Algoma
PUBLIC HEALTH
Santé publique Algoma

BOARD OF HEALTH MEETING

NOVEMBER 22, 2017

Sault Ste. Marie Community Room A

www.algomapublichealth.com

November 22, 2017 - Board of Health Meeting Book

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information only

7. New Business

8. Correspondence

a. Alcohol Modernization in Ontario

b. Caffeinated Energy Drinks

c. Expert Panel

15. Adjournment

ALGOMA PUBLIC HEALTH
BOARD OF HEALTH MEETING
NOVEMBER 22, 2017 @ 5:00PM
SAULT STE MARIE ROOM A, SSM
A*G*E*N*D*A

1.0 Meeting Called to Order — Mr. Lee Mason, Board Chair

a. Declaration of Conflict of Interest

2.0 Adoption of Agenda Items — Mr. Lee Mason, Board Chair

Resolution
THAT the agenda items dated November 22, 2017 be adopted as circulated.

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

a. October 25, 2017 – Board of Health Meeting

Resolution
THAT the Board of Health minutes for the meeting dated October 25, 2017 be adopted as circulated.

b. November 8, 2017 – Special Meeting of the Board

Resolution
THAT the Board of Health minutes for the meeting dated November 8, 2017 be adopted as circulated.

4.0 Delegations/Presentations.

a. Smoke-free Ontario Tobacco Cessation: 5% in 5 — Ms. Kristy Harper, Program Manager; Ms. Janet Allen, Public Health Nurse

5.0 Business Arising from Minutes

6.0 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 November 2017 be adopted as presented.

b. Finance and Audit Committee Report — Mr. Ian Frazier, Committee Chair

i. Committee Chair Report for November 2017

Resolution
THAT the Finance & Audit Committee report for the month of November 2017 be adopted as presented.

ii. Draft Financial Statements for the Period Ending September 30, 2017

Resolution
THAT the Financial Statements for the Period Ending September 30, 2017 be approved as presented.

UNAPPROVED

iii. Draft APH 2018 Public Health Operating & Capital Budget

Resolution

THAT the Finance and Audit Committee recommends and put forth to the Board of Health for approval the draft APH 2018 Public Health Operating & Capital Budget

iv. 2017 Contribution to APH Reserve Fund

Resolution

THAT the Finance and Audit Committee recommends that the Board of Health approved a contribution of $200,000 into the Reserve Fund from Algoma Public Health's operating count.

v. Renewal of Service Contract with the Innovation Centre

Resolution

THAT the Board of Health approves:

1. *The Sault Ste. Marie Innovation Centre (SSMIC) to continue to provide geographic information system (GIS) and other information management services to APH.*
2. *The 3-year contract renewal between APH and SSMIC as presented.*

vi. Approved minutes September 13, 2017 ***– for information only***

c. Governance Standing Committee Report — Ms. Deborah Graystone, Committee Chair

i. Committee Chair Report for October 2017

Resolution

THAT the Governance Standing Committee report for October 2017 be adopted as presented.

ii. Policy Review
02-05-015 – Conflict of Interest Policy

Resolution

THAT the Board of Health approves the proposed changes to policy 02-05-015 – Conflict of Interest.

iii. Approved Minutes September 13, 2017 – ***for information only***

7.0 New Business/General Business

8.0 Correspondence — Mr. Lee Mason, Board Chair

a. Alcohol Modernization in Ontario
- i) Letter to Minister Hoskins from Northwestern Health Unit dated October 31, 2017
- ii) Resolution from Thunder Bay District Health Unit dated October 18, 2017

b. Caffeinated Energy Drinks
- i) Letter to Ministers from Peterborough Public Health dated October 31, 2017
- ii) Letter to Minister Taylor from Peterborough Public Health dated October 31, 2017

UNAPPROVED

c. Expert Panel on Public Health Report
- i) Letter to Minister Hoskins from Northwestern Health Unit dated October 23, 2017
- ii) Letter to Minister Hoskins from Mr. Mihevc, Chair of City of Toronto Board of Health dated October 31, 2017
- iii) Letter to Minister Hoskins from Kingston, Frontenac and Lennox & Addington dated October 26, 2017
- iv) Letter to Ms. Martino from Sudbury & District Health Unit dated October 27, 2017
- v) Letter to Provincial Boards of Health from York Region dated October 20, 2017
- vi) Letter to Minister Hoskins from Porcupine Health Unit dated October 31, 2017
- vii) Letter to Minister Hoskins from Thunder Bay District Health Unit dated October 18, 2017
- viii) Resolution 2017-02 from Haliburton, Kawartha, Pine Ridge District Health Unit dated October 19, 2017
- ix) Letter to Minister Hoskins from Renfrew County and District Health Unit dated October 31, 2017
- x) Letter to Minister Hoskins from the Association of Ontario Public Health Business Administrators dated November 1, 2017
- xi) Letter to Premier Wynne and Minister Hoskins from Regional Municipality of Waterloo dated November 2, 2017
- xii) Letter to Minister Hoskins from Grey Bruce Health Unit dated November 14, 2017
- xiii) Memorandum to Premier Wynne from Durham Region dated November 9, 2017

d. Healthy Menu Choices Act
- i) Letter to Minister Hoskins from Grey Bruce Health Unit dated October 25, 2017

e. Health Promotion Resource Centres
- i) Letter to Minister Hoskins from Grey Bruce Health Unit dated October 25, 2017

f. Legalization of Cannabis
- i) Letter to Minister Naqvi from Elgin St. Thomas Public Health dated October 23, 2017

g. Nutritious Food Basket
- i) Letter to Minister Hoskins from Kingston, Frontenac and Lennox & Addington Public Health dated October 26, 2017

h. Report of the Rowan's Law Advisory Committee
- i) Memorandum to Premier Wynne from Durham Region dated November 9, 2017

i. Smoke-Free Modernization
- i) Letter to Minister Hoskins from Simcoe Muskoka District Health Unit dated October 25, 2017

9.0 Items for Information

a. alPHa Information Break – November 1, 2017 — Mr. Lee Mason, Board Chair

UNAPPROVED

10.0 Addendum

11.0 That The Board Go Into Committee Mr. Lee Mason, Board Chair

Resolution
THAT the Board of Health goes into committee.

Agenda Items:

a. Adoption of previous in-committee minutes dated October 27, 2017
b. Litigation or Potential Litigation
c. Labour Relations and Employee Negotiations

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

Resolution
THAT the Board of Health goes into open meeting

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

14.0 Announcements: Mr. Lee Mason, Board Chair

Next Board Meeting:
January 24, 2018 at 5:00pm
Sault Ste. Marie, Room A, Sault Ste. Marie

15.0 That The Meeting Adjourn Mr. Lee Mason, Board Chair

Resolution
THAT the Board of Health meeting adjourns

UNAPPROVED

5% In Five

One Big, Incredibly Innovative, Integrated, Collaborated, Comprehensive Strategy to Get Algoma Smokers to Quit

Kristy Harper, Program Manager, Chronic Disease Prevention, Injury Prevention & Genetics
Janet Allen, Public Health Nurse, Tobacco-Control Program Coordinator

November 22, 2017

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Chronic Disease Prevention

Goal:
To reduce the burden of preventable chronic diseases of public health importance

- Assess the health of our communities
- Increase public awareness about healthy living behaviours
- Collaborate with our communities
- Create or enhance supportive environments
- Support healthy public policies

Health topics we focus on to influence healthy behaviours to reduce chronic disease, include: physical activity, healthy eating, healthy weights, alcohol use, **tobacco use**, and exposure to ultraviolet radiation.

Chronic Disease Prevention

Comprehensive Tobacco Control

Prevention

- Education on existing and emerging tobacco related issues
- Youth engagement and development

Cessation

- Community partnerships to address gaps in tobacco cessation
- Provide consultation services to organizations and worksites
- Integrate quit smoking supports into client services

Protection

- Support the implementation and enforcement of the Smoke Free Ontario Act

5% in Five

Why:

- 2015 Algoma Cancer Report identifies significantly higher than provincial incidence rates for lung and bronchus cancer (64.7 versus 52.5 per 1000,000) and smoking rates (23.6% versus 17.8%)

What:

- A Call to Action to reduce smoking rates by 5% over five years across the district.
- 100,000 cumulative quit attempts by the approximately 22,000 smokers in Algoma would be needed to achieve this goal

When:

- 2016-2020 , designated 2015 as a partnership strategy planning year

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5% in Five

Who:

- A district-wide 5% in five year partnership collaborative to move a coordinated strategy forward

How:

- Initiate opportunities for quit smoking support groups and mobile cessation clinics for worksites
- support a communication campaign that highlight quit stories
- promote the First Week Challenge quit contest

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5% in Five

How:

- Each partner would also up their game in some way to support quit attempts

APH would:

- Coordinate quarterly meetings
- Enhance its own quit smoking supports
- Map out cessations services offered in Algoma
- Help smokers navigate services
- Develop a cessation services directory pamphlet
- Coordinate the communication campaign on behalf of the partnership

Partnering Agencies

Algoma
Nurse Practitioner-Led Clinic

PTCC CFC
Program Training and Consultation Centre
A resource centre of the Ontario Tobacco Strategy
Centre de formation et de consultation
Un centre de ressources de la Stratégie Ontarienne de lutte contre le tabac

ESSAR STEEL

SAULT COLLEGE

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THE ONTARIO TOBACCO RESEARCH UNIT
UNITÉ DE RECHERCHE SUR LE TABAC DE L'ONTARIO
Generating knowledge for public health

Group Health Centre

Superior Family Health Team

Blind River District Health Centre
Pavillon Santé du District de Blind River

ÉQUIPE SANTÉ FAMILIALE ELLIOT LAKE FAMILY HEALTH TEAM

North Channel
Nurse Practitioner-Led Clinic

LADY DUNN HEALTH CENTRE
Centre de santé Lady Dunn

RICHMONT


St. Joseph's General Hospital
Elliot Lake

N'Mninoeyaa
Aboriginal Health Access Centre

SAULT AREA HOSPITAL
HÔPITAL DE SAULT-SAINTE-MARIE

How Are We Evaluating the Successes to Date?

Formal evaluation work plan developed with the help of the Ontario Tobacco Research Unit (OTRU) and input from the strategy's partners

- Do the partners continue to be engaged?
- Have smoking cessation strategies been integrated in to practice at partner agencies?
- Has there been examples of innovation in encouraging quit attempts in Algoma?
- Has the strategy sought out opportunities to fund and expand initiatives?

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Engagement

11 Partners Interviewed ~ Themes Identified

- ✓ Building and integrating opportunities
- ✓ Supporting low cost innovation
- ✓ Advancing partnerships
- ✓ Strengthening capacity
- ✓ Identifying lessons learned
- ✓ Securing resources
- ✓ Targeting sites and populations
- ✓ Tracking outcomes

Supporting Collaboration

Individual cessation committees meet every other month to look at local issues and gaps in quit smoking services in their local communities

Quarterly teleconferences bring all the partners together across Algoma for strategy planning, sharing and networking

Strategy Development

Partner surveys conducted annually for input into strategy initiatives

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Integration

Resources
A District-wide "Ready to Quit" pamphlet created to support streamlined information to services

STOP Program
18 partners offer intensive cessation support

STOP Program
966 Enrollees

District Star
The Blind River Hospital is now implementing the Ottawa Model for smoking cessation

Quit Smoking Contest
247 Registrants

Quit Smoking Support Groups
Algoma Nurse Practitioner–Led Clinic & APH pilot fall 2017

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Innovation

Sault Ste. Marie Workplace

The Ontario Finnish Resthome Association integrates opportunities for smoking behaviour change support and resources with employees during monthly wellness sessions and during annual wellness audits

District Workplace

Richmont Mines Inc. Island Gold Mine has run 2 cessation sessions that helped set up 18 employees with ongoing quit supports and Nicotine Replacement Therapy on site

"This is My Quit Story" Communication Campaign

Radio: 118,700 persons
Social Media: 67,093 persons
Post/Clicks on Social Media: 23,929
Reactions on Social Media: 1084
Comments on Social Media: 98
Shares on Social Media : 223

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Additional Support

Funding

- Proposal and revisions submitted to the Ministry of Health and Long Term Care Research Fund in April 2017

- Program Training Consultation Centre Communication Campaign Funding received ($27,000)

FUEL UP for Another Great Year

Let's Keep Reaching for the Stars!

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MEDICAL OFFICER OF HEALTH/CHIEF EXECUTIVE OFFICER BOARD REPORT

NOVEMBER 22, 2017

Prepared by: Dr. Marlene Spruyt, Medical Officer of Health/CEO

and the Leadership Team

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APH AT-A-GLANCE

Fall is a busy season in public health and November probably one of the busiest months. School immunization programs are delivering hepatitis B, Meningitis and HPV vaccines to all Grade 7 students in the district and the annual universal influenza immunization program (UIIP) is in full swing. We order and provide vaccines to other healthcare providers in the district including physician and nurse practitioner clinics, hospital and long term care institutions and we provide immunization services to individuals in our communities through on site and outreach clinics. Pharmacists no longer order vaccine through public health although we still perform annual fridge inspections to confirm their compliance with cold chain requirements.

APH influenza clinics experienced a change this year from a system of appointment only access. There was a 16% no show rate in previous years and this year we adopted a combined system where clinics with booked appointments also provided access to walk-ins. In addition we have reached out to more community partners such as the Neighborhood Resource Center (NRC) in SSM to offer vaccine to individuals attending for other purposes. In previous years staff from all other programs were pulled to deliver flu immunizations and this year we have worked to minimize the disruption to other programming. Some hiccups have been experienced along the way which is inevitable when there are system changes, but we are working through the issues and learning from them to make further improvements.

One of our public health inspectors, Kara Flannigan, has been awarded the National Sanitation Foundation (NSF) International Food Safety Award (to be shared with another nominee). The NSF International Food Safety Award is presented in partnership with the Environmental Health Foundation of Canada to a practicing Public Health Inspector who has made outstanding contributions primarily in the promotion of food safety in Canada. The recipient shall display the highest level of dedication, commitment, inspiration and leadership in the field of environmental health, with a focus on food safety. Kara was nominated based on many factors (passion inside and outside work, length of commendable service, ongoing efforts made to the community in helping find ways of diverting foods destined for waste to those who could benefit etc.).

I was able to attend the alPHa Fall meeting on November 3 where the Council of Medical Officers of Health (COMOH) focused on submissions to the Expert Panel as well as sharing of LHIN engagement strategies and as always general public health updates. I will be in Toronto on November 16 for a MOHLTC Public Health Summit which was called to begin roll out of the new standards. Further updates about this process will be forthcoming.

PROGRAM HIGHLIGHTS

ENVIRONMENTAL HEALTH

Director: Sherri Cleaves
Manager: Jonathon Bouma

Topic: Radon

This report addresses the following requirements of the Ontario Public Health Standards (2014): Health Hazard Prevention and Management:

- **Requirement #1:** The board of health shall conduct surveillance of the environmental health status of the community in accordance with the Identification, Investigation and Management of Health Hazards Protocol, 2008 (or as current); and
- **Requirement #3:** The board of health shall increase public awareness of health risk factors associated with the following health hazards: Indoor air quality

This report addresses the following Strategic Directions:

- Improve Health Equity
- Be Accountable

Ontario Public Health Standards Goal:

- To prevent or reduce the burden of illness from health hazards in the physical environment

What is radon?

Radon is a colorless, odourless and radioactive gas that is found naturally in the environment and is produced when uranium found in soil, rock or water decays. It can be found in the soil all over Canada but is particularly high in the Canadian Shield geography. Radon gas enters into buildings through cracks in foundation walls and floors, or gaps around pipes and cables. Radon levels are generally highest in basements and crawl spaces because these areas are nearest to the source and are usually poorly ventilated. Radon that is released outdoors is diluted in the air and is not a threat to human health. However, in enclosed spaces, like basements, it can accumulate to higher levels.

Breathing in radon gas for extended periods of time (years) can potentially be hazardous to human health. Radon is the leading cause of lung cancer among non-smokers. In people who smoke, exposure to radon significantly increases the risk of lung cancer. Ontario has about 850 lung cancer deaths each year due to radon exposure[1].

Radon Exposure in the District of Algoma

Health Canada recommends taking corrective action when radon concentrations are above 200 Bq/m^3. However, any exposure to radon poses some level of risk, and reducing radon exposure to levels as low as reasonably achievable can help prevent some lung cancers.

Estimated radon exposures in homes in the District of Algoma are displayed in the following table[2].

Radon Concentration	Percentage of Algoma households affected
Less than 50 Bq/m^3	69.9%
50 to less than 100 Bq/m^3	10.8%
100 to less than 150 Bq/m^3	7.5%
150 to less than 200 Bq/m^3	3.2%
At or above 200 Bq/m^3	8.6%

Consistent with radon exposure patterns across Ontario, many more homes in Algoma are affected by radon levels in the lower range. Reducing radon exposure to levels as low as reasonably achievable will target a greater proportion of the population and prevent more lung cancer deaths, than a targeted "high risk" strategy alone.

The following table illustrates the theoretical number of radon-attributable lung cancer deaths that could be prevented each year in Ontario and in Algoma, if all homes at or above the indicated levels were remediated to natural background levels (10 to 30 Bq/m^3).

Radon concentration as threshold for remediation (currently 200 Bq/m^3)	Cumulative number of lung cancer deaths prevented annually (%)	
	Algoma	**Ontario**
At or above 200 Bq/m^3	3 (24.3%)	91 (10.8%)
At or above 150 Bq/m^3	4 (26.6%)	149 (17.6%)
At or above 100 150 Bq/m^3	5 (36.8%)	233 (27.5%)
At or above 50 Bq/m^3	7 (47.8%)	389 (46.0%)
Below 50 Bq/m^3	14 (100%)	847 (100%)

Radon mitigation

Health Canada recommends that steps should be taken to lower the radon level in a home whenever the average annual radon concentration exceeds 200 Bq/m^3 in the normal occupancy area (the lowest lived-in location where a person spends more than 4 hours per day). Construction measures to reduce indoor radon levels typically involve sealing openings in a home where radon could be entering, depressurizing around the foundation of a building, and/or increasing mechanical ventilation of the home.

Public health interventions for radon

Individual Testing

All homes have different levels of radon, and therefore the only way to determine a household's exposure is to test radon concentration in the home. Testing is best conducted in the winter months when flow of air is at its lowest.

APH is raising awareness and encouraging testing across the district in November, designated the Radon Action Month in Canada. Kits are available year-round at local hardware stores and there are also professional companies in Ontario that can use specialized equipment to measure radon levels in homes.

Building Code Amendments

Long term policy advocacy is supported by APH to amend the Ontario Building Code to strengthen building code requirements to construct new structures with radon levels well below 200 Bq/m³. This pre-build requirement to control soil gas emissions is already in effect in Elliot Lake which has proven to have higher levels of uranium in the soil resulting in higher amounts of radon gas accumulation in homes.

From a health equity perspective, amending the building code offers a more long-term and equitable solution than individual testing. This is because not all homeowners can afford the construction measures required for radon mitigation, and these measures are not an option for renters.

In 2016, the Ministry of Municipal Affairs did consider broader requirements for radon mitigation in the construction of all new homes[3]. APH will continue to monitor policy developments in this area, and advocate as appropriate for building code amendments that further protect residents from radon.

References

1. Ontario Agency for Health Protection and Promotion (Public Health Ontario). Radon risks and realities. March 2015. Accessed 2017-11-09 from https://www.publichealthontario.ca/en/DataAndAnalytics/OntarioHealthProfile/Pages/OHP-IWR-Radon.aspx.
2. Health Canada. Cross-Canada survey of radon concentration in homes: final report. Ottawa, ON: Her Majesty the Queen in Right of Canada, represented by the Minister of Health; 2012. Available from: http://www.hc-sc.gc.ca/ewh-semt/alt_formats/pdf/radiation/radon/survey-sondage-eng.pdf.
3. Ministry of Municipal Affairs. Overview summary document: potential changes to Ontario's building code: fall 2016 consultation. 2016. Queen's Printer for Ontario. http://www.mah.gov.on.ca/Page14998.aspx#Next+Edition.

FAMILY HEALTH

Director: Laurie Zeppa
Manager: Hannele Dionisi and Leslie Wright

Topic: Breastfeeding

This report addresses the following requirements of the Ontario Public Health Standards (2014) or Program Guidelines/ Deliverables:

- Family Health Program Standard-Child Health

This report addresses the following Strategic Directions:

- Collaborate Effectively
- Health Equity

Health Canada, Canadian Paediatric Society, Dietitians of Canada, and the Breastfeeding Committee for Canada support '*breastfeeding - exclusively for the first six months, and sustained for up to two years or longer with appropriate complementary feeding - is important for the nutrition, immunologic protection, growth, and development of infants and toddlers*.' (Health Canada)

Breastfeeding is important because it:

- Improves the health of infants and children by reducing the risk of asthma, SIDS, certain childhood cancers
- Assists with chronic disease prevention (i.e. cancer, type 2 diabetes, osteoporosis, obesity)
- Helps with food security;

The Ontario Public Health Program Standards includes as a societal outcome: *there is an increased rate of exclusive breastfeeding until six months, with continued breastfeeding until 24 months and beyond*. In accordance with the Public Health Funding and Accountability Agreement Indicator**,** of achieving Baby-Friendly Initiative (BFI) designation, ongoing infant feeding surveillance is collected at various time points. Since BFI designation in 2010 and re-designation in 2016 this data has been routinely compared with the provincial data. In 2016 breastfeeding initiation rates across Algoma were 80%, at 48hr contact they remained at 82%, at 2 weeks they dropped to 63% and at 6 weeks 52%. This decrease in breastfeeding duration is consistent within the province and collectively we continue to aim for higher rates. BFI requires a 75% average across all time points.

A fundamental indicator of breastfeeding success, increased breastfeeding duration and exclusivity is eliminating unnecessary formula supplementation. This practice alone will reduce disparities, increase exclusive breastfeeding, increase breastfeeding duration, and improve maternal and child health outcomes. Best practice suggests that babies only receive breast milk unless there is a medical indication or informed decision by parent to receive formula. Routinely providing the baby with formula may lead the mother to stop breastfeeding before intended.

In October APH partnered with the Sault Area Hospital (SAH) in an effort to promote breastfeeding by creating new breastfeeding posters. These large scale posters aim to create awareness for both staff and families in the Maternal Child Unit. This site was selected initially because approximately 85% of all births in Algoma occurred at Sault Area Hospital in 2016. Expansion of this campaign to include hospitals within the District is currently being explored. This initiative was developed as part of the ongoing commitment of the APH-SAH Liaison Committee which provides an opportunity to discuss and explore strategies to influence breastfeeding success

The poster campaign outlined 4 key messages that can help mothers “to be successful from the start” and achieve exclusive breastfeeding duration of 6 months as recommended by World Health Organization.

1. Immediate skin-to-skin after birth
2. Remove milk from your breasts within the first 30 minutes after birth
3. Do not introduce formula unless medically necessary.
4. Feed you baby often in the first few days. Follow your baby’s feeding cues.

In an ongoing effort to support families within our communities, APH services include, a Registered Nurse available on the Parent Child Information Line (PCIL) for any questions, the Parent Child Information Centre (PCIC) drop-in clinic, and breastfeeding appointments with a Lactation Consultant are available by appointment or Ontario Telemedicine Network (OTN).

In the Parent Child Information Centre the Public Health Nurse provides information to families about infant feedings, infant weight gain, maternal mental health, safe sleep, safety, as well as other topics of healthy growth and development. Data related to the number of client visits to the PCIC and scheduled appointments for BF consultations are collected annually. In 2015 and 2016 the total PCIC visits were 1703 and 1323 and the BF consultations were 237 and 416 respectively. The noted decrease in PCIC visit in 2016 may have been influenced by the availability of weekly BF appointments.

SEXUAL HEALTH

Director: Sherri Cleaves
Manager: Roylene Bowden

Topic: Sexual Health Services

This report addresses the following requirements of the Ontario Public Health Standards (2014) or Program Guidelines/ Deliverables:

1. Prevent and reduce the burden of sexually transmitted and blood borne infections.
2. Promote healthy sexuality

This report addresses the following Strategic Directions:

- Improve Health Equity
- Collaborate Effectively
- Be Accountable

Ontario Public Health Standards Goal

- To prevent or reduce the burden of sexually transmitted infections and blood-borne infections
- To promote healthy sexuality

What is healthy sexuality?

Healthy sexuality requires a positive and respectful approach to sexuality and sexual relationships. It is much more than avoiding sexually transmitted infections (STIs) and unintended pregnancies. It involves acquiring the skills, knowledge and behaviours to maintain good sexual and reproductive health throughout life[1].

A snapshot of sexually transmitted infections (STIs) in Algoma

In Ontario, key STIs are reportable to public health. This allows the identification of individuals who may have been infected (i.e. cases and their contacts), so that they are advised to seek appropriate testing and treatment.

The following table provides a broad overview of 2016 STI rates in Algoma, compared to Ontario[2].

STI	*Incidence (number of new cases per 100,000 people)*	
	Algoma	**Ontario**
Chlamydia	278.5	299.7
Gonorrhea	82.9	48.6
Syphilis	5.2	15.2
Hepatitis B	0.87	0.80
Hepatitis C	61.1	31.2
HIV	1.75	5.90

APH Sexual Health Program Highlights

The Sexual Health Program at Algoma Public Health (APH) provides both clinical and health promotion services to our communities within the District of Algoma. Public health nurses speak openly about sexual health to promote a culture of healthy sexuality. Sexual Health nurses empower clients to have safe sexual relations, access appropriate testing for STIs, and reduce their risk of unintended pregnancy.

To control and reduce STI rates in Algoma, and to improve the sexual health of the population, the APH Sexual Health Program offers a variety of clinical services to our communities. Some highlights are described below.

Sexual Health Information Line

- Confidential phone line staffed daily with a public health nurse
- Clients from across the District of Algoma seek advice on
    - pregnancy prevention, testing, and other pregnancy-related options
    - STI and blood-borne infection testing
- 3,330 calls received in 2016; 3,297 calls received in 2017 as of October 24

Sexual Health Clinics

- Clinical services in Sault Ste. Marie, Blind River, Elliot Lake, Thessalon, and Wawa, including testing and treatment of STIs and supporting client needs for birth control
- 5,340 sexual health clinic visits in 2016; 4,064 clinic visits in 2017 as of October 24
- Birth control sales to clients aged 14 to 24 years
    - 2016: 998
    - 2017 (as of October 24): 849
- Birth control sales to clients aged 25 years and over
    - 2016: 1,707
    - 2017 (as of October 24): 1,237
- In 2013-2014, 81% of Algoma residents with gonorrhea infection received appropriate first line antibiotic treatment by their primary care provider as recommended by provincial guidelines, one of the highest percentages in the province (54.6% of individuals with gonorrhea received first line treatment in Ontario overall)[3]. Given that Algoma continues to have higher gonorrhea rates compared to the province, this "treatment as prevention" approach remains an important part of controlling local STI transmission.

Sexual Health and Health Equity

In addition to offering services on site, APH Sexual Health Program acknowledges the importance of collaboration with our community partners and key stakeholders to improve access to services for our priority populations and those affected by health inequities. To decrease barriers for accessing services, Outreach Services are offered on a drop-in basis, and no appointments are necessary.

On September 27, 2017, the Sault Pride Drop In Clinic was held in Sault Ste. Marie, in partnership with APH Vaccine Preventable Diseases program staff and local HIV/AIDS Resource Program (HARP). Clients accessed STI testing, rapid HIV testing, and birth control assessments. Eligible clients were also immunized against hepatitis A, hepatitis B and human papillomavirus (HPV). This clinic demonstrated a collaborative model of care, and improved access for our LGBTQ populations. We are currently in the planning stages of a Sexual Health/Vaccine Preventable Disease Drop In Clinic targeting our youth population.

The Neighbourhood Resource Centre (NRC) is a drop-in centre in downtown Sault Ste. Marie which offers a variety of health and social services for priority populations. Sexual health PHNs offer drop-in clinics at this location twice per month. In addition to STI testing, pregnancy testing and options, rapid HIV testing, condom distribution and community referrals, the PHNs provide naloxone kits and immunize against the flu.

References:

1. Health Canada. Sexual Health and Promotion. 2016. Accessed 2017-11-09 at https://www.canada.ca/en/health-canada/services/healthy-living/sexual-health-promotion.html.
2. Public Health Ontario. Query: Algoma Public Health: Counts and crude rates by public health unit and year. Toronto, ON: Ontario Agency for Health Protection and Promotion; 2017 Nov 1 [cited 2017 Nov 8]. Available from: http://www.publichealthontario.ca/en/DataAndAnalytics/Query/Pages/default.aspx
3. Ontario Agency for Health Protection and Promotion (Public Health Ontario). Treatment patterns among gonorrhea cases in Ontario, 2008 to 2014. Toronto, ON: Queen's Printer for Ontario; 2017.

PARTNERSHIPS

Opioid Strategy

Algoma continues to experience higher rates of opioid-related harms compared to the Ontario average. In addition to improving access to harm reduction services across the district, such as naloxone and needle exchange, APH is working with first responders and frontline partners to strengthen local surveillance of opioid overdoses.

On October 2, 2017, the MOH and AMOH met with representatives from the SSM Police Service, SSM Emergency Medical Services, the Sault Area Hospital Emergency Department, and the SSM Drug Strategy. APH presented local data on the acute health burden from opioids, including rates of death, overdoses, hospitalizations, emergency department visits, and opioid addiction. Further discussion with this group identified a need for improved local surveillance, such that in the event of a sudden spike in overdoses, this information could be disseminated in a timely way to facilitate public alerts and first responder response. To that end, APH is currently developing a surveillance strategy that integrates multiple sources of local data, which can be shared with key partners across the district.

PERFORMANCE INDICATORS

Health Protection Indicator Report

2017 Health Protection Indicators	Second Quarter (April–June)					Third Quarter (July - September)					YTD - TOTAL
	WW	SSM	BR	EL	Total	WW	SSM	BR	EL	Total	
Safe Water											
Private Wells – Adverse DW	0	9	5	3	**17**	3	65	30	3	**101**	**121**
Regulated Premise – ADW (O.reg.319)	0	0	1	0	**1**	6	8	2	4	**20**	**22**
BWA issued	0	0	0	2	**2**	3	1	1	0	**5**	**9**
DWA issued	0	0	0	0	**0**	1	1	0	0	**2**	**2**
Beach closures	0	1	1	0	**2**	0	3	3	0	**6**	**8**
Rabies											
#Rabies risk Investigations Initiated	0	41	5	8	**54**	2	62	12	5	**81**	**179**
Food Safety											
Special Event Permits issued	0	35	25	11	**71**	1	73	30	18	**122**	**231**
Food Handler Training (#persons)	0	94	1	30	**125**	0	44	9	0	**53**	**297**
Farmer's Market Approvals	0	25	35	0	**60**	0	8	5	0	**13**	**103**
Health Hazard											
Complaint/Investigations all types	0	51	6	0	**57**	0	63	7	0	**70**	**194**
Land Control – OBC											
Applications/Permits – Class IV	2	37	12	1	**52**	1	46	15	0	**62**	**117**
Communicable Disease Control											
#Institutional outbreaks	0	0	1	1	**2**	0	4	1	0	**5**	**29***
Total outbreak days in quarter	0	0	11	0	**11**	0	67	42	0	**109**	**366**
Gonorrhea	0	7	0	0	**7**	0	1	0	3	**4**	**28**
Chlamydia (6 cases-location not identified)	0	48	1	8	**58***	0	49	1	7	**57**	**194***
BBI (Hep B, C, HIV)	Not divided by district				**18**	Not divided by district				**22**	**72**
Other Reportable Diseases	0	2	1	1	**24***	0	14	1	1	**29***	**88***
Confirmed Influenza Cases	3	10	4	11	**28**	0	0	0	0	**0**	**85**

*includes stats with no location assigned.

