Sep 26, 2018 - Board of Health Meeting

BOARD OF HEALTH MEETING

SSM Community Room A

www.algomapublichealth.com

Sep 26, 2018 - Board of Health Meeting Book

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    a. Next Board of Health Meeting - Date

15. Adjournment

ALGOMA PUBLIC HEALTH
BOARD OF HEALTH MEETING - AGENDA
SEPTEMBER 26, 2018 @ 5:00 PM - SSM ROOM A

BOARD MEMBERS

Ian Frazier - Chair
Sergio Saccucci - 1st Vice Chair
Lee Mason - 2nd Vice Chair
Dr. Patricia Avery
Dr. Lucas Castellani
Deborah Graystone
Sue Jensen
Adrienne Kappes
Dr. Heather O'Brien
Ed Pearce
Karen Raybould
Dennis Thompson

APH EXECUTIVES / MEMBERS

Dr. Marlene Spruyt - MOH/CEO
Dr. Jennifer Loo - AMOH
Justin Pino - CFO /Director, Operations
Antoniette Tomie - Director, HR
Laurie Zeppa - Director, Health Promotion / Prevention
Tania Caputo - Board Secretary

1.0 Meeting Called to Order *Ian Frazier*

a. Declaration of Conflict of Interest

2.0 Adoption of Agenda Items *Ian Frazier*

RESOLUTION THAT the Agenda items dated September 26, 2018 be adopted as presented.

3.0 Adoption of Minutes of Previous Meeting *Ian Frazier*

RESOLUTION THAT the Board of Health minutes for the month of June 2018 be adopted as presented.

4.0 Delegations / Presentations

a. Health Promotion Framework *Kristy Harper*

5.0 Business Arising from Minutes *Ian Frazier*

6.0 Reports to the Board

a. Medical Officer of Health and Chief Executive Officer Reports *Marlene Spruyt*

i. MOH Report - September 2018

RESOLUTON THAT the report of the Medical Officer of Health and CEO for the month of September 2018 be adopted as presented.

ii. Retention of Smoke-Free Ontario Act

Protection of Algoma youth from e-cigarette industry marketing through the retention of Smoke-Free Ontario Act, 2017 provisions that ban the display and promotion of vapour products (electronic or e-cigarettes)

RESOLUTION

b. Finance and Audit Committee Report *Justin Pino*

i. Financial Statements for the period ending July 30, 2018

RESOLUTION	THAT the Financial statements for the period ending July 30, 2018 be approved as presented

ii. **Supply of Security Guard Services** *Justin Pino*

RESOLUTION	Whereas: Algoma Public Health issued Request for Proposal (P2018-08-01) for the Supply of Security Services for its main office of 294 Willow Avenue, Sault Ste. Marie, and Whereas: Section 7(C) Contract/Leases of Algoma Public Health's Procurement Policy (02-04-030) states the Board must approve contracts where the contract/lease is for multiple years and exceeds $55,000 per year Therefore: Be it resolved that the Board of Health for the District of Algoma award the five-year contract (with and APH option to extend for a two year period) to "North East Regional Security Services Inc." being the highest scoring of the qualifying proposals

iii. **Infant Development annual reconciliation** *Justin Pino*

RESOLUTION	THAT the Board of Health receives and approves the Transfer Payment Annual Reconciliation for the Infant Development program as presented.

c. Governance Committee Report *Lee Mason*

i. September 2018 Governance Report

ii. Retirement Benefits for Employees Policy 02-05-050

RESOLUTION	THAT the Retirement Benefits for Employees Policy 02-05-050 be archived as proposed

7.0 New Business/General Business *Ian Frazier*

8.0 Correspondence *Ian Frazier*

a. Consultation Opportunity: National Pharmacare (previously circulated)

b. Letter to the Minister of Health and the Minister of Justice and Attorney General of Canada from Simcoe Muskoka District Health Unit regarding A Public Health Approach to Drug Policy Reform dated July 10, 2018

c. Letter to the Premier from Middlesex-London Health Unit regarding Cannabis Sales Taxation Endorsement dated August 30, 2018

d. Letter to the Premier from Huron County Health Unit regarding Ontario Basic Income Pilot dated September 6, 2018

e. Letter to the Minister of Children, Community and Social Services from Haliburton, Kawartha, Pine Ridge Distrct Health Unit regarding Ontario Basic Income Pilot Project dated August 17, 2018

f. Letter to the Premier, the Minister of Children, Community and Social Services and the Minister of Health and Long Term Care from Sudbury District Health Unit regarding Ontario Basic Income Pilot Project dated August 3, 2018

g. Letter to the Premier, the Minister of Children, Community and Social Services and the Minister of Health and Long Term Care from Timiskaming Health Unit regarding Ontario Basic Income Pilot Project dated August 8, 2018

h. Letter to the Minister of Children, Community and Social Services from Simcoe Muskoka Health Unit regarding Ontario Basic Income Pilot Project dated August 1, 2018

i. Letter to the Minister of Children, Community and Social Services from Peterborough Health Unit regarding Ontario Basic Income Pilot Project dated August 3, 2018

j. Letter to the Premier from Grey Bruce Health Unit regarding Smoke Free Ontario Act dated July 27, 2018

k. Letter to the Premier from Sudbury District Health Unit regarding Smoke Free Ontario Act dated July 3, 2018

l. Letter to the Premier from Chatham-Kent Health Unit regarding Smoke Free Ontario Act dated July 23, 2018

m. Letter to the Minister of Health from Middlesex-London Health Unit regarding Smoke Free Ontario Act dated July 20, 2018

9.0 Items for Information *Ian Frazier*

10.0 Addendum: *Ian Frazier*

11.0 In-Camera

RESOLUTION THAT the Board of Health go In-Camera

Agenda Items: *Ian Frazier*

a. Adoption of in-camera minutes dated April 25, 2018, May 23, 2018, and June 27, 2018

b. Litigation or potential litigation

c. Security of the property of the board

12.0 Open Meeting *Ian Frazier*

a. Resolutions resulting from in-camera meeting

13.0 Announcements / Next Committee Meetings: *Ian Frazier*

Finance & Audit Committee
October 10, 2018 @ 4:30 pm
Prince Meeting Room, 3rd Floor

Next Board of Health Meeting:
October 24, 2018 @ 5:00 pm
Sault Ste. Marie, Room A

14.0 Evaluation

15.0 Adjournment *Ian Frazier*

RESOLUTION THAT the Board of Health meeting adjourns

Ian Frazier, Chair	**Tania Caputo, Secretary**
Date	**Date**

ALGOMA PUBLIC HEALTH
BOARD OF HEALTH MEETING - MINUTES
JUNE 27, 2018 @ 5:00 PM - SSM ROOM A

PRESENT :

BOARD MEMBERS

Sergio Saccucci - 1st Vice Chair
Lee Mason - 2nd Vice Chair
Deborah Graystone
Adrienne Kappes
Dr. Patricia Avery
Dennis Thompson
Karen Raybould
Dr. Lucas Castellani

APH EXECUTIVES / MEMBERS

Dr. Marlene Spruyt - MOH/CEO
Dr. Jennifer Loo - AMOH
Justin Pino - CFO /Director, Operations
Antoniette Tomie - Director, HR
Laurie Zeppa - Director, Health Promotion / Prevention
Tania Caputo - Board Secretary

T/C : None

REGRETS : I. Frazier (Chair), H.O'Brien, S. Jensen

1.0 Meeting Called to Order

a. Declaration of Conflict of Interest

S. Saccucci called the meeting to order at 5:05 pm
J.Pino declared a potential conflict of interest in relation to the IT Service Outsourcing agenda item. This had been noted at the June Finance and Audit Committee meeting - the risk was deemed negligible.

2.0 Adoption of Agenda Items

2018-56

Moved: E. Pearce
Seconded: L. Mason
THAT the Agenda items dated June 27, 2018 be adopted as presented
CARRIED

3.0 Adoption of Minutes of Previous Meeting

a. April 25, 2018 Minutes
b. May 23, 2018 Minutes

2018-57

Moved: L. Mason
Seconded: P. Avery
THAT the Board of Health minutes for the month of April 2018 be adopted as amended and;
THAT the Board of Health minutes for the month of May 2018 be adopted as presented
CARRIED

4.0 Delegations / Presentations

a) Accountability Indicators

M. Spruyt presented on the indicators for 2017. Many questions were asked and explanations provided on a range of topics. M. Spruyt explained that the MOHLTC requires APH to collect certain data and the way it is measured. There was discussion about performance and resulting process changes. Much of the work that is done by Public Health especially health promotion activities is difficult to measure. Public Health interventions interact in complex ways and it may take many years to see an impact on some outcome indicators.

5.0 Business Arising from Minutes

a) Land Acknowledgement

S. Saccucci read the land acknowledgement

6.0 Reports to the Board

a) Medical Officer of Health and Chief Executive Officer Reports

i. MOH Report - June 2018

M. Spruyt's report provided information on APH's All Staff Education day on June 5 as well as the annual alPHa meeting in Toronto on June 11 & 12 and an update on the Cannabis Act that has been passed at the federal level. The Program Highlights included this month were *Reducing Exposure to Health Hazards to Create Healthier Communities* and *Indigenous/First Nations Relationship Building.*

2018-58

Moved: D. Thompson
Seconded: K. Raybould

THAT the report of the Medical Officer of Health and CEO for the month of June 2018 be adopted as presented.

CARRIED

b) Finance and Audit Committee Report

i. Committee Chair Report for June 2018

S. Saccucci thanked J.Pino for providing an overview with respect to the format of the Financial Statement at the June 13 Finance & Audit committee meeting. This will assist the Finance committee members in the understanding of the financial statement for the organization. He also provided commentary on the Financial Statement for the period ending April 30, 2018 as well as the outsourcing for IT services.

2018-59

Moved: P. Avery
Seconded: A. Kappes

THAT the Finance and Audit Committee Chair Report for June 2018 be approved as presented

ii. Financial Statements for the period ending April 30, 2018

Questions were asked in regards to the quarterly payments by municipalities and discussion followed with information provided by J.Pino. Discussion also took place regarding Provincial hiring freeze and M. Spruyt responded with clarification on Public Service vs. Public Sector.

2018-60

Moved: K. Raybould
Seconded: D. Graystone

THAT the Financial Statements for the period ending April 30, 2018 be approved as presented

CARRIED

iii. IT Service Contract

- J. Pino provided an overview of the current IT services contract which is 100 percent outsourced.
- APH working with NE Health Unit collaborative project reviewing operations to provide possible ways the 5 Health Units could work together.
- Current IT contract expires in spring 2019 - we need to hire a consultant with internal IT expertise to assist the RFP development.
- Discussion occurred on models that might occur in the future
- Options from the Collaborative project available in late fall do not provide sufficient lead time for RFP development.
- The request is to extend the current IT contract for a one year term and await any new developments from the Collaborative project before developing an RFP for the required tendering process.

2018-61	**Moved:** E. Pearce **Seconded:** L. Mason THAT the Board of Health approve a one-year extension to the existing Service Level agreement with the current IT service provider under the same terms and conditions as the existing contract. **CARRIED**

iv. Supply of Janitorial Services

J. Pino provided overview on the tender for a 5 year Janitorial Services contract, noting the forecasted savings of approximately $100,000 over the 5 year period.

