positions her research to enable meaningful synergies between health care, public health and social systems to improve population health and ensure a sustainable and equitable healthcare system.

She specializes in population data sources, ranging from primary collected data to administrative data, health and non-health data, as well as in designing new methods to use these data in innovative ways. Dr. Rosella has led the development of population

risk tools to support health decision-making, which are being adapted in several countries. In addition, Dr. Rosella has developed a formal partnership with several health leaders across Canada, including local, provincial, and national health decision-makers focused on diabetes prevention.

Her recent focus on linking prevention efforts to health system sustainability an issue that affects every healthcare system in the world as they grapple with declining funding yet increased demand for healthcare.

Carol Timmings, R.N. B.N.Sc., M.Ed. (Admin)
Director, Child Health and Development
Chief Nursing Officer
Toronto Public Health

Carol Timmings is currently the Director of Child Health and Development and Chief Nursing Officer with Toronto Public Health. She holds a Bachelor of Nursing Science Degree and a Master of Education Degree in Policy & Administration, both from Queen's University.

Carol is a highly developed nursing leader with demonstrated abilities in senior management, healthy public policy, program development and strategic system and service planning. She is a results-oriented executive with extensive experience spanning the areas of chronic disease and injury prevention, child and family health, environmental health, health planning and policy. Her commitment to the social determinants of health and reducing health inequities is consistently evidenced in her approach to public health leadership. As Chief Nursing Officer with Toronto Public Health, Carol is also responsible for nursing human resource planning, quality nursing practice and enhancing nursing contributions to organizational effectiveness related to improved health outcomes at individual, group and population levels.

Over her career, Carol has had extensive executive involvement with professional Associations and Advisory Boards provincially and nationally. She is currently the President of Registered Nurses Association of Ontario (RNAO) and member of the Advisory Board for National Collaborating Centre for Determinants of Health. Previous professional association involvement includes Past-President of Ontario Public Health Association (OPHA) and Past-President of ANDSOOHA - Public Nursing Management in Ontario.

In 2010, Carol received the Association of Local Public Health Agencies Distinguished Service Award in recognition of her outstanding leadership and contributions to public health in Ontario. OPHA also honoured Carol in 2015 with a Lifetime Membership Award, in recognition of her outstanding leadership and contributions to the Association.

Jeffrey Turnbull, MD, FRCPC
Chief of Staff, The Ottawa Hospital
Chief, Clinical Quality, Health Quality Ontario

In addition to a BSc (University of Toronto) and a Master's Degree in Education (University of Western Ontario), Dr. Turnbull received his Doctorate in Medicine at Queen's University and later achieved specialty certification in Internal Medicine through the Royal College of Physicians and Surgeons of Canada in 1982.

Dr. Turnbull has been the Vice Dean of Medical Education at the University of Ottawa (1996-2001), the President of the Medical Council of Canada (1998- 2001), the President of the College of Physicians and Surgeons of Ontario (2006-2007) and finally the President of the Canadian Medical Association (2010-2011).

Dr. Turnbull has pursued an interest in poverty and its effect on health nationally and internationally. He is one of the founders and is currently the Medical Director of Ottawa Inner City Health for the homeless which works to improve the health and access to health care for people who are chronically homeless. As well, he has been involved in education and health services initiatives to enhance community and institutional capacity and sustainable development in Bangladesh, Africa and the Balkans. He is the recipient of several national and international grants and awards, including the Order of Canada, the Order of Ontario, the Queen Elizabeth II Diamond Jubilee Medal and an Honorary Degree of Law from Carleton University.

In addition to being a specialist in Internal Medicine, Dr. Turnbull was the Department Chair of Medicine at The Ottawa Hospital and University of Ottawa from (2001-June 2008), a position he left to take on the role of Chief of Staff. He also served as Senior Medical Officer for Correction Services Canada (2011-2014). He recently took on the role of Chief, Clinical Quality for Health Quality Ontario. He remains committed as a medical educator with special interests in "Poverty and Health Inequity" and associated health policy.