Health Prevention and Promotion Performance Indicator Reports

COMMUNITY ALCOHOL DRUG ASSESSMENT PROGRAM	April to June 2017					July – September 2017					YTD - TOTAL
	WW	SSM	BR	EL	Total	WW	SSM	BR	EL	Total	
Addictions- Overdose Prevention											
Naloxone trainings completed - with at risk individuals	-	-	-	-	**-**	4	69	-	1	**74**	**74**
Addictions-Harm Reduction											
Needles out - distributed	-	70143	-	-	**70143**	-	72446	0	560	**73006**	**219456**
Needles in thru APH/JHS sites	-	27436	-	-	**27436**	-	9351	0	250	**9601**	**58270**
Needles returned thru Drop bins in SSM- estimate*	-	36000	-	-	**36000**	-	39000	n/a	n/a	**39000**	**111000**
Back on track Remedial Measures- individuals trained											
Partnership with CAMH and MTO	-	18	-	-	**18**	-	20	-	-	**20**	**82**
***Bins emptied 1 – 2X per week X 8 weeks = 2000 sharps per full bin X 2 bins**											

COMMUNITY MENTAL HEALTH	April – June 2017	July – September 2017	YTD - TOTAL	NOTES
CMH New Clients: Individuals receiving 1st service	49	56	155	Individuals receiving 1st service are the number of new clients to CMH who have been referred, received an intake, are eligible for psychiatric case management services and have been assigned a case manager.
CMH non registered: Client Interactions	289	319	904	Unidentified client interactions are the number of interactions with individuals who are not registered with the program. This includes program inquiries and brief service provision. These interactions require program staff intervention either by phone or in person.

HEALTHY BABIES HEALTH CHILDREN POSTPARTUM	April – June 2017					July - September 2017					YTD - TOTAL
	WW	SSM	BR	EL	Total	WW	SSM	BR	EL	Total	
Phone calls	10	124	14	7	**155**	9	129	13	10	**161**	**458**
Home visits	1	56	7	5	**69**	2	51	6	3	**62**	**181**

TOBACCO CESSATION	April – June 2017			July - September 2017			YTD - TOTAL
	SSM	District	Total	SSM	District	Total	
Number of APH clients assessed or reassessed for tobacco use using Brief Contact Interventions(BCI)	678	99	**777**	573	127	**700**	**2423**
Number of clients referred by staff to further intensive smoking cessation supports at APH during BCI	148 SSM and District combined		**148**	151 SSM and District combined		**151**	**454**
Number of clients receiving clinic or in-home intensive tobacco cessation services from APH staff	-	-	**-**	-	-	**54**	**194**

CONTRACEPTIVE PURCHASES	April – June, 2017					July – September 30, 2017					
	WW	SSM	BR	EL	Total	WW	SSM	BR	EL	Total	YTD - TOTAL
14-19 years	1	100	-	10	**111**	-	91	-	-	**91**	**263**
20-24 years	-	156	1	5	**162**	-	157	-	-	**157**	**446**
25 -2 9 years	-	198	-	4	**202**	-	198	-	-	**198**	**534**
30+ years	1	181	1	3	**186**	-	173	-	-	**173**	**486**
Total	**2**	**635**	**2**	**22**	**661**	**-**	**619**	**-**	**-**	**619**	**1729**

Calls to the Sexual Health Phone Line	January 1 - March 31, 2017	March 31 - June 30, 2017	July 1 - September 30, 2017	Total for 2017 as of September 1, 2017
	889	908	1125	2922

Calls to the Sexual Health Phone Line	September 1-30, 2016	September 1 - 30, 2017	Difference
	285	408	123

Respectfully submitted,
Dr. Marlene Spruyt

ALGOMA PUBLIC HEALTH

FINANCE AND AUDIT COMMITTEE REPORT

FOR THE NOVEMBER 22, 2017 BOARD MEETING

Meeting held on: November 8, 2017

In attendance:

Justin Pino, Joel Merrylees, Dr. Spruyt, Jennifer Loo, Ian Frazier, Lee Mason, Dr. Patricia Avery, Dennis Thompson

Secretary – Christina Luukkonen

Justin provided a review of the financial statements for the period ended September 30, 2017. A few questions were asked with acceptable answers provided. It is going to be the recommendation of the Committee that the Board approve the financial statements presented for the period ended September 30, 2017.

Justin provided an overview of the 2018 public health budget. A number of questions were asked and particular focus was made on salaries and benefits which equates to 75% of the budget. The Committee received acceptable answers to their questions. It is going to be the recommendation of the Committee that the Board approve the APH 2018 Public Health Operating and Capital Budget.

The Committee received and reviewed a Briefing Note addressing adding additional funds to the Health Unit's Reserve Fund. After a few questions were asked and answered acceptably it is going to be the recommendation of the Committee that the Board approve a contribution in the amount of $200,000 to the Reserve Fund.

The Committee received and reviewed a Briefing Note addressing the proposed renewal of a service contract with the Sault Ste. Marie Innovation Centre (SSMIC). After reviewing the information with Management it is going to be the recommendation of the Committee that the Board approve the renewal of the service contract with SSMIC.

The Committee Members were thanked for volunteering to be on the Committee and their questions and input throughout the year was invaluable and appreciated.

Next meeting is scheduled for February 14, 2018

Chair, Finance and Audit Committee
Algoma Public Health

Nov 15/17
Date

Algoma Public Health
(Unaudited) Financial Statements September 30, 2017

Algoma Public Health
Statement of Operations
September 2017
(Unaudited)

	Actual YTD 2017	Budget YTD 2017	Variance Act. to Bgt. 2017	Annual Budget 2017	Variance % Act. to Bgt. 2017	YTD Actual/ YTD Budget 2017
Public Health Programs						
Revenue						
Municipal Levy - Public Health	$ 2,613,590	$ 2,613,590	$ 0	$ 3,484,786	0%	100%
Provincial Grants - Public Health 75% Prov. Funded	5,481,899	5,481,900	(1)	7,309,200	0%	100%
Provincial Grants - Public Health 100% Prov. Funded	2,093,433	2,093,399	34	2,841,200	0%	100%
Fees, other grants and recovery of expenditures	443,431	464,582	(21,151)	670,476	-5%	95%
Provincial Grants - Funding for Prior Yr Expenses	0	0	-	-		
Total Public Health Revenue	$ 10,632,353	$ 10,653,471	$ (21,118)	$ 14,305,662	0%	100%
Expenditures						
Public Health 75% Prov. Funded Programs	$ 7,697,397	$ 8,641,359	$ 943,962	$ 11,464,463	-11%	89%
Public Health 100% Prov. Funded Programs	1,870,201	2,072,784	202,583	2,841,200	-10%	90%
Total Public Health Programs Expenditures	$ 9,567,598	$ 10,714,143	$ 1,146,545	$ 14,305,662	-11%	89%
Excess of Rev. over Exp. 75% Prov. Funded	$ 841,523	$ (81,287)	$ 922,810	$ (1)		
Excess of Rev. over Exp. 100% Prov. Funded	223,232	20,615	202,617	1		
Provincial Grants for Prior Yr Expenses	-	-	-	-		
Total Rev. over Exp. Public Health	$ 1,064,755	$ (60,672)	$ 1,125,427	$ (0)		
Public Health Programs - Fiscal 17/18						
Provincial Grants and Recoveries	$ -	-	-	-		
Expenditures	0	-	0	-		
Excess of Rev. over Fiscal Funded	(0)	-	(0)	-		
Community Health Programs						
Calendar Programs						
Revenue						
Provincial Grants - Community Health	$ 801,011	$ 801,008	$ 3	$ 1,068,011	0%	100%
Municipal, Federal, and Other Funding	263,092	250,807	12,285	338,455	5%	105%
Total Community Health Revenue	$ 1,064,103	$ 1,051,816	$ 12,287	$ 1,406,466	1%	101%
Expenditures						
Healthy Babies and Children	$ 789,777	$ 801,008	$ 11,231	$ 1,068,011	-1%	99%
Child Benefits Ontario Works	18,099	18,099	-	24,135	0%	100%
Algoma CADAP programs	217,187	226,740	9,552	302,319	-4%	96%
One-Time Funding programs	11,901	12,000	99	12,000	-1%	99%
Total Calendar Community Health Programs	$ 1,036,965	$ 1,057,846	$ 20,882	$ 1,406,465	-2%	98%
Total Rev. over Exp. Calendar Community Health	$ 27,138	$ (6,031)	$ 33,169	$ 1		
Fiscal Programs						
Revenue						
Provincial Grants - Community Health	$ 2,792,363	$ 2,781,857	$ 10,505	$ 5,566,099	0%	100%
Municipal, Federal, and Other Funding	377,011	377,227	(215)	734,703	0%	100%
Other Bill for Service Programs	27,935		27,935			
Total Community Health Revenue	$ 3,197,309	$ 3,159,084	$ 38,225	$ 6,300,802	1%	101%
Expenditures						
Brighter Futures for Children	51,823	54,723	2,900	109,447	-5%	95%
Infant Development	315,392	320,218	4,826	640,434	-2%	98%
Preschool Speech and Languages	309,088	307,128	(1,960)	614,256	1%	101%
Nurse Practitioner	65,776	63,876	(1,900)	127,753	3%	103%
Genetics Counseling	220,575	184,053	(36,522)	367,806	20%	120%
Community Mental Health	1,650,449	1,723,949	73,500	3,449,498	-4%	96%
Community Alcohol and Drug Assessment	350,973	362,078	11,106	724,157	-3%	97%
Healthy Kids Community Challenge	98,108	108,450	10,342	161,350	-10%	90%
Stay on Your Feet	47,336	50,000	2,664	100,000	-5%	95%
Bill for Service Programs	27,741	-	(27,741)	-		
Misc Fiscal	1,371	3,000	1,629	6,100		
Total Fiscal Community Health Programs	$ 3,138,632	$ 3,177,476	$ 38,844	$ 6,300,801	-1%	99%
Total Rev. over Exp. Fiscal Community Health	$ 58,676	$ (18,392)	$ 77,068	$ 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 Nine Months Ending September 30, 2016
(Unaudited)

	Actual YTD 2017	Budget YTD 2017	Variance Bgt. to Act. 2017	Annual Budget 2017	Variance % Act. to Bgt. 2017	YTD Actual/ YTD Budget 2017	Comparison Prior Year: YTD Actual 2016	YTD BGT 2016	Variance 2016
Levies Sault Ste Marie	1,817,229	1,817,229	0	2,422,972	0%	75%	1,772,134	1,772,134	0
Levies Vector Bourne Disease and Safe Water	44,575	44,575	(0)	59,433	0%	75%	44,575	44,575	0
Levies District	751,786	751,786	0	1,002,381	0%	75%	739,560	733,134	6,426
Total Levies	**2,613,590**	**2,613,590**	**0**	**3,484,786**	**0%**	**75%**	**2,556,269**	**2,549,843**	**6,426**
MOH Public Health Funding	5,348,176	5,348,175	1	7,130,900	0%	75%	5,379,571	5,348,375	31,196
MOH Funding Vector Bourne Disease	81,523	81,525	(2)	108,700	0%	75%	81,525	81,525	0
MOH One Time Funding Dental Health	0	0	0	0		0%	0	0	0
MOH Funding Safe Water	52,200	52,200	0	69,600	0%	75%	52,000	52,000	0
Total Public Health 75% Prov. Funded	**5,481,899**	**5,481,900**	**(1)**	**7,309,200**	**0%**	**75%**	**5,513,096**	**5,481,900**	**31,196**
MOH One Needle Exchange	38,031	38,025	6	50,700	0%	75%	38,032	38,025	7
MOH Funding Haines Food Safety	18,450	18,450	0	24,600	0%	75%	18,450	18,450	0
MOH Funding CINOT/Healthy Smiles	577,424	577,425	(1)	769,900	0%	75%	577,425	577,425	0
MOH Funding - Social Determinants of Health	135,377	135,375	2	180,500	0%	75%	135,377	135,375	2
MOH Funding Chief Nursing Officer	91,131	91,125	6	121,500	0%	75%	91,131	91,125	6
MOH Enhanced Funding Safe Water	11,627	11,625	2	15,500	0%	75%	11,625	11,625	0
MOH Funding Unorganized	386,331	386,325	6	515,100	0%	75%	375,227	375,225	2
MOH Funding Infection Control	234,304	234,300	4	312,400	0%	75%	234,304	234,300	4
MOH Funding Diabetes	112,500	112,500	0	150,000	0%	75%			
MOH Funding Northern Ontario Fruits & Veg.	88,054	88,049	5	117,400	0%	75%			
Funding Ontario Tobacco Strategy	325,204	325,200	4	433,600	0%	75%	325,200	325,200	0
MOH Funding Harm Reduction	75,000	75,000	0	150,000	0%	50%			
One Time Funding	0	0	0	0					
Total Public Health 100% Prov. Funded	**2,093,433**	**2,093,399**	**34**	**2,841,200**	**0%**	**74%**	**1,806,771**	**1,806,750**	**21**
Funding for Prior Yr Expenses	**0**	**0**	**0**	**0**		**0%**	**139,000**	**0**	**139,000**
Recoveries from Programs	7,499	7,546	(47)	10,061	-1%	75%	24,793	7,546	17,247
Program Fees	179,095	187,307	(8,213)	249,743	-4%	72%	171,368	185,357	(13,990)
Land Control Fees	108,828	120,000	(11,172)	160,000	-9%	68%	100,300	120,000	(19,700)
Program Fees Immunization	116,899	134,625	(17,726)	179,500	-13%	65%	141,337	120,000	21,337
HPV Vaccine Program	8,458	4,800	3,658	12,500	0%	68%	5,729	7,500	(1,771)
Influenza Program	5,490	1,100	4,390	40,000	399%	14%	1,525	45,000	(43,475)
Meningococcal C Program	1,386	1,200	186	8,000	0%	17%	3,529	7,500	(3,971)
Interest Revenue	11,001	8,004	2,997	10,672	37%	103%	8,414	1,500	6,913
Other Revenues	4,777	0	4,777	0	0%	100%	86,533	123,750	(37,217)
Total Fees, Other Grants and Recoveries	**443,431**	**464,582**	**(21,151)**	**670,476**	**-5%**	**66%**	**543,528**	**618,153**	**(74,625)**
Total Public Health Revenue Annual	**$ 10,632,353**	**$ 10,653,471**	**$ (21,118)**	**$ 14,305,662**	**0%**	**74%**	**$ 10,558,664**	**$ 10,456,646**	**$ 102,018**
Public Health Fiscal									
Panorama			0			0%			
Rabies Software			0			0%			
Smoke Free Ontario NRT			0			0%			
Practicum			0			0%			
Total Provincial Grants Fiscal	**$ -**	**$ -**	**$ -**	**$ -**		**0%**	**$ -**	**$ -**	**$ -**

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 Nine Months Ending September 30, 2016

(Unaudited)

	Actual YTD 2017	Budget YTD 2017	Variance Act. to Bgt. 2017	Annual Budget 2017	Variance % Act. to Bgt. 2017	YTD Actual/ YTD Budget 2017	*Comparison Prior Year:* YTD Actual 2016	YTD BGT 2016	Variance 2016
Salaries & Wages	5,661,974	6,412,549	$ 750,575	$ 8,559,202	-12%	66%	$ 5,959,005	$ 6,229,133	$ 270,128
Benefits	1,470,098	1,494,178	24,080	1,993,632	-2%	74%	1,453,629	1,558,668	105,040
Travel - Mileage	66,509	95,896	29,387	127,861	-31%	52%	86,840	109,947	23,107
Travel - Other	64,787	58,457	(6,330)	77,942	11%	83%	48,370	71,288	22,918
Program	403,203	534,766	131,563	780,528	-25%	52%	529,728	409,333	(120,395)
Office	88,189	101,312	13,124	135,250	-13%	65%	94,607	69,000	(25,607)
Computer Services	412,987	524,639	111,652	699,518	-21%	59%	484,563	671,931	187,367
Telecommunications	256,317	264,296	7,979	325,994	-3%	79%	272,434	162,862	(109,572)
Program Promotion	75,275	128,098	52,823	170,797	-41%	44%	69,846	160,564	90,718
Facilities Expenses	551,589	600,262	48,674	800,350	-8%	69%	584,165	610,443	26,278
Fees & Insurance	263,630	205,322	(58,308)	242,096	28%	109%	293,510	180,904	(112,607)
Debt Management	345,674	345,675	1	460,900	0%	75%	310,440	342,000	31,560
Recoveries	(92,635)	(51,306)	41,329	(68,408)	81%	135%	(70,094)	(105,662)	(35,569)
	$ 9,567,597	$ 10,714,143	$ 1,146,546	$ 14,305,662	-11%	67%	$ 10,117,045	$ 10,470,412	$ 353,367

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 – September 2017

Reporting Period

The September 2017 financial reports include nine months of financial results for Public Health and the following calendar programs; Healthy Babies & Children, Child Benefits Ontario Works, and Algoma CADAP programs. All other programs are reporting six month result from operations year ended March 31st, 2018.

NOTE: Algoma Public Health has NOT received the 2017 Program-Based Grants approval letter from the Ministry of Health and Long-Term Care as of October 27th, 2017. APH had requested approximately $281k in one-time funding initiatives to support the provision of mandatory and related public health programs and services within the District of Algoma. The budget will be adjusted accordingly once approval letters are received by APH.

Statement of Operations (see page 1)

Summary – Public Health and Non Public Health Programs

As of September 30th, 2017, Public Health programs are reporting a $1.1M positive variance.

Total Public Health Revenues are indicating a negative $21k variance. This is a result of Fees, Other Grants & Recoveries being less than budgeted. Program Fees Immunization and Land Control Fees are driving this negative variance. APH typically captures the bulk of its fees between the spring and fall months.

There is a positive variance of $1.1M related to Total Public Health expenses being less than budgeted.

The $943k positive variance associated with the Public Health 75% Provincially Funded Programs is primarily attributed to Salary & Wages expense being less than budgeted. The $751k positive variance associated with Salary and Wages expense is a result of the inherent time lag in filling positions within the agency. Furthermore, the 2017 Public Health Operating budget assumed collectively bargained wage increases for CUPE and ONA staff members from April 2017 through to the end of the calendar year. As of September 30th, 2017, this assumption has not been realized. In addition, the 2017 Public Health Operating Budget included the new positions of Associate Medical Officer of Health (AMOH) and Human Resource (HR) Manager for the full budget year. The HR Manager position was vacant until the end of March 2017 while the AMOH position was vacant until the end of August 2017. In addition, the Environmental Health team has experienced staff turnover this year resulting in unfilled vacancies; a Clerical position has been reduced through attrition, and a Communications role which was built into the budget has yet to be filled.

Travel – Mileage, Program, Office, Computer Services and Program Promotion expenses are also contributing to the positive variance.

100% Provincially Funded Programs typically relate to specific Public Health initiatives and are prescriptive as to what is an eligible expense. The $203k positive variance associated with Public Health 100% Provincially Funded Programs is a result of funding related to the Harm Reduction program received in September 2017. This funding is now reflected in the budget however it is expected a portion of the funds will be returned given the late time in the year it was received by APH. Furthermore Smoke Free Ontario and the Healthy Smiles Programs are contributing to the noted positive variance.

Notes Continued...

As Management is projecting a surplus for the 2017 calendar year, preparations are being made with respect to prioritizing one-time expenditure needs. These include, but are not limited to, building maintenance initiatives, IT and Telecommunication upgrades, and Ergonomic enhancements. Management estimates these incremental one-time expenditures will be between $150k to $200k.

Community Health Calendar programs are operating within budget.

APH's Community Health Fiscal Programs are six months into the fiscal year.

Genetics Counseling is showing a negative $37k variance. APH management is utilizing deferred revenue associated with the program by increasing the program FTE compliment by 0.2; by Public Health increasing the charges associated with the Genetics program for general administration support to more accurately reflect actual usage; and by conducting an additional clinic with the goal of reducing wait times.

Public Health Revenue (see page 2 for details)

Public Health funding revenues are showing a negative $21k variance.

The municipal levies are within budget.

Provincial Grants are within budget.

There is a negative variance of $11k associated with Fees, Other Grants & Recoveries. This is a result of Land Control Fees being less than budgeted. APH typically captures the bulk of its fees between the spring and fall months. The magnitude of the negative variance has been decreasing month-over-month.

There is a negative variance of $18k associated with Program Fees Immunization. This is due to timing of fees received.

Public Health Expenses (see page 3)

Salary & Wages

Salary & Wages expense is indicating a positive variance of $751k. The inherent time lag in filling positions within the agency is the primary contributor to the positive variance associated with the Salary & Wages expense. In addition, the 2017 Public Health Operating budget assumed collectively bargained wage increases for CUPE and ONA staff members from April 2017 through to the end of the calendar year. As of September 30th, 2017, this assumption has not been realized. Furthermore, the 2017 Public Health Operating Budget included the new positions of Associate Medical Officer of Health (AMOH) and Human Resource (HR) Manager for the full budget year. In addition, the Environmental Health team has experienced staff turnover this year resulting in gaping; a Clerical position has been reduced through attrition, and a Communications role which was built into the budget has yet to be filled.

Notes Continued...

Travel-Mileage
Travel – Mileage expense is indicating a positive variance of $29k. Management believes a positive variance will be realized at year-end. Management will look to adjust the Travel-Mileage budget for 2018 to more accurately reflect actual Travel-Mileage expenses.

Program
Program expense is indicating a positive variance of $131k variance. This is a result of Program Materials and Supplies expense being less than budget, specifically vaccine purchases. Management will continue to monitor this line item as the year progresses.

Office
Office expense is indicating a positive variance of $13k variance. This is a result of photocopying expenses being less than budgeted. Management has focused on this area in terms of cost containment by communicating with staff more efficient photocopying methods.

Computer Services
Computer Services expense is showing a positive variance of $111k. The noted variance is a result of timing as some general IT equipment purchases that have yet to be made. Furthermore, the annual Microsoft License renewal has yet to be purchased but is forthcoming which will reduce the noted variance by approximately $80k.

Program Promotion
Program Promotion expense is indicating a positive $53k variance which is due to timing of expenditures not yet incurred. Specifically, staff professional development is below budget by $27k and Promotional expenses are below budget by $23k. Management will continue to monitor this line item to determine if there is opportunity to refine this budget line item for 2018.

Fees & Insurance
Fees & Insurance expense is showing a negative $58k variance. This is a result of higher than anticipated legal fees associated with various matters.

Recoveries
Recoveries are indicating a positive $41k variance. This is a result of Public Health increasing the charges associated with Genetics and Other Community programs for general administration support to more accurately reflect actual usage.

Algoma Public Health

Statement of Financial Position

(Unaudited)

Date: As of September 2017	**September 2017**	December 2016
Assets		
Current		
Cash & Investments	**$ 3,052,988**	$ 2,146,361
Accounts Receivable	**133,193**	509,998
Receivable from Municipalities	**22,745**	9,159
Receivable from Province of Ontario		
Subtotal Current Assets	**3,208,925**	2,665,518
Financial Liabilities:		
Accounts Payable & Accrued Liabilities	**1,199,082**	1,587,880
Payable to Gov't of Ont/Municipalities	**61,854**	321,402
Deferred Revenue	**514,355**	494,864
Employee Future Benefit Obligations	**2,550,458**	2,550,458
Term Loan	**5,903,861**	5,903,861
Subtotal Current Liabilities	**10,229,610**	10,858,466
Net Debt	**-7,020,685**	-8,192,947
Non-Financial Assets:		
Building	**22,732,421**	22,732,421
Furniture & Fixtures	**1,914,772**	1,914,772
Leasehold Improvements	**1,572,807**	1,572,807
IT	**3,244,030**	3,244,030
Automobile	**40,113**	40,113
Accumulated Depreciation	**-7,690,685**	-7,690,685
Subtotal Non-Financial Assets	**21,813,456**	21,813,456
Accumulated Surplus	**14,792,772**	13,620,509

Algoma
PUBLIC HEALTH
Santé publique Algoma

Algoma Public Health

2018 Public Health Operating & Capital Budget

DRAFT

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EXECUTIVE SUMMARY:

Issue:

The Management of Algoma Public Health (APH) is seeking approval of the 2018 Public Health Operating and Capital Budget for mandatory public health programs and services. The Board of Health Finance & Audit Committee has reviewed the 2018 Public Health Operating and Capital Budget and recommends the Board of Health approve the enclosed budget.

Recommended Action:

"That the Board of Health for the District of Algoma Health Unit approves the 2018 Public Health Operating Budget and Capital budget as presented".

Budget Summary:

The 2018 APH Operating & Capital Budget is designed to ensure the Board of Health for the District of Algoma Health Unit is fulfilling its mandate as per the requirements set out in the *Health Protection and Promotion Act*, the draft modernized Ontario Standards for Public Health Programs and Services (OSPHPS), Ontario Public Health Organizational Standards, the Public Health Accountability Agreement, and APH's strategic plan. The 2018 budget reflects no changes in the current service offerings to the clients within the District of Algoma for mandatory cost-shared programs and an increase in programing related to 100% Provincially Funded Programs.

The proposed 2018 budget for mandatory programs and services is $14,415,061 and as compared to the 2017 Board of Health approved budget, represents a 2.7% overall increase. This increase is primarily a result of an increase in the 100% Provincially funded Programs funding. The requested 0.50% increase in the municipal levy will help to offset the 0% increase in the provincial grant for cost-share programs, inherent inflationary pressures and general salary increases primarily through collective bargaining. With the requested 0.50% increase in the municipal levy and a 0% increase in the provincial grant, mandatory cost shared programs will increase by 0.24%.

2018 Financial Assumptions:

- No changes in service offerings to the clients within the District of Algoma with respect to cost-shared programing
- 0% increase in the 2018 provincial cost-shared portion of funding as a result of no system growth funding for mandatory cost-shared programs within the province

- 2.7% overall increase in the Public Health Budget as a result of 100% funded program increases
- 0.50% overall increase in the 2018 municipal levies
- 0.24% overall increase in mandatory cost-shared programs budget
- Updated 2016 Census data used to calculate the levy rate
- Salary increases from collective bargaining agreements are planned to reflect recent collective bargaining agreements of other public health units within the Province
- Salary increases for non-union employees and Management are planned to reflect other public health units within the province.
- Two (2) positions, including a Program Planning and Evaluation Specialist position are built into the budget to better align the Health Unit in meeting its obligations under the new modernized Standards for Public Health Programs and Services
- One (1) Clerical staff position reduced as a result of attrition
- Non-salary costs are based on historical data and where possible efficiencies introduced; adjustments for inflation have been incorporated where appropriate
- Capital and debt repayment plans will be managed within approved (existing) resources

PUBLIC HEALTH BUDGET BACKGROUND:

Provincial Government:

Ontario's health system is undergoing significant transformation and public health will play a key role in this transformation.

Three major initiatives from the Ministry of Health and Long-Term Care (MOHLTC) are underway to support public health to take on this role:

1) Draft Modernized Ontario Standards for Public Health Programs and Services (OSPHPS)
2) The Public Health Work Stream
3) Report of the Minister's Expert Panel on Public Health

Draft Modernized Ontario Standard for Public Health Programs and Services (OSPHPS)

What is the work of public health in Ontario?

In 2017, the Ministry of Health & Long Term Care introduced the draft modernized Ontario Standards for Public Health Programs and Services (OSPHPS). These new

standards will provide a renewed framework for public health programs, services, and accountability moving forward. As transformation occurs within the public health sector, including the role of public health in the broader health system, the changes introduced in the modernized standards aim to maximize public health's contributions to improve the health system. Public health transformation will lead to a more integrated health system that is designed to meet the needs of all Ontarians.

The modernized Standards for Public Health Programs and Services are designed to fulfill three main purposes:

- Incorporate emerging evidence and current accepted best practices in public health.
- Align public health programs and services with broader public health and health system changes.
- Facilitate optimal delivery of public health functions and coordinate delivery of public health programs and services across the full continuum of health.

Boards of health are responsible for the assessment, planning, delivery, management, and evaluation of a range of public health programs and services that address multiple health needs and respond to the contexts in which these needs occur.

Boards of health are to operationalize specific requirements in the standards and protocols and may deliver additional programs and services in response to local needs within their communities, as noted in Section 9 of the HPPA.

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Public Health Work Stream

What is the role of public health in Ontario`s health system?

The introduction of the Patients First Act requires the Chief Executive Officers (CEOs) of Local Health Integration Networks (LHINs) to engage with Medical Officers of Health (MOHs) in their local geographic areas. The Public Health Work Stream is a collaboration between public health and LHINs working to provide guidance on formal engagement parameters for LHINs and local public health across the province.

Expert Panel on Public Health

How does public health need to be organized across the province in order to function effectively within an integrated system?

In January 2017, the Minister of Health and Long-Term Care established an Expert Panel on Public Health to provide advice on structural, organizational and governance for Ontario's public health sector within a transformed health system. The expert panel was asked to consider how to:

- Ensure accountability, transparency and quality of population and public health programs and services
- Improve capacity and equity in public health units across Ontario
- Support integration within the broader health system and the Local Health Integration Networks (LHINs) – the organizations responsible for planning health services
- Leverage public health's expertise and leadership in population health-based planning, decision-making and resource allocation, as well as in addressing health equity and the social determinants of health

The development of the 2018 APH Operating and Capital budget has considered these initiatives in order to best position APH to react to any changes that may be forthcoming and position APH for long-term success in fulfilling its mandate.

For 2017, there was no growth funding for mandatory programs available to any health units within the province. The Ministry continues to advise all public health units to plan for no growth funding with regards to cost-shared programs for the foreseeable future.

The development of the 2018 Operating and Capital Budget reflects this financial reality.

APH 2017 Grant Approval:

As of the date of drafting the 2018 APH Operating and Capital Budget, the Ministry has not provided 2017 grant approvals. As such, Management is unable to provide as status update with regards to the one-time funding requests made by APH.

One-time funding are 100% provincially funded. 2017 requests submitted by APH to the Ministry for their review include:

- Healthy Menu Choices Act Support: ($23,580)
- Replacement of Network Servers: ($147,890)
- Human Papillomavirus Vaccine Expansion: ($10,000)
- Smoke-Free Ontario Expanded Smoking Cessation Programming for Priority Populations: ($30,000)

- Alcohol Awareness Initiative: ($6,678)
- Practicums (2) for Environmental Health: ($20,000)
- New Purpose-Built Vaccine Refrigerators: ($23,681)
- Breastfeeding Promotion #MyBabysHungry: ($14,500)

For context, the Board of Health for the District of Algoma Health Unit has experienced the following historical growth in provincial MOHLTC funding for mandatory cost-shared programs:

Year	Growth (%)	
2018	*0.00%*	*projected*
2017	0.00%	
2016	0.00%	
2015	0.00%	
2014	2.00%	
2013	1.50%	
2012	2.00%	
2011	2.52%	

The 0% or flat-lined adjustment for mandatory programs means revenue constraints for the long-term with continued inflationary pressures related to operating expenses and cost of living and collective bargaining considerations related to salary and benefits. These revenue constraints require APH to ensure all potential sources of revenue and a broad range of cost reduction initiatives are considered.

Program and Service Requirements:

Under the *Health Protection and Promotion Act*, a Board of Health has legal responsibilities for ensuring the delivery of health services and programs in accordance with the *Act* and Regulations. The Public Health Accountability Agreement commits Boards of Health to achieving fourteen mandatory performance indicators and one monitoring indicator.

RECOMMENDED 2018 PUBLIC HEALTH BUDGET:

Action Plan to Manage Funding Formula Impact:

- Development of 2018 APH Operating and Capital Budget to ensure it is aligned with APH's strategic directions and MOHLTC Accountability Agreement and most recently the draft modernized OSPHPS.

- Continue to submit one-time funding requests to the MOHLTC through the Program-Based Grants Process
- Control spending by ensuring APH is receiving "value for dollars" spent
- Identification of process improvements and improved efficiency opportunities
- Utilization of additional funding opportunities (i.e. through the Northern Ontario Heritage Fund)

2017 Revenue Generating & Cost Savings Initiatives:

Identification of revenue generating and cost savings opportunities is necessary in order to attain a balanced budget for 2018 and in anticipation of ongoing funding pressures. Management and the Finance and Audit Committee have worked extremely hard in the context of significant fiscal pressures to achieve this important goal. Noted below is a summary of key initiatives built into the 2018 APH Operating and Capital Budget that will result in cost savings or incremental revenue generation for APH.

2018 Cost Savings/Revenue Generating Initiatives

#	Initiative	Amount
1	Phone Integration of APH's Voice & Data Infrastructure	$ 28,000
2	Photocopying cost containment improvements	$ 2,000
3	Increase in Ontario Building Code Fees	$ 13,000
4	Microsoft Licencing price reduction	$ 20,000
5	Program Administration cost recoveries	$ 36,000
6	Other Revenue and Rent Recoveries	$ 29,000
TOTAL		$ 128,000

In addition to the above, 2017 Cost Savings/Revenue Generating Initiatives will continue for 2018 where applicable (i.e. HST Recovery Services performed in-house).