2018-62	**Moved:** K. Raybould **Seconded:** P. Avery Whereas: Algoma Public Health issued Request for Proposal (P2018-05-01) for the Supply of Janitorial Services for its main office at 294 Willow Avenue, Sault Ste. Marie, and Whereas: Section 7 (c) Contract/Leases of Algoma Public Health's Procurement Policy (02-04-030) states the Board must approve contracts where the contract/lease is for multiple years and exceeds $55,000 per year Therefore: Be it resolved that the Board of Health for the District of Algoma award the five-year contract (with an APH option to extend for a two year period) to " SQM Janitorial Services Inc." being the lowest price of the qualifying proposals **CARRIED**

7.0 New Business/General Business

8.0 Correspondence

a. Letter to the Minister of Justice from Perth District Health Unit regarding Repeal of Section 43 of the Criminal Code dated June 14, 2018

9.0 Items for Information

a. Disposition of alPHa June 2018 Resolutions

b. GBHU BOH Motion 2018-39, Cannabis Sales Taxation Revenue

c. GBHU BOH Motion 2018-50, Oral Health Recommendations and Report

d. GBHU BOH Motion 2018-51, Food Literacy Curricula

e. GBHU BOH Motion 2018-52, Youth Exposure to Smoking in Movies

10.0 Addendum:

a. Briefing Note - IT Service Outsourcing - Updated document for item **6. b) iii.**

L. Castellani, L. Zeppa and J.Pino excused themselves prior to In-Camera session

11.0 In-Camera - 6:16 pm

2018-63	**Moved:** K. Raybould **Seconded:** A. Kappes THAT the Board of Health go In-Camera **CARRIED**

Agenda Items:

a. Adoption of in-camera minutes dated May 23, 2018 and April 25, 2018

b. Litigation or potential Litigation

12.0 Open Meeting - 6:29 pm

The Board of Health returned to open meeting without report

a. Resolutions resulting from in-camera meeting: None

14.0 Announcements / Next Committee Meetings:

Governance Standing Committee

September 12, 2018 @ 4:30 pm

Prince Meeting Room, 3rd Floor

Next Board of Health Meeting:

September 26, 2018 @ 5:00 pm

Sault Ste. Marie, Room A

15.0 Adjournment - 6:35 pm

2018-65	**Moved:** K. Raybould **Seconded:** A. Kappes THAT the Board of Health meeting adjourns **CARRIED**

Sergio Saccucci, **1st Vice Chair**	**Tania Caputo, Secretary**
Date	**Date**

Health Promotion

Kristy Harper, Program Manager Community Wellness & Chief Nursing Officer

September 26th, 2018

Algoma PUBLIC HEALTH
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Public Health

Public health is defined as the organized efforts of society to keep people healthy and prevent injury, illness and premature death. It is a combination of programs, services and policies that protect and promote health.

The goal of public health in Ontario is to improve and protect the health and well-being of the population of Ontario.

Public Health focuses on **population health approach**, which includes efforts to promote health and prevent disease in populations.

The Chief Public Health Officer's Report on State of Public Health in Canada, 2008
Ontario Public Health Standards, 2018

Algoma PUBLIC HEALTH
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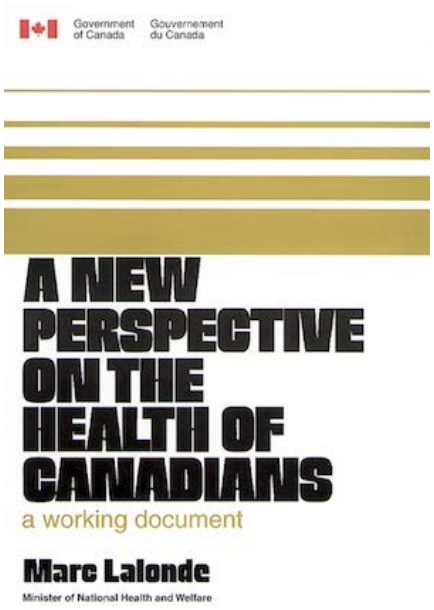
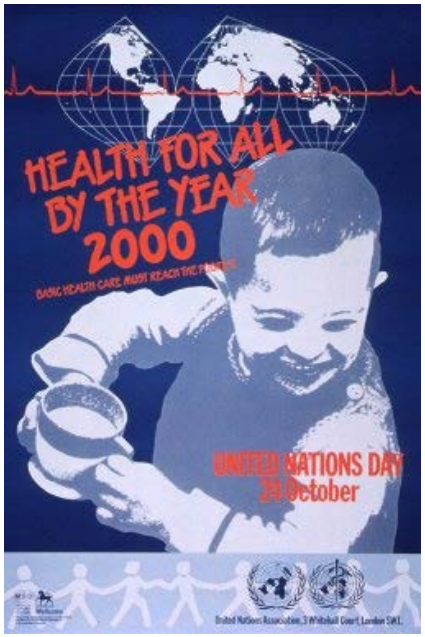
Public Health

- **Health Protection** – ensure water, air and food are safe, control infectious diseases and protection from environmental threats.
- **Health Surveillance** – ongoing use of health data to monitor and forecast health events.
- **Disease and Injury Prevention** – investigation, contact tracing, preventative measures to reduce risk of disease and outbreaks, and activities to promote healthy lifestyles.
- **Population Health Assessment** – understanding the health of communities or populations to inform policies, programs and services.
- **Health Promotion** – preventing disease, improving health through public policy, community interventions, public participation and advocacy on determinants of health.
- **Emergency Preparedness and Response** – planning for natural and man-made disasters.

The Chief Public Health Officer's Report on The State of Public Health in Canada, 2008

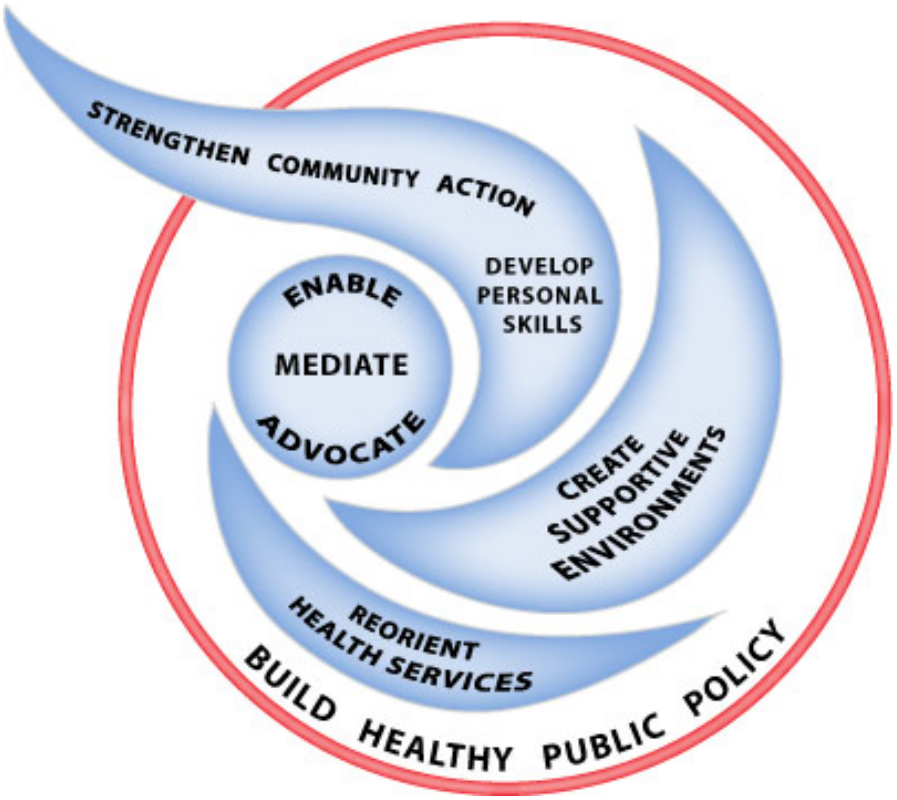
The Health Promotion Movement





Ottawa Charter for Health Promotion (1986)

Health Promotion is the process of enabling people to increase control over, and to improve, their health. Health Promotion is not just the responsibility of the health sector, but goes beyond healthy life-styles to well-being.



Ontario Public Health Standards, 2018
Ottawa Charter for Health Promotion, 1986

The Ottawa Charter in Action at Algoma Public Health

Algoma
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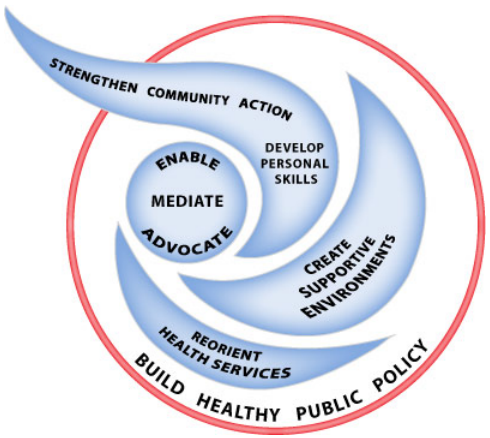

Develop Personal Skills

- Health promotion supports personal and social development through providing information, education for health, and enhancing life skills.

- Developing personal skills is facilitated at homes, schools, workplaces and community settings with goal to build capacity so that individuals will make healthy lifestyle choices.

Algoma Public Health:

- Provides awareness and education on health impacts of tobacco use.

- Deliver evidence informed tobacco cessation services.

Ottawa Charter for Health Promotion, 1986

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Strengthening Community Action

- Health promotion works through concrete and effective community action to set priorities, make decisions, plan and implement strategies to achieve better health.

- Empower communities to take ownership and control.

Ottawa Charter for Health Promotion, 1986

Create Supportive Environments

- Providing environments in all settings such as home, work, and play that are safe and enjoyable.
- Changing patterns of life, work and leisure can impact health. The way our society is organized should help to support health.

Algoma Public Health:

- Provides ongoing consultation and support to workplaces with wellness initiatives
- Provides consultation with municipalities on smoke free spaces

Ottawa Charter for Health Promotion, 1986

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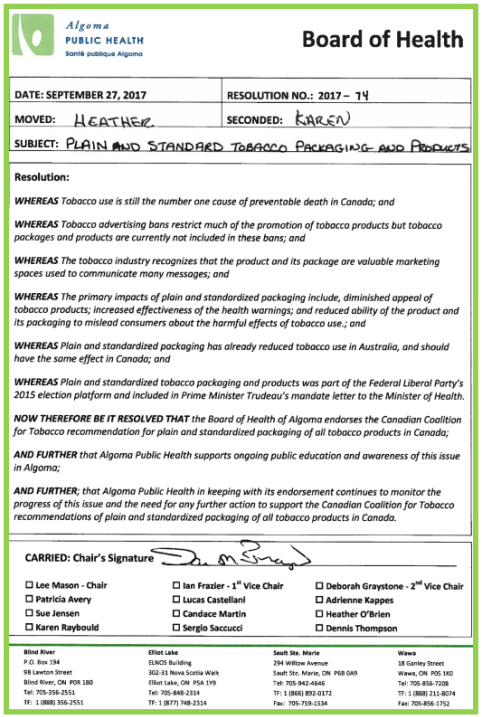
Build Healthy Public Policy

- Health promotion goes beyond health care. It puts health on the agenda of policy makers in all sectors and at all levels, directing them to be aware of the health consequences of their decisions and accept responsibilities for health.

- Health promotion policy combines diverse but complementary approaches including legislation, fiscal measures, taxation, and organizational change.