As a result of the Ministry advising Public Health Units to continue to plan for flat-line funding for mandatory cost-shared programs, APH may only request a 0% increase in growth funding for mandatory programs from the Ministry of Health & Long Term Care and proposes a 0.50% increase in municipal levies.

Revenues

Cost-shared programs and services are funded through the province, municipalities and other sources of revenue, such as interest revenue, and user fees. The province also contributes funding for services to Unorganized Territories. Refer to Appendix 1.

Provincial

Pursuant to section 76 of the Health Protection & Promotion Act, the Minister may make grants for the purposes of this Act on such conditions as he or she considers appropriate.

In 2015, the Ministry of Health & Long Term Care began the process of implementing a new public health funding formula for mandatory programs. The adapted public health funding model identifies an "appropriate" share for each Board of Health that reflects the needs in relation to other Boards of Health. While the model attempts to lessen the impact of a region's population to account for equity and needs of a region, the weight given to a region's population still drives the formula. This is evident in the fact that health units with a higher population density are the ones that are below their model-based share and are the health units who have received mandatory cost-shared funding increases. The relevance of the formula will be minimal in 2017 as the Ministry has communicated that no growth funding is available to distribute. Since the implementation of the new funding formula, it is estimated the Board of Health for APH has received $290,000 less based on a standard growth rate of 2%.

The 2018 budgeted 100% provincially funded programs have increased by 12.8% relative to 2017. This is a result of funding provided by the province for the implementation of the Harm Reduction Program Enhancement, and the Northern Ontario Fruit and Vegetable Program. Furthermore, Management has budgeted receiving funds from the province in relation to the Medical Officer of Health/Associate Medical Officer of Health Compensation Initiative as this will be the first budget year in some time in which the Board of APH has these roles on a full time basis and is eligible to apply for this funding initiative. Budgeted Revenues in the form of Provincial grants have been adjusted for 2018 to reflect this.

Municipal

In 2017, in the spirit of enhancing relationships with the communities APH serves, the Board of Health extended an invitation to all twenty one (21) obligated municipalities within the District of Algoma offering to present to their respective councils what public health does within their community, legislative framework highlights, and APH's Budget. Ten (10) presentations were made in total; nine (9) to municipalities and one (1) to the Algoma District Municipal Association. All were well received. The legislative framework noted during the presentations indicated;

Pursuant to section 72 of the Health Protection & Promotion Act, obligated municipalities in a health unit shall pay,

(a) the expenses incurred by or on behalf of the board of health of the health unit in the performance of its functions and duties under the HPPA or any other act; and

(b) the expenses incurred by or on behalf of the MOH of the board of health in the performance of his or her functions and duties under the HPPPA or any other Act.

With respect to the cost-shared programs, APH's projected funding ratio for 2018 is 70% provincial funding and 30% municipal funding.

Factors driving APH's funding ratio is the Ministry's decision in 2016 to fund the Healthy Smiles program at 100% Provincially Funded thus removing these dollars from the Ministry's portion of the cost-shared formula. In addition, since 2015 APH has received 0% growth with respect to Ministry cost-shared funding while receiving growth funding from the respective Municipalities within the District of Algoma in the form of levy increases. These municipal dollars have allowed the Board of Health to make contribution decisions with respect to the Board's Reserve Fund, keeping in mind the Board's risk management strategy.

APH has historically used Census data as the mechanism to apportion costs amongst the municipalities within the District of Algoma. The 2018 APH Operating and Capital Budget is the first budget year to reflect the updated 2016 census data. Relative to the 2011 census data, the 2016 census data reflects a 2,093 population reduction or 1.97% decrease within the District of Algoma. To maintain the equivalent amount of revenues generated from the levy, the amount per capita has increased to $33.47 per capita based on 2017 levy receipts. As a result of the updated 2016 Census data, some municipalities within the District of Algoma will see an increase in their respective apportionment of the levy while other municipalities will see a decrease.

As a means of ensuring no changes in service offerings to the clients within the District of Algoma, a 0.50% overall increase in the levy is requested from obligated municipalities, subject to Board approval. Refer to Appendix 2.

For context, the Board of Health for the District of Algoma Health Unit has experienced the following historical growth with respect to the municipal levy.

Year	Levy Increase	
2018	*0.50%*	*proposed*
2017	2.50%	
2016	4.50%	
2015	4.16%	
2014	2.00%	
2013	1.00%	
2012	2.00%	

User Fees

Health Equity serves as one of APH's strategic directions. APH is very mindful that a strong public health system ensures access to public health programs and services for those groups of people within our population that most need them. As such, when assessing the costs and benefits of increasing user fees, APH has taken a strategic view.

In June of 2017, the Board of Health approved a nominal price increase related to the Ontario Building Code Fees. This has been built into the 2018 APH Operating and Capital Budget. It should be noted that the Land Control program is funded only through the fees generated. As such APH must ensure that it is at least covering the cost incurred to administer the program.

Expenses

Expenses are primarily driven through staff salary and benefits in the form of collective bargaining agreements, goods and service contracts and through inflation. Refer to Appendix 3.

Both bargaining units' collective agreements expired March 31st, 2017 but ONA has yet to be fully negotiated. The Finance and Audit Committee reviewed and recommended that the enclosed budget be presented to the board prior to the Board of Health ratifying the CUPE Collective Agreement. As such, Management has had to make assumptions with respect to salary and benefits for the 2017 and 2018 budget operating years. As salary and benefits constitute approximately 75% of all expenses, this lack of clarity does present some risk with regards budgeted figures presented. With regards to staffing, APH continues to review "value-for-dollar" for each role within the organization.

Inflationary pressures will continue to place upward pressures on APH's operating costs.

The Consumer Price Index five-year average is as follows:

- Canada: 1.38%

- Ontario: 1.56%

Many progressive agencies add 0.25% investment factor when assessing the impact of inflation to not only maintain but also generate sustainable growth. When assessing the value of the levy, the rate of inflation may be a factor to consider.

Salary and Wages

Salary and Wages expenses are projected to increase by 4.8% compared to 2017.

Both CUPE and ONA collective agreements expired on March 31st, 2017. At the time of drafting the 2018 Public Health Operating and Capital Budget there is uncertainty as to what salaries and wages expense will be for 2018. An estimate is built into the budget with regards to salary and wages for all Public Health employees for 2018 that management believes is representative of Public Health collective bargaining increases throughout the province.

For context, a summary of Public Health Full Time Equivalent (FTE) is noted below:

Year	FTE	
2018	*121*	*proposed*
2017	120	
2016	122	

Compared to 2017, the Public Health FTE count has expanded by one (1) FTE from 120 in 2017 to a proposed 121 in the 2018 APH Operating and Capital Budget. This is a result of the creation of two (2) positions, including a Program Planning and Evaluation Specialist position to better align the health unit with the new modernized Ontario Standards for Public Health Programs and Services (OSPHPS). The increase in these two positions is offset by the reduction of one (1) clerical staff through attrition.

Benefits

Benefit expenses are projected to increase by 5.2% compared to 2017.

This is a result of increased salary and wages expense as noted above as well as increasing costs associated with non-statutory benefits that the health unit is committed to.

Travel

Travel expenses are projected to decrease by 4.9% compared to 2017.

This is a result of revising the travel budget to more accurately reflect actual travel expenses incurred in 2017.

Program

Program expenses are projected to decrease by 2.9% compared to 2017.

Since the Ministry has indicated that mandatory cost-shared program funding will remain flat lined, associated Program expenses to administer the program have been budgeted to reflect this reality.

Equipment

Equipment expenses are projected to decrease by 32.9% compared to 2017.

Since APH is projecting a surplus for 2017 with regards to mandatory cost-shared programs, Equipment Expenses that would have been budgeted in 2018 have been pulled forward to 2017 thus reducing budgeted Equipment Expenses for 2018.

Office Expenses

Office expenses are projected to decrease by 3.6% compared to 2017.

Management has focused on controlling print cost in 2017 and expects this decrease in spending to continue in 2018. APH continues to explore cost savings initiatives within each program such as utilization of public sector vendor of record (VOR) program, gradual transition of centralizing APH's procurement processes allowing APH to capitalize on volume discounts and developing staff procurement expertise.

Computer Services

Computer Services expenses are projected to increase by 2.1% compared to 2017.

Annual Microsoft licensing costs are expected to reduce by approximately $32k for 2018. This is offset by utilizing APH's Service Level Agreement with MicroAge, allowing for APH to access MicroAge's corporate resources to help with IT requests by approximately $45k.

Telecommunications

Telecommunications expenses are projected to decrease by 7.0% compared to 2017.

This is a result of savings generated from the Boards decisions to consolidate APH's voice infrastructure (phone connectivity) and data infrastructure (computer connectivity allowing the secure use of Internet and various other business applications) services. Improved system performance is also being achieved through these services.

Program Promotion

Program promotion expenses are projected to decrease by 11.1% compared to 2017.

This is a result of the reduction of Media dollars aligned to general agency needs that have historically been unspent and limiting spending where appropriate to keep the overall levy increase to a minimum. Promotional activities continue to be in line with APH's strategic plan.

Facility Leases

Facility Leases expense is projected increase by 4.0% as compared to 2017.

The Blind River Lease agreement is for a 20 year term with a commencement date of February 1, 2008. Basic Rent increases in five year increments. As such, 2018 is a year in which monthly rent payments are scheduled to increase. This increase is reflected in the Facilities Lease expense line. APH's current lease agreement at its Elliot Lake and Wawa offices remain unchanged for 2018.

Building Maintenance

Building Maintenance expenses are projected to decrease by 1.8% compared to 2017.

Since APH is projecting a surplus for 2017 with regards to mandatory cost-shared programs, Building Maintenance that would have been budgeted in 2018 has been pulled forward to 2017 thus reducing budgeted Building Maintenance expenses for 2018.

Fees & Insurance

Fees & Insurance expenses are projected to decrease by 5.6% as compared to 2017.

Board member expenses have been reduced by $10k to more accurately reflect actual spending.

Expense Recoveries

Expense Recoveries are projected to increase by 52.5% compared to 2017.

Expense Recoveries are administrative allocations from Community Health programs to Public Health programs. An example would be Public Health charging a Community Health program for administrative services related to clerical support or financial reporting support. In order to more accurately reflect the work Public Health is supporting with respect to Community Health programs, Management is ensuring adequate administrative charges for non-public health programs. This is in line with the Boards strategy to ensure it is accountable for the dollars it receives and spends by not subsidizing non-public health programs.

Debt Management

Debt Management expenses are projected to remain constant compared to 2017.

APH debt servicing costs will be financed through operations. The loan related to 294 Willow Avenue property continues for four (4) more years with monthly payments applied according to schedule.

Capital Expenses

APH is well positioned with regards to its office infrastructure to support the clients within the District of Algoma.

APH is currently seeking a building conditions assessment that is to be funded through the Ministry of Community and Social Services. This will help to facilitate a formal Building Capital Plan. Until such time, APH will continue to ensure adequate maintenance of its owned facility located at 294 Willow Avenue in Sault Ste. Marie.

2018 Operating & Capital Plan Recommendation

"That the Board of Health for the District of Algoma Health Unit approves the 2018 Public Health Operating and Capital Budget as presented".

DRAFT

Algoma PUBLIC HEALTH
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Briefing Note

www.algomapublichealth.com

To: Algoma Public Health Board of Health

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

Date: November 22, 2017

Re: 2017 Contribution to APH Reserve Fund

☐ For Information ☐ For Discussion ☒ For a Decision

ISSUE:

In accordance with Board of Health Policy 02-05-065 - Reserve Fund,

"the Board of Health in each year may provide in its estimates for a reasonable amount to be paid into the reserve funds provided that no amount shall be included in the estimates which is to be paid into the reserve funds when the cumulative balance of all the reserve funds in the given year exceeds 15 percent of the regular operating revenues for the Board of Health approved budget for the mandatory cost shared programs and services".

The 2016 Audited Financial Statements are complete and Management believes that there will not be any material changes from the 2016 Settlement that was submitted to the Ministry. The current amount of funds in the Reserve Fund is approximately $325,000. Any contribution decisions to the Reserve Fund must consider the cumulative balance of the Reserve Fund. Specifically, the cumulative balance of the Reserve Fund in any given year is not to exceed 15 percent of Algoma Public Health's (APH's) regular operating revenues for mandatory cost shared programs and services as mandated by the Board of Health policy. In 2016, total mandatory cost shared revenues derived by APH was $10,530,691, 15% of which equates to $1,579,603.

RECOMMENDED ACTION:

It is recommended that the Board of Health approves:

1) A contribution of $200,000 into the Reserve Fund from APH's operating account.

BACKGROUND:

APH's Board of Health established a Reserve Fund Policy in June of 2015. The purpose of the establishment of a Reserve Fund is to be better prepared to:

- meet any unexpected costs that may arise in the future;
- help offset one-time or capital expenditures;
- help offset any revenue shortfalls;
- minimize fluctuations in funding;
- help manage cash flows and;
- avoid application of additional levies to municipalities in the event of any cash shortfalls.

Maintaining sufficient balances in reserves is a critical component of long-term financial planning as it strengthens long-term financial sustainability. It is a financial "safety net".

In reviewing APH's cash forecasting model and factoring in APH's lowest daily liquidity position within the last year, management believes a contribution of $200,000 to the Reserve Fund will not negatively impact working capital requirements while satisfying the parameters noted in the Board of Health Policy.

As every provincial dollar received that is unspent by the Board of Health must be returned to the Ministry, Reserves can only be generated through municipal dollars.

As APH has transitioned from the traditional cost-shared formula of 75% provincially funded and 25% municipal funded to a cost-shared formula in which the municipalities contributed more than the minimum requirement of 25%, this financing strategy has better positioned the Board of Health to be in a financial position to make contributions to the Reserve Fund.

By continually striving to achieve efficiency within its operations, more municipal dollars become available to contribute towards the Reserve Fund.

FINANCIAL IMPLICATIONS:

The contribution of $200,000 into APH's Reserve Fund will reduce APH' working capital however management believes working capital levels are sufficient to sustain operations.

The financial implication of contributing to APH's Reserve Fund is it minimizes the risk to the agency with respect to any unexpected or unpredicted events, or extraordinary expenditures which would otherwise cause fluctuations in APH's operating and capital budgets.

A contribution of $200,000 will increase the Reserve balance to approximately $525,000. Appendix A attached is an overview of Reserve balances from December 31st, 2014 with projections for December 31st, 2017.

CONTACT:

J. Pino, Chief Financial Officer

Appendix A to Briefing Note: 2017 Contribution to APH Reserve Fund

Algoma Public Health
2015-2017 Reserves Overview

		2015			2016			2017		
Reserves	**Balance Dec 31 2014**	**Contributions [1]**	**Drawdowns**	**Balance Dec 31 2015**	**Contributions [2]**	**Drawdowns [3]**	**Balance Dec 31 2016**	**Contributions [4]**	**Drawdowns**	**Projected Balance Dec 31 2017**
Reserves set aside by Board	$ 322,233	$ 384,102	$ -	$ 706,335	$ 2,429	-$384,062	$ 324,702	$ 200,000	$ -	$ 524,702

Notes:
(1) 2015 Contributions consist of insurance settlement funds from EL mall collapse & interest income
(2) 2016 Contributions consists of interest income
(3) 2016 Drawdowns consists of use of insurance settlement funds to help finance new EL office space
(4) 2017 proposed contributions consist of surplus dollars generated through improved efficiencies and proportional increases in cost shared formula

Algoma PUBLIC HEALTH
Santé publique Algoma

Briefing Note

www.algomapublichealth.com

To: Algoma Public Health, Board of Health

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

Date: November 22, 2017

Re: Renewal of Service Contract with the Sault Ste. Marie Innovation Centre (SSMIC)

☐ For Information ☐ For Discussion ☒ For a Decision

ISSUE:

Algoma Public Health's (APH) current three-year contract with the Sault Ste. Marie Innovation Centre will expire at the end of December 2017. In order to renew this contract, Board of Health approval is required.

Specifically, Section 6.1 Contract/Leases of APH's Procurement policy states that the Board of Health must approve contracts where:

a) Irregularities preclude the award of a contract to the lowest bidder in the Tendering and Request for Quotation process and the 'total acquisition costs' exceeds $50,000
b) A bid solicitation has been restricted to a single source supply and the total acquisition cost of such goods or services exceeds $50,000
c) The contract/lease is for multiple years and exceeds $50,000

Conditions b) and c) are relevant in this case, and therefore require board approval.

RECOMMENDED ACTION:

It is recommended that the Board of Health approves:

1. the Sault Ste. Marie Innovation Centre (SSMIC) to continue to provide a geographic information system (GIS) and other information management services to APH
2. the 3-year contract renewal between APH and SSMIC

BACKGROUND:

APH core functions include population health assessment, surveillance, health protection, health promotion, disease prevention, and emergency preparedness. Epidemiology provides foundational support to this work, by studying the distribution and determinants of health and applying this knowledge to improve population health and health equity.

At the local health unit level, epidemiologic capacity includes access to health-related data across time and space, as well as an infrastructure to support data management, visualization, and analysis.

The Community Geomatics Centre department of the SSMIC operates an Integrated Geomatics System for the City of Sault Ste. Marie, PUC Services Inc., Sault Ste. Marie Economic Development Corporation, Algoma Public Health, and nearly fifty other organizations in the District of Algoma. SSMIC has provided geographic information system (GIS) and other information management services to APH for over 15 years through three- to five-year contracts.

Services which SSMIC provide APH include:

- Data visualization and mapping (e.g. for vector-borne diseases such as West Nile Virus disease and Lyme disease)
- Creation of data products which leverage local data infrastructure (e.g. localization of aging elements in water distribution system as relevant for potential sources of lead in drinking water)
- Support for geographic allocation and deployment of APH staff (e.g. mapping of public health inspector boundaries, school assignment for public health nurses)
- Availability of information management and data analysis capacity in urgent or emergent situations (e.g. analysis and visualization of disease transmission patterns during outbreaks)
- GIS training, access and user support

Please refer to the APH Sole Source Justification form attached in Appendix 1.

FINANCIAL IMPLICATIONS:

The financial commitment of the SSMIC contract is noted below. It is a three-year contract.

Services include ongoing access to GIS and information management services for relevant public health programs.

Year 1: $37,874.16 + HST
Year 2: $38,631.60 + HST
Year 3: $39,404.28 + HST **TOTAL value of contract: $115,910.04 + HST**

CONTACT:

Dr. Jennifer Loo, AMOH
Justin Pino, CFO

Appendix 1

ALGOMA PUBLIC HEALTH
SOLE SOURCE PROCUREMENT JUSTIFICATION FORM

Date Submitted	November 22, 2017
Program	Administration
Product/Service:	**Sault Ste Marie Innovation Centre (SSMIC) Geographic Information System (GIS) and Information Management Services**
Budget Code:	10-100-125
Provider:	Sault Ste Marie Innovation Centre 99 Foster Drive, Level Six (Civic Centre) Sault Ste. Marie ON Canada P6A 5X6
Staff requesting	
Program Manager	
Program Director	Dr. Jennifer Loo

Situational Assessment:

Algoma Public Health's current contract with the Sault Ste. Marie Innovation Centre will expire at the end of December 2017.

SSMIC has provided geographic information system (GIS) and other information management services to APH for over 15 years through three- to five-year contracts. SSMIC services support health unit epidemiologic capacity and provide data products which leverage a unique and specifically local data infrastructure.

Sole Source Procurement Justification: (*Please Reference applicable conditions as per Section 5.5 of APH's Procurement Policy 02-04-030)*

- Compatibility of a purchase with existing equipment, facilities, or services is a paramount consideration
    - SSMIC operates an Integrated Geomatics System for not only APH, but the City of Sault Ste. Marie, PUC Services Inc., Sault Ste. Marie Economic Development Corporation, and nearly fifty other organizations in the District of Algoma. SSMIC is unique in having established a local data infrastructure that leverages community partnerships and data linkages. APH has participated in various community partnerships and local projects which have harnessed the SSMIC shared data infrastructure.

- Where it is most cost effective or beneficial to APH
    - APH requires ongoing epidemiologic capacity and access to local geospatial health data to carry out core public health functions. SSMIC is the unique provider of a highly local data infrastructure, and has provided GIS and other information management services to APH for over 15 years.
    - APH does not currently have the internal capacity to functionally conduct GIS work or engage in spatial epidemiology. Hiring additional staff to provide this capacity internally would be more costly to APH compared to contracting the services of SSMIC.

- When the procurement is for technical services in connection with the assembly, installation or servicing of equipment of a highly technical or specialized nature
    - The analysis and management of geospatial data requires considerable technical expertise in GIS and spatial epidemiology. SSMIC services provide support to APH in this capacity, with respect to both technical expertise and the asset of a well-established local data infrastructure.

Program Director Signature: _____

Chief Executive Officer Signature (if required) _____

Board Chair Signature (if required): _____

ALGOMA PUBLIC HEALTH
FINANCE AND AUDIT COMMITTEE MEETING
SEPTEMBER 13, 2017
PRINCE MEETINGROOM, 3RD FLOOR, SSM
MINUTES

COMMITTEE MEMBERS PRESENT:	Patricia Avery	Ian Frazier	Lee Mason Dennis Thompson
APH STAFF PRESENT:	Dr. Jennifer Loo	Associate Medical Officer of Health	
	Justin Pino	Chief Financial Officer	
	Joel Merrylees	Manager of Accounting and Budgeting	
	Christina Luukkonen	Recording Secretary	
REGRETS:	Dr. Marlene Spruyt	Medical Officer of Health	
GUESTS	Carlo DiCandia, Algoma Financial Group		

1) CALL TO ORDER:
Mr. Frazier called the meeting to order at 4:32 pm

2) DECLARATION OF CONFLICT OF INTEREST
Mr. Frazier called for any conflict of interests. Mr. Frazier and Mr. Thompson both identified as clients of Algoma Financial Group.

3) ADOPTION OF AGENDA ITEMS

FC2017-24 Moved: P. Avery
Seconded: D. Thompson

THAT the agenda items for the Finance and Audit Committee dated September 13, 2017 be adopted as amended.
CARRIED.

4) ADOPTION OF MINUTES

Correction to attendance list.

FC2017-25 Moved: P. Avery
Seconded: D. Thompson

THAT the minutes for the Finance and Audit Committee dated June 14, 2017 be adopted as amended.
CARRIED.

5) Presentation

a. Insurance Broker Services – Carlo DiCandia, Algoma Financial Group
Mr. DiCandia from Algoma Financial Group requested an opportunity to present their services to the Finance & Audit Committee. A copy of their proposal was provided to the committee as part of their agenda package.

The committee will discuss the options and report back to the Board.

APPROVED

Mr. Pino to follow-up with our current broker regarding going out to market for price comparison.

Committee has decided to explore options further for possible February 2019 renewal.

6) FINANCIAL STATEMENTS

Mr. Pino spoke to the draft financial statements provided in the agenda package. Questions answered to the satisfactory of the committee.

The Ministry audit follow-up has been deferred until the Spring of 2018.

a. Draft Financial Statements for the Period ending July 31, 2017

FC2017-26 Moved: L. Mason
Seconded: D. Thompson

THAT the Finance and Audit Committee recommends the draft Financial Statements for the Period ending July 31, 2017 and puts forward to the Board for approval.

CARRIED.

7) BUSINESS ARISING FROM MINUTES - None

8) NEW BUSINESS/GENERAL BUSINESS - None

9) ADDENDUM - None

10) IN-COMMITTEE

FC2017-27 Moved: L. Mason
Seconded: P. Avery

THAT the Finance and Audit Committee goes in-committee at 5:25pm.

Agenda items:

a. Adoption of in-committee minutes: April 19, 2017
b. Security of the Property of the Board

CARRIED.

11) OPEN MEETING

FC2017-29 Moved: L. Mason
Seconded: P. Avery

THAT the Finance and Audit Committee goes into open meeting at 5:37pm.

CARRIED.

12) NEXT MEETING: November 8, 2017 @ 4:00-6:30pm

13) THAT THE MEETING ADJOURN:

FC2017-30 Moved: L. Mason
Seconded: P. Avery

THAT the meeting of the Finance and Audit Committee adjourns at 5:39pm.

APPROVED

CARRIED.

APPROVED

Algoma Public Health

Governance Standing Committee Meeting Report

October 30, 2017

The committee was presented with draft Code of Conduct and Conflict of Interest Policies. The code of Conduct required additional amendments and will be reviewed again at the next meeting in February. The Conflict of Interest Policy was reviewed, discussed and is being brought forth to the Board for approval.

There was a MOH/CEO Performance Evaluation draft presented to the Governance Committee. The discussion was led by Lee Mason - several suggestions were made and discussion about the frequency and process of implementation occurred. This will be brought back to our next meeting with amendments.

It was brought to the attention of the Governance Committee that there should be board involvement in new board member orientation. Ian Frazier will develop a draft plan for orientation will bring back to next meeting with suggestions.

Remaining agenda items regarding policies for Board Minutes, In-Committee Material Posting-Circulation-Retention, Meeting and Access to Information along with Board Evaluation were deferred to our next meeting in February.

Deborah Graystone

Committee Chair

APPROVED BY:	Board of Health	**REFERENCE #:**	02-05-015
DATE:	O: January 18, 1995 Revised: October 28, 2015 Revised: September 27, 2017	**SECTION:**	Board
PAGE:	1 of 2	**SUBJECT:**	Conflict of Interest

POLICY:

Each member of the Board of Health has the obligation to avoid ethical, legal, financial or other conflicts of interest and to ensure that their activities and interests do not conflict with their obligations to the Board of Health of the Algoma District Health Unit (operating as Algoma Public Health) or its welfare.

~~The basic concept underlying the development of guidelines on conflict of interest is to prevent conflict of interest from arising by placing responsibility on the member for disclosing~~

It is the responsibility of the individual to disclose any conflicts of interest to the meeting ~~or for removing oneself from the Board if employment with the Board is being sought by the member.~~

If there is any doubt as to a perception of conflict the member shall discuss with the chair and/or Board of Health for direction.

A board member should not use information that is not public knowledge, obtained as a result of his or her appointment, for personal benefit.

No board member should divulge confidential information obtained as a result of his or her appointment unless legally required to do so.

A Board member shall remove oneself from the Board of Health if Employment at APH is being sought.

The purpose of the Conflict of Interest Policy is to:

i) assist individual board members in determining when his or her participation on a board decision/discussion has the potential to be used for personal or private benefit, financial or otherwise;
ii) protect the integrity of the Board as a whole and its members by following the conflict of Interest Policy and Procedures

Definitions: A conflict of interest situation arises where a member either on his/her own behalf or while acting for, by, with or through another, has any direct or indirect non-pecuniary or pecuniary interest in any contract or transaction with the Board or in any contract or transaction that is reasonably likely to be affected by a decision of the Board.
Where the board member or their close relative or friend or affiliated entity uses the board member's position with the APHU to advance their personal or financial interests;

Actual conflict of interest: a situation where a board member has a private or personal interest that is sufficiently connected to his or her duties and responsibilities as a board member that it influences the exercise of these duties and responsibilities

Perceived conflict of interest: a situation where reasonably well-informed persons could ~~properly~~ have a reasonable belief that a board member may have an actual conflict even where that is not the case in fact

PROCEDURE:

1) At the beginning of every Board meeting, the Board Chair shall ask and have recorded in the minutes whether any board member has a conflict to declare in respect to any agenda item.

2) ~~A~~If a board member believes that he or she has an **actual conflict of interest** in a particular matter, he or she shall,

(a) prior to any consideration of the matter, declare to the Chair of the Board or the Chair of the relevant Committee that he or she has a conflict of interest that prevents him or her from participating;

(b) not take part in the discussion of or vote on any question in respect of the matter;

(c) leave for the portion of the meeting related to the matter; and

(d) not attempt in any way to influence the voting or do anything which might be reasonably perceived as an attempt to influence other councillors or committee members or the decision relating to that matter.

~~2)~~3) ~~Board member shall declare a conflict of interest at the earliest opportunity. In an open session of a Board meeting the member may remain in the room.~~ Should the Board be in an in-camera session the board member shall leave the room until the agenda item has been decided.

~~3)~~4) In situations where a board member declares **a perceived conflict of interest** the Board will determine by majority vote whether the member(s) participate in the discussion and vote on the item. The minutes should reflect the discussion and the Board decision on the matter. Alternately the board member may decide on his or her own accord to not participate in the discussion and to not vote on the agenda item in question.

~~4)~~5) ~~Resignation in writing from the Board p~~Prior to seeking employment with programs administered by the Board the member shall provide a letter of resignation; however, the member may seek re-appointment if not successful in the job competition.

Where a conflict of interest is discovered during or after consideration of a matter it is to be declared to the Board at the earliest opportunity and recorded in the minutes. If the board determines that the involvement of the member declaring the conflict influenced the decision on the matter, the Board shall re-examine the matter and may rescind, vary, or confirm its decision. Any action taken by the Board shall be recorded in the minutes

Where there has been a failure on the part of a Board member to comply with this policy, unless the failure is the result of a bona fide error in judgement as determined by the Board, the Board shall request that the Chair, :

i) Issue a verbal reprimand ; or
ii) Issue a written reprimand; or
iii) Request that the Board member resign or
~~iv)~~ Seek dismissal of the Board member based on regulations relevant as to how the board member \ was appointed.

APPROVED BY:	Board of Health	**REFERENCE #:**	02-05-015
DATE:	O: January 18, 1995 Revised: October 28, 2015 Revised: September 27, 2017	**SECTION:**	Board
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It is the responsibility of the individual to disclose any conflicts of interest to the meeting

If there is any doubt as to a perception of conflict the member shall discuss with the chair and/or Board of Health for direction.

A board member should not use information that is not public knowledge, obtained as a result of his or her appointment, for personal benefit.

No board member should divulge confidential information obtained as a result of his or her appointment unless legally required to do so.

A Board member shall remove oneself from the Board of Health if Employment at APH is being sought.

The purpose of the Conflict of Interest Policy is to:

i) assist individual board members in determining when his or her participation on a board decision/discussion has the potential to be used for personal or private benefit, financial or otherwise;
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Where the board member or their close relative or friend or affiliated entity uses the board member's position with the APHU to advance their personal or financial interests;

Actual conflict of interest: a situation where a board member has a private or personal interest that is sufficiently connected to his or her duties and responsibilities as a board member that it influences the exercise of these duties and responsibilities

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   (a) prior to any consideration of the matter, declare to the Chair of the Board or the Chair of the relevant Committee that he or she has a conflict of interest that prevents him or her from participating;

   (b) not take part in the discussion of or vote on any question in respect of the matter;

   (c) leave for the portion of the meeting related to the matter; and

   (d) not attempt in any way to influence the voting or do anything which might be reasonably perceived as an attempt to influence other councillors or committee members or the decision relating to that matter.

3) Should the Board be in an in-camera session the board member shall leave the room until the agenda item has been decided.

4) In situations where a board member declares **a perceived conflict of interest** the Board will determine by majority vote whether the member(s) participate in the discussion and vote on the item. The minutes should reflect the discussion and the Board decision on the matter. Alternately the board member may decide on his or her own accord to not participate in the discussion and to not vote on the agenda item in question.

5) Prior to seeking employment with programs administered by the Board the member shall provide a letter of resignation; however, the member may seek re-appointment if not successful in the job competition.

Where a conflict of interest is discovered during or after consideration of a matter it is to be declared to the Board at the earliest opportunity and recorded in the minutes. If the board determines that the involvement of the member declaring the conflict influenced the decision on the matter, the Board shall re-examine the matter and may rescind, vary, or confirm its decision. Any action taken by the Board shall be recorded in the minutes

Where there has been a failure on the part of a Board member to comply with this policy, unless the failure is the result of a bona fide error in judgement as determined by the Board, the Board shall request that the Chair, :

i) Issue a verbal reprimand ; or
ii) Issue a written reprimand; or
iii) Request that the Board member resign or

Seek dismissal of the Board member based on regulations relevant as to how the board member \ was appointed.

ALGOMA PUBLIC HEALTH
GOVERNANCE STANDING COMMITTEE MEETING
SEPTEMBER 13, 2017 @ 5:30PM
PRINCE MEETINGROOM, 3RD FLOOR, SSM
MINUTES

COMMITTEE MEMBERS PRESENT: Ian Frazier Deborah Graystone Lee Mason Heather O'Brien

APH STAFF PRESENT:	Dr. Jennifer Loo	Associate Medical Officer of Health
	Antoniette Tomie	Director of HR and Corporate Services
	Christina Luukkonen	Recording Secretary
REGRETS:	Dr. Marlene Spruyt	Medical Officer of Health

1) CALL TO ORDER:
Ms. Graystone called the meeting to order at 5:45pm

2) DECLARATION OF CONFLICT OF INTEREST
Ms. Graystone called for any conflict of interests; none were reported.