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Board of Health

DATE: SEPTEMBER 27, 2017	RESOLUTION NO.: 2017 – 74
MOVED: HEATHER	SECONDED: KAREN

SUBJECT: PLAIN AND STANDARD TOBACCO PACKAGING AND PRODUCTS

Resolution:

WHEREAS *Tobacco use is still the number one cause of preventable death in Canada; and*

WHEREAS *Tobacco advertising bans restrict much of the promotion of tobacco products but tobacco packages and products are currently not included in these bans; and*

WHEREAS *The tobacco industry recognizes that the product and its package are valuable marketing spaces used to communicate many messages; and*

WHEREAS *The primary impacts of plain and standardized packaging include, diminished appeal of tobacco products; increased effectiveness of the health warnings; and reduced ability of the product and its packaging to mislead consumers about the harmful effects of tobacco use.; and*

WHEREAS *Plain and standardized packaging has already reduced tobacco use in Australia, and should have the same effect in Canada; and*

WHEREAS *Plain and standardized tobacco packaging and products was part of the Federal Liberal Party's 2015 election platform and included in Prime Minister Trudeau's mandate letter to the Minister of Health.*

NOW THEREFORE BE IT RESOLVED THAT *the Board of Health of Algoma endorses the Canadian Coalition for Tobacco recommendation for plain and standardized packaging of all tobacco products in Canada;*

AND FURTHER *that Algoma Public Health supports ongoing public education and awareness of this issue in Algoma;*

AND FURTHER; *that Algoma Public Health in keeping with its endorsement continues to monitor the progress of this issue and the need for any further action to support the Canadian Coalition for Tobacco recommendations of plain and standardized packaging of all tobacco products in Canada.*

CARRIED: Chair's Signature

☐ Lee Mason - Chair	☐ Ian Frazier - 1st Vice Chair	☐ Deborah Graystone - 2nd Vice Chair
☐ Patricia Avery	☐ Lucas Castellani	☐ Adrienne Kappes
☐ Sue Jensen	☐ Candace Martin	☐ Heather O'Brien
☐ Karen Raybould	☐ Sergio Saccucci	☐ Dennis Thompson

Blind River	Elliot Lake	Sault Ste. Marie	Wawa
P.O. Box 194 98 Lawton Street Blind River, ON P0R 1B0 Tel: 705-356-2551 TF: 1 (888) 356-2551	ELNOS Building 302-31 Nova Scotia Walk Elliot Lake, ON P5A 1Y9 Tel: 705-848-2314 TF: 1 (877) 748-2314	294 Willow Avenue Sault Ste. Marie, ON P6B 0A9 Tel: 705-942-4646 TF: 1 (866) 892-0172 Fax: 705-759-1534	18 Ganley Street Wawa, ON P0S 1K0 Tel: 705-856-7208 TF: 1 (888) 211-8074 Fax: 705-856-1752

Ottawa Charter for Health Promotion, 1986

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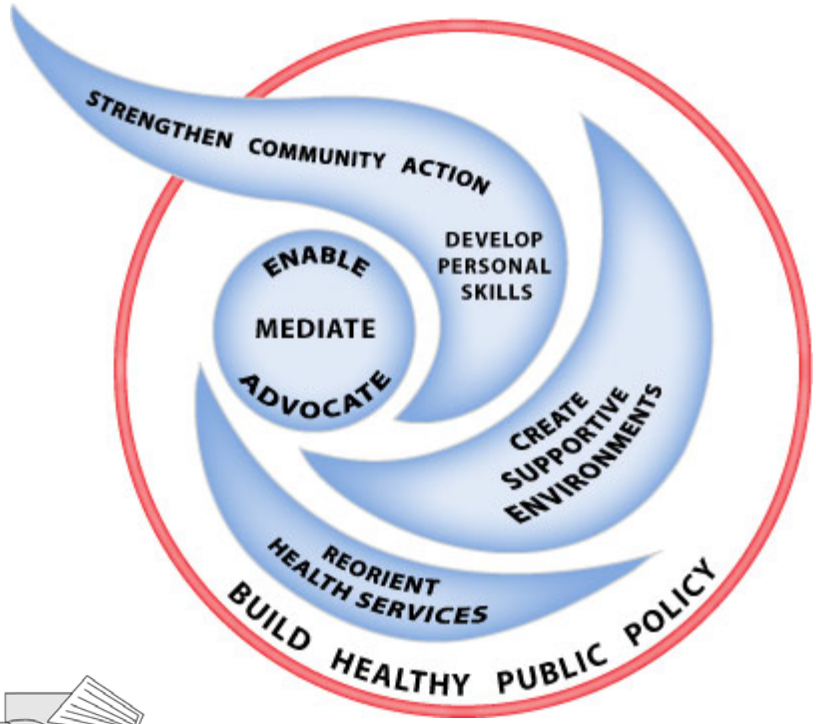
Reorient Health Services

- The responsibility for health promotion in health services is shared among individuals, community groups, health professionals, health services and governments. They must work together towards a health care system which contributes to the pursuit of health.

Ottawa Charter for Health Promotion, 1986

Healthy Choices. Happy Kids.

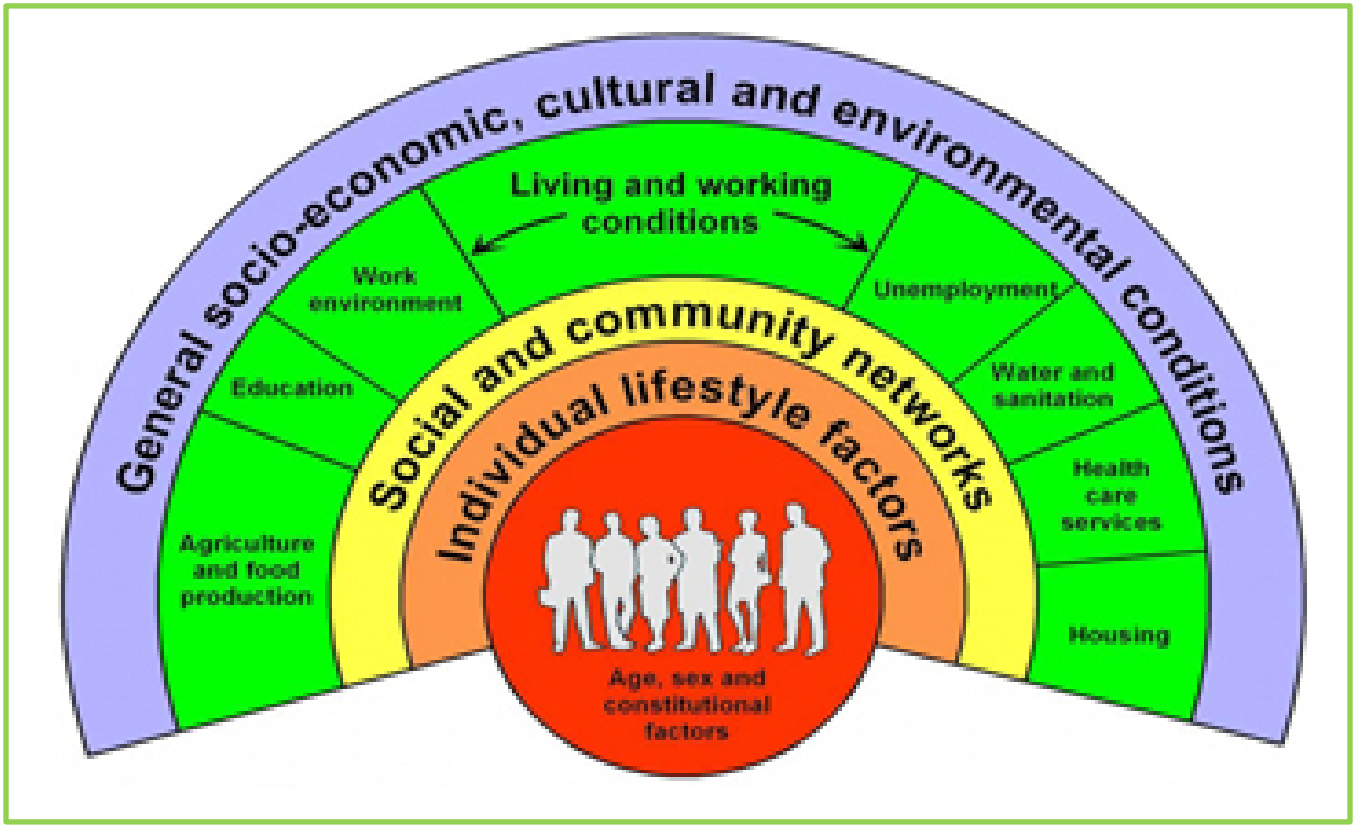


DRUG STRATEGY
SSM & AREA

FIVE

Building Healthy Schools Together
Ensemble, bâtissons des écoles en santé

Algoma PUBLIC HEALTH
Santé publique Algoma



Dahlgren & Whitehead, 1991

Algoma
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September 2018

Medical Officer of Health / CEO

James Street Market – Healthy Kids Challenge

Laurie Zeppa (left) , Mike Nadeau CEO of SSM District Social Services Admin. Board) and son Tyler (centre), Tracey McLelland (right)

Community Health Profile Launch

Hilary Cutler (left) , Jordan Robson (centre), Jennifer Loo (right)

Prepared by:
Dr. Marlene Spruyt and the Leadership Team

Presented to:
Algoma Public Health Board of Health
9/26/2018

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APH AT-A-GLANCE

Algoma has enjoyed a very warm and dry summer and we were fortunate to not be troubled by as many forest fires as our Northern Ontario neighbours.

The Ministry of Health and Long Term Care (MOHLTC) slowly emerged from its caretaker mode under the direction of the newly elected government. Some new regulations and legislation were to be implemented on July 1, 2018 and some of these have been rolled back by our new government. The most significant of these was the revised Smoke Free Ontario Act (2017) which had been introduced and amended to include protective measures for public exposure to vaping compounds and cannabis. The implementation was revoked and we are still operating under the older version of Smoke Free Ontario Act and the Electronic Cigarettes Act. This leaves gaps in terms of protecting our youth which is concerning and for this reason we are bringing forward a resolution which you will see as a separate item in my report.

Another issue of public health concern is the removal of the current Health Education curriculum in Ontario Schools. This 2015 version had been developed with considerable input by public health experts and the public. School Boards are currently working with the 1998 curriculum while they await a revised version.

As you are aware poverty is a major determinant of health and the rollback of the increase to social assistance rates and minimum wage will have impacts on our vulnerable populations. It should be noted that individuals surviving on limited income will spend any additional resources they receive locally thereby contributing to the overall local economy.

Resolving the issues of poverty and health is a complex problem and further research will help inform us about which public policies will be most effective. Consequently, we are disappointed to hear that the Basic Income project is being terminated prematurely. Information from this pilot project would have been helpful for future evidence informed decision making.

As part of our ongoing celebration of 50 years of APH we hosted the annual conference for the Association of Ontario Public Health Business Administrators (AOPHBA) on Sept 11-13. The conference was well attended with representation from almost every health unit. Along with the professional development sessions the attendees were introduced to our community with a guided walk along SSM waterfront provided by the Director of Planning, Don McConnell, a river cruise and an Italian dinner and bocce competition.

Other activities for the public continue to roll out across the district with Yoga, Learn to Curl events and movie nights. We are working on details for our final event to be held at the SSM office on the afternoon of November 28 (our regular scheduled BOH meeting day). You may wish to hold some additional time in your calendar to participate in the afternoon activities prior to the BOH meeting.

PROGRAM HIGHLIGHTS

Topic: School Health

From: Roylene Bowden, Manager, School Health
Laurie Zeppa, Director, Prevention and Promotion

Public Health Goal:
To achieve optimal health of school-aged children and youth through partnership and collaboration with school boards and schools.

- **Collect and analyze relevant data** to monitor trends over time, emerging trends, priorities, and health inequities related to the health of school-aged children and youth and report and disseminate the data.
- Develop and implement a program of **public health interventions using a comprehensive health promotion** approach to improve the health of school-aged children and youth.
- Offer **support to school boards and schools** to assist with the implementation of health-related curricula and health needs in schools.
- Conduct **surveillance, oral screening**, and report data and information.
- Provide the **Healthy Smiles Ontario (HSO)** Program.
- **Enforce the Immunization of School Pupils Act** and assess the immunization status of children.
- Promote and provide provincially funded **immunization programs** to eligible students through school-based clinics.

Key Messages
- Health and education are interdependent; healthy students are better learners, better educated individuals are healthier.
- Working in partnership with school boards using a comprehensive health promotion approach supports healthy school-aged children.
- Algoma students in grade 7/of grade 7 age are vaccinated for hepatitis B (72.8%), human papillomavirus (60.2%), and meningococcal disease (85.5%).
- 100% of Algoma elementary schools receive oral health screening.

Introduction
Improving and protecting the health and well-being of school-aged children and youth is a priority for Ontario's public health sector. Education is a key determinant of health; healthier students are better prepared to learn, and education contributes to overall health.[1] Schools are key settings to reach children and families, and to integrate health promotion programs and services.[1]

Algoma Public Health (APH) works in consultation and collaboration with school boards, principals, teachers, parent groups and students to support development of healthy environments, curriculum, resources, and healthy policies. [2]

APH's School Heath team is multidisciplinary; comprised of public health nurses, registered dental hygienists and educators, registered practical nurses, a registered dietician, a youth engagement coordinator, and support staff. Work of the School Health team is guided by the *Ontario Public Health Standards (OPHS)*, *School Health Guideline, 2018, Oral Health Protocol, 2018*, and *Immunization for Children in Schools and Licensed Childcare Settings Protocol, 2018*.

APH aligns to 4 school boards across the district:

- Algoma District School Board
- Huron Superior Catholic District School Board
- Conseil Scolaire Catholique du Nouvel-Ontario
- Conseil Scolaire Public du Grand Nord de l'Ontario

Population Health Snapshot

APH collects, analyzes, and reports on school health data. The following are broad summaries of vaccine and oral health coverage in schools, as well as data on healthy eating; healthy weights and body image.[3] For additional details please refer to the ***Community Health Profile*.**

- Algoma 7-year olds are up to date with their immunizations. Coverage ranges from 72.6% (Varicella) to 98.3% (Rubella), with coverage for all immunizations being above provincial averages.
- Algoma 12-year olds are doing well on vaccines for meningococcal (84.8%), and hepatitis B (73.4%), with room for improvement for the human papillomavirus (HPV), at 61.5% coverage for 13-year olds.
- Immunization coverage for Algoma 17-year olds ranges from 82.7% (Pertussis) to 99.2% (Rubella), with coverage for all immunizations being above provincial averages.
- 65% of Algoma primary school students do not have cavities, fillings, or missing teeth during dental screening.
- Nearly 80% of Algoma youth aged 12-17 years state they do not eat fruits and vegetables at least five times a day or more.
- About 1 in 4 (22.1%) youth aged 12-17 years in Algoma are overweight or obese.
- Children in Algoma aged 10-24 years struggle with body image, specifically eating disorders, at a rate that is higher than the North East Local Health Integration Network (NE LHIN) and Ontario.
    - Children learn the foundations of mental wellness early in life; schools are an optimal setting for promoting skills that help youth achieve and sustain positive mental health throughout their life course.[2]

Intervention

The School Health team uses a Comprehensive School Health (CSH) approach to address public health issues in schools. CSH is a coordinated, integrated approach that engages and empowers students, school staff, parents, and the broader school community to address and influence healthy school

policies,[1] as well as multiple health-related topics, some of which include: concussion and injury prevention, mental health promotion, physical activity and sedentary behaviour, substance use and harm reduction, violence and bullying, and on/off road safety.[2]

APH will be promoting the inclusion of the following 5 domains to help schools, school boards, parents, and community partners work together to develop a comprehensive approach to healthy schools, which includes program design, implementation, and evaluation, as well as promoting healthy public policies.[4]

1. Curriculum, teaching, learning
2. School, classroom leadership
3. Student engagement
4. Social, physical environment
5. Home, school, community partnership

The School Health team provides oral/dental screening in 100% of elementary schools within the District of Algoma and will refer eligible students to the Healthy Smiles Ontario (HSO) provincially-funded program.
Additionally, APH provides school-based immunizations to grade 7 students to prevent against diseases including hepatitis B, human papillomavirus, and meningococcal disease.

Next Steps

The modernization of the OPHS provided impetus to move all APH school-based programs into one program implementation plan. This provides an opportunity for the staff to develop a common understanding of the role of public health in the school setting, plan collectively, and monitor outcomes. The *School Health Guideline, 2018* outlines evidence-based practices and strategies that promote effective and sustainable collaborations and partnerships.

The 2018-19 school year will focus on working with schools to assess the needs of the school-aged population and providing public health support aligned to the Ontario Ministry of Education's *Foundations for a Healthy School*, while maintaining the mandated clinical school-based programs. In keeping with the overarching goal of public health, the School Health team has an upstream, "early" opportunity to improve the health and well-being of the population and reduce inequities.

Health + Education = Opportunity

References

1. Joint Consortium for School Health. (2018). Comprehensive school health. Summerside, PE: Joint Consortium for School Health. Retrieved from http://www.jcsh-cces.ca/index.php/about/comprehensive-school-health
2. Ontario Ministry of Health and Long-Term Care. (2018). School Health Guideline, 2018. Retrieved from http://www.health.gov.on.ca/en/pro/programs/publichealth/oph_standards/docs/protocols_guidelines/School_Health_Guideline_2018.pdf
3. Algoma Public Health. Community Health Profile. (2018). Sault Ste. Marie (ON): Algoma Public Health; 2018. Internal document.
4. Ontario Ministry of Education. (2016). Healthy Schools: Foundations for a Healthy School. Retrieved from http://www.edu.gov.on.ca/eng/healthyschools/foundations.html

Topic: Community Health Profile/FASST

Most of you would have received the advance release of our **2018 Community Health Profile** (CHP). The public launches took place across the district during the week of September 17 and I hope that some of you were able to attend the events. Attendance varied across the district with an exceptionally good turnout of both public and media for the SSM event.
Our internal programs and community partners have use of this data to assist them in meeting the needs of our residents.
I want to take this opportunity to commend the excellent work done by our newly developed Foundations and Strategic Support Team (FASST) who have worked on this project for many months under the direction of Dr Jennifer Loo. This profile was essential as a first step to begin the process of reviewing and updating our strategic plan. That work shall begin in 2019.

APH PARTNERSHIPS

The funding cycle for the Healthy Kids Community Challenge has come to an end. Although there was some opportunity to apply for extended funding this was limited to only 4 sites in the province and our local partners did not feel they would meet the criteria. Our Community Wellness team will continue to work with communities to sustain this momentum.

In collaboration with the IPAC Regional Support Team – North, APH is hosting an education day focusing on infection prevention and control (IPAC) on October 2, 2018. This free event is for infection control professionals/delegates and managers with IPAC program responsibilities across all health care sectors.

Our partnership with the Ontario Aboriginal HIV/AIDS Strategy (OAHAS) has been formalized. They will be renting space from us for the next year and will have 2 employees doing outreach in the community.

Respectfully submitted,

Dr. Marlene Spruyt

HEALTH INDICATORS

		2018 Q1 JAN - MAR	2018 Q2 APRIL TO JUNE					2018 YEAR TO DATE					2017 YEAR END
HBHC POSTPARTUM		**Q1**	**WW**	**SSM**	**BR**	**EL**	**Q2**	**WW**	**SSM**	**BR**	**EL**	**YTD**	**2017 YE**
	Phone Calls	**127**	3	96	16	3	**118**	6	200	24	14	**244**	**621**
	Home Visits	**49**	1	49	4	0	**54**	2	93	6	0	**101**	**244**

COMMUNITY MENTAL HEALTH	**Q1**	**Q2**	**YTD**	**2017 YE**
CMH New Clients: Individuals receiving 1st service	**61**	**51**	**112**	**209**
CMH non registered: Client Interactions	**313**	**322**	**635**	**1182**

CADAP LHIN FUNDED PROGRAMS	**Q1**	**Q2**	**YTD**	**2017 YE**
New Client admissions - Clinics / programs	**155**	**77**	**232**	
Direct Client interactions / group or individual including anonymous clients (AS / SRP groups included)	**355**	**265**	**620**	
Back on Track Group - 1 and 2 day course participants / group participants - every 90 days	**14**	**17**	**31**	

SUBSTANCE MISUSE		**Q1**	**WW**	**SSM**	**BR**	**EL**	**Q2**	**WW**	**SSM**	**BR**	**EL**	**YTD**	**2017 YE**
Addictions - Overdose Prevention	**Naloxone trainings completed - with at risk individuals**	**131**					**208**					**339**	**200**
Needle Exchange	**Needles distributed**	**86,066**		77,054	23	2,030	**79,107**		159,099	23	6,051	**165,173**	**293,382**
	Needles returned - NEP (estimates)	**19,625**		13,928	0	1,319	**15,247**		32,553	0	2,319	**34,872**	**70,649**
	Needles returned - Drop Bins SSM (estimates)	**59,872**		63,851			**63,851**		123,723			**123,723**	**151,440**

HEALTH PROTECTION		**Q1**	**WW**	**SSM**	**BR**	**EL**	**Q2**	**WW**	**SSM**	**BR**	**EL**	**YTD**	**2017 YE**
Safe Water	**Private Wells - Adverse DW**	**10**	4	32	8	3	**47**	4	38	12	3	**57**	**232**
	Regulated Premise - ADW(O.reg.319)	**0**	3	1	2	0	**6**	3	1	2	0	**6**	**25**
	Boil Water Advisory (BWA) issued	**5**	3	2	3	0	**8**	3	4	5	1	**13**	**11**
	Drinking Water Advisory (DWA) issued	**1**	1	0	1	0	**2**	1	1	1	0	**3**	**3**
	Beach Closures	**0**	0	0	0	0	**0**	0	0	0	0	**0**	**8**
Rabies	**Rabies risk investigations initiated**	**35**	1	44	4	2	**51**	1	72	7	6	**86**	**217**
Food Safety	**Special Event Permits issued**	**52**	3	48	24	17	**92**	4	79	41	20	**144**	**268**
	Food Handler Training (# persons)	**134**	9	108	21	21	**159**	19	202	35	37	**293**	**411**
	Farmers Market Approvals	**28**	0	21	19	5	**45**	0	21	19	5	**73**	**108**
Health Hazard	**Complaint / Investigations all types**	**34**	0	44	7	0	**51**	0	75	8	2	**85**	**228**
Land Control - OBC	**Applications / Permits - Class IV**	**6**	2	43	11	1	**57**	2	49	11	1	**63**	**145**

HEALTH PROTECTION		Q1	WW	SSM	BR	EL	Q2	WW	SSM	BR	EL	YTD	2017 YE
Communicable Disease Control	Institutional outbreaks	17	1	5	0	1	7	1	19	1	3	24	26
	Outbreak days in quarter	201	5	53	0	17	67	5	212	17	42	268	424
	Gonorrhea	6	0	5	0	0	5	0	11	0	0	11	40
	Chlamydia	75	1	53	3	3	63	1	53	3	3	138	291
	BBI (Hep B, C, HIV)	26	32	0	0	0	32	32	26	0	0	58	85
	Confirmed influenza cases	135	19	0	0	0	19	19	111	24	0	154	87
	Other reportable diseases	42					10					52	124