3) ADOPTION OF AGENDA ITEMS
GC2017-14 Moved: L. Mason
Seconded: I. Frazier
THAT the agenda items for the Governance Standing Committee dated September 13, 2017 be adopted as amended.
CARRIED.

4) ADOPTION OF MINUTES
GC2017-15 Moved: I. Frazier
Seconded: L. Mason
THAT the minutes for the Governance Standing Committee dated June 15, 2017 be adopted as amended.
CARRIED.

5) BUSINESS ARISING FROM MINUTES
a. Prevention and Promotion Performance Indicator Report
Committee members provided feedback on template presented. Dr. Loo identified the items being reported is based on reports programs are currently running. Committee members identified additional information they would like to see reported. Suggested changes to be made to the template. Template will become part of the MOH Board report on a quarterly basis.

b. 02-05-075 Elections and Selection Process for Board Chair, Vice-Chairs or Committee Members. Committee approved with changes.
GC2017-16 Moved: L. Mason
Seconded: I. Frazier
THAT the Governance Standing Committee recommends and puts forth to the Board of Health a new policy 02-05-075 – Elections and Selection Process for Board Chair, Vice-Chairs or Committee

APPROVED

members for approval.
CARRIED.

6) NEW BUSINESS/GENERAL BUSINESS

a. Policy 02-05-015 – Conflict of Interest
The Governance Standing Committee discussed the changes to the Conflict of Interest policy that was presented. Ms. Luukkonen to send electronic copy out to committee members to provide their additional feedback on policy. Final revision to come back to the Committee in November.

b. Policy 02-05-030 – Code of Conduct
Mrs. Luukkonen to send electronic documents to committee members for their revisions. Final revisions to come back to the Committee in November.

c. Policy 02-05-080 – Performance Evaluation for MOH CEO
Mr. Mason provided a summary on a new policy regarding the performance evaluation for the MOH CEO. Final policy and forms to come forward in the November Committee meeting.'

Committee members requested the New Board Member Checklist used by the Board Secretary be shared with committee members again.

7) ADDENDUM: N/A

8) IN COMMITTEE: N/A

9) OPEN MEETING: N/A

10) NEXT MEETING: November 2, 2017 @5:00pm

11) THAT THE MEETING ADJOURN:

GC2017-17 Moved: I. Frazier
Seconded: L. Mason
THAT the Governance Standing Committee meeting adjourns at 6:49pm.
CARRIED.

APPROVED

Northwestern Health Unit
www.nwhu.on.ca

210 First Street North
Kenora, ON P9N 2K4

October 31, 2017

DELIVERED VIA E-MAIL

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

Attention: The Honourable Eric Hoskins

Dear Hon. Hoskins:

Re: Urgent provincial action needed to address the potential health harms from the modernization of alcohol retail sales in Ontario

On behalf of Northwestern Health Unit Board of Health, I am writing to call on the Government of Ontario to fulfil its commitment (as announced in December 2015) to develop a comprehensive, province wide strategy to minimize harm and support the safe consumption of alcohol, in light of the expansion of alcohol sales in Ontario. Alcohol remains the most harmful drug in society, impacting tens of thousands of Ontarians every year.

Alcohol is no ordinary commodity; alcohol causes injury, addiction, disease, and social disruption and is one of the leading risk factors for disability and death in Canada. Alcohol has significant costs to the individual and society from both a health and financial perspective. These costs include health care, law enforcement, prevention, lost productivity and premature mortality. As such, a comprehensive, evidence-based approach is critical to limit these harms.

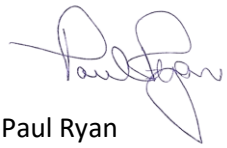
The Ontario Government has committed to social responsibility as it increases the availability of alcohol; however, actions by government since 2014 indicate that economic interests are superseding the health and well-being of Ontarians. Such developments include the increased availability of alcohol at up to 450 grocery stores, wine and cider in farmers' markets, online sales of alcohol through the LCBO and the expansion of bars, restaurants and retail outlets permitted at alcohol manufacturing sites.

It is well established that increased alcohol availability leads to increased consumption and alcohol-related harms. A comprehensive, provincially led alcohol strategy can help mitigate the harms of alcohol. Effective policy interventions include socially responsible alcohol pricing, limits on the number of retail outlets and hours of sale, and restrictions on alcohol marketing. Strong evidence shows that these three policy levers are among the most effective interventions especially when paired with

targeted interventions such as drinking and driving countermeasures, enforcement of the minimum legal drinking age as well as screening, brief intervention and referral activities.

In order to address the health and social harms of alcohol, and the impact of increased access, a comprehensive strategy is needed We are calling on the government to both fulfil its promise and prioritize the health and wellbeing of Ontarians by enacting a comprehensive, evidence-based alcohol strategy as soon as possible.

Sincerely,



Paul Ryan
Board Chair

C: The Honourable Charles Sousa
Premier Kathleen Wynne
Office of the Minister

Thunder Bay District Health Unit

Board of Health Resolution

MOVED BY: C. Bryson **SECONDED BY:** J. Daiter

SOURCE: TBDHU Board of Health **DATE:** October 18, 2017 **Page 1 of 1**

RESOLUTION NO.: 85-2017

ITEM NO.: 8.1

X	CARRIED		AMENDED		LOST		DEFERRED/ REFERRED

J. Virdiramo
CHAIR

RE: Provincial Alcohol Strategy Endorsement

THAT with respect to Report No. 49 – 2017 (Injury and Substance Misuse Prevention) we recommend that:

- The Thunder Bay District Board of Health supports the Ontario Public Health Association Advocacy package; and
- A letter be sent requesting that the Government of Ontario fulfils its commitment to develop a provincial strategy to minimize harm and support the safe consumption of alcohol, copied to Ontario Public Health Units.

FOR OFFICE USE ONLY --- RESOLUTION DISTRIBUTION

	TO:	*INSTRUCTIONS:*	*TO:*	*INSTRUCTIONS:*
1.	L. Roberts		S. Oleksuk	
2	J. Piper			
3				
4				
5				
6				File Copy

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 31, 2017

The Honourable 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

The Honourable Mitzie Hunter
Minister of Education
22nd Floor, Mowat Block
900 Bay Street
Toronto, Ontario M7A 1L2
mhunter.mpp.co@liberal.ola.org

The Honourable Deborah Matthews
Minister of Advanced Education and Skills Development
3rd Floor, Mowat Block
900 Bay Street
Toronto, Ontario M7A 1N3
dmatthews.mpp.co@liberal.ola.org

Dear Honourable Ministers:

Re: Restriction of Marketing and Sale of Caffeinated Energy Drinks to Children and Youth

Caffeinated energy drinks (CEDs) present a health concern for children and youth. These beverages replace healthy choices, have caffeine levels that may exceed maximum daily recommendations, and contain added sugar and other ingredients. Cases of serious medical reactions linked to CEDs have also been reported. The Canadian Paediatric Society also recently released a position statement outlining the risks of CEDs for children and youth.[1] However, in 2014, in Ontario, 29% of students in grades 7-12 reported consuming energy drinks.[2] CEDs are available for sale to children, and youth, and are heavily marketed to these demographics.

The Ontario Ministry of Education's School Food and Beverage Policy, Policy/ Program Memorandum 150 (2010), has classified CEDs as "not permitted for sale". As review of this policy is conducted, we recommend that caffeinated energy drinks, and other foods and beverages high in caffeine and sugar, continue to be restricted from sale in elementary and secondary schools.

Although not currently available for purchase at elementary and secondary schools, school-aged children and youth still have ample opportunity to purchase CEDs at local convenience stores, gas stations, grocery stores, municipal facilities, and post-secondary recreation facilities where many children participate in activities on a regular basis. It would be our recommendation that the school policy be extended into a broader strategy to protect children and youth in additional settings. This strategy could include development of legislation complementing PPM 150 to restrict marketing and sale of CEDs and other foods and beverages high in sugar and caffeine in facilities operated by post-secondary institutions that are frequented by children and youth.

The Canadian Medical Association also supports a ban on the sale of CEDs to Canadians under legal drinking age.[3] Any provincial strategy to restrict the sale and marketing of CEDs to children and youth should complement changes at the federal level to restrict marketing to children under 17 currently outlined in Bill S-228 and the consultation document, "Restricting Marketing to Children".

On behalf of Peterborough Public Health and the residents of Hiawatha and Curve Lake First Nations, and the County and City of Peterborough, we ask you to continue your work on moving this important issue forward.

Sincerely,

Original signed by

Mayor Mary Smith
Chair, Board of Health

/ag

cc: Local MPPs
Dr. David Williams, Chief Medical Officer of Health
Association of Local Public Health Agencies
Ontario Boards of Health

References:

1. Pound, C., and Blair, B. 2017 (September). Energy and sports drinks in children and adolescents. Canadian Paediatric Society Position Statement.
Retrieved from: http://www.cps.ca/en/documents/position/energy-and-sports-drinks

2. Cumming, T., Patton, R., Rynard, V., Manske, S. 2016 (December). 2014/2015 Canadian Tobacco, Alcohol and Drugs Survey: Health Profile for Ontario. Waterloo (ON): Propel Centre for Population Health Impact, 1- 14.
Retrieved from: https://uwaterloo.ca/canadian-student-tobacco-alcohol-drugs-survey/sites/ca.canadian-student-tobacco-alcohol-drugs-survey/files/uploads/files/cst14_provincialprofile_ontario_20170116_a.pdf

3. Canadian Medical Association. 146th annual meeting of the Canadian Medical Association, August 19–21, 2013, Calgary, AB. DM 5–25.
Retrieved from: https://www.cma.ca/En/Pages/ 2013-resolutions.aspx

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 31, 2017

The Honourable Ginette Petitpas Taylor
Minister of Health
Government of Canada
House of Commons
Ottawa, ON K1A 0A6
Ginette.PetitpasTaylor@parl.gc.ca

Dear Minister Petitpas Taylor:

Re: Restriction of Marketing and Sale of Caffeinated Energy Drinks to Children and Youth

Caffeinated energy drinks (CEDs) present a health concern for children and youth. These beverages replace healthy choices, have caffeine levels that may exceed maximum daily recommendations, and contain added sugar and other ingredients. Cases of serious medical reactions linked to CEDs have also been reported. The Canadian Paediatric Society also recently released a position statement outlining the risks of CEDs for children and youth.[1] However, in 2014, 29% of Ontario students in grades 7-12 reported consuming energy drinks.[2] CEDs are available for sale to children, and youth, and are heavily marketed to these demographics. Peterborough Public Health commends the Federal Government for identifying the restriction of marketing of unhealthy foods to children under 17 as a priority for action, and supports Bill S-228. We request that CEDs and other foods and beverages high in caffeine and sugar are included as the complementary definition of unhealthy food is developed.

Beyond the restriction of marketing, we would like to see more done to protect our young people. Currently there are no federal regulations restricting the sale of CEDs to children and youth. Elementary, secondary, and post-secondary school students have ample opportunity to purchase energy drinks at post-secondary recreation facilities, local convenience stores, gas stations, grocery stores, and municipal facilities. The Canadian Medical Association supports a ban on the sale of CEDs to Canadians under legal drinking age in their jurisdiction.[3] The Peterborough Board of Health also supports restricting the sale of CEDs to children and youth. We request that this be considered when amendments to the Food and Drug Regulations are enacted after the conclusion of the Temporary Marketing Authorization period.

On behalf of Peterborough Public Health and the residents of Hiawatha and Curve Lake First Nations, and the County and City of Peterborough, we ask you to continue your work on moving this important issue forward.

Sincerely,

Original signed by

Mayor Mary Smith
Chair, Board of Health

/ag

cc: Local MPs
Dr. Theresa Tam, Interim Chief Public Health Officer
Association of Local Public Health Agencies
Ontario Boards of Health

References:

1. Pound, C., and Blair, B. 2017 (September). Energy and sports drinks in children and adolescents. Canadian Paediatric Society Position Statement.
   Retrieved from: http://www.cps.ca/en/documents/position/energy-and-sports-drinks

2. Cumming, T., Patton, R., Rynard, V., Manske, S. 2016 (December). 2014/2015 Canadian Tobacco, Alcohol and Drugs Survey: Health Profile for Ontario. Waterloo (ON): Propel Centre for Population Health Impact, 1- 14.
   Retrieved from: https://uwaterloo.ca/canadian-student-tobacco-alcohol-drugs-survey/sites/ca.canadian-student-tobacco-alcohol-drugs-survey/files/uploads/files/cst14_provincialprofile_ontario_20170116_a.pdf

3. Canadian Medical Association. 146th annual meeting of the Canadian Medical Association, August 19–21, 2013, Calgary, AB. DM 5–25.
   Retrieved from: https://www.cma.ca/En/Pages/ 2013-resolutions.aspx

Northwestern Health Unit
www.nwhu.on.ca

210 First Street North
Kenora, ON P9N 2K4

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

October 23, 2017

Dear Minister Hoskins,
Thank you for the opportunity to provide feedback on the recommendations in the Expert Panel Report "Public Health within an Integrated Health System" released on June 9, 2017. We recognize that the work of the Expert Panel was challenging and hope that our feedback is considered constructive and useful to establish next steps towards an improved system.

Our analysis of the report indicates that there are a number of flaws in the assumptions feeding this report and in the process used to develop the recommendations (Appendix 1). This might explain why the recommendations are counterproductive to the some of the original principles laid out by the panel (Appendix 2). Overall the recommendations will have substantial negative impacts that would not justify the potential, but not assured, benefits (Appendix 3).

For communities in Northwestern Health Unit's service area, we have grave concerns that the recommendations will lead to a reduction in public health services and programming (Appendix 4). Northwestern Ontario is a large geographical area which includes two time zones, is similar width as the distance from Windsor to Ottawa, and accounts for over a third of the province's geography. There is one large urban centre (Thunder Bay), as well as a similar sized population that is dispersed through many vibrant, rural communities. A single regional board would be challenged by a substantial geography and the unique differences at the local level.

Through resolution (attached), the Board of Health has supported the response from the Association of Municipalities of Ontario (AMO) and The Association of Local Public Health Agencies (alPHa).

Ultimately, the Board of Health of Northwestern Health Unit is focused on our mission to improve the quality and length of life in our communities, and we support your vision as laid out in *Patients First*. We recognize the value of an improved integration with the broader health system, and the benefits from stronger considerations of health equity, disease prevention, health promotion and health protection among health care service providers and facilities.

In order to strengthen integration with the broader health system, we believe there would be much benefit from a **comprehensive review of other potential options that can achieve the vision of *Patients First,*** including options that would "retrofit" the current system. We at Northwestern Health unit are actively working towards this vision and remain a committed partner and stakeholder towards a strong health sector.

Sincerely,

Paul Ryan
Chair, Board of Health of the Northwestern Health Unit

C: Dr. Bob Bell, *Deputy Minister - Health and Long-Term Care*
Roselle Martino, *Assistant Deputy Minister - Health and Long-Term Care, Population and Public Health Branch*
Sharon Lee Smith, *Associate Deputy Minister - Health and Long-Term Care, Policy and Transformation*
Dr. David Williams*, Chief Medical Officer of Health*
Pat Vanini, *Executive Director - AMO*
Dr. Penny Sutcliffe, *Chair - COMOH*
Linda Stewart, *Executive Director - Association of Local Public Health Agencies*
Chairs, *Ontario Boards of Health*
Sarah Campbell, MPP (Kenora – Rainy River)

Attachment: NWHU BOH Resolutions 87-2017; 88-2017; 89-2017

Appendix 1:

Flaws in the assumptions and process in developing the recommendations of the report:

Flawed assumption/process	Comment
Page 6: **Principle: Boundary changes will be necessary to align public health with LHINs, and to support systems planning**	This principle is NOT necessary as there may be other options of working with the LHINs that do not require boundary changes and still allow public health to support systems planning
Page 9: **The Expert Panel did not attempt to "retrofit" the current system**	The decision not to consider "retrofitting" options is an important concern. There is no justification for why the panel would focus on scenarios that did not attempt "retrofitting", which may be potentially cost-saving and more effective at achieving the mandate.
Page 9: **Challenges in smaller health units include a lack of critical mass and surge capacity**	There are other options to address surge capacity other than through a regional board of health e.g. memorandums of understanding, shared service agreements. . NWHU has had adequate critical mass to meet the current Ontario Public Health Standards and generally meet targets on accountability indicators.
Page 9: **Smaller health units have challenges recruiting and retaining key skilled public health personnel**	The challenges with recruiting and retaining key skilled public health personnel is secondary to the rural nature of NWHU. A regional board of health would have the exact same challenges, and would address such challenges the exact same way that the current system addresses it i.e. visiting service providers.
Page 9: **Lack of mechanisms to coordinate across health units making it challenging to collaborate, share resources and maximize effectiveness within the public health sector**	In general health units, including Northwestern Health Unit have a number of management and MOH cross-organizational committees and tables that allow collaboration, sharing of resources, and working towards common goals.
Implicit assumption that the relationship with the LHIN is required for health system planning	Currently NWHU has many productive and effective relationships across the region with hospitals, family health teams, health access centres, long term care homes, etc. A relationship with the LHIN is only one of many relationships that are required to have a positive influence on the health care system.
Effectiveness of the recommendations	There is a lack of evidence to indicate that the recommendations will achieve the goals under *Patients first*. The recommendations are very disruptive to the system. They also lead to instability which can lead to difficult with recruitment and retention of staff and reduce the focus on public health goals and activities. Both of these can have negative impacts on public health work and reputation, which is counterproductive to the goals and intents of *Patients First*.

Appendix 2:

Recommendations are counterproductive to the principles laid out by the panel

- Counterproductive to principle #2 on page 6. Regional public health entities will weaken local relationships with municipalities and local community partners.
- Counterproductive to principle #6: Regional public health entities will be less responsive in considering local needs and priorities.

Appendix 3:

Potential benefits and negative effects of the recommendations:

Benefits	Negative effects
• Potential efficiencies of some functions being regional[a] • Improved ease of working with the Local Health Integration Networks[ab]	• Regional public health entities may be less responsive to local needs and priorities; which reduces the effectiveness of public health work. • Regional boards of health may weaken relationships with local partners e.g. school boards, municipalities, local agencies including local health care service providers. • Regional boards of health may have less municipal representation overall which may reduce disengagement of municipalities as a key public health partner • Cost on resources and staff time for the planning and implementation of the recommendations • Potentially higher cost of the system after implementation e.g. wage harmonization, collective agreements. Amalgamations have been demonstrated not to be cost-saving, and past experience has indicated that the resulting system is more expensive than before amalgamation. • Planning and implementation of the recommendations would lead to organizational instability leading to loss of staff to other sectors (particularly staff who are proactive or have higher expertise) • The instability created by the recommendations may negatively affect relationship building with First Nation on-reserve communities or associated agencies. • The instability created by the recommendations reduces efforts and takes the focus off public health work. This may have negative impacts on the quality of work and reputation which can ultimately weaken the public health system.

[a]both of these benefits can be achieved through other methods that are less disruptive to the system than the recommendations of the Expert Panel report

[b]the Local health Integration Network is only one of many partners in the health care service sector. Local public health units currently have many existing and productive relationships within the health care service sector.

Appendix 4:

Considerations that are particularly relevant to Northwestern Health Unit:

- *Local Boards of Health are better able to meet local needs*: Northwestern Health Unit has an organizational model that is directly reflective and responsive to the types of populations and geographies that they serve. We utilize a decentralized model that is designed to ensure that (1) services and programming is reflective of the needs of the community, (2) staff live in/near the community which leads to more effective relationship building and community engagement, and (3) offices are distributed across the region to reduce travel time for clients and staff. This model suits the population health needs of Northwestern Health Unit. A more centralized model utilized by a regional board of health located in a larger urban centre could reduce or weaken public health programs and services for rural communities.

- *A Large geographical area would be challenging for a regional board of health*: Northwestern Ontario is a large geographical area that includes two time zones with a width similar to the distance from Windsor to Ottawa and accounts for over a third of the area of Ontario (please see map). Organizations/agencies that cover a geographical area as large as what is being proposed in the Expert Panel Report generally provide less service in rural areas, and/or have difficulties with engaging/servicing the populations west of Thunder Bay. Switching from Local Boards of Health to a regional Board of Health for Northwestern Ontario will ultimately require increased bureaucratic levels to allow an effective organization.

Northwestern Health Unit
www.nwhu.on.ca

NORTHWESTERN HEALTH UNIT

BOARD OF HEALTH

MOTION/RESOLUTION

No. 86 -2017

Moved by ..... Marion Smith .....

Seconded by ..... L. MacDonald .....

THAT the Board of Health for the Northwestern Health Unit endorse the letter from alPHa to Minister Eric Hoskins, MOHLTC, regarding the Expert Panel Report "Public Health within an Integrated Health System", dated October 17, 2017.

	Yea	Nay	Abstained	Disclosure of Interest
C. Baron				
D. Brown				
Y. Kirlew				
L. MacDonald				
J. Ruete				
P. Ryan				
T. Sachowski				
S. Smith				
D. Squires				
B. Thompson				

CARRIED___ Date: October 20, 2017

Chair..... Paul Ryan .....

Northwestern Health Unit
www.nwhu.on.ca

NORTHWESTERN HEALTH UNIT

BOARD OF HEALTH

MOTION/RESOLUTION

No. 87 -2017

Moved by L. MacDonald

Seconded by Sharon Smith

THAT the Board of Health for the Northwestern Health Unit endorse the briefing note from AMO regarding the Expert Panel Report "Public Health within an Integrated Health System", dated October 12, 2017.

	Yea	Nay	Abstained	Disclosure of Interest
C. Baron				
D. Brown				
Y. Kirlew				
L. MacDonald				
J. Ruete				
P. Ryan				
T. Sachowski				
S. Smith				
D. Squires				
B. Thompson				

CARRIED___ Date: October 20, 2017

Chair Paul Ryan

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NORTHWESTERN HEALTH UNIT

BOARD OF HEALTH

MOTION/RESOLUTION

No. 88 -2017

Moved by .....

Seconded by .....

THAT the Board of Health for the Northwestern Health Unit approve the letter to Dr. Eric Hoskins, Minister of Health regarding the Northwestern Health Unit's position on the Expert Panel Report "Public Health within an Integrated Health System released June 9, 2017

AND FURTHER that the Board of Health supports the sending of packages to each of the municipalities within its service area, to include copies of the Northwestern Health Unit's position letter, AMO's Position statement, alPHa's position letter, copies of NWHU's passed resolutions supporting AMO and alPHa's feedback as well as a letter encouraging each municipality to send correspondence to Minister Hoskins regarding the proposed changes to the Public Health System.

	Yea	Nay	Abstained	Disclosure of Interest
C. Baron				
D. Brown				
Y. Kirlew				
L. MacDonald				
J. Ruete				
P. Ryan				
T. Sachowski				
S. Smith				
D. Squires				
B. Thompson				

CARRIED___ Date: October 20, 2017

Chair.....

JO MIHEVC
COUNCILLOR | WARD 21 | ST. PAUL'S WEST

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

October 31, 2017

Dear Minister Hoskins:

I am writing in follow up to my August 8, 2017 letter, which outlined my initial concerns regarding the Expert Panel on Public Health's report entitled, *Public Health within an Integrated Health System*. Since my letter, I have had the opportunity to participate in a consultation session with other Board of Health Chairs across Ontario, and I appreciated the opportunity to learn more about the Expert Panel goals, as well as the opportunity to share feedback directly with Ministry of Health and Long-Term Care (Ministry) staff. I have also had the time to further review and reflect on the Expert Panel's report and consider the advice from our Medical Officer of Health and what my colleagues across the province are expressing when it comes to the impact the Expert Panel's recommendations will have on the public health landscape in the province.

First, I wish to reiterate what other boards of health chairs have already expressed, which is that both the public health community and the municipal sector embrace opportunities for change, especially if public health capacity, service delivery, and accountability can be improved. We also support building linkages, fostering collaboration and health system connection – these are important to meeting the health needs of all Ontarians. However, organizational redesign and integration of public health within the health care system are not the solution to achieving these overarching goals.

I have previously conveyed my concerns regarding the recommendation that would divide the City of Toronto into three separate public health entities, and the impacts on the delivery of efficient and coherent public health programs and service and health equity. I also want to bring your attention to concerns associated with the proposed governance of free-standing autonomous boards of health. This governance structure is a departure from the City Toronto Board of Health governance model which is a semi-autonomous board, where public health services are embedded in the municipal structure, City Council has final approval over annual public health budgets, and staff are City employees.

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Changing our governance to a free-standing autonomous board would mean:

- loss / weakening of the municipal voice in public health decision making by increasing the number of community members, provincial appointments (including chairs, vice-chairs and finance); and appointments of Local Health Integration Networks' (LHIN) board members, and other health and social sector appointees;
- loss / weakening of financial oversight and accountability – City of Toronto will no longer have fiscal oversight and City Council will no longer have the ability to approve the public health budget
- loss / weakening of healthy public policy - no longer a direct relationship with the City structure or Council and its committees.

This latter point is of particular importance to successful health outcomes and population health.

Municipalities have jurisdiction over important matters that impact the social and environmental determinants of health. Municipal involvement in the public health decision-making process (and public health's involvement in municipal decision-making) helps shape important policy and planning decisions including: municipal planning, transportation, housing and social services. The City of Toronto Board of Health has contributed immensely to the City's social and environmental determinants of health including contributing to the City's road safety plan, the complete streets guidelines, Toronto Poverty Reduction Strategy, subsidized transit fare programs, the food strategy that works with City partners to promote access to affordable healthy food, menu labelling pilot and the creation of healthy public policy such as the smoking bylaw, banning pesticide use, and establishing the Body Safe/Personal Service Setting licencing and inspection system to name a few.

Maintaining municipal jurisdiction over important public health decisions is critical to the health of the whole population, especially when 60% of an individual's health is affected by their social, economic and physical environment[1] – areas that public health has an important role to play in partnership with their municipalities and other community partners. The Expert Panel's recommendations to geographically align public health with the LHINs and create freestanding autonomous boards of health would therefore place population health and healthy public policy at significant risk. This risk, in addition to the significant costs associated with funding three separate regional public health entities for Toronto, requires careful review, consideration, cost-benefit analysis and negotiation with the municipal sector.

If collaboration with the rest of the health system is a desired outcome, there are a number of alternative approaches that can achieve the same outcome without requiring geographic realignment and separation from the municipality, including partnership agreements. Currently, Toronto Public Health has strong and productive relationships in place with the health system in our City, including long-standing partnerships with community health centres, Toronto Academic Health Science Network (TAHSN) hospitals, primary care, and the Toronto Area LHINs.

In closing, I would like to reiterate my appreciation for the opportunity to meet with Ministry staff in September. However, my concerns have not changed and I encourage you to carefully examine the Expert Panel recommendations and the impacts they would have on public health system and population health outcomes. I also wish to reiterate my request that the Ministry consult with the municipal sector on this matter, and specifically, City of Toronto officials. On

October 30, 2017, our Board of Health adopted a report from Dr. Eileen de Villa, Medical Officer of Health, in response to the Expert Panel report. The Board of Health's decision was submitted directly to the Ministry for consideration.

Sincerely,

Joe Mihevc, Chair, City of Toronto Board of Health; Councillor, Ward 21, St. Paul's

c. Dr. Eileen de Villa, Medical Officer of Health, Toronto Public Health
Giuliana Carbone, Deputy City Manager, City of Toronto
Peter Wallace, City Manager, City of Toronto
Mayor John Tory
Dr. Bob Bell, Deputy Minister, Ministry of Health and Long-Term Care
Roselle Martino, Assistant Deputy Minister, Ministry of Health and Long-Term Care, Population and Public Health Branch
Sharon Lee Smith, Associate Deputy Minister, Ministry of Health and Long-Term Care, Policy and Transformation
Dr. David Williams, Chief Medical Officer of Health
Dr. Penny Sutcliffe, Chair, COMOH
Association of Local Public Health Agencies
Chairs, Ontario Boards of Health

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Matthew L. Gaskell
Commissioner of
Corporate Services

November 9, 2017

COPY

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

RE: Memorandum from Dr. R. Kyle, Commissioner and Medical Officer of Health – re: Expert Panel Report on Public Health
Our File: P00

Please be advised that Committee of the Whole of Regional Council considered the above matter and at a meeting held on November 8, 2017, Council adopted the following recommendations of the Committee:

"A) That the correspondence from the Association of Municipalities of Ontario (AMO) urging the province to not adopt any or all of the recommendations of the report from the Minister's Expert Panel on Public Health and the correspondence from the Association of Local Public Health Agencies (alPHa) highlighting its concerns with the recommendations of the report from the Minister's Expert Panel on Public Health, be endorsed; and

B) That the Premier of Ontario, Minister of Health and Long-Term Care, Durham's MPPs, Central East LHIN CEO, Chief Medical Officer of Health and all Ontario boards of health be so advised."

Attached for your reference is a copy of the Memorandum from Dr. Kyle, Commissioner and Medical Officer of Health, dated November 1, 2017.

Ralph Walton
Regional Clerk/Director of Legislative Services

RW/np

Attach.

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

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c. 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)
Deborah Hammons, Chief Executive Officer, Central East LHIN
Dr. David Williams, Chief Medical Officer of Health
Ontario Boards of Health
Dr. R.J. Kyle, Commissioner and Medical Officer of Health

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The Regional Municipality of Durham

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MEMORANDUM

To: Committee of the Whole

From: Dr. Robert Kyle

Date: November 1, 2017

Re: Expert Panel Report on Public Health

On July 20, 2017, the province released the attached report from the Minister's Expert Panel on Public Health, entitled Public Health within an Integrated Health System. The Expert Panel on Public Health was established in January 2017 to provide advice on structural, organizational and governance changes for Ontario's public health sector within a transformed health system. The province accepted feedback from stakeholders on the Expert Panel's recommendations until October 31, 2017.

On October 12, 2017, the Association of Municipalities of Ontario (AMO) sent a letter to the Minister of Health and Long-Term Care which urges the province to not adopt any or all of the recommendations of the Expert Panel. In summary, AMO clearly stated that it does not support the recommendations of the Expert Panel and listed a number of concerns, many of which are relevant to Region of Durham. Concerns included: public health losing its local and community focus; reducing local leadership's voice in decision-making; and the impact to public health units that are fully integrated within a municipal system, including staff that are municipal employees. AMO emphasized that municipal governments are funding partners in public health rather than stakeholders and that implementing the Expert Panel's recommendation could lead to a municipal reduction to cost-sharing.

Similarly, the Association of Local Public Health Agencies (alPHa) sent a letter to the Minister on October 17, 2017 highlighting its concerns with the Expert Panel's recommendations. Concerns included: major system disruption in the absence of feasibility studies and cost-benefit analysis; a realignment of boundaries which inappropriately places stronger emphasis on public health's relationship with healthcare rather than existing relationships within municipal boundaries; a need for tailored strategies to enhance public health capacity; and local public health capacity which will not withstand the large-scale system disruption proposed by the Expert Panel. It was recommended that the province implement and evaluate initiatives currently underway including the new Standards for Public Health Programs and Services,

new Accountability Framework, and findings of the Public Health Work Stream before the Expert Panel's recommendations are given further consideration.

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

a) The correspondences from AMO and alPHa as regards the report from the Minister's Expert Panel on Public Health are endorsed; and

b) The Premier of Ontario, Minister of Health and Long-Term Care, Durham's MPPs, Central East LHIN CEO, 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

KFL&A Public Health

October 26, 2017

Hon. Eric Hoskins
Minister of Health and Long-Term Care
10th Floor, 80 Grosvenor Street
Toronto, Ontario
M7A 2C4

Dear Minister Hoskins:

RE: KFL&A Public Health's Response to the Report of the Minister's Expert Panel on Public Health

On behalf of the Kingston, Frontenac and Lennox &Addington (KFL&A) Board of Health, we would like to thank you for the opportunity to review and consider the Report of the Minister's Expert Panel on Public Health: "Public Health within an Integrated Health System" released on June 20, 2017. This has allowed the Board of Health to consider the potential implications on the KFL&A region regarding the quality of public health programs and services available to residents, their delivery, the improved accountability and the value for dollar of provincial and municipal funding.

This Board agrees that capacity and equity across Ontario's public health units, including KFL&A Public Health, must be improved and agree that public health expertise can and should be leveraged where appropriate to assist in broader health system planning and integration. We understand the vision of Patients First addressed in the Expert Panel report and its desired outcome to promote health, reduce disparities and help Ontario residents live long and healthy lives. It is suggested that a Patients First vision can be accomplished by strengthening linkages and partnerships between the healthcare system and public health.

KFL&A Public Health and the South East Local Health Integration Network (SELHIN) have created and maintained a strong and vibrant partnership, which allows us to work together to accomplish a Patients First vision. It is important to note that we are not the only local health unit that has accomplished and maintained these types of bonds. We have welcomed the opportunity to partner on key relevant issues in our region and Ontario, such as the opioid crisis and its surveillance, influenza preparedness, surge preparedness, primary care partnerships, health equity assessments and infomatics—South East Health Integrated Information Portal (SHiiP) and Acute Care Emergency Surveillance (ACES). It is this agency's intent to continue working together regarding these issues and others that may arise. This agency will also look for efficiencies with our sister health units in the SELHIN, given the current fiscal environment.

However, we have major concerns regarding the overemphasis on more fully integrating public health into the healthcare system. This integration is bound to lead to a major disruption within the existing public health system without a clearly defined rationale and explanation of how these changes would improve health system capacity or support public health in achieving its goal of health promotion and protection for residents of Ontario. Additionally, there is concern that the proposed geography for the regional health authorities (RHA) is problematic in that it doesn't align with the LHIN geography, it remains highly imbalanced, and the process and criteria for generating those boundaries was not transparent in the report.

The Board has reviewed the many concerns that were addressed in the Association of Municipalities of Ontario (AMO), the Association of Local Public Health Agencies (alPHa), the Council of Medical Officers of Health (COMOH), and Leeds, Grenville and Lanark District Health Unit (LGLDHU) reports and recognize the implications the Expert Panel's recommendations will have on our local health unit, as well as public health in Ontario. This includes but is not limited to:

- Integrating public health into the healthcare system may lead to a loss of focus on the local community.
    - Local public health should remain considerably autonomous from healthcare, because its focus is separate. The healthcare system tends to focus on the treatment of individual patients, where public health's aim is to prevent illness and injury in local populations, as well as promote policies to reduce health inequities and improve population health at large. Firmly integrating the two systems has the potential to dilute public health's mandate and shift it away from local population-based services, focusing more on support for the under-resourced primary care systems.
    - Integration may be beneficial in that applying a public health lens to healthcare service planning and delivery will benefit healthcare. However, healthcare itself is a relatively minor factor in determining what makes populations healthy or unhealthy. Seventy-five percent of what keeps a community healthy is not healthcare; public health works with that 75%. It is not the role of public health to fix health system problems and inefficiencies. While we may play an advisory role in this regard, we feel that remaining autonomous will protect the important role we play in addressing the determinants of health that lie outside the healthcare sector.

- Amalgamation of some public health units may be beneficial and even necessary to create critical mass, but this is not universally appropriate for all units.
    - In some areas of Ontario, there may be benefits to amalgamation where there are many health units with small populations being served. New amalgamations could be better mapped onto existing LHIN boundaries.
    - However, even amalgamation at these small levels will present a challenge that is incredibly complex, disruptive and expensive to undertake.
    - Amalgamation will be significantly more challenging and less beneficial in northern, rural and remote areas, given the populations in these regions are much smaller and widespread. In some cases, the application of the recommended changes may reduce the capacity of some health units.
    - It has been proposed that amalgamation down to 20 units as opposed to 14 may be more reasonable.

- Many of the current public health units, including KFL&A, are already strongly linked to their municipal governments and services.
    - Transitioning to the proposed regional public health structure may damage or even sever these bonds, which will have a negative impact on the quality of public health services and programs provided to residents.
    - There are, of course, units that have not been able to create or maintain these types of bonds, and in that case, it is necessary to fix what is broken whether this be accomplished by encouraging open communication and collaboration with their municipalities and local LIHNs or by implementing small scale amalgamation. However, in the case of those units with strong and vibrant connections, if it isn't broken, don't fix it.

- A reduction in local leadership voice in decision making and weakening of the municipal voice.
  - If amalgamation to as few as 14 units were to take place, not all municipalities would have a seat on the Board. There will be far fewer municipal representatives distributed across far fewer boards of health that are expected to stay the same size.
  - This is a potential problem when considering the amalgamation of 36 health units into just 14, which is more than a 50% reduction.
  - This will result in less communication with and involvement of municipalities in directing public health work for their own communities. It will also impact the ability of local public health units to engage in healthy public policy work—a core part of our responsibilities. This will be at a cost to the health of local residents.
  - This will especially impact the rural and remote areas, which will likely end up with no direct voice.

- The effect and cost of changing single leadership to joint leadership.
  - The Expert Panel recommends a change of the best-practice model of single leadership to joint leadership [combined Medical Officer of Health (MOH) and Chief Executive Officer (CEO)].
  - The associated costs of adding an additional layer of infrastructure with senior leaders and their staff must be considered. Will the funding for these costs come from existing local programs and services?
  - Separating authority and responsibility can inhibit the ability to lead an organization. The concern is that the MOHs must have both the responsibility and authority to carry out their role. It is not unreasonable to predict that joint leadership with a CEO will result in the marginalization of the MOH at the local level and an erosion of authority to carry out duties, currently legislated under the *Health Protection and Promotion Act*.

- The allocation of municipal funding.
  - On average, municipal governments fund 38% of the public health costs for mandatory programs. Implementation of these changes will create significant fiscal disruption and likely reduction in the contribution of municipalities to mandatory programs and services, especially given the high expense of implementing the Expert Panel's recommendations.
  - What is the guarantee that municipal funding will be allocated to fund programs and services in the community it came from?

It is evident that to maintain and improve its current function, public health in Ontario should not be integrated into the healthcare system to the degree proposed by the Expert Panel. While there is obvious importance to some level of integration by working and collaborating with the healthcare system and its members, the larger focus must remain on the local community and working with the wide range of partners outside the healthcare system. Much of what determines one's health is not within the direct scope of the healthcare system. Hospitals and their boards could be amalgamated within the LHINs to create efficiencies and effectiveness at addressing many local issues. Health rather than healthcare is the public health mandate, and it is difficult to see the benefit of aligning local public health units to the healthcare system to the degree recommended.

These concerns and others identified by the AMO, alPHa, COMOH and LGLDHU must be addressed by the Expert Panel and then revisited and judged by the field to be acceptable before recommendations can be implemented. Amalgamations are complex and costly and in many cases, they don't necessarily

produce the desired outcomes and efficiencies. Undertaking such a task, especially province wide, necessitates careful feasibility studies to ensure that the benefits are worth the significant disruption to the public health system and outweigh the costs. The current report contains little to no analysis or evidence on the implications of integration or information on how the proposed model would be implemented and funded. Given the complexity of implementation and with so many details left to work out, we cannot support the proposed changes without clear articulation of the benefits and justification of the costs. The document does not convince this Board of Health that the Expert Panel's recommendations are the only or even the best way to move forward.

Regardless, the KFL&A Board of Health will continue to work locally with a community focus and maintain the key elements of the transformation agenda: modernization of the current standards, improved accountability, and continued demonstration of value for money. Fix what is broken; small health units that lack a critical mass and capacity to deliver services would benefit from amalgamation, but if it is not broken don't fix it.

Yours truly,

Denis Doyle

Denis Doyle, Chair
KFL&A Board of Health

Copy to: KFL&A Board members
Ontario Boards of Health
Association of Local Public Health Agencies
S. Kiwala, MPP, Kingston and the Islands
R. Hillier, MPP, Lanark-Frontenac-Lennox and Addington

Kingston, Frontenac and Lennox & Addington Public Health www.kflaph.ca

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October 27, 2017

Via email: PHTransformation@ontario.ca

Ms. Roselle Martino
Assistant Deputy Minister
Population and Public Health Division
Ministry of Health and Long-Term Care
10th Floor, 80 Grosvenor Street
Toronto, ON M7A 2C4

Dear Ms. Martino:

On behalf of the Sudbury & District Board of Health, I would like to thank you for the opportunity to comment on the Report of the Minister's Expert Panel on Public Health. In its review, the Board of Health considered the analyses of the Association of Local Public Health Agencies (alPHa), dialogue at the Ministry's Expert Panel information sessions, and the deliberations of the Association of Municipalities of Ontario (AMO), among other discussions.

Please note that the Sudbury & District Board of Health endorses alPHa's submission dated October 17, 2017, which is attached to this letter.

We applaud the Minister for his attention to this important sector of the health system in the context of health system transformation, and we recognize the Expert Panel members for their hard work in carrying out the Minister's mandate.

We would like to note that many of the principles and criteria that guided the work of the Expert Panel resonated with us, including in particular, the importance of maintaining a strong independent voice for public health, continuing to build meaningful relationships with municipalities and other community partners, the importance of accountability and transparency, and the need to ensure appropriate and equitable public health capacity across Ontario.

The perspectives of the Sudbury & District Board of Health are informed by the fact that we are an autonomous governance body for local public health in Northern Ontario. Our region is characterized by its diversity of urban, rural, and remote communities; our rich cultures of Indigenous and Francophone heritage; and our largely resource-based economies. Board of Health members are passionate about local health. They have in-depth knowledge of our area and members' perspectives guide the work of our Health Unit, ensuring we are accountable to all our communities and municipalities.

The Sudbury & District Board of Health recognizes the need for strengthening the Ontario public health system, and we applaud the recent government initiatives to modernize the Ontario Public Health Standards, strengthen accountability structures and processes, and ensure effective linkages with health system planning through engagement with Local Health Integration Networks (LHINs). However, we are deeply concerned that the Expert Panel's proposed changes will severely weaken key pillars of our system, which are widely recognized as the strongest in the country. These key pillars include our governance, funding and operational connections with local municipalities, our focus on upstream determinants of health versus downstream planning and provision of health care, the combined specialized/administrative leadership of the medical officer of health and chief executive officer, and our ability to be nimble and responsive to local needs. Very practically, we are deeply concerned about the magnitude of the change recommended and the significant and long-lasting system disruption, opportunity costs, and service gaps that would be expected with implementation.

Following careful consideration and engaged dialogue on the Expert Panel recommendations, the Board of Health generated the following key questions and comments for your consideration:

<u>Questions/Clarification Sought:</u>

1. We are unclear on the rationale or why a change of such magnitude is being proposed especially when we understand that other government initiatives are underway to address equity, accountability, and engagement with LHINs (standards modernization, accountability framework, Public Health/LHIN work stream).
2. We are unclear on why the default model is not a single leadership MOH/CEO model as the recommendation is counter to best practices and creates another layer incurring additional costs.
3. Would the MOH report to the CEO or still report to the board?
4. Why is it assumed that provincial appointees would be more accountable to the government?
5. We are mapping to the LHINs (geography and structure), but do we know if the LHIN model is/has been successful in achieving the LHIN goals of improving access to care and patient experience? What evidence supports that this same model will be effective in maintaining a strong and independent public health system before we mirror it?
6. Why is the focus on linkages between public health and the health sector when our most upstream work is done in partnership with other sectors to impact on the determinants of health?
7. What provisions will be made to ensure the *local voice* at the regional level, such as the establishment of local advisory panels, to prioritize local/individual needs and requests, to then funnel them up to the regional board of health for consideration?

<u>Potential Benefits:</u>

1. The recommended model may allow for the sharing of expertise; therefore, improving capacity for certain health units. However, there are other less disruptive changes that could achieve this such as the creation of regional hubs of specific expertise.
2. May allow for some explicit skills-based board selection; however, this is currently possible through the provincial appointment process.

Potential Concerns:

1. There is an apparent lack of empirical evidence base upon which the recommendations are founded.
2. We anticipate significant financial costs associated with the recommendations and are very concerned who would pay for this and would want to ensure that no service reductions would result.
3. We anticipate significant disruptions for public health services associated with implementing the recommendations.
4. With the dissolution of five boards of health (in the Northeast) and creation of one regional board of health, we are very concerned about the loss of local voice in governing and directing public health programs and services to understand and meet the needs of our communities.
5. The Report's recommendations seem to create another layer in the system, and we have concerns about inefficiencies.
6. There is an apparent contradiction in policy direction in that while LHINs are increasingly focusing on local areas (i.e. the establishment of sub-LHINs), the Expert Panel recommends a reduced local presence for public health.
7. There is no recognition of unique characteristics of Ontario with respect to North and South—there may be structures and leadership models that would work better in the north and we advocate for more flexibility to address such characteristics.
8. There are so many assumptions we would have to make as there are few details in the Report, making it very difficult to comment on many aspects of the Report.

Essential Messages for Maintaining an Effective Public Health System:

1. The importance of linkages with local communities for programming, understanding their needs, and leveraging these partnerships must be recognized.
2. The need to continue to be able to work upstream on the social determinants of health must be preserved and efforts should be enhanced.
3. The need for robust local representation on boards of health—planning and control for local flexibility (versus region-based planning)—must be recognized.
4. Medical officer of health must report to the board, and the default should be the combined MOH/CEO role.
5. It must be ensured that our capacity to respond to local public health needs remains at least at the current level.
6. The outcomes must be evaluated if this model is implemented.
7. It must be ensured that any associated additional costs with implementation (one-time and ongoing) are not taken from current operating budget.
8. Public health needs to remain separate from LHINs to preserve the function and capacity of public health. The proposed model leaves us susceptible to erosion; whereas, the current model ensures that LHINs and public health are collaborative partners working to enhance health for all.

In closing, the Board of Health wishes to thank you for the opportunity to comment on the Expert Panel Report. We see the current dialogue as an opportunity to continue to strengthen our public health system. From our local public health perspective in Northern Ontario, we reiterate our support for the key pillars—strong governance and operational connections with local

municipalities, focus on upstream determinants of health versus downstream health care, the combined specialized/administrative leadership of the medical office of health/CEO, and our ability to be nimble and responsive to local needs.

We are committed to creating opportunities for health for all in our communities, and to that end, we are also committed to being constructive partners with government to continue to improve our local and provincial public health system. Thank you and we very much look forward to further conversations with you on this important initiative.

Sincerely,

René Lapierre, Chair
Sudbury & District Board of Health

Enclosure: alPHa submission

On behalf of Board of Health members:

René Lapierre, Chair, appointed by the Municipal Council of the City of Greater Sudbury
Jeffery Huska, Vice-Chair, appointed by the Municipal Council of the City of Greater Sudbury
Maigan Bailey, appointed by the Municipal Council of the City of Greater Sudbury
Janet Bradley, appointment by Lieutenant Governor in Council
James Crispo, appointment by Lieutenant Governor in Council
Robert Kirwan, appointed by the Municipal Council of the City of Greater Sudbury
Richard Lemieux, appointed jointly by the Municipal Councils of the municipalities of French River, Markstay-Warren and St. Charles
Stewart Meikleham, appointed jointly by the Municipal Council of the Town of Espanola, the Municipal Councils of the townships of Baldwin and Sables-Spanish River and the Municipal Council of The Corporation of the Township of Nairn and Hyman
Paul Vincent Myre, appointed by the Municipal Council of the City of Greater Sudbury
Ken Noland, appointed jointly by the Municipal Council of the Town of Gore Bay, the Municipal Councils of The Corporation of the Town of Northeastern Manitoulin and the Islands and The Corporation of the Municipality of Killarney and the Municipal Councils of the townships of Assiginack, Barrie Island, Billings, Burpee and Mills, Central Manitoulin, Cockburn Island, Gordon and Tehkummah
Rita Pilon, appointed by the Municipal Council of the Township of Chapleau
Mark Signoretti appointed by the Municipal Council of the City of Greater Sudbury
Nicole Sykes, appointment by Lieutenant Governor in Council
Carolyn Thain, appointed by the Municipal Council of the City of Greater Sudbury

cc: Linda Stewart, Executive Director, Association of Local Public Health Agencies
Pat Vanini, Executive Director, Association of Municipalities of Ontario
Alison Stanley, Executive Director, Federation of Northern Ontario Municipalities
Mayors, Sudbury & District Health Unit Constituent Municipalities
Ontario Boards of Health

alPHa
Association of Local
PUBLIC HEALTH
Agencies

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alPHa's members are the public health units in Ontario.

alPHa Sections:

Boards of Health Section

Council of Ontario Medical Officers of Health (COMOH)

Affiliate Organizations:

Association of Ontario Public Health Business Administrators

Association of Public Health Epidemiologists in Ontario

Association of Supervisors of Public Health Inspectors of Ontario

Health Promotion Ontario

Ontario Association of Public Health Dentistry

Ontario Association of Public Health Nursing Leaders

Ontario Society of Nutrition Professionals in Public Health

30 YEARS 1986-2016

October 17, 2017

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

Dear Minister Hoskins:

On July 20, 2017, you released the report of the Expert Panel (EP) on Public Health, Public Health within an Integrated Health System. This report fulfills part of the proposal introduced in your Patients First discussion paper [2015] "to appoint an Expert Panel to advise on opportunities to deepen the partnership between LHINs and local public health units, and how to further improve public health capacity and delivery" [p20]. We thank you, and the EP members, for the completion of this effort and for making the recommendations public for consultation in a timely manner.

The Association of Local Public Health Agencies (alPHa) is the non-profit organization that provides support to the 36 local public health agencies (boards of health and public health units) in Ontario to promote a strong, effective and efficient public health system in the province. alPHa brings together the senior leadership of local public health (LPH), including board of health members, medical and associate medical officers of health, and senior managers in each of the public health disciplines – nursing, inspection, nutrition, dentistry, health promotion, epidemiology and business administration.

As such, alPHa is the collective voice of the organizations and professional leadership that are subject to the EP recommendations. It is with this lens that we have reviewed the recommendations of the EP and have surveyed our member boards of health for input. While alPHa will provide comment from a system level perspective, we expect that the Association's sections, affiliates and member boards of health will provide feedback from their own perspectives.

Our members have been consistent and clear that the mandates of LPH and healthcare are and should remain separate and distinct. Irrespective of the influence of local circumstances, we are collectively concerned that the attempt to align these mandates to the degree recommended by the EP will be to the detriment of our ability to promote and protect health at the community level. We are not starting with a blank slate in Ontario. The LPH system has many strengths that we believe would be eroded by the EP proposals. We urge that the following overarching concerns be carefully considered as part of any analysis for potential implementation.

1. **System disruption.** The magnitude of the changes recommended is significant and careful feasibility studies need to be conducted to ensure that the benefits to the effectiveness of the LPH system outweigh the costs. The EP proposes an 'end state' for LPH that will require major disruption of every facet of the system, from governance to program delivery. With so many details yet to be mapped out and given the complexity of on-the-ground implementation, we cannot support the proposed changes. We are not convinced that the EP recommendations are the only or best way forward.

2. **Fit with the work of LPH.** Local public health distinguishes itself from the healthcare system (i.e., hospitals, home care, family physicians, medical specialists, etc.) in that LPH focuses on the primary prevention of illness and injury and the promotion of public policies that impact the health of the general population. A population health approach seeks to improve the health of the entire population and reduce health inequities among certain groups in the population. This helps individuals, groups, and communities to have a fair chance to reach their full health potential. This also prevents disadvantage by social, economic, or environmental conditions.

   The work of LPH is largely focused upstream, using a population health approach as articulated in the Ontario Public Health Standards. Upstream work includes working with healthcare and non-healthcare sectors to advocate, design, implement and evaluate policies and programs that prevent diseases and their risk factors and promote and protect health, before people become patients in the first place. Bringing the LPH population health lens to healthcare service planning and delivery will certainly have a positive impact on the health system, but, healthcare is a relatively minor factor in what makes populations healthy or unhealthy. Addressing the social determinants of health through a collaborative upstream approach yields a much greater return on investment and widespread gains in the health outcomes of Ontario's population. Health, rather than healthcare, is our mandate and it is difficult for us to see the benefit to the aims of LPH of closer alignment with the healthcare system to the degree recommended by the EP. Realigning the boundaries of public health units with those of LHINs places stronger emphasis on the relationship with healthcare than existing relationships that promote health and fall within municipal boundaries such as housing, employment, planning and school boards. We cannot support the goal of better integration with the healthcare system if it comes at the expense of the structures that support upstream work that is most effectively done in collaboration at the local level with sectors outside of healthcare.

3. **Meeting local needs.** Again, using a population health approach, much of the work of LPH is accomplished through partnerships with local governments, schools and other community stakeholders to develop healthy public policies, build community capacity to address health issues and promote environments that instill and habituate healthy behaviours. Local public health has a strong vision for the health of all Ontarians that encompasses providing the best opportunities for health considering the broad spectrum of what is known to cause the best conditions for health, i.e., the social determinants of health. From that perspective, alPHa has already expressed support, with caveats regarding LPH capacity, for the proposal in Patients First that recommends better integration of population health within the health system. We do

see value in formalizing working linkages between LHINs and LPH, as we believe that they will help to build on existing successful collaborations in addition to ensuring that population and public health priorities inform health planning, funding and delivery. We already know that a rigid or one-size-fits-all approach will not equitably meet the needs of Ontarians in all parts of the province and will not permit the public health system to leverage the diversity of systems, organizations and services in different parts of the province. This is one of the strengths of our system, and we recommend the identification and focused examination of areas of the province where needs are not being met through current structures, so that tailored strategies can be developed to enhance capacity.

4. **Local public health capacity.** LPH capacity for most public health units has been steadily eroding over years of no increases in Ministry-approved budgets. The implementation of the new Standards for Public Health Programs and Services, new Accountability Framework, and new requirements under the *Patients First Act, 2016* are expected to stretch LPH capacity even further, and we believe that it will not withstand the large-scale system disruption proposed by the EP. We note that, while more is being asked of LPH, the budgeted amount for the Population and Public Health Division that provides LPH with most of its funding decreased by .42 percent from the previous year in the 2017-18 budget that gave an overall increase of 3.62 percent to the Ministry of Health and Long-Term Care (MOHLTC).

Given the concerns that we have expressed about the massive systemic change proposed by the EP aimed at fostering LPH-LHIN collaboration, we would like to propose that the work of the Public Health Work Stream that was established to define the formal relationship between LHIN Chief Executive Officers (CEOs) and LPH Medical Officers of Health (MOH) under the *Patients First Act, 2016* be allowed to further develop as an alternative solution.

While the EP focused on a 'ideal' end state with little consideration of implementation challenges [implementation was not within the EP's mandate], the work of the Public Health Work Stream resulted in proposed frameworks for LPH and LHIN engagement that were developed considering the current structure and organization of both LPH and LHINs. The mandate of the Work Stream was to define the parameters for engagement and the set of actions required of LHIN CEOs and LPH MOHs to support local health planning and service delivery decision-making, including definition of specific processes and structures to be established. Upon completion of this work, the Population and Public Health Division surveyed MOHs regarding the recommendations presented in the *Report Back from the Public Health Work Stream*. At present, we are awaiting the publication of the survey results and an open and transparent discussion of the results with government representatives.

We suggest that the desired outcomes for a strong public health sector in an integrated health system stated in the EP Report may better be achieved through focusing on the frameworks proposed by the Work Stream as well as the results of research, such as the locally driven collaborative project, *Patients First – Public Health Units and LHINs working together for population health*.

In closing, we recommend that the initiatives underway including the new Standards for Public Health Programs and Services, new Accountability Framework, and findings of the Public Health Work Stream and other provincial and national actions in progress be implemented and evaluated before the EP recommendations are given further consideration.

We look forward to further consultation and transparent discussion of the way forward. alPHa will continue to provide comment as the work underway evolves and becomes public.

Yours truly,

Carmen McGregor,
President

Copy: Dr. Bob Bell, Deputy Minister
Sharon Lee Smith, Associate Deputy Minister
Roselle Martino, Assistant Deputy Minister,
Dr. David Williams, Chief Medical Officer of Health
Dr. Peter Donnelly, President and CEO, Public Health Ontario
Pat Vanini, Executive Director, AMO
Ulli S. Watkiss, City Clerk, City of Toronto
Giuliana Carbone, Deputy City Manager, City of Toronto
Boards of Health (Chair, Medical Officer of Health and CEO)

York Region

Corporate Services
Regional Clerk's Office

VIA EMAIL

October 20, 2017

Attention: Provincial Boards of Health

Re: Public Health within an Integrated Health System: Response to the Recommendations of the Minister's Expert Panel on Public Health

Regional Council, at its meeting held on October 19, 2017, adopted the following recommendations of the Commissioner of Community and Health Services and Medical Officer of Health's Report No. 1 regarding "Public Health within an Integrated Health System: Response to the Recommendation of the Minister's Expert Panel on Public Health":

1. York Region Council and the York Region Board of Health do not support the Expert Panel on Public Health recommendations including the separation of Public Health from the York Region structure.

2. Council and the Board of Health approve Attachment 1 as its response to the recommendations made by the Minister of Health and Long-Term Care's Expert Panel on Public Health, and direct staff to submit the response to the Ministry of Health and Long-Term Care by the consultation deadline of October 31, 2017.

3. This report be circulated by the Regional Clerk to all nine local municipalities, York Region Members of Provincial Parliament, Canadian Union of Public Employees Local 905 (York Region Unit), Ontario Nurses Association Local 16, the Association of Municipalities of Ontario, the Association of Local Public Health Agencies, the other 35 Boards of Health and the other 46 of the Province's Consolidated Municipal Service System Managers/District Social Services Administration Boards.

4. The Regional Chair be requested to arrange a meeting with the Minister of Health and Long-Term Care to outline the Region's concerns regarding the Expert Panel on Public Health's recommendations.

5. The Minister of Health and Long-Term Care be requested to hold a province-wide public consultation if they decide to proceed with the Expert Panel on Public Health's proposed recommendations.

A copy of Minute No. 147 of the Council of the Regional Municipality of York held on October 19, 2017 is enclosed for your information. A copy of the report considered by Regional Council, along with Attachment 1, can be found on york.ca.

Please contact Katherine Chislett, Commissioner of Community and Health Services at 1-877-464-9675 ext. 72023 or Dr. Karim Kurji, Medical Officer of Health at ext. 74012 if you have any questions with respect to this matter.

Sincerely,

Christopher Raynor
Regional Clerk

/S. Dumont
Attachments

October 31, 2017

Porcupine
Health Unit • Bureau de santé

Honourable Eric Hoskins
Minister of Health and Long-Term Care
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Dear Minister Hoskins:

Re: Response to the recommendations of the Minister's Expert Panel Report on Public Health: *Public Health within an Integrated Health System*

Thank you for the opportunity to provide feedback regarding the Report of the Minister's Expert Panel on Public Health, released this summer.

The Porcupine Health Unit (PHU) is the largest health unit by geographical area in the Province at 266,291 km^2. While the population represented may be smaller, at 87,815 the PHU serves a population rich in mining, forestry, indigenous and francophone cultures. We see higher rates of tobacco use, obesity, and heart disease. The PHU has an autonomous Board of Health with very engaged elected municipal members, and two provincial appointees, who are knowledgeable of the unique needs and strengths of their communities and dedicated to ensuring the provision of effective public health initiatives.

The Board of Health (BOH) for the PHU has significant concerns regarding the recommendations of the expert panel, and feels there would be detrimental implications for our Northern communities if implemented as presented. The recommendation to regionalize Ontario's 36 health units into 14 larger public health entities risks losing the very strength of Public Health in Ontario. Municipal connections are key to the work of public health, and losing this local voice will increase equity gaps, especially in smaller, northern communities. There is great variability in the north, even amongst our current communities, and regionalizing will create Boards of Health that are distant and less able to recognize and address local needs to protect and promote the heath of communities. Although the report states one of the criteria of the recommendations was to "enhance public health's strong local presence and effective relationships with municipalities" (p.10); the PHU feels regionalization will have the opposite effect, and reduce this local connection. Each community brings different qualities, history, strengths, assets and challenges. Without representation at larger regional Boards these important details will not be taken into consideration in addressing local public health priorities. Maintaining governance strongly embedded with local municipalities is thus critical to the success of public health.

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

Another area of concern is the recommendation to integrate Public Health within the healthcare system. The vast majority of the work of public health occurs outside of the healthcare system, with many other multi-sector partners. Placing public health under the umbrella of healthcare services risks decreasing focus on the prevention, protection, and the social determinants of heath. In addition to this, it threatens important connections with other sectors such as the Ministry of Education, Ministry of Children and Youth Services, and local partners to address important issues that impact the health of a population. There is concern for the dilution of public health resources, awareness and focus as acute care concerns take priority. The PHU team currently collaborates with health system partners, including the NELHIN, and primary care, on issues that cross our mandates and serve to improve opportunities for health in Northern community members.

Overall, the PHU is deeply concerned by the magnitude of changes recommended by the panel, and urges the Ministry to take the time for more extensive consideration of the feedback provided, and consider less disruptive, evidence based alternatives that may strengthen Ontario's public health system and improve equitable opportunities for health and well-being for our population.

The Board of Health for the Porcupine Health Unit, at the October 27, 2017 meeting, passed a resolution (attached) which outlines these concerns and endorses the response from the Association of Municipalities of Ontario (AMO) and the Association of Local Public Health Agencies (alPHa). We urge the Ministry to take into account all of these concerns and consider evidence-based alternatives that are less disruptive and aim to strengthen Ontario's Public Health system.

Sincerely,

Gilles Chartrand

Gilles Chartrand, Chair
Board of Health for the Porcupine Health Unit

Encl.

cc: Honourable Kathleen Wynne, Premier of Ontario
Linda Stewart, Executive Director, Association of Local Public Health Agencies
Ontario Boards of Health
Member Municipalities of the Porcupine Health Unit
Gilles Bisson, MPP, Timmins - James Bay

Date: 17/ 10 / 27
y m d

Porcupine
Health Unit • Bureau de santé

R-2017. 61

MOVED BY: Pat Bamford

SECONDED BY: Andrew Marks

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WHEREAS the Ministry of Health and Long-Term Care has released the Report of the Minister's Expert Panel on Public Health, entitled *Public Health within an Integrated Health System*, on July 20 2017, which advocates for regional Boards of Health, that mirror the geographic boundaries of the current Local Health Integration Networks in the Province of Ontario; and

WHEREAS part of the rationale of this proposal is to integrate Public Health within the broader healthcare system, along with addressing capacity issues of some smaller Boards of Health; and

WHEREAS the capacity limitations of smaller health units has been exacerbated by the Ministry's imposition of a per capita funding model on Public Health; and

WHEREAS there is no clear evidence to justify such a change, nor any indication that less disruptive alternatives were considered by the Panel; and

WHEREAS regionalization into larger Public Health entities will result in reduced local municipal connections which are so integral to Public Health; and

WHEREAS weakening municipal representation on Boards of Health reduces the local voice, which is critical in recognizing unique local needs, resulting in greater gaps in health equity in smaller, Northern communities; and

WHEREAS the majority of the work of Public Health occurs outside the health care system, with these strong municipal and local connections; and embedding Public Health within the health care system risks the responsiveness and autonomy of Public Health to protect and promote the health of our communities; and

WHEREAS the costs of such a major restructuring will be substantial, in terms of both funds and staff resources, which may negatively impact the provision of Public Health programs and services;

NOW THEREFORE BE IT RESOLVED THAT the Board of Health for the Porcupine Health Unit has significant concerns regarding the recommendations of the Expert Panel Report and urges the Province to clearly identify the concerns it is trying to address, and consider alternative courses of action to address those concerns and further strengthen the Public Health system in Ontario; and

FURTHER THAT the Board of Health for the Porcupine Health Unit supports the Association of Local Public Health Agencies, and the Association of Municipalities of Ontario's responses to the Expert Panel Report; and

FURTHERMORE THAT this resolution be circulated to Boards of Health in Ontario, the Association of Local Public Health Agencies, Member Municipalities of the Porcupine Health Unit, MPP's representing the Porcupine Health Unit area, the Minister of Health and Long-Term Care, and the Premier of Ontario.

(circle as appropriate)

CARRIED DEFEATED

Gilles Chartrand
Board Chair

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

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TBDHU.COM

October 18, 2017

DELIVERED VIA E-MAIL & REGULAR MAIL
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:

Re: Urgent provincial action needed to address the potential health harms from the modernization of alcohol retail sales in Ontario

On behalf of the Thunder Bay District Board of Health, I am writing to call on the Government of Ontario to fulfil its commitment (as outlined in its 2015 Budget) to develop a comprehensive, province wide strategy to develop initiatives to support safe consumption of alcohol, in light of the expansion of alcohol sales in Ontario. Alcohol remains the most harmful drug in society, impacting tens of thousands of Ontarians every year.