CONTRACEPTIVE PURCHASES	Q1	WW	SSM	BR	EL	Q2	WW	SSM	BR	EL	YTD	2017 YE
14-19 years	55		35			35		90			90	394
20-24 years	95		79			79		174			174	631
25-29 years	171		157			157		328			328	764
30 + years	166		172			172		338			338	712
Total	487	0	443	0	0	443	0	930	0	0	930	2501

CALLS TO THE SEXUAL HEALTH LINE	1203					997					2200	2514

TOBACCO CESSATION	Q1		SSM	DISTR.	Q2					YTD	2017 YE
Number of APH cliens assessed or reassessed for tobacco use using Brief Contact Interventions (BCI)	713		509	54	563					1276	2953
Number of clients referred by staff to further intensive smoking cessation supports at APH during BCI (includes district)	123				87					210	548
Number of clients receiving clinic or in-home intensive tobacco cessation services from APH staff	80		48	16	64					143	264

Shaded - Indicates data not available

Algoma PUBLIC HEALTH
Santé publique Algoma

Board of Health

DATE: September 26, 2018	**RESOLUTION NO.: 2018 -**
MOVED:	**SECONDED:**
SUBJECT: Title: Protection of Algoma youth from e-cigarette industry marketing through the retention of *Smoke-Free Ontario Act, 2017* provisions that ban the display and promotion of vapour products (electronic or e-cigarettes)	

Resolution:

WHEREAS	the health and financial burden of disease caused by smoking in Ontario remains unacceptably high; and
WHEREAS	Algoma's smoking rates are double that of Ontario; and
WHEREAS	Algoma youth are less likely to remain abstinent from smoking; and
WHEREAS	17.4% of northern Ontario high school students used e-cigarettes in the past year despite the fact that it is illegal to sell or supply e-cigarettes to anyone under 19 years of age; and
WHEREAS	when adolescents use e-cigarettes, they are at risk of multiple health harms, including nicotine addiction, impaired brain development, and a higher risk of ever smoking tobacco cigarettes; and
WHEREAS	retailers with interior advertising and promotion of e-cigarettes are more likely to sell these products to youth; and
WHEREAS	when adolescents use e-cigarettes, they are at risk of multiple health harms, including nicotine addiction, impaired brain development, and a higher risk of ever smoking tobacco cigarettes; and
WHEREAS	retailers with interior advertising and promotion of e-cigarettes are more likely to sell these products to youth; and
WHEREAS	Canada's e-cigarette market may see a similar transformation as in the United States, where newer e-cigarette products containing higher levels of nicotine have achieved widespread popularity and market share among youth and young adults following intense, targeted marketing and promotion; and
WHEREAS	as currently written, the *Smoke-Free Ontario Act, 2017* includes provisions that ban the display and promotion of vapour products; and
WHEREAS	the provincial government has paused the *Smoke-Free Ontario Act, 2017* prior to its coming into force on July 1, 2018, in order to review provisions around vaping;

CARRIED: Chair's Signature _____

☐ **Ian Frazier - Chair**	☐ **Sergio Saccucci - 1st Vice Chair**	☐ **Lee Mason - 2nd Vice Chair**
☐ **Patricia Avery**	☐ **Lucas Castellani**	☐ **Deborah Graystone**
☐ **Adrienne Kappes**	☐ **Sue Jensen**	☐ **Ed Pearce**
☐ **Heather O'Brien**	☐ **Karen Raybould**	☐ **Dennis Thompson**

NOW THEREFORE BE IT RESOLVED that the Board of Health for Algoma Public Health write to the Honourable Christine Elliott, Ontario Minister of Health and Long-Term Care, and to local Members of Provincial Parliament, Mr. Ross Romano and Mr. Michael Mantha, to recommend that Sections 4(1) and 4(2) of the *Smoke-Free Ontario Act* are retained as currently written, such that they (a) prohibit the display of vapour products in a manner that would permit a customer to view or handle the product before purchasing it; and (b) prohibit the promotion of vapour products in any place they are sold or in any manner if the promotion is visible from outside a place they are sold or offered for sale.

AND FURTHER THAT copies be sent to the Chief Medical Officer of Health of Ontario, Dr. David Williams, to the Association of Local Public Health Agencies (alPHa), and to the Council of Medical Officers of Health (COMOH).

CARRIED: Chair's Signature _____

☐ **Ian Frazier - Chair**	☐ **Sergio Saccucci - 1st Vice Chair**	☐ **Lee Mason - 2nd Vice Chair**
☐ **Patricia Avery**	☐ **Lucas Castellani**	☐ **Deborah Graystone**
☐ **Adrienne Kappes**	☐ **Sue Jensen**	☐ **Ed Pearce**
☐ **Heather O'Brien**	☐ **Karen Raybould**	☐ **Dennis Thompson**

Algoma Public Health
(Unaudited) Financial Statements July 31, 2018

Algoma Public Health
Statement of Operations
July 2018
(Unaudited)

	Actual YTD 2018	Budget YTD 2018	Variance Act. to Bgt. 2018	Annual Budget 2018	Variance % Act. to Bgt. 2018	YTD Actual/ YTD Budget 2018
Public Health Programs						
Revenue						
Municipal Levy - Public Health	$ 2,626,635	$ 2,626,634	$ 1	$ 3,502,179	0%	100%
Provincial Grants - Cost Shared Funding	4,388,536	4,388,537	(1)	7,523,200	0%	100%
Provincial Grants - Public Health 100% Prov. Funded	1,747,792	1,748,224	(432)	2,996,950	0%	100%
Fees, other grants and recovery of expenditures	328,003	399,062	(71,059)	699,214	-18%	82%
Total Public Health Revenue	$ 9,090,966	$ 9,162,458	$ (71,491)	$ 14,721,543	-1%	99%
Expenditures						
Public Health Cost Shared	$ 6,449,081	$ 6,818,467	$ 369,386	$ 11,724,592	-5%	95%
Public Health 100% Prov. Funded Programs	1,553,469	1,758,495	205,026	2,996,951	-12%	88%
Total Public Health Programs Expenditures	$ 8,002,550	$ 8,576,962	$ 574,412	$ 14,721,543	-7%	93%
Excess of Rev. over Exp. Cost Shared Funding	$ 894,093	$ 595,767	$ 298,326	$ 2		
Excess of Rev. over Exp. 100% Prov. Funded	194,323	(10,271)	204,594	(2)		
Total Rev. over Exp. Public Health	$ 1,088,416	$ 585,496	$ 502,920	$ 0		
Healthy Babies Healthy Children						
Provincial Grants and Recoveries	$ 625,986	625,981	(5)	1,070,986	0%	100%
Expenditures	592,822	627,066	(34,244)	1,070,986	-5%	95%
Excess of Rev. over Exp.	33,164	(1,084)	34,248	(0)		
Public Health Programs - Fiscal 18/19						
Provincial Grants and Recoveries	$ 75,904	75,904	-	227,700		
Expenditures	103,797	97,000	6,797	227,700		
Excess of Rev. over Fiscal Funded	(27,893)	(21,096)	(6,797)	-		
Community Health Programs						
Calendar Programs						
Revenue						
Provincial Grants - Community Health	$ -	$ -	$ -	$ -		
Municipal, Federal, and Other Funding	194,250	193,958	292	332,500	0%	100%
Total Community Health Revenue	$ 194,250	$ 193,958	$ 292	$ 332,500	0%	100%
Expenditures						
Child Benefits Ontario Works	12,141	14,292	2,151	24,500	-15%	85%
Algoma CADAP programs	158,583	179,667	21,084	308,000	-12%	88%
One-Time Funding programs	0	0	-	-	#DIV/0!	#DIV/0!
Total Calendar Community Health Programs	$ 170,724	$ 193,958	$ 23,234	$ 332,500	-12%	88%
Total Rev. over Exp. Calendar Community Health	$ 23,526	$ (0)	$ 23,526	$ 0		
Fiscal Programs						
Revenue						
Provincial Grants - Community Health	$ 1,848,829	$ 1,871,891	$ (23,061)	$ 5,646,442	-1%	99%
Municipal, Federal, and Other Funding	259,671	311,621	(51,950)	724,253	-17%	83%
Other Bill for Service Programs	13,960		13,960			
Total Community Health Revenue	$ 2,122,460	$ 2,183,512	$ (61,051)	$ 6,370,695	-3%	97%
Expenditures						
Brighter Futures for Children	24,474	38,149	13,675	114,447	-36%	64%
Infant Development	202,006	213,928	11,922	643,783	-6%	94%
Preschool Speech and Languages	216,169	204,418	(11,751)	614,256	6%	106%
Nurse Practitioner	46,881	47,817	937	145,452	-2%	98%
Genetics Counseling	145,760	122,602	(23,158)	367,806	19%	119%
Community Mental Health	1,153,957	1,183,140	29,183	3,548,298	-2%	98%
Community Alcohol and Drug Assessment	208,236	241,384	33,148	724,152	-14%	86%
Healthy Kids Community Challenge	66,681	75,000	8,319	112,500	-11%	89%
Stay on Your Feet	28,912	33,333	4,421	100,000	-13%	87%
Bill for Service Programs	11,192	-	(11,192)	-		
Misc Fiscal	-	-	-	-		
Total Fiscal Community Health Programs	$ 2,104,268	$ 2,159,772	$ 55,504	$ 6,370,694	-3%	97%
Total Rev. over Exp. Fiscal Community Health	$ 18,192	$ 23,740	$ (5,547)	$ 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 Seven Months Ending July 31, 2018
(Unaudited)

	Actual YTD 2018	Budget YTD 2018	Variance Bgt. to Act. 2018	Annual Budget 2018	Variance % Act. to Bgt. 2018	YTD Actual/ YTD Budget 2018	Comparison Prior Year: YTD Actual 2017	YTD BGT 2017	Variance 2017
Levies Sault Ste Marie	1,819,323	1,819,323	0	2,425,762	0%	75%	1,817,229	1,817,229	0
Levies Vector Bourne Disease and Safe Water	44,574	44,574	0	59,433	0%	75%	44,575	44,575	(0)
Levies District	762,738	762,738	0	1,016,984	0%	75%	753,722	751,786	1,936
Total Levies	**2,626,635**	**2,626,635**	**0**	**3,502,179**	**0%**	**75%**	**2,615,526**	**2,613,590**	**1,936**
MOH Public Health Funding	4,284,529	4,284,529	0	7,344,900	0%	58%	4,159,692	4,159,692	0
MOH Funding Vector Borne Disease	63,407	63,408	(1)	108,700	0%	58%	63,407	63,408	(1)
MOH Funding Safe Water	40,600	40,600	0	69,600	0%	58%	40,600	40,600	0
Total Public Health Cost Shared Funding	**4,388,536**	**4,388,537**	**(1)**	**7,523,200**	**0%**	**58%**	**4,263,699**	**4,263,700**	**(1)**
MOH Funding Needle Exchange	37,743	37,743	0	64,700	0%	58%	29,579	29,575	4
MOH Funding Haines Food Safety	14,350	14,350	0	24,600	0%	58%	14,350	14,350	0
MOH Funding Healthy Smiles	449,108	449,109	(1)	769,900	0%	58%	449,108	449,108	(0)
MOH Funding - Social Determinants of Health	105,293	105,293	0	180,500	0%	58%	105,293	105,292	1
MOH Funding - MOH / AMOH Top Up	73,332	73,763	(431)	126,450	-1%	58%	0	0	0
MOH Funding Chief Nursing Officer	70,879	70,879	0	121,500	0%	58%	70,879	70,875	4
MOH Enhanced Funding Safe Water	9,043	9,043	0	15,500	0%	58%	9,043	9,043	0
MOH Funding Unorganized	309,400	309,400	0	530,400	0%	58%	300,479	300,475	4
MOH Funding Infection Control	182,236	182,236	0	312,400	0%	58%	182,236	182,233	3
MOH Funding Diabetes	87,500	87,500	0	150,000	0%	58%	87,500	87,500	0
MOH Funding Northern Ontario Fruits & Veg.	68,472	68,472	0	117,400	0%	58%	68,484	68,484	0
Funding Ontario Tobacco Strategy	252,936	252,936	0	433,600	0%	58%	252,937	252,931	7
MOH Funding Harm Reduction	87,500	87,500	0	150,000	0%	58%	0	0	0
One Time Funding	0	0	0	0		0%	0	0	0
Total Public Health 100% Prov. Funded	**1,747,792**	**1,748,224**	**(432)**	**2,996,950**	**0%**	**58%**	**1,569,888**	**1,569,866**	**22**
Recoveries from Programs	36,440	23,283	13,157	27,450	57%	133%	5,868	5,869	(1)
Program Fees	125,934	138,696	(12,762)	237,764	-9%	53%	138,953	145,684	(6,731)
Land Control Fees	83,160	93,333	(10,173)	160,000	-11%	52%	72,610	93,333	(20,723)
Program Fees Immunization	60,437	107,916	(47,479)	185,000	-44%	33%	96,113	104,708	(8,595)
HPV Vaccine Program	298	14,000	(13,703)	20,000	0%	1%	8,458	3,300	5,158
Influenza Program	0	0	0	25,000	0%	0%	5,490	1,100	4,390
Meningococcal C Program	77	2,000	(1,924)	10,000	0%	1%	1,386	1,200	186
Interest Revenue	19,494	8,167	11,327	14,000	139%	139%	7,293	6,225	1,068
Other Revenues	2,164	11,667	(9,503)	20,000	0%	11%	4,777	0	4,777
Total Fees, Other Grants and Recoveries	**328,003**	**399,062**	**(71,059)**	**699,214**	**-18%**	**47%**	**340,947**	**361,419**	**(20,473)**
Total Public Health Revenue Annual	**$ 9,090,966**	**$ 9,162,458**	**$ (71,492)**	**$ 14,721,543**	**-1%**	**62%**	**$8,790,060**	**$8,808,575**	**$ (18,515)**
Public Health Fiscal									
Panorama	0	0	0	0	#DIV/0!	0%	0	0	0
Smoke Free Ontario NRT	0	0	0	0	#DIV/0!	0%	0	0	0
Practicum	3,336	3,336	0	10,000	0%	33%	0	0	0
Other One Time Fiscal Funding	72,568	72,568	0	217,700	0%	33%	0	0	0
Total Provincial Grants Fiscal	**$ 75,904**	**$ 75,904**	**$ -**	**$ 227,700**	**0%**	**33%**	**$ -**	**$ -**	**$ -**

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 Seven Months Ending July 31, 2018

(Unaudited)

	Actual YTD 2018	Budget YTD 2018	Variance Act. to Bgt. 2018	Annual Budget 2018	Variance % Act. to Bgt. 2018	YTD Actual/ YTD Budget 2018	*Comparison Prior Year:* *YTD Actual 2017*	*YTD BGT 2017*	*Variance 2017*
Salaries & Wages	$ 4,827,877	$ 5,200,836	$ 372,959	$ 8,953,731	-7%	54%	$ 4,394,577	$ 4,926,447	$ 531,871
Benefits	1,237,894	1,232,554	(5,340)	2,126,952	0%	58%	1,164,678	1,161,208	(3,471)
Travel - Mileage	37,555	70,916	33,361	120,775	-47%	31%	47,613	74,586	26,972
Travel - Other	80,708	43,750	(36,958)	75,000	84%	108%	49,322	45,466	(3,856)
Program	360,934	399,425	38,491	669,715	-10%	54%	334,026	422,591	88,564
Office	53,089	68,197	15,108	116,909	-22%	45%	71,098	78,687	7,590
Computer Services	382,315	447,764	65,449	782,881	-15%	49%	318,540	408,052	89,512
Telecommunications	149,349	176,927	27,578	303,304	-16%	49%	134,594	143,963	9,370
Program Promotion	76,884	98,936	22,052	167,223	-22%	46%	45,387	99,632	54,244
Facilities Expenses	464,279	463,750	(529)	820,000	0%	57%	458,578	466,871	8,292
Fees & Insurance	121,549	165,888	44,339	228,450	-27%	53%	234,635	180,806	(53,829)
Debt Management	268,858	268,858	-	460,900	0%	58%	268,858	268,858	1
Recoveries	(58,740)	(60,840)	(2,100)	(104,297)	-3%	56%	(76,414)	(39,905)	36,510
	$ 8,002,550	$ 8,576,961	$ 574,411	$ 14,721,543	-7%	54%	$ 7,445,493	$ 8,237,263	$ 791,770

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 – July 2018

Reporting Period

The July 2018 financial reports include seven 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 four month results from operations year ended March 31st, 2019.

Statement of Operations (see page 1)

Summary – Public Health and Non Public Health Programs

As of July 31st, 2018, Public Health programs are reporting a $503k positive variance.

Total Public Health Revenues are indicating a negative $71k variance. This is a result timing of receipts of Fees, Other Grants & Recoveries. Land Control Fees and Program Fees Immunization 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 $574k related to Total Public Health expenses being less than budgeted. Salary and Wages expense is driving this positive variance. The variance is a result of the time lag in filling vacant positions within the agency.

APH's Public Health Programs Budget was adjusted in May to reflect the up to $214,000 in additional base funding and up to $227,000 in one-time funding from the Ministry of Health and Long-Term Care. As total expenses have increased relative to 2017, this increase in funding is contributing to the size of the positive variance associated with Public Health Programs.

Community Health Calendar programs are operating within budget.

APH's Community Health Fiscal Programs are four months into the fiscal year and as such actual expenses are relatively aligned with budget. Genetics Counseling is showing a negative $23k variance. APH management continues to use deferred revenue associated with the program to ensure actual program costs are fairly reflected. The general administration support Public Health provides to the Genetics Program more accurately reflects actual usage.

Community Alcohol and Drug Assessment Program is showing a $33k positive variance. This is a result of the time to fill a vacant position.

Public Health Revenue (see page 2)

Public Health funding revenues are showing a negative $71k variance.

The municipal levies are within budget.

Cost Shared and 100% Provincially Funded revenues are within budget.

Notes Continued...

Fees, Other Grants & Recoveries are showing a negative variance of $71k. Land Control Fees are showing a negative $10k variance. As forecasted, the size of this negative variance is reducing month-over-month as the bulk of the fees are collected during the summer months. In addition, Program Fees Immunization is showing a $47k negative variance. Management will adjust the Program Fees Immunization budget for 2019 to more accurately reflect actual fees received.

Public Health Expenses (see page 3)

Salary & Wages
The $373k positive variance associated with Salary and Wages expense is a result of the time lag in filling vacant positions within the agency. Also contributing to the positive variance associated with Salary and Wages expense is the increase in base funding APH received in 2018 which was not budgeted.

Travel - Mileage
Travel – mileage expense is indicating a positive $33k variance. Staff travel within the district typically increases from spring to fall. As the year progresses this positive variance is expected to reduce.

Travel - Other
Travel – Other expense is indicating a negative $37k variance. Relative to 2017 Year-to-Date actual expenses, Travel-Other has increased. Part of the reason for increased Travel-Other expense is the fact that APH hosted the "Bridges Out of Poverty' workshop in Sault Ste. Marie in which all staff were required to attend. This resulted in increased travel expenses as staff from the district offices attended the workshop. Aside from this event, Travel-Other expense is higher than anticipated. Management will continue to monitor this line item as the year progresses.

Program
Program expense is indicating a positive $38k variance. This is a result of timing of Program Material and Supply expenses not yet incurred.

Office
Office expense is showing a positive $15k variance. This is a result of timing of expenses not yet incurred.

Computer Service
Computer Services expense is showing a positive variance of $65k. The noted variance is a result of timing as general IT equipment purchases budgeted have yet to be made. Furthermore, the annual Microsoft License renewal has yet to be purchased. Once these purchases are made, the noted positive variance will decrease.

Notes Continued...

Telecommunications
Telecommunications expense is less than budget. APH's contract for warranty of telephone hardware expires in 2018. At the time the 2018 budget was developed there was uncertainty as to whether further warranty was needed given the age of the assets. Management built the expense into the budget however these costs have not been realized as of July. Management is currently reviewing options with MicroAge as to the best solution related to the warranty of the hardware.

Program Promotion
Program Promotion expense is indicating a positive $22k variance. This is a result of timing of expenses not yet incurred.

Fees & Insurance

Fees & Insurance expense is indicating a positive $44k variance. APH did receive one-time funding related to legal cost incurred associated with a Public Health policy matter. This one-time funding and associated costs are now reflected in one-time Fiscal Funding as opposed to Public Health cost-shared programs.

Financial Position - Balance Sheet (see page 7)

APH's liquidity position continues to be stable and the bank has been reconciled as of July 31st, 2018. Cash includes $525k in short-term investments.

Long-term debt of $5.29 million is held by TD Bank @ 1.95% for a 60 month term (amortization period of 180 months) and matures on September 1, 2021. $309k of the loan relates to the financing of the Elliot Lake office renovations with the balance related to the financing of the 294 Willow Avenue facility located in Sault Ste. Marie.

There are no material Accounts Receivable collection concerns.

With respect to Receivables from Municipalities, APH issued a letter to an obligated municipality regarding late levy payments. Payment has since been received.

Algoma Public Health

Statement of Financial Position

(Unaudited)

Date: As of July 2018	**July 2018**	December 2017
Assets		
Current		
Cash & Investments	**$ 3,326,588**	$ 2,931,699
Accounts Receivable	**236,457**	489,631
Receivable from Municipalities	**349,742**	30,769
Receivable from Province of Ontario		
Subtotal Current Assets	**3,912,787**	3,452,099
Financial Liabilities:		
Accounts Payable & Accrued Liabilities	**1,231,862**	1,436,721
Payable to Gov't of Ont/Municipalities	**144,050**	543,083
Deferred Revenue	**441,429**	512,747
Employee Future Benefit Obligations	**2,704,275**	2,704,275
Term Loan	**5,554,992**	5,554,992
Subtotal Current Liabilities	**10,076,607**	10,751,817
Net Debt	**-6,163,820**	-7,299,718
Non-Financial Assets:		
Building	**22,732,421**	22,732,421
Furniture & Fixtures	**1,911,323**	1,911,323
Leasehold Improvements	**1,572,807**	1,572,807
IT	**3,244,030**	3,244,030
Automobile	**40,113**	40,113
Accumulated Depreciation	**-8,586,824**	-8,586,824
Subtotal Non-Financial Assets	**20,913,869**	20,913,869
Accumulated Surplus	**14,750,049**	13,614,152

Financial Information of

ALGOMA PUBLIC HEALTH

Infant Development Program

(unaudited)

Year ended March 31, 2018

KPMG LLP
111 Elgin Street, Suite 200
Sault Ste. Marie ON P6A 6L6
Canada
Telephone (705) 949-5811
Fax (705) 949-0911

REVIEW ENGAGEMENT REPORT

To the Members of the Board of the Algoma Public Health

At the request of Algoma Public Health, we have reviewed the statement of revenue and expenditures of the Infant Development Program of the Algoma Public Health for the year ended March 31, 2018. Our review was made in accordance with Canadian generally accepted standards for review engagements and accordingly consisted of primarily inquiry, analytical procedures and discussion related to information supplied to us by the management. Our review was performed to determine whether the information presented is consistent with management's financial records of the Algoma Public Health and Ministry of Community and Social Services year-end settlement form for the program.