Alcohol is no ordinary commodity; alcohol causes addiction, disease, and social disruption and is one of the leading risk factors for disability and death in Canada. Alcohol has significant costs to the individual and society from both a health and financial perspective. These costs include health care, law enforcement, prevention, lost productivity and premature mortality. As such, a comprehensive, evidence-based approach is critical to limit these harms.

The Ontario Government has committed to social responsibility as it increases the availability of alcohol; however, actions by government since 2014 indicate that economic interests are superseding the health and well-being of Ontarians. Such developments include the increased availability of alcohol at 450 grocery stores, wine and cider in farmers markets, online sales of alcohol through LCBO and the expansion of bars and restaurants permitted at alcohol manufacturing sites.

It is well established that increased alcohol availability leads to increased alcohol-related harms. A provincially led alcohol policy can help mitigate the harms of alcohol. Effective interventions to reduce alcohol-related problems include socially responsible pricing of alcohol, limits on the number of retail outlets and hours of sale and alcohol marketing controls. These three policy levers have strong evidence to show that they are among the most effective interventions especially when paired with targeted interventions such as drinking and driving counter measures, enforcement of minimum drinking age as well as screening and brief intervention and referral activities.

.../2

In order to address the health and social harms of alcohol a strategy is necessary, particularly in light of the expanded sales in grocery stores, farmers markets and online. We are calling on the government to both fulfil its promise and prioritize the health and wellbeing of residents by enacting a comprehensive, evidence-based alcohol strategy as soon as possible.

Thank you for your consideration of this matter.

Sincerely,

Joe Virdiramo, Chair
Thunder Bay District Board of Health

cc: The Honourable Charles Sousa
Premier Kathleen Wynne
Ontario Boards of Health

RESOLUTION #2017-02- Board of Health October 19, 2017

Title: Response of the Board of Health for the Haliburton, Kawartha, Pine Ridge District Health Unit to the Report of the Minister's Expert Panel on Public Health – Public Health within an Integrated Health System

WHEREAS In January 2017, the Minister of Health and Long-Term Care established an Expert Panel on Public Health to provide advice on structural, organizational and governance changes for Ontario's public health sector within a transformed health system;

WHEREAS On July 20, 2017, the Ministry of Health and Long-Term Care released the Report of the Minister's Expert Panel on Public Health – Public Health within an Integrated Health System ;

WHEREAS The Expert Panel made recommendations regarding: Optimal Organizational Structure for Public Health; Optimal Geographic Boundaries; Optimal Leadership Structure; and Optimal Approach to Governance;

WHEREAS The Expert Panel's recommendations included that Ontario: establish 14 regional public health entities; establish catchment areas for the 14 regional public health entities that are consistent with LHIN boundaries and respect existing municipal boundaries; and establish a consistent governance structure for regional boards of health with specific features regarding governance, appointees, size, Indigenous representation, Francophone representation, diversity and inclusion, qualifications, appointment process, board compensation, committees, and succession planning and implementation;

WHEREAS The Expert Panel also proposed leadership considerations for regional public health entities and their functional departments as well as local public health service delivery areas;

WHEREAS The Expert Panel recognized that if implemented, the recommendations will mean large organizational change for the sector. While the Expert Panel was not asked to make specific recommendations about implementation, it identified the following elements that should be considered in developing an implementation plan: legislation; funding; and transition planning/change management;

WHEREAS On October 12, 2017, the Association of Municipalities of Ontario (AMO) released its response to the Expert Panel's Report;

WHEREAS In its response AMO indicated that after consideration by its Board of Directors and Health Task Force it does not support the recommendations of the Expert Panel on Public Health and urged the government not to adopt them given there is no clear evidence to justify such changes to the public health system. AMO also indicated in its response that integrating public health within the health care system, would completely change and dilute over time the mandate of the local public health system;

WHEREAS On October 17, 2017, the Association of Local Public Health Agencies (alPHa) released its response to the Expert Panel's Report;

WHEREAS In its response, alPHa indicated that its members have been consistent and clear that the mandates of Local Public Health (LPH) and healthcare are and should remain separate and distinct; irrespective of the influence of local circumstances, alPHa is collectively concerned that the attempt to align these mandates to the degree recommended by the Expert Panel will be to the detriment of its members' ability to promote and protect health at the community level; alPHa believes that the LPH system has many strengths that would be eroded by the Expert Panel proposals; alPHa urges that the following overarching concerns be carefully considered as part of any analysis for potential implementation: system disruption, fit with the work of LPH, meeting local needs, and LPH capacity;

WHEREAS In its response, alPHa also indicated that given the concerns that it expressed about the massive systemic change proposed by the Expert Panel aimed at fostering LPH-LHIN collaboration, it would like to propose that the work of the Public Health Work Stream that was established to define the formal relationship between LHIN Chief Executive Officers (CEOs) and LPH Medical Officers of Health (MOH) under the *Patients First Act, 2016* be allowed to further develop as an alternative solution;

WHEREAS In addition, alPHa recommended that the initiatives underway including the new Standards for Public Health Programs and Services, new Accountability Framework, and findings of the Public Health Work Stream and other provincial and national actions in progress be implemented and evaluated before the Expert Panel recommendations are given further consideration; and

WHEREAS The Board of Health has the same concerns as AMO and alPHa regarding the Expert Panel Report;

NOW THEREFORE BE IT RESOLVED that the Board of Health for the Haliburton, Kawartha, Pine Ridge District Health Unit endorse both the AMO and alPHa responses to the Expert Panel Report on Public Health and that AMO and alPHa are so advised;

AND FURTHER that the Premier of Ontario, Minister of Health and Long-Term Care, MPPs for Northumberland—Quinte West and Haliburton—Kawartha Lakes—Brock, Municipalities of Northumberland and Haliburton Counties and the City of Kawartha Lakes, Chief Medical Officer of Health, Assistant Deputy Minister, Population and Public Health Division, Ministry of Health and Long-Term Care, Central East LHIN CEO, South East LHIN CEO, and Ontario boards of health are so advised.

RESOLUTION #2017-02- Board of Health October 19, 2017

Title: Response of the Board of Health for the Haliburton, Kawartha, Pine Ridge District Health Unit to the Report of the Minister's Expert Panel on Public Health – Public Health within an Integrated Health System

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WHEREAS The Expert Panel also proposed leadership considerations for regional public health entities and their functional departments as well as local public health service delivery areas;

WHEREAS The Expert Panel recognized that if implemented, the recommendations will mean large organizational change for the sector. While the Expert Panel was not asked to make specific recommendations about implementation, it identified the following elements that should be considered in developing an implementation plan: legislation; funding; and transition planning/change management;

WHEREAS On October 12, 2017, the Association of Municipalities of Ontario (AMO) released its response to the Expert Panel's Report;

WHEREAS In its response AMO indicated that after consideration by its Board of Directors and Health Task Force it does not support the recommendations of the Expert Panel on Public Health and urged the government not to adopt them given there is no clear evidence to justify such changes to the public health system. AMO also indicated in its response that integrating public health within the health care system, would completely change and dilute over time the mandate of the local public health system;

WHEREAS On October 17, 2017, the Association of Local Public Health Agencies (alPHa) released its response to the Expert Panel's Report;

WHEREAS In its response, alPHa indicated that its members have been consistent and clear that the mandates of Local Public Health (LPH) and healthcare are and should remain separate and distinct; irrespective of the influence of local circumstances, alPHa is collectively concerned that the attempt to align these mandates to the degree recommended by the Expert Panel will be to the detriment of its members' ability to promote and protect health at the community level; alPHa believes that the LPH system has many strengths that would be eroded by the Expert Panel proposals; alPHa urges that the following overarching concerns be carefully considered as part of any analysis for potential implementation: system disruption, fit with the work of LPH, meeting local needs, and LPH capacity;

WHEREAS In its response, alPHa also indicated that given the concerns that it expressed about the massive systemic change proposed by the Expert Panel aimed at fostering LPH-LHIN collaboration, it would like to propose that the work of the Public Health Work Stream that was established to define the formal relationship between LHIN Chief Executive Officers (CEOs) and LPH Medical Officers of Health (MOH) under the *Patients First Act, 2016* be allowed to further develop as an alternative solution;

WHEREAS In addition, alPHa recommended that the initiatives underway including the new Standards for Public Health Programs and Services, new Accountability Framework, and findings of the Public Health Work Stream and other provincial and national actions in progress be implemented and evaluated before the Expert Panel recommendations are given further consideration; and

WHEREAS The Board of Health has the same concerns as AMO and alPHa regarding the Expert Panel Report;

NOW THEREFORE BE IT RESOLVED that the Board of Health for the Haliburton, Kawartha, Pine Ridge District Health Unit endorse both the AMO and alPHa responses to the Expert Panel Report on Public Health and that AMO and alPHa are so advised;

AND FURTHER that the Premier of Ontario, Minister of Health and Long-Term Care, MPPs for Northumberland—Quinte West and Haliburton—Kawartha Lakes—Brock, Municipalities of Northumberland and Haliburton Counties and the City of Kawartha Lakes, Chief Medical Officer of Health, Assistant Deputy Minister, Population and Public Health Division, Ministry of Health and Long-Term Care, Central East LHIN CEO, South East LHIN CEO, and Ontario boards of health are so advised.

November 1, 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:

Thank you for providing us the opportunity to respond to the report of the Expert Panel on Public Health which you released on July 20, 2017. You will find our comments, organized by general areas of concern, hereunder:

Lack of Evidence to Support Proposed Model

The Goals of Patients First and the Desired Outcome: A Strong Public Health Sector within an Integrated Health System (page 5 of the Expert Panel report) reflect a vision for Public Health that is difficult to find fault with. However, the Panel's report provides little evidence or analysis to demonstrate that the proposed model/solution is the best option for achieving the vision or improves the overall delivery of public health services or the health of the population provincially. In the end, any changes to the structure and governance of the province's Public Health system must be evidence informed to ensure the best possible population health outcomes and achievement of stated goals and objectives.

The Mandate of Public Health of Public Health Must be Maintained & Preserved

The Panels' report envisions an end state where Public Health is part of an integrated health system, works more effectively with the other parts of the system and is recognized and valued for their work. There are significant concerns within the public health field that integration within a system that is focused on health treatment and care, will result in a dilution of the public health mandate. If the province is committed to the integration of Public Health within the overall health system, it will be necessary to address these concerns in real and practical ways and demonstrate their commitment to maintaining a strong independent public health sector within the integrated system. If resources, mandate and expertise are not safeguarded and protected, the overall effectiveness of the current Public Health System may actually be diminished. Additionally, it can be argued that building stronger linkages with LHINs, and Public Health support to integrated planning can occur and be accomplished without the structural and organization changes proposed in the Panel's recommendations.

The Need for Change - One Size Does Not Fit All

If implemented, the panel's recommendations will fundamentally change the delivery of Public Health in the province of Ontario and within all of the existing 36 health units. The report does not articulate what the underlying problem(s) are that need to be fixed. If the government has specific concerns they are trying to address, then it would be prudent to test less disruptive alternatives in those health units where the province has concerns and identified problems. The magnitude of change and potential disruption to the system is very significant. Public Health needs and issues in Ontario are too diverse for a one-size fits all solution; forcing a one-size fits all approach has the potential to undermine and weaken the role and effectiveness of Health Units that are operating well.

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Focus on Local Communities and Municipal Partners in Current System

In many areas of the province, Health Units have been successful at effectively embedding their work within local communities and municipalities. This enables the differing needs of the local communities to be effectively met, effective relationships to be built with community organizations, and collaboration/alignment with municipalities in planning and delivering services that have a direct correlation or connection to determinants of health. There are many examples where the local political engagement, ownership and oversight have been instrumental in moving Public Health initiatives forward. Furthermore, for those Health Units that are embedded within municipal structures, the new system will result in disconnection and less involvement with these important partners who have been instrumental in helping to move the work of Public Health forward and enhancing its profile.

Labour Relations Implications

With the proposed model, the financial cost of the large scale boundary changes and mergers in Public Health will be very significant and will include wage harmonization, renegotiation of pay equity plans, bringing together differing organizational cultures, policy/procedures integration, layoffs/bumping/terminations, severance costs, legal fees, consultant fees, organizational structure issues, and union mergers/certifications/jurisdiction issues. There is no indication in the panel's report that due consideration has been given to the significance and magnitude of the disruption and costs on the overall public health system in Ontario. The province needs to be aware of the financial and human resources impacts before making a final decision on the recommendations; only then will the decision be made with full information that informs whether it will be worth it in the end to apply a change of this magnitude to the province's Public Health system.

Potential Reduction in Overall Resources/Funding in the PH System

In many Health Units, municipalities currently contribute more than 25% of the cost shared funding. If municipalities have less control and input into the decision making related to Public Health programs and services, or other municipalities within the LHIN boundary are paying a lessor share, there may be a reluctance to maintain current municipal cost sharing. As a result, there could be a reduction in overall financial resources within the Public Health system. In addition, there is concern that the ability to address local needs will be diminished with less local participation on the newly structured Boards of Health. While the report explicitly states that funding was out of scope, there are many outstanding questions that would need to be considered and addressed before finalizing the new model; designing and finalizing the system without addressing the unanswered funding questions would be foolhardy and irresponsible.

Transition Planning and Change Management

The Panel's report speaks to transition planning and change management as it pertains to the change in the board of governance for Public Health Units. However, there is little reference to the importance of or significance of the change management processes that will be required from organizational perspectives to move the system from its current status to the desired end state. The need for investment in change management processes and supports and the sheer volume of work of work that will be required to achieve a consolidation of this magnitude cannot be underestimated and must be planned for.

What Is Positive or Helpful About the Proposed Model

The proposed model provides for improved linkages and collaboration with other parts of the health care system (including LHINs); in addition, as a result of Public Health's involvement, there will be more focus on social determinants of health and greater health equity through a population health approach to health service planning and delivery.

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The Expert Panel's goal of improved capacity within the Public Health system is a worthwhile goal. This is particularly true for the majority of health units where capacity has been diminished or constrained as a result the Ministry's application of the new funding formula beginning in 2015. However, while the goal and intention is positive, if there is truly a commitment to expanding capacity, resolution of the funding issues across the public health system will need to be addressed; the total investment in the Public Health system in Ontario may need to be enhanced.

The panel's Intention and commitment to maintain flexibility to address local needs in the proposed model is also positive. However, as indicated above we are concerned that with the loss of political engagement and other challenges, in reality there may actually be less responsiveness to local needs.

The focus on enhancing the skill of board members (in areas where this has been a problem) and reinforcement of board roles/responsibilities is important. Strong governance within the Public Health System is imperative to effective outcomes, transparency and accountability.
The proposed model presents opportunities for economies of scale and enhanced efficiencies for shared services particularly in the area of corporate/business services if there is fewer than 36 unique ways of doing things. Additionally, the new model should ensure that every Health Unit has access to specialized services that may not have been practical for smaller health units in the current model.

Additional Questions that the AOPHBA Membership Has

- What is the proposed timing of the decision making process?
- What is the proposed timing of the implementation if the decision is to proceed with the proposed model?
- If the recommendations are implemented, what will the criteria for success that the new model will be measured against?
- What will be the cost sharing/funding arrangements going forward?
- Will the Ministry continue to utilize the current funding formula that it began using in 2015? What are the implications when some Health Units within a LHIN boundary are deemed "over their share" and others are "under their share"?
- Will there be one time funding to support the necessary transition and close-out costs of moving to the new model? (These costs will be significant).

We thank you again for the opportunity to provide input, and hope to be involved further in these discussions as these momentous changes are considered by the Ministry.

Yours very truly,

Don West
President, Association of Ontario Public Health Business Administrators (AOPHBA)

cc: The Honourable Kathleen Wynne, Premier of Ontario
Dr. Robert Bell, Deputy Minister, Health and Long-Term Care
Dr. David Williams, Chief Medical Officer of Health
Linda Stewart, Executive Director, Association of Local Public Health Agencies
Ontario Boards of Health

Regional Municipality of Waterloo

OFFICE OF THE REGIONAL CHAIR
Ken Seiling

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November 2, 2017

The Honourable Kathleen Wynne
Premier of Ontario
Legislative Building
Queen's Park
Toronto ON M7A1A2

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

Dear Kathleen and Eric,

Please find attached a report which has the unanimous support of Regional Council with regards to the expert panel on public health. I appreciate the consultation but am concerned that the original report was heavily biased by its composition and its failure to examine the role and merits of integrated health units. I believe that this view is widely shared among the integrated public health units.

Thanks for the opportunity for input. I do hope that the Province will not proceed with what will be a most damaging step for public health in our Region and in other Regions and single tier cities.

Regards,

Ken Seiling
Regional Chair

Encl.

c: Area Members of Provincial Parliament (MPPs)
Mike Murray, CAO, Region of Waterloo
Dr. Liana Nolan, Commissioner/Medical Officer of Health, Region of Waterloo
MARCO Members and Other Boards of Health in Ontario
Association of Municipalities of Ontario (AMO)
Association of Local Public Health Agencies (alPHa)
Waterloo-Wellington Local Health Integration Network (WWLHIN)

Report: PHE-17-06

Region of Waterloo

Public Health and Emergency Services

To: Chair Geoff Lorentz and Members of the Community Services Committee

Date: October 24, 2017 **File Code:** A16-40

Subject: Response to the Report of the Minister's Expert Panel on Public Health

Recommendation:

That the Regional Municipality of Waterloo take the following actions in response to the Report of the Minister's Expert Panel on Public Health:

(a) Advise the Premier and the Minister of Health and Long Term Care (MOHLTC) that the Region of Waterloo supports the current fully-integrated approach to Public Health delivery in Waterloo Region;

(b) Advise the Premier and the MOHLTC that the Region of Waterloo does NOT support the recommendations of the Expert Panel, and urge the government not to adopt the Expert Panel recommendations;

(c) Endorse Report PHE-17-06 as the Region of Waterloo's response to the consultation regarding the report of the Minister's Expert Panel on Public Health;

(d) Endorse The Association of Municipalities of Ontario's position which also opposes the recommendations of the Minister's Expert Panel on Public Health; and

(e) Forward a copy of this report to the Premier of Ontario, the Minister of Health and Long Term Care, all local MPPs, the Association of Municipalities of Ontario (AMO), the Association of Local Public Health Agencies (alPHa), the other 35 Boards of Health in Ontario and the Waterloo-Wellington Local Health Integration Network (LHIN).

Summary:

This report is the Region of Waterloo response to the Expert Panel report released on

July 20th, 2017 regarding possible Public Health restructuring in order to more closely align public health with the health care system. The Ministry of Health and Long Term Care has asked for feedback by way of a consultation process which closes October 31st.

Regional staff believe that Waterloo Region has been, and continues to be well-served by the current integrated approach to public health delivery in this community. Staff recommend that the Region NOT support the recommendations of the Expert Panel for a number of reasons: there is no evidence to suggest that the recommendations would improve public health delivery or population health in Waterloo Region; there are significant unanswered questions about the implications of the recommendations for this community; and there are real risks for the disruption of public health service delivery in the Region of Waterloo if the recommended model is implemented. Removing public health from the current integrated municipal structure locally has the potential to weaken the role of public health in our community and undo much good work that has been done, decrease municipal public support, weaken the ability of public health to be partners in municipal services, planning and programming, and lower the profile of our public health programs and services locally.

Concerns and feedback regarding the proposal (detailed within the report beginning on page 6) include the following:

- **There is demonstrated success in delivering public health services in Regional and Single Tier Public Health Units;** the new model may have unintended negative impacts for public health service delivery in the Region of Waterloo.
- **All changes to the structure and governance of the province's public health system should be evidence informed to ensure best possible population health outcomes.** The report contains little analysis and evidence to demonstrate the recommended model represents the best option or improves the overall delivery of public health services in the province generally, and in Waterloo Region specifically.
- **The mandate of public health must be maintained and preserved;** there is a risk that integration within the health system (which is dominated by a focus on care and treatment) will dilute the public health mandate.
- **Overall funding for the public health system must be maintained. Resources should not be diverted to new administrative structures, and local levies should not be spread beyond municipal boundaries;** there is a risk that the proposed changes will result in diminished supports (financial and in-kind) if the role of municipalities in the delivery of public health is lessened. There is also the risk that local levy shares will be spread over other municipalities, thus diminishing program spending within the Region.

- **Testing of any new model should take place in areas where the Province has identified issues;** if the government wishes to test a new model for public health delivery, it should be done first in the existing autonomous health units where the province has identified concerns, prior to considering such changes to health units that are integrated within municipal structures.
- **Municipal boundaries must be respected in any model that is implemented;** a municipality should not be served by more than one public health entity or Local Health Integration Network (LHIN).

A recent press release and briefing note issued by the Association of Municipalities of Ontario (AMO) indicates that they also do not support the recommendations of the Expert Panel on Public Health; AMO is urging the government not to adopt the recommendations.

Report:

Context for the Report of the Minister's Expert Panel on Public Health

In December 2016, the Ontario government passed the Patients First Act (the Act) which included reforms to both the structure and function of the health system in the province of Ontario. As a result of the Act, the public health sector was to become part of a more integrated health system and there were to be more formalized relationships and linkages between Public Health Units and the Local Health Integration Networks (LHINs).

In January 2017, the Expert Panel on Public Health (the Panel) was created by the Ministry of Health and Long-Term Care; the panel was tasked with providing advice to the Ministry regarding the structure, organization and governance of Ontario's public health sector within the transformed system.

The Panel's report "Public Health within an Integrated System, Report of the Minister's Expert Panel on Public Health" (Appendix 1) was released on July 20th, 2017. As indicated in the report, the Panel was "asked to consider:

1. The optimal organizational structure for public health in Ontario to:
    - Ensure accountability, transparency and quality of population and public health programs and services
    - Improve capacity and equity in public health units across Ontario
    - Support integration with the broader health system and LHINs, the organizations responsible for planning health services
    - Leverage public health's expertise and leadership in population health-based planning, decision-making and resource allocation, as well as in addressing healthy equity and the social determinants of health.
2. How best to govern and staff the optimal organizational structure."

Consultation on the report and the associated recommendations continues until October 31st, 2017.

Ministry of Heath & Long Term Care (MOHLTC) Perspective re: Issues with Current State of Public Health

From a provincial perspective, there are a number of challenges with the current structure, organization and governance of public health. The challenges identified by MOHLTC staff in the areas of structure and organization include:

- Lack of integration of public health within the health system
- Misalignment of boundaries (i.e. LHINS, municipal, PHU's)
- Too many PHU's (36), with significant variation in size and geographic regions, insufficient critical mass and surge capacity
- Variation in PHU service delivery and minimal coordination between PHU's
- Variable capacity of the public health sector to participate in an integrated health system

The challenges identified by MOHLTC staff in the areas of governance and accountability include:

- Variation in public health sector governance models resulting in the following impacts provincially:
    - Differences in how priorities are set and decisions are made (programs and services)
    - Differences in accountability relationships of the Medical Officer of Health to the Board of Health
    - Differences in the autonomy of Boards of Health at the local level
    - Tensions between municipal and provincial health priorities
- Lack of consistency in the skills, experience, backgrounds and priorities of members of Boards of Health across the province
- Recruitment and retention of Medical Officers of Health

The challenges identified by ministry staff do not exist consistently across the province. Few if any of the issues have manifested themselves within Waterloo Region.

Summary of the Expert Panel Recommendations

Key recommendations from the Expert Panel Report include the following:

Governance:

- Replace current 36 Public Health units with 14 free standing autonomous regional boards of health (aligning the geographic boundaries for the new entities

with the exiting LHIN boundaries).
- Board membership would consist of 12-15 appointees including municipal, provincial, citizen and other non public health sector (e.g. education, LHIN, social sector, etc.)
- Membership to reflect diversity of the community, skills and experience
- Establishment of standing committees to be defined in Regulations

Structure:

- The 14 new regional public health entities would be led by a Chief Executive Officer who would report directly to the Board of Health; a Regional Medical Officer of Health and a Senior Public Health Leadership team.
- Local Public Health Service Delivery Areas or sub-divisions of the regional entities to be located in multiple local communities and which are staffed by a Local Medical Officer of Health (reporting to the Regional Medical Officer of Health), local program and service management staff, and multidisciplinary teams of staff.

As indicated in the report, the proposed structure of 14 regional public health entities is intended to allow public health to:

- Centralize administrative and specialized public health functions at the regional level,
- Be accountable for public health standards provincially,
- Collaborate with LHINs and other partners to plan and tailor health services in their regions,
- Establish local public health service delivery areas within regions, based on population and geography, and
- Locate public health programs and services in local communities to maintain local engagement.

Impact and Implications of Panel Recommendations for Region of Waterloo Public Health

Region of Waterloo Public Health is 1 of 11 Public Health Units that currently operate under the administration of a regional or other municipal government structure. It operates in a fully integrated manner with other regional departments in areas such as social services, child care, housing, water supply, transportation, planning and community safety. Public Health occupies space at 99 Regina Street, Waterloo and at 150 Main in Cambridge and benefits significantly from shared corporate services including Finance, Information Technology, Human Resources and Citizen Services, Legal Services and Council and Administrative Services. Regional Council serves as the Board of Health.

The current integrated system in Waterloo Region has significant benefits from both a Public Health and Regional perspective; innovative approaches and effective collaborations in areas such as water protection and water quality, the Regional Official Plan, active transportation and by-law implementation (e.g. tobacco and pesticides) are examples where the municipally integrated model of public health governance has worked to the overall benefit of the community. If the recommendations from the Panel are accepted and implemented, Public Health would no longer be a part of the Region of Waterloo, and the integration and coordination with other Regional programs would be severely compromised. Regional Council's role as the Board of Heath would cease. There would be no impact on the delivery of paramedic services by the Region.

In the new model, Public Health programs and services within Waterloo Region would be delivered by a regional public health entity with geographic boundaries the same as the Waterloo Wellington LHIN. The service delivery catchment area would also include the majority of the geographic area currently served by the Wellington Dufferin Guelph Health Unit. As one of 14 free standing autonomous regional boards of health, the Waterloo Wellington Public Health Entity would be governed by a Board with 12-15 members and led by a Chief Executive Officer, a Regional Medical Officer of Health and Senior Public Health Leadership. Within each LHIN area, the model also proposes the existence of several Local Public Health Service Delivery Areas; each would be lead by a Local Medical Officer of Health and Program Service Managers and staffed by multi-disciplinary front-line teams; the number of service delivery areas for each LHIN has not been confirmed at this time.

Region of Waterloo's Response Regarding the Expert Panel Report

The provincial government has not committed to any specific next steps regarding the report recommendations beyond the consultation processes that conclude October 31st, 2017. The proposed changes recommended by the Expert Panel generally align with Ministry goals of integration of public health within the health care system. However, the Panel's report does not include analysis and evidence to demonstrate the changes are the best possible approach; the report does not address how the current mandate of Public Health would be protected; financial implications have not be considered or detailed in the report. Implementation of the report's recommendations creates a risk that there would be a potential loss of alignment with municipal partners and other key public health stakeholders locally. In general, the report provides no evidence that the recommendations would improve the delivery of public health services in the province as a whole or in specific geographic regions, or result in improvements to population health in Ontario.

For all the reasons noted above, Regional staff recommend that the Region NOT support the recommendations of the Expert Panel. Staff believe that Waterloo Region has been, and continues to be well-served by the current integrated approach to public

health delivery in this community.

From a Region of Waterloo perspective, key areas of concern with the Expert Panel recommendations include the following:

- **There is demonstrated success in Regional and Single Tier Public Health Units; one size does not fit all.** Public Health in Waterloo Region (similar to other Regional and Single Tier PHUs) currently performs its provincially mandated programs but is fully integrated into the regional structure where it is engaged and collaborates in areas including housing, social services, child care, water supply, transportation and planning. In addition, Public Health receives cost effective support from the Region's corporate areas including human resources, legal, finance and information technology. Our public health unit has benefited significantly from local political engagement, ownership and oversight, most notably during situations such as the implementation of the tobacco by-law locally. Separating public health units such as Waterloo Region Public Health which are currently part of the Regional government structure may have unintended negative consequences related to governance, processes and collaboration, and result in the dis-integration of public health from other municipal services.

  The province's goal of addressing some existing challenges of structure, organization, governance, and accountability within Ontario's public health system does not require a one size fits all model of standardization. The challenges the Ministry is trying to address do not exist consistently across the province, and certainly have not been identified in Waterloo Region. Current structure, organization, governance and accountability is working effectively in Waterloo Region. Removing public health from the current integrated municipal structure locally has the potential to weaken the role of public health in our community and undo much good work that has been done, decrease municipal public support, weaken the ability of public health to be partners in municipal services, planning and programming and lower the profile of our public health programs and services locally. The ministry should consider alternative or hybrid models across the province in order to best meet the needs of communities and populations served.

- **All changes to the structure and governance of the province's public health system should be evidence informed to ensure best possible population health outcomes.** The panel's report does not include analysis of the implications of the recommended integration from a program/service, patient or cost/benefit perspective. Public health's role in affecting the social determinants of health cannot be overstated. The capacity of the system to achieve the goal of a healthy population regardless of age, sex, language, socioeconomic status or

geography needs to be strengthened; removing public health units from municipal structures/partnerships could negatively impact success in addressing social determinants of health. There needs to documented analysis and evidence demonstrating that any proposed changes are the best way to achieve the desired outcome.

- **The mandate of public health should be maintained and preserved.** Public Health's core function is the prevention of disease, and the protection and promotion of health. If fully implemented, the panel's recommendations will fundamentally change the public health system and place it within the health care system. There is a risk that integration within the health system (which is dominated by a focus on care and treatment) will dilute the Public Health mandate and shift away from local population based services and work with a wide range of partners including municipalities, school boards and community organizations toward health-care and clinical services. The benefits of local municipal integration in addressing the non-health care related aspects of public health, such as the determinants of health and collaboration with local and municipal non-health care partners is critical to the mandate of public health.

  A key goal of Patients First was to strengthen linkages and partnerships between the health care system and public health. In addition, the Ontario Public Health Standards review also aimed to build stronger linkages between Public Health Units and LHINs, to support integrated planning within an integrated health care system. Formalized linkages and public health support to integrated planning can occur without the structural and organizational changes proposed in the Panel's recommendations. Structural integration as proposed in the report is not a prerequisite for the accomplishment of these goals.

- **Overall funding for the public health system must be maintained; resources should not be diverted to new administrative structures, and local levies should not be spread beyond municipal boundaries.** There is a risk that the proposed changes will result in diminished supports (financial and in-kind) if the role of municipalities in the delivery of public health is lessened. There is also the risk that local levy shares will be spread over other municipalities, thus diminishing program spending within the Region.

  Any changes to the system should not increase funding obligations of municipalities and must promote long-term sustainability and adequate resourcing of the public health system. In the current model, significant in kind administrative and back office support and shared services are provided by municipalities, and a significant number of regions and municipalities cover funding gaps or pay more than 25% of approved cost shared budgets. In the

proposed model, these local financial supports to public health would disappear and program support would diminish.

Rather than a new funding and oversight relationship with LHIN's, the continuation of a direct relationship between the Ministry of Health and Long-Term Care would help to ensure that the envelope of public health funding is at least maintained and public health programs sufficiently resourced in the long term. In addition, any transition costs related to changes in the system should be funded separately by the Ministry of Health and Long Term Care; the current funding envelope for local public health must be maintained for the delivery of programs and services.

- **Testing of any new model should take place in areas where the Province has identified issues.** If the government wishes to test a new model for public health delivery, it should be done first in the existing autonomous health units where the province has identified concerns, prior to considering such changes to health units that are integrated within municipal structures.

  If implemented, the panel's recommendations will fundamentally change the delivery of public health in the province of Ontario and locally in Waterloo Region. The magnitude of change and potential disruption to the system is very significant. If after weighing the benefits and risks of implementing the proposed changes the ministry decides to proceed, there must be commitment to change management processes, time for transition, risk mitigation strategies and course correction as necessary at the local, regional and provincial level.

  In the proposed model, new administrative structures would need to be created in the 14 new autonomous health entities. The new structure would need to be better or at least equivalent to what is currently offered by the Region in order to justify the disruption and risk to current effective public health service delivery in the Region of Waterloo. Given the proposed structure would need to be created and is untested, consideration should be given by the Ministry to implementation of the proposed model with existing autonomous health units first, leaving the existing large municipally integrated health units intact (covering most of the population of urban Ontario) until such time as the proposed structure can be examined and evaluated as to impact on public health service delivery following implementation in the autonomous health units.