A review does not constitute an audit and, consequently, we do not express an audit opinion on the statement of revenue and expenditures.

Based on our review, nothing has come to our attention that causes us to believe that the statement of revenue and expenditures is not, in all material respects, in accordance with the basis of presentation as required by Ministry of Children and Youth Services.

KPMG LLP

Chartered Professional Accountants, Licensed Public Accountants

Sault Ste. Marie, Canada
July 19, 2018

ALGOMA PUBLIC HEALTH

Infant Development Program

Statement of Revenue and Expenditures
(unaudited)

Year ended March 31, 2018, with comparative information for 2017

	Budget	2018	2017
Revenue:			
Provincial grants	$ 621,935	$ 621,935	$ 621,935
Expenditures:			
Salaries and benefits	521,499	518,361	516,487
Occupancy	50,354	52,193	51,756
Travel and training	29,000	29,058	23,758
Administration	16,000	16,040	16,000
Program materials and supplies	13,182	13,089	15,351
Telephone	5,400	6,412	5,378
Equipment	–	1,356	7,707
Professional development	5,000	2,004	2,831
Professional fees	–	2,000	–
Expenses recovered	(18,500)	(18,578)	(17,333)
	621,935	621,935	621,935
Excess of revenue over expenditures	$ –	$ –	$ –

See accompanying note to financial information.

ALGOMA PUBLIC HEALTH

Infant Development Program

Note to Financial Information
(unaudited)

Year ended March 31, 2018

Basis of accounting:

The statement of revenue and expenditures report has been prepared in accordance with the basis of presentation as required by Ministry of Children and Youth Services. The following principles have been applied:

- Revenue and expenses are reported on the accrual basis of accounting.
- Capital expenditures are recorded as expenses rather than being capitalized.

TRANSFER PAYMENT ANNUAL RECONCILIATION

SECTION I: SUMMARY, CERTIFICATION and VERIFICATION

SERVICE PROVIDER / DELIVERY AGENT: District of Algoma Health Unit
FOR THE YEAR ENDED: Mar. 31, 2018 (e.g. Mar. 31, 2018)
SERVICE CONTRACT/CFSA APPROVAL NUMBER: C25359 - 1

PART A: SUMMARY

LINE	SERVICES					
100	Service (Detail Code) Name	Service (Detail Code) Name	Executive and Allotment Control	Total Eligible Expenditures (pending final Ministry review and approval)	Total Approved Ministry Funding	Summary of Revised Ministry Funding after Financial Flexibility (pending final Ministry review and approval)
101	A476	Infant Development	CYSEX034-AL09	$ 621,935	$ 621,935	$ 621,935
102	0			$ -	$ -	$ -
103	0			$ -	$ -	$ -
104	0			$ -	$ -	$ -
105	0			$ -	$ -	$ -
106	0			$ -	$ -	$ -
107	0			$ -	$ -	$ -
108	0			$ -	$ -	$ -
109	0			$ -	$ -	$ -
110	0			$ -	$ -	$ -
111	0			$ -	$ -	$ -
112	0			$ -	$ -	$ -
113	0			$ -	$ -	$ -
114	0			$ -	$ -	$ -
115	0			$ -	$ -	$ -
116	0			$ -	$ -	$ -
117	0			$ -	$ -	$ -
118	0			$ -	$ -	$ -
119	0			$ -	$ -	$ -
120	0			$ -	$ -	$ -
121	0			$ -	$ -	$ -
122	0			$ -	$ -	$ -
123	0			$ -	$ -	$ -
124	0			$ -	$ -	$ -
125	0			$ -	$ -	$ -
126	0			$ -	$ -	$ -
127	0			$ -	$ -	$ -
128	0			$ -	$ -	$ -
129	0			$ -	$ -	$ -
130	0			$ -	$ -	$ -
131	0			$ -	$ -	$ -
132	0			$ -	$ -	$ -
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141	0			$ -	$ -	$ -
142	0			$ -	$ -	$ -
143	0			$ -	$ -	$ -
144	0			$ -	$ -	$ -
145	0			$ -	$ -	$ -
146	0			$ -	$ -	$ -
147	0			$ -	$ -	$ -
148	0			$ -	$ -	$ -
149	0			$ -	$ -	$ -
TOTAL				$ 621,935	$ 621,935	$ 621,935

PART B: CERTIFICATION BY SERVICE PROVIDER / DELIVERY AGENT AUTHORITY

I hereby certify that, to the best of my knowledge, the financial data in the Transfer Payment Annual Reconciliation to which this certification is attached, is true, correct, agrees with the books and records of the organization and has been prepared in accordance with the Technical Instructions and ministry financial policies provided by the Ministry of Community and Social Services and the Ministry of Children and Youth Services.

Signature of Service Provider / Delivery Agent Authority (LINE 143)

Name of Service Provider/Delivery Agent Authority (LINE 143)

Title of Service Provider/Delivery Agent Authority (LINE 143)

Date (dd/mm/yy) (LINE 150)

PART C: VERIFICATION BY THE BOARD OF DIRECTORS

The above certification, together with the Transfer Payment Annual Reconciliation, was received and approved by:

the Board of Directors _____ day of _____ , _____. **(LINE 160)**

Chairperson of the Board of Directors: _____ **(LINE 170)**
Signature

Name of Chairperson or Designate

Title

Section I

simcoe muskoka
DISTRICT HEALTH UNIT

By email at: Ginette.PetitpasTaylor@parl.gc.ca and Jody.Wilson-Raybould@parl.gc.ca

July 10, 2018

The Honourable Ginette Petitpas Taylor
Minister of Health
House of Commons
Ottawa, Ontario
Canada
K1A 0A6

The Honourable Jody Wilson-Raybould
Minister of Justice and Attorney General of Canada
House of Commons
Ottawa, Ontario
Canada
K1A 0A6

Dear Ministers Petitpas Taylor and Wilson-Raybould,

Re: A Public Health Approach to Drug Policy Reform

On June 20, 2018, the Simcoe Muskoka District Health Unit Board of Health (SMDHU BOH) endorsed the recommendations of the Canadian Public Health Association (CPHA) from their 2017 Position Statement, in regards to decriminalization of illicit psychoactive substances (IPS). These recommendations call for a shift from addressing IPS as a criminal issue to that of a pressing public health issue, through implementing the following recommendations:

a) Decriminalize the possession of small quantities of currently illegal psychoactive substances for personal use and provide summary conviction sentencing alternatives, including the use of absolute and conditional discharges;
b) Decriminalize the sales and trafficking of small quantities of IPS by young offenders using legal provisions similar to those noted above;
c) Develop probationary procedures and provide a range of enforcement alternatives including a broader range of treatment options, for those in contravention of the revised drug law;
d) Develop the available harm reduction and health promotion infrastructure such that all those who wish to seek treatment can have ready access;
e) Provide amnesty for those previously convicted of possession of small quantities of IPS; and

f) Provide expanded evidence-informed harm reduction options that include, for example, improved access to supervised consumption facilities and drug purity testing services.

In light of the opioid crisis facing Simcoe and Muskoka, and Canada as a whole, the SMDHU BOH has endorsed this position based on research and evidence that Canada's historical approach to drug policy based on criminalization has created a three-fold problem. The first is the financial burden on our enforcement, justice and corrections infrastructure, estimated at multi-billions of dollars per year[i].

The second is that criminalization has created and perpetuated stigma that alienates those who choose to use drugs, who are often seeking to escape mental or physical pain. This same stigma disproportionately affects marginalized populations such as those living in poverty, those living with mental health issues, and Indigenous communities[ii]. Research identifies how stigma in fact perpetuates drug use by reducing empathy, and drives persons away from supports such as treatment and counselling[iii].

The third aspect of the problem is that exposure to the criminal justice system is harmful to those who use drugs. This approach exposes the person to a wider criminal element, disassociates them from their family or other supports, and creates immense stress[iv]. Additionally, a criminal record impairs a person's ability to find and maintain employment, housing or education. Further, the nature of arrests, penal penalties and court processes further disrupts Opioid Agonist (Replacement) Therapy, exacerbates the incidence of HIV and Hepatitis and worsens management of these conditions, and creates significantly heightened risk for overdose upon release[v].

In light of extensive evidence that criminalization perpetuates problematic drug-use and compounds its associated harms, we strongly urge you to consider decriminalization of illicit psychoactive substances with a concomitant investment in health services. We call upon your government to reform the necessary policies to more effectively and humanely address drug use and addiction as major societal priorities.

Decriminalization of IPS, in order to be most effective, must be accompanied with commensurate investments in harm reduction, treatment and mental health infrastructure. Where this multi-tiered approach has been implemented in other countries, such as in Portugal, measurably positive outcomes have resulted, including pronounced reductions in overdose deaths and substantial increases in entry to drug treatment[vi]. Funds for these health investments would be made available from reduced costs within justice, enforcement and corrections services that are anticipated to result from this shift from a criminalized system to a public health approach.

Please see attached a copy of the 2017 CPHA Position Statement for your reference.

Sincerely,

ORIGINAL Signed By:

Scott Warnock
Board of Health Chair
Simcoe Muskoka District Health Unit

SW:LS:mk

Encl.

c. Honourable Christine Elliott, Minister of Health and Long-Term Care for Ontario
Honourable Caroline Mulroney, Attorney General of Ontario
Dr. David Williams, CMOH
Ms. Roselle Martino, ADM
Ontario Boards of Health
Association of Local Public Health Agencies
Ontario Public Health Association
Canadian Public Health Association
MPs and MPPs in Simcoe Muskoka
Mayors and Councils in Simcoe Muskoka
North Simcoe Muskoka and Central Local Health Integration Network

[i] Department of Justice Canada (2008) *Cost of Crime in Canada*
[ii] Csete J. et. al (2016) The Lancet Commissions. *Public Health and international drug policy*. The Lancet Vol 387, April2, 2016
[iii] Global Commission on Drug Policy (2017). *The World Drug Perception Problem*. 2017 Report. Executive Summary. P.7
[iv] Canadian Mental Health Association (2018). *Care Not Corrections: Relieving the Opioid Crisis in Canada*. April 2018
[v] Csete J. et. al (2016) The Lancet Commissions. *Public Health and international drug policy*. The Lancet Vol 387, April2, 2016
[vi] Hughes, C. and Stevens, A. (2011). Harm Reduction Digest [44] *A resounding success or a disastrous failure: Re-examining the interpretation of evidence on the Portuguese decriminalization of Illicit Drugs*. Drug And Alcohol Review (January 2012) 31, 101-113

Municipality of Chatham-Kent
Public Health Unit
PO Box 1136, 435 Grand Avenue West, Chatham, ON N7M 5L8
Tel: 519.352.7270 Fax: 519.352.2166
Email ckhealth@chatham-kent.ca

July 23, 2018

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

Delivered via email

Dear Premier Ford,

RE: Pause in Implementation of the Smoke-Free Ontario Act, 2017

At a special meeting of the Chatham-Kent Board of Health on July 16, 2018, the Board received a staff presentation (attached) regarding the pause of the implementation of the *Smoke-Free Ontario Act, 2017* (SFOA, 2017). The Board felt there was significant evidence presented to raise concerns over the provincial government's pause of this important legislation.

While gains have been made in tobacco control, and the rate of smoking is declining, tobacco remains the leading cause of preventable disease and death in Ontario. According to the **Canadian Substance Use Costs and Harms Study** released in June 2018, substance use costs the Canadian economy $38.4 billion, or almost $1,100 for every person in Canada, with tobacco use alone contributing to 31.2% ($12.0 billion) of these costs, second only to alcohol ($14.6 billion or 38.1%).