- **Municipal boundaries must be respected.** Region of Waterloo Public Health is committed to continue the development and maintenance of an effective relationship with the Waterloo Wellington LHIN. However, existing municipal boundaries and relationships with municipal partners must be respected. The

entire geographic area of Waterloo Region is within the current boundary of the Waterloo Wellington LHIN; any potential modification to LHIN boundaries in the future should ensure that all of Waterloo Region continues to be within one LHIN boundary.

The Association of Municipalities of Ontario's Response to the Recommendations of the Expert Panel

A recent press release and briefing note issued by the Association of Municipalities of Ontario (AMO) indicates that they also do not support the recommendations of the Expert Panel on Public Health; AMO is urging the government not to adopt the recommendations. The press release and briefing note are included as attachments to this report.

Ontario Public Health Standards

Under the Health Protection and Promotion Act, Region of Waterloo Council serves as Waterloo Region's Board of Health. Boards of Health are expected to adhere to the Ontario Public Health Standards, which outline the expectations for providing public health programs and services.

This report provides information that supports the ongoing education for Board of Health members to help them remain abreast of emerging public health issues and developments. Specifically, this report provides summary information regarding the recently released report of the Minister's Expert Panel on Public Health – Public Health within an Integrated Health System. The recommendations contained in the report are currently under consideration by the Ministry of Health and Long Term Care; consultation continues until October 31st, 2017. If approved, the recommendations would fundamentally change the governance, structure and delivery of public health services within Waterloo Region.

Corporate Strategic Plan:

Region of Waterloo Public Health works in collaboration with other regional departments and our community partners to build healthy and supportive communities. The 2015-2018 strategic plan focus areas of particular relevance and significance are:

- Healthy, Safe and Inclusive Communities and
- Responsive and Engaging Government Services.

Financial Implications:

The majority of the Public Health programs and services are funded within the Department's existing base budgets for Public Health Mandatory Programs; the budgets are established by Regional Council (as the Board of Health) and are funded up to 75%

by the province's Ministry of Health & Long Term Care with the remainder funded by the local tax levy. To a lesser extent, some programs are funded 100% by the province.

Public health funding was not within the scope of the Panel's mandate and therefore the recommendations contained in the Panel's report do not specifically address the funding of public health programs. However, the Panel has flagged that the current public health funding model may be a barrier to implementing the proposed structure and has recommended revisiting the current funding arrangement for the delivery of public health programs in the province.

Other Department Consultations/Concurrence:

Nil

Attachments

Attachment 1: AMO Press Release
Attachment 2: AMO Briefing
The link to the full Report of the Minister's Expert Panel on Public Health is available at: http://www.health.gov.on.ca/en/common/ministry/publications/reports/public_health_panel_17/default.aspx

Prepared By: **Anne Schlorff**, Acting Commissioner

Approved By: **Anne Schlorff**, Acting Commissioner
Dr. Hsiu-Li Wang, Acting Medical Officer of Health

Attachment 1: AMO Press Release

AMO Association of Municipalities Ontario

BREAKING NEWS

October 12, 2017

AMO Opposes Proposed Changes to Public Health System

The government is considering far reaching changes to the public health system based on recommendations made by the Expert Panel on Public Health in their report – Public Health within an Integrated Health System, which was released on July 20, 2017.

After careful consideration by AMO's Board of Directors and our Health Task Force, AMO does not support the recommendations of the Expert Panel on Public Health and urges the government not to adopt them.

If the Expert Panel recommendations are implemented, it will completely change and dilute over time the mandate of the local public health system by integrating it with the health care system. There was no analysis provided by either the Expert Panel or the Ministry on the implications of this proposed integration from either a patient, program/service, or cost benefit analysis perspective. Further information on AMO's analysis position is found in the attached briefing note.

AMO is encouraging municipal leaders and councils to review the report and voice their opposition to Minister Dr. Eric Hoskins, Minister of Health and Long-Term Care, and local MPP's.

AMO Contact: Monika Turner, Director of Policy, mturner@amo.on.ca, (416) 971-9856 ext. 318.

200 University Ave., Suite 801 Toronto ON M5H 3C6 Canada | Tel: 416.971.9856 | Fax: 416.971.6191 | Toll-Free in Ontario: 1.877.426.6527 | amo@amo.on.ca

Attachment 2: AMO Briefing Note

Association of Municipalities Ontario

BRIEFING NOTE

To: AMO Membership

Date: October 12, 2017

Subject: AMO's Response to the Expert Panel on Public Health

ISSUE: AMO does not support the recommendations of the Expert Panel on Public Health as outlined in the report, Public Health within an Integrated Health System, released on July 20, 2017. In the AMO President's correspondence, AMO demands that the government not change the public health system as recommended. The President's letter dated October 12, 2017 is included in this note in Appendix A.

SUMMARY OF AMO'S RESPONSE:

AMO does not support the recommendations of the Expert Panel on Public Health. We urge the Minister of Health and Long-Term Care and the provincial government not to adopt the recommendations given there is no clear evidence to justify such changes to the public health system. Integrating public health within the health care system would completely change and dilute over time the mandate of the local public health system.

ANALYSIS:

If the Expert Panel recommendations are implemented it will completely change the public health system and place it within the health care system. Neither the Expert Panel nor the Ministry have provided analysis on the implications of integrating from either a patient, program/service, or cost benefit analysis perspective. There is no solid empirical foundation provided to support the proposed change.

Many within the municipal sector are very opposed to integration of public health within the broader health care system for many reasons:

- Public Health will lose its local focus – even if there are local public health service delivery areas.
- The Public Health Units in Regional and Single-Tier municipal governments are fully integrated into the municipal system – regarding governance, as employees and linked to other parts of municipal services (i.e. planning, transit, housing, social services).
- There is a risk that integration will dilute the Public Health mandate and shift away from local population-based services toward clinical services to support the primary care system given those under resourced needs.

Creating coverage in larger geographic areas may help create critical mass, however, integration will be challenging in northern, rural and remote areas given smaller, spread out populations.

The recommendations concerning governance will weaken the local elected official voice by seeking to increase community members (LHINs, school boards) appointed to Boards of Health. The local elected official voice is important to reflect overall community need. The new model will only serve

to dilute municipal government involvement in Public Health. Being an elected official is a core competency. Elected officials bring a lens of value for money and the needs of the broader community.

It is suggested that the further that Public Health gets from the municipal core, the more the Province should be responsible for funding. Municipal governments may be less inclined to top up funding or contribute other in-kind municipal resources especially in the case of single-tier and regional governments where full integration of Public Health into the municipal system is the case. It may also be challenging to maintain close connections between local councils and Boards the larger and more regional they become. Municipal governments should have a strong role. It cannot be assumed that this will continue in a new model. This is a significant risk.

AMO's Health Task Force and the AMO Board carefully considered the matter of the Expert Panel's recommendations. AMO is opposed to the new proposed model for the reasons listed above. It is simply not clear that the benefits are worth the significant proposed disruption to the system. As well, it is also not clear the exact problem that the government is trying to address and, more broadly, what is the vision for the health care system. Until this is known and agreed to, as funding partners, it is challenging to respond to the need for change in Public Health.

In making its decision, the Board was guided by the following principles:

1. **Preserve the mandate of Public Health** – To make sure Public Health and its staff is not overwhelmed by the needs of health care services. Maintaining the distinctive role of Public Health to provide preventative and population-based health services that meet local needs, as a complimentary and equal partner to primary care's provision of clinical treatment services.

2. **Maintain the full range of current functions of Public Health** – To fulfill the mandate and desired public health outcomes ranging from disease prevention and health promotion to research and knowledge transfer. These are essential components to a well-functioning public health system.

3. **Enhance the capacity of Public Health** – To achieve better prevention and population health outcomes for local communities.

4. **Increase access to high quality health care informed by population health planning** – To guide primary care delivery that meets local needs.

5. **Achieve equity in health outcomes** – To benefit all individuals and regions of the Province in an equitable manner.

6. **Maintain local flexibility** – To ensure a One Size Doesn't Fit All model of standardization acknowledges the diversity of Ontario including areas of the Province (north-south, east-west, and rural-urban), and the diverse health need in different regions.

7. **Good public and fiscal policy** – To ensure change is driven by a clear public policy purpose and backed by evidence that any new arrangements will better suit that purpose. Change must be cost neutral for municipal governments.

8. **Facilitate greater partnerships and collaboration** – To maintain and strengthen linkages with the broader health care system but also with municipal and community services.

9. **Achieve good governance relationships** – To ensure that proper oversight models are in place that are appropriate for a public health organization, and for services, which are municipally funded.

10. **Support funding relationships** – To promote long-term sustainability with adequate resourcing and an appropriate direct relationship between Public Health and the Ministry of Health and Long-Term Care, rather than a new funding and oversight relationship with Local Health Integration Networks (LHINs).

11. **Accountable** – To establish clear accountability to both the public at the local level and to the Province.

12. **Transparent** – To build public confidence that models and structures achieve good outcomes at a reasonable cost.

BACKGROUND:

Public Health

Public health services, including both disease prevention and health promotion, are an essential part of Ontario's health services continuum. Municipal governments play a major role, often as the employer, and have significant responsibilities in delivering public health services. Ontarians are served by 36 local boards of health that are responsible for populations within their geographic borders. Most boards are autonomous entities while some have the local municipal council serving as the board of health. Among other requirements mandated by the Province, local boards of health are responsible for implementing the provincially mandated 2008 Ontario Public Health Standards.

Currently, public health services are cost shared as a 75% provincial and 25% municipal responsibility. In 1998, under the *Services Improvement Act*, municipalities became responsible for 100% funding of all public health units and services. This was quickly amended in 1999, when the 50/50 cost sharing arrangement between the municipal and the provincial governments was reintroduced. It stayed at this level throughout the 2000 Walkerton tragedy and the 2003 SARS outbreak.

In 2004, the provincial government launched Operational Health Protection to address long-standing public health system capacity issues that included phased-in increases to the provincial share of public health funding to 75% by 2007. Under the *Health Protection and Promotion Act*, 1990, the Province may provide grants to municipalities to assist with public health costs whereas municipal governments are legislatively responsible for public health funding. In 2006, the Capacity Review Committee's (CRC) report was released. CRC's recommendations on changes to governance and amalgamations of specific health units were not implemented by the Province.

In 2015, the last year data is available, municipal governments funded 38%, on average, of the public health costs for mandatory programs/Ontario Public Health Standards (source: 2015 FIR of conditional grants). So, municipal governments are paying above the required cost sharing amounts.

Expert Panel on Public Health

To review and envision a new role for Public Health with the context of the *Patients First Act* and the revised standards, the government convened an Expert Advisory Panel. Gary McNamara, Mayor of Tecumseh, was appointed to the panel by the Minister, as an individual, not as a municipal representative selected by AMO.

The work of the Expert Panel is important, as it has come up with recommendations to the government intended to redefine the role of Public Health for years to come. The Minister gave the panel a mandate to look at how public health could operate within an integrated health system. The panel tabled the report to the Minister in June 2017.

The key recommendation proposes an end state for Public Health within an Integrated Health System that would have Ontario establish 14 regional public health entities—that are consistent with the LHIN boundaries.

Other Expert Panel Report recommendations include:

Proposed Leadership Structure consisting of:

- Regional public health entity with a CEO that reports to the Board and a Regional Medical Officer of Health (MOH) who reports to the Board on matters of public health and safety.
- Under each regional entity would be a Local Public Health Service Delivery Area with a Local Medical Officer of Health (reporting to the Regional MOH), local public health programs and services.

Proposed Board of Health Governance would be freestanding autonomous boards:

- Appointees would be municipal members (with formula defined by regulation), provincial appointees, citizen members (municipal appointees), and other representatives (e.g. education, LHIN, social sector, etc.).
- varied member numbers of 12 – 15
- diversity and inclusion – board should reflect the communities they serve
- qualifications – skills-based and experience
- Board to have the right mix of skills, competencies, and diverse populations.
- "Municipalities should also be encouraged to appoint a mix of elected officials and members of the community to ensure diversity and continuity and to reduce challenges elected officials may experience balancing their municipal responsibilities with their responsibilities for public health."

The Expert Panel was not asked to make specific recommendations on implementation; however, they did identify elements that should be considered in developing an implementation plan. These elements include:

Legislation

Funding – It was noted that "as part of implementation planning the Ministry will need to revisit funding constructs in order to implement the recommendations".

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Transition Planning/Change Management – with wording that says:

- "The transition from the current 36 local boards of health to a smaller number of regional boards of health will have particular implications for municipalities and municipal members. It is important that the new board structure recognizes and protects municipal interests, while recognizing the potential for competition for municipal seats."
- "To ensure greater consistency across the province, it may be helpful to work with the Association of Municipalities of Ontario to develop the criteria for municipal representation on the new regional boards."
- Effective linkages with LHINs and the Health System.

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Appendix A

Association of Municipalities Ontario

Office of the President

Sent via e-mail: Eric.Hoskins@Ontario.ca

October 12, 2017

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

Dear Minister Hoskins:

After careful consideration by our Board of Directors and our Health Task Force, AMO does not support the recommendations of the Expert Panel on Public Health and urges you and the provincial government not to adopt them.

If the Expert Panel recommendations are implemented, it will completely change and dilute over time the mandate of the local public health system by integrating it with the health care system. There was no analysis provided by either the Expert Panel or the Ministry on the implications of this proposed integration from either a patient, program/service, or cost benefit analysis perspective. There was no clear demonstration of any benefits of such a change in the public health system.

Our many concerns on the Expert Panel recommendations include:

- Public health will lose its local and community focus. It is currently integrated within its communities with multiple local linkages with both public and private bodies and organizations.
- A large number of the current public health units are fully integrated within a municipal system that enables coordinated planning, policy and program work with and between municipal services such as land use planning, transit, parks, housing and social services. The health unit staff are also municipal employees.
- For the autonomous public health units, there are also strong and vibrant local linkages with their municipal governments and services that would be severed or at least damaged by moving to a regional public health structure.
- The proposed governance model will reduce the local leadership voice in decision-making.
- Ensuring critical mass for emergencies does not need to be addressed only structurally.
- Serving the populations in rural and northern Ontario is already challenging. Experience has shown that making an entity regional does not generally help such situations.
- Amalgamations are not for the faint of heart and they do not generally produce the expected outcomes or efficiencies.

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Municipal governments are your funding partners in public health – not merely stakeholders. In 2015, the last year data is available, municipal governments funded 38%, on average, of the public health costs for mandatory programs. To act upon the Expert Panel's recommendations, would create significant fiscal churn and likely municipal reduction in our cost-sharing world.

Given the grave concerns of what would be lost by implementation of these recommendations without any evidence of benefit lead us to our decision not to support them. The significant municipal interest and stake in this matter cannot be understated. We are asking for your commitment not to adopt all or any of these recommendations.

We would appreciate an opportunity to discuss this with you soon.

Sincerely,

Lynn Dollin
AMO President

cc: The Honourable Kathleen Wynne, Premier
The Honourable Bill Mauro, Minister of Municipal Affairs
Dr. Robert Bell, Deputy Minister, Health and Long-Term Care
Sharon Lee Smith, Associate Deputy Minister, Health and Long-Term Care
Roselle Martino, Assistant Deputy Minister, Health and Long-Term Care

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November 14, 2017

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

Dear Minister Hoskins:

Re: Consultation on the *Public Health within an Integrated Health System: Report of the Minister's Expert Panel on Public Health*

On behalf of the Board of Health for the Grey Bruce Health Unit, I welcome the opportunity to provide feedback on the recommendations contained in the Expert Panel *Report Public Health within an Integrated Health System,* released on June 9, 2017.

The Board recognizes the Expert Panel members for their hard work. We hope that our comments will be useful to establishing next steps towards our shared goal of improving the public health system in Ontario.

The Board discussed the Expert Panel Report factoring in the analyses of the Association of Local Public Health Agencies (alPHa) (Attachment 1), dialogue at the Ministry's Expert Panel information sessions, and the deliberations of the Association of Municipalities of Ontario (AMO) (Attachment 2), among other discussions.

The Board supports the objectives of the government of Ontario to enhance the public health system's capacity, accountability, quality and transparency, and to bring a population health focus to the health system. We strongly support the underlying principles that the Expert Panel followed in developing their recommendations, especially the need to maintain a strong independent voice for public health and to preserve meaningful relationships with municipalities and other community partners. We realize that the recommended model may improve capacity in some health units through sharing of expertise and resource, and that it may better communication and increase collaboration among regions.

While we value the recent initiatives to modernize the Ontario Public Health Standards, strengthen accountability, and ensure effective linkages with Local Health Integration Networks (LHINs), we are concerned that the proposed model presented by the Expert Panel will be detrimental to the public health system.

Our concerns stem from the following points:

We object to the loss of the local voice in governance and its implications for understanding local needs and in directing public health programs and services to meet those needs. Much of the work in public health is done in close collaboration with municipal partners, and as such, public health governance must remain local, ensuring accountability to municipalities, the province, and the local population as a whole.

Maintaining meaningful local representation requires the Medical Officer of Health/CEO remain accountable to a local board of health. Therefore, the Board cannot support changes that jeopardize linkages with, and the representation provided, at the municipal level.

The lack of evidence-based and/or practice-based support to the recommendations is problematic. No rationale is offered to support changes of this magnitude, especially in light of the other initiatives proposed or underway such as standards modernization, updates to accountability frameworks, and public health and LHIN engagement through the Patients First Act. Additionally, no systematic plan or process is put forward that would serve as a guide to direct this change or any method to provide a thorough and timely evaluation of the recommended model's structure, process, and outcomes.

The proposed alignment of health unit and LHIN boundaries raises a number of concerns.

- It has not been proven that the LHIN, as a model, has been successful in achieving the goal of improving access to care and patient experience.
- There is no evidence that a LHIN/public health unit boundary alignment will result in a stronger public health system.
- The recommendations appear to be based on an unfounded assumption that the linkage between public health and healthcare is less than optimal. The current close work and collaboration between public health and the hospitals, primary care, and other parts of the healthcare system point to a different and more positive version of those relationships.
- Most importantly, the emphasis on the linkages between public health and the LHIN as a way of strengthening public health is overvalued. The LHIN works within the sphere of the healthcare sector while public health works upstream through partnership with other sectors to impact on the determinants of health.

The financial and administrative complexities associated with shifting to the proposed new model could result in disruptions to public health services. The proposal fails to address:

- The major costs associated with shifting from current administrative structures to new ones.
- The entanglement and disentanglement related to merging different health units that already have different union representations and different collective agreements.
- Potential impacts on funding models due to misaligned municipal boundaries.
- The creation of extra layer(s) of bureaucracy in the system, which more often than not, results in reduced response time and inefficiencies.
- The lack of clarity on the source of funding to cover the financial cost associated with the recommendations, which are anticipated to be substantial. Any cost related to the implementation, whether one-time or ongoing, must not be taken from operating budgets.

As described public heath mainly works upstream from the healthcare sector by addressing the social determinents of health. Although strong collaboration and partnership between public health and the healthcare sector have developed to enhance the health for all, the two sectors have separate and distinct roles. It is our concern that the proposed model of integration will result in erosion of both the function and capacity of public health in the province.

Thank you for the opportunity to provide our input and we look forward to ongoing dialogue with the Ministry in implementing its health system transformation mandate.

Sincerely,

David Inglis, Chair
Board of Health for the Grey Bruce Health Unit

On behalf of Board of Health members:
Alan Barfoot - County of Grey Warden - Vice-Chair
Kevin Eccles - County of Grey
Mitch Twolan - Warden - Bruce County
Sue Paterson - County of Grey
Arlene Wright - County of Grey
Mike Smith - Bruce County
Rev. David Shearman - Provincial Appointee
Laurie Laporte - Provincial Appointee
Will Rogers - Cross-Board Member

Enclosure: alPHa submission, AMO submission

cc:

Dr. Bob Bell, Deputy Minister
Sharon Lee Smith, Associate Deputy Minister
Roselle Martino, Assistant Deputy Minister
Dr. David Williams Chief Medical Officer of Health
Carmen McGregor, President, alPHa
Linda Stewart, Executive Director, alPHa
Lynn Dollin, President, AMO
Pat Vanini, Executive Director, AMO,
Wardens, County of Grey, Bruce County
Mayors, Municipalities in Grey and Bruce
Ontario Boards of Health
Bill Walker, MPP
Lisa Thompson MPP
Jim Wilson, MPP
CEO, Southwest LHIN
CEO, Waterloo Wellington LHIN
CEO, North Simcoe Muskoka LHIN

alPHa
Association of Local
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Agencies

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E-mail: info@alphaweb.org

alPHa's members are the public health units in Ontario.

alPHa Sections:

Boards of Health Section

Council of Ontario Medical Officers of Health (COMOH)

Affiliate Organizations:

Association of Ontario Public Health Business Administrators

Association of Public Health Epidemiologists in Ontario

Association of Supervisors of Public Health Inspectors of Ontario

Health Promotion Ontario

Ontario Association of Public Health Dentistry

Ontario Association of Public Health Nursing Leaders

Ontario Society of Nutrition Professionals in Public Health

30 YEARS 1986-2016

October 17, 2017

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

Dear Minister Hoskins:

On July 20, 2017, you released the report of the Expert Panel (EP) on Public Health, Public Health within an Integrated Health System. This report fulfills part of the proposal introduced in your Patients First discussion paper [2015] "to appoint an Expert Panel to advise on opportunities to deepen the partnership between LHINs and local public health units, and how to further improve public health capacity and delivery" [p20]. We thank you, and the EP members, for the completion of this effort and for making the recommendations public for consultation in a timely manner.

The Association of Local Public Health Agencies (alPHa) is the non-profit organization that provides support to the 36 local public health agencies (boards of health and public health units) in Ontario to promote a strong, effective and efficient public health system in the province. alPHa brings together the senior leadership of local public health (LPH), including board of health members, medical and associate medical officers of health, and senior managers in each of the public health disciplines – nursing, inspection, nutrition, dentistry, health promotion, epidemiology and business administration.

As such, alPHa is the collective voice of the organizations and professional leadership that are subject to the EP recommendations. It is with this lens that we have reviewed the recommendations of the EP and have surveyed our member boards of health for input. While alPHa will provide comment from a system level perspective, we expect that the Association's sections, affiliates and member boards of health will provide feedback from their own perspectives.

Our members have been consistent and clear that the mandates of LPH and healthcare are and should remain separate and distinct. Irrespective of the influence of local circumstances, we are collectively concerned that the attempt to align these mandates to the degree recommended by the EP will be to the detriment of our ability to promote and protect health at the community level. We are not starting with a blank slate in Ontario. The LPH system has many strengths that we believe would be eroded by the EP proposals. We urge that the following overarching concerns be carefully considered as part of any analysis for potential implementation.

1. **System disruption.** The magnitude of the changes recommended is significant and careful feasibility studies need to be conducted to ensure that the benefits to the effectiveness of the LPH system outweigh the costs. The EP proposes an 'end state' for LPH that will require major disruption of every facet of the system, from governance to program delivery. With so many details yet to be mapped out and given the complexity of on-the-ground implementation, we cannot support the proposed changes. We are not convinced that the EP recommendations are the only or best way forward.

2. **Fit with the work of LPH.** Local public health distinguishes itself from the healthcare system (i.e., hospitals, home care, family physicians, medical specialists, etc.) in that LPH focuses on the primary prevention of illness and injury and the promotion of public policies that impact the health of the general population. A population health approach seeks to improve the health of the entire population and reduce health inequities among certain groups in the population. This helps individuals, groups, and communities to have a fair chance to reach their full health potential. This also prevents disadvantage by social, economic, or environmental conditions.

   The work of LPH is largely focused upstream, using a population health approach as articulated in the Ontario Public Health Standards. Upstream work includes working with healthcare and non-healthcare sectors to advocate, design, implement and evaluate policies and programs that prevent diseases and their risk factors and promote and protect health, before people become patients in the first place. Bringing the LPH population health lens to healthcare service planning and delivery will certainly have a positive impact on the health system, but, healthcare is a relatively minor factor in what makes populations healthy or unhealthy. Addressing the social determinants of health through a collaborative upstream approach yields a much greater return on investment and widespread gains in the health outcomes of Ontario's population. Health, rather than healthcare, is our mandate and it is difficult for us to see the benefit to the aims of LPH of closer alignment with the healthcare system to the degree recommended by the EP. Realigning the boundaries of public health units with those of LHINs places stronger emphasis on the relationship with healthcare than existing relationships that promote health and fall within municipal boundaries such as housing, employment, planning and school boards. We cannot support the goal of better integration with the healthcare system if it comes at the expense of the structures that support upstream work that is most effectively done in collaboration at the local level with sectors outside of healthcare.

3. **Meeting local needs.** Again, using a population health approach, much of the work of LPH is accomplished through partnerships with local governments, schools and other community stakeholders to develop healthy public policies, build community capacity to address health issues and promote environments that instill and habituate healthy behaviours. Local public health has a strong vision for the health of all Ontarians that encompasses providing the best opportunities for health considering the broad spectrum of what is known to cause the best conditions for health, i.e., the social determinants of health. From that perspective, alPHa has already expressed support, with caveats regarding LPH capacity, for the proposal in Patients First that recommends better integration of population health within the health system. We do

see value in formalizing working linkages between LHINs and LPH, as we believe that they will help to build on existing successful collaborations in addition to ensuring that population and public health priorities inform health planning, funding and delivery. We already know that a rigid or one-size-fits-all approach will not equitably meet the needs of Ontarians in all parts of the province and will not permit the public health system to leverage the diversity of systems, organizations and services in different parts of the province. This is one of the strengths of our system, and we recommend the identification and focused examination of areas of the province where needs are not being met through current structures, so that tailored strategies can be developed to enhance capacity.

4. **Local public health capacity.** LPH capacity for most public health units has been steadily eroding over years of no increases in Ministry-approved budgets. The implementation of the new Standards for Public Health Programs and Services, new Accountability Framework, and new requirements under the *Patients First Act, 2016* are expected to stretch LPH capacity even further, and we believe that it will not withstand the large-scale system disruption proposed by the EP. We note that, while more is being asked of LPH, the budgeted amount for the Population and Public Health Division that provides LPH with most of its funding decreased by .42 percent from the previous year in the 2017-18 budget that gave an overall increase of 3.62 percent to the Ministry of Health and Long-Term Care (MOHLTC).

Given the concerns that we have expressed about the massive systemic change proposed by the EP aimed at fostering LPH-LHIN collaboration, we would like to propose that the work of the Public Health Work Stream that was established to define the formal relationship between LHIN Chief Executive Officers (CEOs) and LPH Medical Officers of Health (MOH) under the *Patients First Act, 2016* be allowed to further develop as an alternative solution.

While the EP focused on a 'ideal' end state with little consideration of implementation challenges [implementation was not within the EP's mandate], the work of the Public Health Work Stream resulted in proposed frameworks for LPH and LHIN engagement that were developed considering the current structure and organization of both LPH and LHINs. The mandate of the Work Stream was to define the parameters for engagement and the set of actions required of LHIN CEOs and LPH MOHs to support local health planning and service delivery decision-making, including definition of specific processes and structures to be established. Upon completion of this work, the Population and Public Health Division surveyed MOHs regarding the recommendations presented in the *Report Back from the Public Health Work Stream*. At present, we are awaiting the publication of the survey results and an open and transparent discussion of the results with government representatives.

We suggest that the desired outcomes for a strong public health sector in an integrated health system stated in the EP Report may better be achieved through focusing on the frameworks proposed by the Work Stream as well as the results of research, such as the locally driven collaborative project, *Patients First – Public Health Units and LHINs working together for population health*.

In closing, we recommend that the initiatives underway including the new Standards for Public Health Programs and Services, new Accountability Framework, and findings of the Public Health Work Stream and other provincial and national actions in progress be implemented and evaluated before the EP recommendations are given further consideration.

We look forward to further consultation and transparent discussion of the way forward. alPHa will continue to provide comment as the work underway evolves and becomes public.

Yours truly,

Carmen McGregor,
President

Copy: Dr. Bob Bell, Deputy Minister
Sharon Lee Smith, Associate Deputy Minister
Roselle Martino, Assistant Deputy Minister,
Dr. David Williams, Chief Medical Officer of Health
Dr. Peter Donnelly, President and CEO, Public Health Ontario
Pat Vanini, Executive Director, AMO
Ulli S. Watkiss, City Clerk, City of Toronto
Giuliana Carbone, Deputy City Manager, City of Toronto
Boards of Health (Chair, Medical Officer of Health and CEO)

BRIEFING NOTE

To: AMO Membership

Date: October 12, 2017

Subject: AMO's Response to the Expert Panel on Public Health

ISSUE: AMO does not support the recommendations of the Expert Panel on Public Health as outlined in the report, Public Health within an Integrated Health System, released on July 20, 2017. In the AMO President's correspondence, AMO demands that the government not change the public health system as recommended. The President's letter dated October 12, 2017 is included in this note in Appendix A.

SUMMARY OF AMO'S RESPONSE:

AMO does not support the recommendations of the Expert Panel on Public Health. We urge the Minister of Health and Long-Term Care and the provincial government not to adopt the recommendations given there is no clear evidence to justify such changes to the public health system. Integrating public health within the health care system would completely change and dilute over time the mandate of the local public health system.

ANALYSIS:

If the Expert Panel recommendations are implemented it will completely change the public health system and place it within the health care system. Neither the Expert Panel nor the Ministry have provided analysis on the implications of integrating from either a patient, program/service, or cost benefit analysis perspective. There is no solid empirical foundation provided to support the proposed change.

Many within the municipal sector are very opposed to integration of public health within the broader health care system for many reasons:

- Public Health will lose its local focus – even if there are local public health service delivery areas.
- The Public Health Units in Regional and Single-Tier municipal governments are fully integrated into the municipal system – regarding governance, as employees and linked to other parts of municipal services (i.e. planning, transit, housing, social services).
- There is a risk that integration will dilute the Public Health mandate and shift away from local population-based services toward clinical services to support the primary care system given those under resourced needs.

Creating coverage in larger geographic areas may help create critical mass, however, integration will be challenging in northern, rural and remote areas given smaller, spread out populations.

The recommendations concerning governance will weaken the local elected official voice by seeking to increase community members (LHINs, school boards) appointed to Boards of Health. The local elected official voice is important to reflect overall community need. The new model will only serve

to dilute municipal government involvement in Public Health. Being an elected official is a core competency. Elected officials bring a lens of value for money and the needs of the broader community.

It is suggested that the further that Public Health gets from the municipal core, the more the Province should be responsible for funding. Municipal governments may be less inclined to top up funding or contribute other in-kind municipal resources especially in the case of single-tier and regional governments where full integration of Public Health into the municipal system is the case. It may also be challenging to maintain close connections between local councils and Boards the larger and more regional they become. Municipal governments should have a strong role. It cannot be assumed that this will continue in a new model. This is a significant risk.

AMO's Health Task Force and the AMO Board carefully considered the matter of the Expert Panel's recommendations. AMO is opposed to the new proposed model for the reasons listed above. It is simply not clear that the benefits are worth the significant proposed disruption to the system. As well, it is also not clear the exact problem that the government is trying to address and, more broadly, what is the vision for the health care system. Until this is known and agreed to, as funding partners, it is challenging to respond to the need for change in Public Health.

In making its decision, the Board was guided by the following principles:

1. **Preserve the mandate of Public Health** – To make sure Public Health and its staff is not overwhelmed by the needs of health care services. Maintaining the distinctive role of Public Health to provide preventative and population-based health services that meet local needs, as a complimentary and equal partner to primary care's provision of clinical treatment services.

2. **Maintain the full range of current functions of Public Health** – To fulfill the mandate and desired public health outcomes ranging from disease prevention and health promotion to research and knowledge transfer. These are essential components to a well-functioning public health system.

3. **Enhance the capacity of Public Health** – To achieve better prevention and population health outcomes for local communities.

4. **Increase access to high quality health care informed by population health planning** – To guide primary care delivery that meets local needs.

5. **Achieve equity in health outcomes** – To benefit all individuals and regions of the Province in an equitable manner.

6. **Maintain local flexibility** – To ensure a One Size Doesn't Fit All model of standardization acknowledges the diversity of Ontario including areas of the Province (north-south, east-west, and rural-urban), and the diverse health need in different regions.

7. **Good public and fiscal policy** – To ensure change is driven by a clear public policy purpose and backed by evidence that any new arrangements will better suit that purpose. Change must be cost neutral for municipal governments.

8. **Facilitate greater partnerships and collaboration** – To maintain and strengthen linkages with the broader health care system but also with municipal and community services.

9. **Achieve good governance relationships** – To ensure that proper oversight models are in place that are appropriate for a public health organization, and for services, which are municipally funded.

10. **Support funding relationships** – To promote long-term sustainability with adequate resourcing and an appropriate direct relationship between Public Health and the Ministry of Health and Long-Term Care, rather than a new funding and oversight relationship with Local Health Integration Networks (LHINs).

11. **Accountable** – To establish clear accountability to both the public at the local level and to the Province.

12. **Transparent** – To build public confidence that models and structures achieve good outcomes at a reasonable cost.

BACKGROUND:

Public Health

Public health services, including both disease prevention and health promotion, are an essential part of Ontario's health services continuum. Municipal governments play a major role, often as the employer, and have significant responsibilities in delivering public health services. Ontarians are served by 36 local boards of health that are responsible for populations within their geographic borders. Most boards are autonomous entities while some have the local municipal council serving as the board of health. Among other requirements mandated by the Province, local boards of health are responsible for implementing the provincially mandated 2008 Ontario Public Health Standards.

Currently, public health services are cost shared as a 75% provincial and 25% municipal responsibility. In 1998, under the *Services Improvement Act*, municipalities became responsible for 100% funding of all public health units and services. This was quickly amended in 1999, when the 50/50 cost sharing arrangement between the municipal and the provincial governments was reintroduced. It stayed at this level throughout the 2000 Walkerton tragedy and the 2003 SARS outbreak.

In 2004, the provincial government launched Operational Health Protection to address long-standing public health system capacity issues that included phased-in increases to the provincial share of public health funding to 75% by 2007. Under the *Health Protection and Promotion Act*, 1990, the Province may provide grants to municipalities to assist with public health costs whereas municipal governments are legislatively responsible for public health funding. In 2006, the Capacity Review Committee's (CRC) report was released. CRC's recommendations on changes to governance and amalgamations of specific health units were not implemented by the Province.

In 2015, the last year data is available, municipal governments funded 38%, on average, of the public health costs for mandatory programs/Ontario Public Health Standards (source: 2015 FIR of conditional grants). So, municipal governments are paying above the required cost sharing amounts.

Expert Panel on Public Health

To review and envision a new role for Public Health with the context of the *Patients First Act* and the revised standards, the government convened an Expert Advisory Panel. Gary McNamara, Mayor of Tecumseh, was appointed to the panel by the Minister, as an individual, not as a municipal representative selected by AMO.

The work of the Expert Panel is important, as it has come up with recommendations to the government intended to redefine the role of Public Health for years to come. The Minister gave the panel a mandate to look at how public health could operate within an integrated health system. The panel tabled the report to the Minister in June 2017.

The key recommendation proposes an end state for Public Health within an Integrated Health System that would have Ontario establish 14 regional public health entities—that are consistent with the LHIN boundaries.

Other Expert Panel Report recommendations include:

Proposed Leadership Structure consisting of:

- Regional public health entity with a CEO that reports to the Board and a Regional Medical Officer of Health (MOH) who reports to the Board on matters of public health and safety.
- Under each regional entity would be a Local Public Health Service Delivery Area with a Local Medical Officer of Health (reporting to the Regional MOH), local public health programs and services.

Proposed Board of Health Governance would be freestanding autonomous boards:

- Appointees would be municipal members (with formula defined by regulation), provincial appointees, citizen members (municipal appointees), and other representatives (e.g. education, LHIN, social sector, etc.).
- varied member numbers of 12 – 15
- diversity and inclusion – board should reflect the communities they serve
- qualifications – skills-based and experience
- Board to have the right mix of skills, competencies, and diverse populations.
- "Municipalities should also be encouraged to appoint a mix of elected officials and members of the community to ensure diversity and continuity and to reduce challenges elected officials may experience balancing their municipal responsibilities with their responsibilities for public health."

The Expert Panel was not asked to make specific recommendations on implementation; however, they did identify elements that should be considered in developing an implementation plan. These elements include:

Legislation

Funding – It was noted that "as part of implementation planning the Ministry will need to revisit funding constructs in order to implement the recommendations".

Transition Planning/Change Management – with wording that says:

- "The transition from the current 36 local boards of health to a smaller number of regional boards of health will have particular implications for municipalities and municipal members. It is important that the new board structure recognizes and protects municipal interests, while recognizing the potential for competition for municipal seats."
- "To ensure greater consistency across the province, it may be helpful to work with the Association of Municipalities of Ontario to develop the criteria for municipal representation on the new regional boards."
- Effective linkages with LHINs and the Health System.

Appendix A

Association of Municipalities Ontario

Office of the President

Sent via e-mail: Eric.Hoskins@Ontario.ca

October 12, 2017

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

Dear Minister Hoskins:

After careful consideration by our Board of Directors and our Health Task Force, AMO does not support the recommendations of the Expert Panel on Public Health and urges you and the provincial government not to adopt them.

If the Expert Panel recommendations are implemented, it will completely change and dilute over time the mandate of the local public health system by integrating it with the health care system. There was no analysis provided by either the Expert Panel or the Ministry on the implications of this proposed integration from either a patient, program/service, or cost benefit analysis perspective. There was no clear demonstration of any benefits of such a change in the public health system.

Our many concerns on the Expert Panel recommendations include:

- Public health will lose its local and community focus. It is currently integrated within its communities with multiple local linkages with both public and private bodies and organizations.
- A large number of the current public health units are fully integrated within a municipal system that enables coordinated planning, policy and program work with and between municipal services such as land use planning, transit, parks, housing and social services. The health unit staff are also municipal employees.
- For the autonomous public health units, there are also strong and vibrant local linkages with their municipal governments and services that would be severed or at least damaged by moving to a regional public health structure.
- The proposed governance model will reduce the local leadership voice in decision-making.
- Ensuring critical mass for emergencies does not need to be addressed only structurally.
- Serving the populations in rural and northern Ontario is already challenging. Experience has shown that making an entity regional does not generally help such situations.
- Amalgamations are not for the faint of heart and they do not generally produce the expected outcomes or efficiencies.

Municipal governments are your funding partners in public health – not merely stakeholders. In 2015, the last year data is available, municipal governments funded 38%, on average, of the public health costs for mandatory programs. To act upon the Expert Panel's recommendations, would create significant fiscal churn and likely municipal reduction in our cost-sharing world.

Given the grave concerns of what would be lost by implementation of these recommendations without any evidence of benefit lead us to our decision not to support them. The significant municipal interest and stake in this matter cannot be understated. We are asking for your commitment not to adopt all or any of these recommendations.

We would appreciate an opportunity to discuss this with you soon.

Sincerely,

Lynn Dollin
AMO President

cc: The Honourable Kathleen Wynne, Premier
The Honourable Bill Mauro, Minister of Municipal Affairs
Dr. Robert Bell, Deputy Minister, Health and Long-Term Care
Sharon Lee Smith, Associate Deputy Minister, Health and Long-Term Care
Roselle Martino, Assistant Deputy Minister, Health and Long-Term Care

DURHAM REGION

The Regional Municipality of Durham

Corporate Services
Department
Legislative Services

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Matthew L. Gaskell
Commissioner of
Corporate Services

November 9, 2017

COPY

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

RE: Memorandum from Dr. R. Kyle, Commissioner and Medical Officer of Health – re: Expert Panel Report on Public Health
Our File: P00

Please be advised that Committee of the Whole of Regional Council considered the above matter and at a meeting held on November 8, 2017, Council adopted the following recommendations of the Committee:

"A) That the correspondence from the Association of Municipalities of Ontario (AMO) urging the province to not adopt any or all of the recommendations of the report from the Minister's Expert Panel on Public Health and the correspondence from the Association of Local Public Health Agencies (alPHa) highlighting its concerns with the recommendations of the report from the Minister's Expert Panel on Public Health, be endorsed; and

B) That the Premier of Ontario, Minister of Health and Long-Term Care, Durham's MPPs, Central East LHIN CEO, Chief Medical Officer of Health and all Ontario boards of health be so advised."

Attached for your reference is a copy of the Memorandum from Dr. Kyle, Commissioner and Medical Officer of Health, dated November 1, 2017.

Ralph Walton
Regional Clerk/Director of Legislative Services

RW/np

Attach.

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

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c. 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)
Deborah Hammons, Chief Executive Officer, Central East LHIN
Dr. David Williams, Chief Medical Officer of Health
Ontario Boards of Health
Dr. R.J. Kyle, Commissioner and Medical Officer of Health

DURHAM REGION

The Regional Municipality of Durham

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MEMORANDUM

To: Committee of the Whole

From: Dr. Robert Kyle

Date: November 1, 2017

Re: Expert Panel Report on Public Health

On July 20, 2017, the province released the attached report from the Minister's Expert Panel on Public Health, entitled Public Health within an Integrated Health System. The Expert Panel on Public Health was established in January 2017 to provide advice on structural, organizational and governance changes for Ontario's public health sector within a transformed health system. The province accepted feedback from stakeholders on the Expert Panel's recommendations until October 31, 2017.

On October 12, 2017, the Association of Municipalities of Ontario (AMO) sent a letter to the Minister of Health and Long-Term Care which urges the province to not adopt any or all of the recommendations of the Expert Panel. In summary, AMO clearly stated that it does not support the recommendations of the Expert Panel and listed a number of concerns, many of which are relevant to Region of Durham. Concerns included: public health losing its local and community focus; reducing local leadership's voice in decision-making; and the impact to public health units that are fully integrated within a municipal system, including staff that are municipal employees. AMO emphasized that municipal governments are funding partners in public health rather than stakeholders and that implementing the Expert Panel's recommendation could lead to a municipal reduction to cost-sharing.

Similarly, the Association of Local Public Health Agencies (alPHa) sent a letter to the Minister on October 17, 2017 highlighting its concerns with the Expert Panel's recommendations. Concerns included: major system disruption in the absence of feasibility studies and cost-benefit analysis; a realignment of boundaries which inappropriately places stronger emphasis on public health's relationship with healthcare rather than existing relationships within municipal boundaries; a need for tailored strategies to enhance public health capacity; and local public health capacity which will not withstand the large-scale system disruption proposed by the Expert Panel. It was recommended that the province implement and evaluate initiatives currently underway including the new Standards for Public Health Programs and Services,

new Accountability Framework, and findings of the Public Health Work Stream before the Expert Panel's recommendations are given further consideration.

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

a) The correspondences from AMO and alPHa as regards the report from the Minister's Expert Panel on Public Health are endorsed; and

b) The Premier of Ontario, Minister of Health and Long-Term Care, Durham's MPPs, Central East LHIN CEO, 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

October 25, 2017

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:

Re: Assessment of the Healthy Menu Choices Act

On June 23, 2017 at a regular meeting of the Board for the Grey Bruce Health Unit, the Board considered the attached correspondence from Peterborough Public Health and Leeds, Grenville and Lanark District Health Unit regarding the indicators of success of the newly implemented Healthy Menu Choices Act. The following motion was passed:

Moved by: David Shearman Seconded by: Mike Smith

"THAT, the Board of Health supports the positions of Leeds, Grenville and Lanark District Health Unit and Peterborough Public Health calling for transparency regarding the indicators of success of the newly implemented Healthy Menu Choices Act, and further THAT the Board requests transparency regarding the evaluation of related promotional activities."

Carried

Sincerely,

David Inglis, Chair
Board of Health
Grey Bruce Health Unit

Cc: 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

June 7, 2017

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: Assessment of the Healthy Menu Choices Act

On behalf of our Board of Health, I am writing to you in support of the Leeds, Grenville and Lanark District Health Unit's call for transparency regarding the indicators of success of the newly implemented Healthy Menu Choices Act. Our Board believes that it is important to equip consumers to make informed food choices. Given the significant investment of resources it takes to implement the Healthy Menu Choices Act at a local level, we request that the provincial government communicate to all stakeholders how the impact of the Act will be assessed.

In addition to indicators of success of the newly implemented act, our board requests transparency regarding the evaluation of related promotional activities and campaigns led by the Ministry of Health and Long-Term Care. Possible considerations to evaluate include:

- the effectiveness of emphasizing calories (rather than a whole foods approach, emphasizing the importance of a variety of nutrients, from minimally processed foods);
- the effects of the marketing campaign comparing equally unhealthy choices, and use of messages with sexual overtones (e.g., food items stripping);
- short and long term effectiveness of act on choices made by Ontarians;
- possible adverse effects of labelling of calories alone in relation to disordered eating patterns and promoting healthy relationships with food; and
- accuracy of calories displayed on menus compared to what consumers are purchasing.

Our board of health is committed to protecting and promoting the health and well-being of our residents. We are supportive of evidence based interventions that accomplish health goals and would welcome information regarding the evaluation of both the Healthy Menu Choices Act, and the approach taken to promote Ministry-led awareness activities that support our local efforts.

Yours in health,

Mayor Mary Smith
Chair, Board of Health

/ag
Encl.

cc: Local MPPs
Dr. David Williams, Chief Medical Officer of Health, MOHLTC
Association of Local Public Health Agencies
Ontario Boards of Health

March 22, 2017

VIA EMAIL

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

Dear Minister Hoskins:

The Leeds, Grenville and Lanark Board of Health is very concerned about two recent initiatives of the Ministry of Health and Long-Term Care – the Expert Panel on Public Health and the Healthy Menu Choices Act.

With respect to the Expert Panel on Public Health, you stated in your letter of January 18, 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."

We have learned that the work of the Expert Panel will be done in confidence and will not include consultation with local public health units. This is in contrast to the Liberal government's commitment to transparency in its work. The Expert Panel will be making recommendations that could have a profound impact on how we do business, and yet we won't have any opportunity to provide input into the discussion or the options being considered. To rectify this concern, the Board requests that all recommendations from the Expert Panel be made public, and that a formal consultation process be undertaken with all Ontario public health units before any decisions are made about the integration of public health into the broader health system.

The implementation of the Healthy Menu Choices Act requires a significant investment of resources at the local level and among the food premise industry. Concerns have been raised by other organizations about the effectiveness of this measure. Has the Ministry of Health and Long-Term Care identified indicators of success that will assess if this investment is justified; and are these indicators being tracked? The Liberal government has publicly stated a commitment to accountability. The Board of Health requests that the Minister respect this commitment and notify all parties how the impact of the Healthy Menu Choices Act will be assessed.

Sincerely,

Anne Warren, Chair
Board of Directors
Leeds, Grenville and Lanark District Health Unit

AW/hb

cc: Steve Clark, MPP Leeds-Grenville
Randy Hillier, MPP Lanark-Frontenac-Lennox and Addington
Jack MacLaren, MPP Carleton-Mississippi Mills
Ontario Boards of Health

October 25, 2017

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:

Re: Health Promotion Resource Centres

On July 28, 2017 at a regular meeting of the Board for the Grey Bruce Health Unit, the Board considered the attached correspondence from Leeds, Grenville and Lanark District Health Unit regarding funding for Health Promotion Resource Centres. The following motion was passed:

Moved by: Arlene Wright Seconded by: Mitch Twolan

"THAT, the Board of Health support the letter from Leeds Grenville and Lanark District Health Unit requesting that the province reconsider the decision to eliminate the funding for the Health Promotion Resource Centres to be replaced with annual competitive grants."

Carried

Sincerely,

David Inglis, Chair
Board of Health
Grey Bruce Health Unit

Cc: All Ontario Boards of Health

Encl.

Leeds, Grenville & Lanark District
HEALTH UNIT
Your Partner in Public Health

July 5, 2017

VIA EMAIL

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

Dear Minister Hoskins:

On March 31, 2017, many agencies funded as Health Promotion Resource Centres were informed that their funding for the Resource Centre would end as of March 2018. These Resource Centres provide crucial support to our local level work in tobacco, alcohol and nutrition, including access to data, research, and evaluation support.

- The Training Enhancement in Applied Cessation Counselling program (TEACH) provides the high level, in-depth cessation training needed by the frontline staff at health units.
- The Program Training and Consultation Centre (PTCC) provides training, education, and knowledge sharing to ensure our activities are evidence based, new staff are knowledgeable, and current staff stay informed.
- The Ontario Tobacco Research Unit (OTRU) provides the expertise in monitoring and evaluation that is needed to ensure that objectives are realistic and activities are effective.
- The effect that the Youth Advocacy Training Institute (YATI) has had on youth tobacco prevention in Ontario is extremely significant. Their collective experience and knowledge of youth engagement and training is why there are so many passionate youth advocates in tobacco control today!
- The Smoking and Health Action Foundation (SHAF) provides supports for smoke-free housing Ontario and support for tenants and landlords looking to make a positive change in their environment when living in a multi-unit dwelling whether it be an apartment, a condo, rental unit, or supportive housing.
- The Health Promotion Capacity Building-Alcohol Policy Centre (HPCB-AP) addresses alcohol-related harm in communities across Ontario. HPCB-AP supports the development, implementation, assessment, and coordination of alcohol policies across different settings and levels (e.g., schools, colleges, workplaces, municipalities, provinces, etc.).
- The Nutrition Resource Centre (NRC) provides training, education, and knowledge sharing to ensure program and policy development are evidence-based and can be tailored to meet local needs.

Our local health promotion work is more effective and efficient because of the dedicated and proficient staff at these centres. These Resource Centres support cross-pillar work and have been very useful in collaborative campaigns at the provincial, regional, local, and even federal level.

The substitute of having a Health and Wellness grant available to fill the void left by these Resource Centres is not a viable alternative. Annual competitive grants do not offer the stability needed for any kind of sustainable resources or support. The projects that are supported by the Resource Centres can span several years from planning to evaluation.

I would appreciate it if you could reconsider the decision to eliminate the funding for the Health Promotion Resource Centres, and I look forward to your response.

Sincerely,

Anne Warren, Chair
Board of Directors
Leeds, Grenville and Lanark District Health Unit

AW/hb

cc: Gord Brown, MP Leeds-Grenville
Steve Clark, MPP Leeds-Grenville
Randy Hillier, MPP Lanark-Frontenac-Lennox and Addington
Jack MacLaren, MPP Carleton-Mississippi Mills
Ontario Boards of Health

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elginhealth.on.ca

October 23, 2017

The Honourable Yasir Naqvi
Attorney General of Ontario 720 Bay Street, 11th Floor
Toronto, Ontario M7A 2S9
vnaqvi.mpp@liberal.ola.org

Dear Minister Naqvi:

Re: Ontario's safe and sensible framework to manage federal legalization of cannabis

On October 11 2017, at a regular meeting of the Board of Health at Elgin St. Thomas Public Health (ESTPH), a letter was brought forward from Peterborough Public Health that applauded the Province of Ontario and the Cannabis Secretariat on releasing their plans for regulating cannabis once it is federally legalized. ESTPH contributed to the July 2017 provincial consultation on the proposed cannabis framework as part of the Ontario Public Health Unit Collaboration on Cannabis (OPHUCC). ESTPH shares in Peterborough Public Health's enthusiasm to see that Ontario's newly released plan aligns with various areas of the submission such as:

- Establishing a safe and responsible supply chain of cannabis using a government monopoly, where cannabis will not be sold alongside alcohol in Ontario,
- Setting the minimum age of purchase to 19,
- Prohibiting the smoking of cannabis in public places,
- Developing a public information campaign, to complement the federal government's public awareness campaign,
- Developing a comprehensive prevention and harm reduction approach to promote awareness of cannabis-related harms,
- Working with and supporting enforcement partners to keep our roads safe, and
- Working with municipalities to choose the most appropriate store locations.

We urge the Province to continue to use a public health approach in the legalization of cannabis. While the Federal Government has responsibility for setting packaging and advertising restrictions, ESTPH requests the provincial regulations include the following:

- Adopt plain packaging,
- Prohibit the production and sale of products that are attractive to youth,
- Require that all cannabis products be sold in a child-resistant container and be marked with a universal symbol indicating the container holds cannabis, and
- Restrict all forms of cannabis product and cannabis company promotion, including sponsorship, endorsement, branding, and point-of-sale advertising.

ESTPH commends Ontario on their promise that “revenues associated with cannabis legalization will be reinvested to ensure the Province meets the priorities of protecting young people, focusing on public health and community safety, promoting prevention and harm reduction, and eliminating the illegal market”. We look forward to learning more about the reinvestment strategy and how our public health work may be supported by this.

The Board of Health for Elgin St. Thomas Public Health is committed to working together to promote and protect the health and well-being of people who live, work and play in Elgin County. The Board looks forward to further details in order to support our community in this transition period.

Sincerely,

Dr. Joyce Lock
Medical Officer of Health

Cynthia St. John
Executive Director

c. Honourable Kathleen Wynne, Premier
Honourable Dr. Eric Hoskins, Minister of Health and Long-Term Care
Jeff Yurek, MPP Elgin-Middlesex-London
Dr. David Williams, Chief Medical Officer of Health
Association of Local Public Health Agencies
Ontario Boards of Health
Municipal Councils in Elgin St. Thomas

KFL&A Public Health

October 26, 2017

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

Dear Minister Hoskins,

RE: Advocacy for the Nutritious Food Basket

At its meeting of October 25, 2017, the Kingston, Frontenac and Lennox & Addington (KFL&A) Board of Health passed the following motion:

> **THAT the KFL&A Board of Health recommend to the Ontario Minister of Health and Long-Term Care that the Ontario Ministry of Health and Long-Term Care provide and support an updated Nutritious Food Basket Protocol with the modernized Standards for Public Health Programs and Services to ensure consistent data collection and methodology for community-level food costing across the province.**
>
> **FURTHER THAT the KFL&A Board of Health recommend that a copy of this memorandum be forwarded to Hon. Peter Milczyn, Minister of Housing (Responsible for the Poverty Reduction Strategy and the Food Security Strategy); Hon. Helena Jaczek, Minister of Community and Social Services; the Ontario Society of Nutrition Professionals in Public Health; members of provincial parliament, S. Kiwala, Kingston and the Islands, and R. Hillier, Lanark-Frontenac-Lennox and Addington; Ontario boards of health; and the Association of Local Public Health Agencies**

The Nutritious Food Basket (NFB) is an important surveillance tool used by all Ontario local public health agencies to inform food security programs and policy work. The modernization of the Ontario Standards for Public Health Programs and Services (OSPHPS) provides an opportunity to update it. Food Insecurity is an ongoing public health issue and the removal of the NFB Protocol could have negative consequences on food security programs, policies and partnerships.

Not having a mandatory, consistent, ministry-supported approach to collecting and using community-level data on the cost of food across the province is concerning. We may be left with more work to create a patchwork of poor data sets without year-to-year comparability. Furthermore,

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Napanee 613-354-3357 Fax: 613-354-6267
Sharbot Lake 613-279-2151 Fax: 613-279-3997

the provincial government's decision not to monitor household food insecurity as part of the Canadian Community Health Survey for 2015 and 2016 will have a significant impact on food security monitoring and program planning.

The lack of adequate food cost and food security surveillance data limits the ability to monitor these trends for program planning, limits our ability to assess the impact of policies over time, and could negatively impact our agency's ability to comply with the modernized OSPHPS expectations related to health equity, evidence-informed practice, and addressing community needs. In addition, the lack of this surveillance data could have serious consequences on other ministry-supported initiatives including the Ontario Basic Income Pilot, the Ontario Poverty Reduction Strategy, and the Ontario Food Security Strategy, and specifically Bill 6, Ministry of Community and Social Services Amendment Act, 2016. Bill 6 calls for the establishment of a Social Assistance Research Commission to annually determine the cost of living in different parts of the province, with recommended rates of provincial social assistance based on analysis of the cost of regional basic necessities including the NFB.

The KFL&A Board of health urges the Ministry of Health and Long-Term Care to provide and support an improved Nutritious Food Basket Protocol with the modernized Standards for Public Health Programs and Services to ensure consistent data collection and methodology for community-level food costing across the province.

Yours truly,

Denis Doyle

Denis Doyle, Chair
KFL&A Board of Health

Copy to: KFL&A Board of Health Members
Hon. Peter Milczyn, Minister of Housing (Responsible for the Poverty Reduction Strategy and the Food Security Strategy)
Hon. Helena Jaczek, Minister of Community and Social Services
Ontario Society of Nutrition Professionals in Public Health
S. Kiwala, MPP, Kingston and the Islands
R. Hillier, MPP, Lanark-Frontenac-Lennox and Addington
Boards of Health, Local Public Health Agencies
Association of Local Public Health Agencies

Kingston, Frontenac and Lennox & Addington Public Health www.kflaph.ca

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ALGOMA PUBLIC HEALTH

November 9, 2017

COPY

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

The Regional Municipality of Durham

Corporate Services
Department
Legislative Services

605 ROSSLAND ROAD EAST
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WHITBY, ON L1N 6A3
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905-668-7711
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Matthew L. Gaskell
Commissioner of
Corporate Services

RE: Memorandum from Dr. R. Kyle, Commissioner and Medical Officer of Health – re: Report of the Rowan's Law Advisory Committee Our File: P00

Please be advised that Committee of the Whole of Regional Council considered the above matter and at a meeting held on November 8, 2017, Council adopted the following recommendations of the Committee:

"A) That the correspondence from the Association of Local Public Health Agencies (alPHa) expressing support for the implementation of the recommendations contained in the Report of the Rowan's Law Advisory Committee be endorsed; and

B) That the Premier of Ontario, Minister of Tourism, Culture and Sport, Minister of Health and Long-Term Care, Minister of Education, Durham's MPPs, Chief Medical Officer of Health and all Ontario boards of health be so advised."

Attached for your reference is a copy of the Memorandum from Dr. Kyle, Commissioner and Medical Officer of Health, dated November 1, 2017.

Ralph Walton
Regional Clerk/Director of Legislative Services

RW/np

Attach.

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

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c. The Honourable Eleanor McMahon, Minister of Tourism, Culture and Sport
The Honourable Eric Hoskins, Minister of Health and Long-Term Care
The Honorable Mitzie Hunter, Minister of Education
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
N. Wellsbury, Clerk, Town of Ajax
A. Greentree, Clerk, Municipality of Clarington
D. Shields, City Clerk, City of Pickering
D. Leroux, Clerk, Township of Uxbridge
T. Gettinby, CAO/Clerk, Township of Brock
A. Brouwer, Clerk, City of Oshawa
J.P. Newman, Clerk, Township of Scugog
C. Harris, Clerk, Town of Whitby
Dr. R.J. 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 1, 2017

Re: Report of the Rowan's Law Advisory Committee

In June 2016, the Rowan's Law Advisory Committee was established to review the jury recommendations made as a result of the Coroner's inquest into the death of high school rugby player Rowan Stringer. The *Rowan's Law Advisory Committee Act, 2016* required the Committee to provide advice to the government with respect to head injury prevention and treatment. The Report of the Rowan's Law Advisory Committee was submitted to the Minister of Tourism, Culture and Sport in September 2017. The report contains 21 recommended actions directed to all organized amateur sports, both school-based and non-school based, in Ontario, grouped into five themes: surveillance, prevention, detection, management and awareness.

On October 6, 2017, the Association of Local Public Health Agencies (alPHa) sent a letter to the Minister of Tourism, Culture and Sport expressing support for the implementation of the recommendations of the Rowan's Law Advisory Committee.

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

a) The correspondence from alPHa as regards the Report of the Rowan's Law Advisory Committee is endorsed; and

b) The Premier of Ontario, Minister of Tourism, Culture and Sport, Minister of Health and Long-Term Care, Minister of Education, 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

simcoe muskoka
DISTRICT HEALTH UNIT

October 25, 2017

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

Dear Minister Hoskins,

On March 15, 2017, the Board of Health for the Simcoe Muskoka District Health Unit passed a motion to write to the federal government in supporting the approaches identified at the 2016 summit, A Tobacco Endgame for Canada and its target of reducing tobacco use to less than five per cent by 2035. Accordingly, we communicated with the Ministry of Health and Long-Term care in recommending that modernization of the Smoke-Free Ontario Strategy include the recommendations identified in the tobacco endgame. In supporting these recommendations, the Province and its partners can successfully address and minimize the preventable death and disease caused by tobacco product use and reduce the unmaintainable drain it places on our health care system.

The Board of Health is therefore pleased to review the recently released "Smoke-Free Ontario Modernization" Report of the Executive Steering Committee. In particular, the Board of Health is encouraged by the report's evidence-based recommendations, supports and strategies which identify actionable and achievable outcomes for future action that are in keeping with the resolutions by the Association of Local Public Health Agencies that identified the need for intensified and targeted tobacco controls to protect and promote the health of Ontario residents. Further, the Board of Health commends the Executive Steering Committee in recognizing that Ontario is closer to ending the tobacco epidemic despite on-going efforts by the tobacco industry who demonstrate a profound, self-serving disinterest in its customers' health and a calculating, sophisticated determination to resist any regulation. Thus, The Board of Health recommends that the province proceed with developing a renewed Smoke-Free Ontario strategy committing to the endgame target with a smoking prevalence of less than 5% by 2035, by employing the bold strategies recommended in the Smoke Free Ontario Modernization report.

Ontario's success in alleviating this tobacco epidemic requires strong leadership and action by your Ministry to strengthen and create legislation and supports that will diminish addiction to products that are the single greatest threat to the health of Ontarians. We look forward to working with the province as it updates the Smoke-Free Ontario strategy.

Sincerely,

ORIGINAL SIGNED BY

Scott Warnock,
Chair, Board of Health

c. Simcoe Muskoka Municipal Councils
Ontario Boards of Health
Central Local Health Integration Network
North Simcoe Muskoka Local Health Integration Network
Association of Local Public Health Agencies

alPHa
Association of Local PUBLIC HEALTH Agencies

Information Break

November 1, 2017
This 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.

alPHa Responds to Report by Expert Panel on Public Health

Both alPHa and the COMOH section have submitted their responses to government on the Expert Panel on Public Health's report, *Public Health within an Integrated Health System*. The submissions have been shared widely with the alPHa membership, and can be viewed by clicking the links below. A special resource page has also been created on the alPHa website to house these responses as well as those by various health units, and other background materials related to the Expert Panel's report.

Read alPHa's response to the Expert Panel report
Read COMOH's response to the Expert Panel report
View alPHa's Expert Panel report response web page

New alPHa Executive Director

The alPHa Board of Directors has appointed Loretta Ryan as the association's Executive Director, effective November 6, 2017. A certified professional planner, Loretta joins alPHa after 17 years with the Ontario Professional Planners Institute where her work intersected with local public health on the Institute's initiatives on healthy and sustainable communities. Members will have a chance to meet Loretta as she will be attending the alPHa meetings on November 3 in Toronto. Welcome, Loretta!
Learn more about Loretta here

Government News: Round Up

Canada invests in cannabis education and awareness campaign (Oct. 31)

Ministry of Finance shares next steps on establishing cannabis retail stores with municipalities (Oct. 27)

Chief Public Health Officer of Canada releases Annual Report on State of Public Health, Designing Healthy Living (Oct. 26)

New school policy requires care plans for students with medical needs (Oct. 24)

Ontario expands Early Years programming (Oct. 24)

Federal health minister marks one-year anniversary of Healthy Eating Strategy (Oct. 20)

Minister of Community Safety & Correctional Services and Attorney General make statement on cannabis enforcement summit (Oct. 19)

Bill 148, *Fair Workplaces, Better Jobs Act,* passes second reading (Oct. 18)

Ontario funds 48 programs to tackle poverty, increase food security(Oct. 17)

Province releases Smoke-Free Ontario Modernization report (Oct. 10)

Health System Integration update (Oct. 10)

Update on Ontario Basic Income pilot (Oct. 4)

Province creating Opioid Emergency Task Force (Oct. 4)

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alPHa Website Feature: Current Consultations

alPHa lists current consultation opportunities for health units and boards to provide input to government on a range of public health-related legislation, regulations and issues. Click the link below to view.
Visit the alPHa Current Consultations page here

Upcoming Events - Mark your calendars!

November 3, 2017 - Fall alPHa Meetings (COMOH, BOH Section), DoubleTree by Hilton Downtown Toronto Hotel. Registration has now closed. Questions? Send them to karen@alphaweb.org

February 23, 2018 - Winter alPHa Meeting, Novotel Toronto Centre, 45 The Esplanade, Toronto. Details TBA.

March 21-23, 2018 - The Ontario Public Health Convention (TOPHC) 2018, Beanfield Centre, Toronto.

June 10, 11 & 12, 2018 - alPHa Annual General Meeting & Conference, Novotel Toronto Centre, 45 The Esplanade, Toronto.

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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.