The healthcare burden associated with tobacco remains high; in 2014, substance use-related healthcare costs amounted to $11.1 billion in Canada, with tobacco use contributing to 53.1% ($5.9 billion) of these costs.

It is understood that the delayed implementation of the SFOA, 2017 is because the government wishes to review the new regulations related to vaping and how e-cigarettes could be used as a cessation tool. Although more research needs to be done to understand the long-term effects of e-cigarette use, a recently published (2018) comprehensive evidence review by the National Academies of Science, Engineering and Medicine concluded the following:

…/2

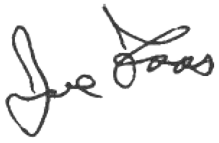
- The effectiveness of e-cigarettes as a cessation aid for smokers is unclear.
- E-cigarette use is associated with subsequent cigarette smoking among youth.
- While chemical levels of second-hand exposure from e-cigarettes are lower than that of combustible tobacco cigarettes, this exposure could have the potential to lead to adverse health effects.

From these findings, it cannot be assumed that e-cigarettes are harmless. The modernized legislation would protect Ontarians from second hand smoke and vapour, and regulate not only the sale, supply, use, display, and promotion of tobacco and vapour products, but also the smoking of medicinal cannabis. These are important policy measures to reduce tobacco use to 5% by 2035 and protect the health of Ontarians, especially vulnerable populations, including youth. It is critical that any policy framework that allows vaping as a cessation tool include safeguards to prevent youth uptake.

The Chatham-Kent Public Health Unit and the Chatham-Kent Board of Health look forward to continuing to work collaboratively with the Ontario government to protect Ontarians from the effects of tobacco, vapour, and cannabis. We urge the government to reconsider implementing the *Smoke-Free Ontario Act, 2017* as intended and without delay so that all Ontarians are able to live, learn, work, and play in the healthiest environment possible.

The public health community looks forward to the opportunity to share their expertise and experience, working together under the leadership of the Ministry of Health and Long-Term Care, to create a healthier, more productive population with enhanced quality of life and reduced health care costs.

Sincerely,



Joe Faas
Chair,
Chatham-Kent Board of Health

Attachment

c: Hon. Christine Elliott, Minister of Health and Long-Term Care
Hon. Monte McNaughton, MPP, Lambton-Kent-Middlesex
Rick Nicholls, MPP, Chatham-Kent – Leamington
Ontario Boards of Health

August 30, 2018

Premier Doug Ford
Legislative Building
Queen's Park
Toronto, ON M7A 1A1

Dear Premier Ford,

Re: Dedicated funding for local public health agencies from cannabis sales

At its May 17, 2018 meeting, under Correspondence item a), the Middlesex-London Board of Health voted to endorse the following correspondence item:

a) Date: 2018 March 28 [received April 11]
Topic: Dedicated funding for local public health agencies from cannabis sales
From: Hastings Prince Edward Public Health
To: Premier Kathleen Wynne
Background:
At its meeting on March 6, 2018, the Hastings Prince Edward Board of Health passed a motion to urge the provincial government to dedicate a portion of cannabis excise tax revenue from the federal government to local public health agencies in Ontario. The rationale for investing additional resources is based on the importance of investment in the prevention pillar of the comprehensive cannabis control strategy being delivered by public health agencies.
Recommendation: Endorse

It was moved by Mr. Hunter, seconded by Mr. Peer, *that the Board of Health endorse item a) Re: Dedicated funding for local Public Health agencies from cannabis sales taxation revenue.*

Cannabis is the most widely used illicit substance in Canada with nearly half of Canadians reporting to have ever used. Compared to their counterparts in other developed countries, Canadian youth are the highest users of cannabis, with use peaking in the young adult age group. Local public health units are uniquely positioned to be able to work collaboratively with our municipal, education and enforcement partners to ensure that the legalization of cannabis does not unduly burden our most vulnerable citizens, including children and youth, individuals with personal or family history of mental health problems and pregnant women.

Sincerely,

Joanne Vanderheyden

Joanne Vanderheyden, Chair
Middlesex-London Board of Health

cc: Honourable Christine Elliott, Minister of Health and Long-Term Care
Maureen Piercy, Chair, Hastings Prince Edward Public Health Board of Health
All Ontario Health Units

HASTINGS PRINCE EDWARD
Public Health

Main Office – Belleville
179 North Park Street, Belleville, ON K8P 4P1
T: 613-966-5500 |1-800-267-2803 | **F:** 613-966-9418
TTY: 711 or 1-800-267-6511
www.hpepublichealth.ca

March 28, 2018

Premier Kathleen Wynne
Legislative Building
Queen's Park
Toronto, ON M7A 1A1

Re: Dedicated funding for local Public Health agencies from cannabis sales taxation revenue

Dear Premier Wynne,

At its meeting on March 06, 2018, the Hastings Prince Edward (HPEPH) Board of Health passed the following motion:

THAT the HPEPH Board of Health urge the provincial government to dedicate a portion of the cannabis excise tax revenue from the federal government to local Public Health agencies in Ontario.

On December 12, 2017, the Federal Government announced that the revenue generated from the taxation of cannabis sales will be split with provinces and territories according to the following principals:

- Provinces and territories will receive 75% of this revenue while the federal government will retain 25%.
- The federal portion of cannabis excise tax revenue will be capped at $100 million annually and any revenue above this limit would be provided to provinces and territories.
- With respect to this revenue, provinces and territories will work with municipalities according to shared responsibilities towards legalization.

Subsequently, on March 09, 2018 the Ontario Government sent a press release titled, **"Ontario Supporting Municipalities to Ensure Safe Transition to Federal Cannabis Legalization"**. In the release it was noted that it would: "Provide public health units with support and resources to help address local needs related to cannabis legalization." While this release made no specific reference to how much, or how resources would be invested within the Public Health system, it is reassuring that the Ontario Government recognizes the importance of investment in the comprehensive cannabis control strategy delivered by local public health agencies. To help meet the Government of Ontario's twin goals of creating a safe and sensible framework to

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1P Manor Ln., L1-024, PO Box 99, Bancroft, ON K0L 1C0
T: 613-332-4555 | **F:** 613-332-5418

Prince Edward County
Suite 1, 35 Bridge St., Picton, ON K0K 2T0
T: 613-476-7471 | **F:** 613-476-2919

Quinte West
499 Dundas St. W., Trenton, ON K8V 6C4
T: 613-394-4831 | **F:** 613-965-6535

manage legalized cannabis, and of having the lowest provincial/territorial smoking rate in Canada, it is essential to invest in the prevention pillar of the comprehensive cannabis control strategy and to provide adequate resources for the implementation and enforcement of the revised smoke-free legislation that now includes cannabis.

Local Public Health agencies are uniquely placed to increase public awareness of the health risks of cannabis use and driving under the influence of cannabis. Local Public Health agencies are also primed to prevent the renormalization of smoking through the legalization of cannabis. This Public Health work is foundational to helping keep our communities healthy and safe – a goal that we share with the Government of Ontario.

Although local Public Health agencies are partially funded by municipalities, we recognize that their ability to share funding from cannabis excise tax revenue with local Public Health agencies may be limited due to other conflicting priorities. With dedicated funding from this revenue, local Public Health agencies will be better resourced to provide the essential public awareness work, education and enforcement that is required with the legalization of cannabis. It is important that prevention be a pillar of cannabis legalization from the outset and dedicated funding to local Public Health agencies is an important component of supporting and strengthening this pillar.

We urge the Ontario Government to dedicate sufficient resources to local Public Health agencies to ensure that both education and enforcement are a priority.

Thank you for your consideration of this request. Please do not hesitate to contact me if you have any questions or concerns.

Sincerely,

Maureen Piercy
Chair
Hastings Prince Edward Public Health Board of Health

Copy
Honourable Charles Sousa, Provincial Minister of Finance
Honourable Dr. Helena Jaczek, Provincial Minister of Health and Long-Term Care
Mr. Todd Smith, MPP, Prince Edward-Hastings
Mr. Lou Rinaldi, MPP, Northumberland-Quinte West
Association of Local Public Health Agencies
Boards of Health in Ontario
Dr. Ian Gemmill, MOH HPEPH

HURON
COUNTY

September 6, 2018

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

Dear Premier Ford,

We are writing to urge you to reconsider your recent decision to cancel the Ontario Basic Income Pilot.

As you know, the aim of the pilot is to investigate the potential for a basic income to improve the income security of vulnerable Ontarians and increase their chances of breaking the cycle of poverty. It is also designed to permit the evaluation of an initiative that is potentially a simpler and more economically effective form of social assistance than current social assistance programs: Ontario Works (OW) and Ontario Disability Support Program (ODSP) – systems that to date have kept people mired in poverty.

This pilot is recognized throughout our province and internationally as a pivotal opportunity to study the impact of basic income on a range of economic, social, and health outcomes in modern day Ontario.

With the extent of the societal impact of poverty, income inequality, and growing precarious employment, basic income is widely recognized as a key policy area to explore to help address these issues. In addition, the pilot was intended to measure outcomes in areas such as food security, mental health, health and healthcare usage, housing stability, education and training and employment and labour market participation. These are all key determinants of health.

In fact, there is consistent and ample evidence that health outcomes improve as income rises. People living with low income are at far greater risk of a range of preventable medical conditions, including cancer, diabetes, heart disease, and mental illness. Improving incomes is an exceptionally effective public health intervention that reduces poverty and its impact, and also contributes to reducing the burden on Ontario's health care system. The pilot has the potential to tell us to what degree increased income provides people with the stability they need to break the cycle of poverty, get back on track and succeed.

The pilot was based on a detailed and well-researched proposal authored by Senator Hugh Segal, which was in turn subject to a broad consultation that received input from over 35,000 Ontarians and support from each of the province's major political parties. Moreover, the pilot has been carefully designed, is limited in time and scope and is not significantly costlier than the payments that OW or ODSP would have transferred to those who are participating.

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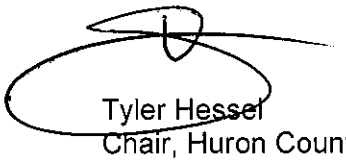
A great deal of time and resources have already been invested in effectively planning and implementing this pilot. We feel that it would be a substantial waste to terminate it so prematurely, without the opportunity to first learn from it. As such, we encourage you to reconsider your decision to cancel this very important initiative.

Sincerely,



Tyler Hessel
Chair, Huron County Board of Health

cc: Christine Elliott, Minister of Health and Long-Term Care
Lisa Thompson, Member of Provincial Parliament, Huron-Bruce
All Ontario Boards of Health
Loretta Ryan, Association of Local Public Health Agencies
Dr. David Williams, Chief Medical Officer of Health

HALIBURTON, KAWARTHA, PINE RIDGE DISTRICT HEALTH UNIT

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Hon. Lisa MacLeod
Minister of Children, Community and Social Services
14th Floor, 56 Wellesley St. W
Toronto, ON M7A 1E9
Sent via email to: lisa.macleod@pc.ola.org

August 17, 2018

Dear Minister MacLeod,

Re: Cancellation of the Basic Income Pilot Project

On behalf of the Board of the Health for the Haliburton, Kawartha, Pine Ridge District Health Unit, I am writing to urge you to reconsider the decision to cancel the Ontario Basic Income Pilot Project. This very important initiative would have provided the Province with valuable information regarding the impact of basic income on health, social, and economic well-being.

In a position statement released in June of 2016 (attached), the Haliburton, Kawartha, Pine Ridge District Health Unit (Health Unit) cited research and evidence in its support of Basic Income Guarantee as an essential component of a strategy to effectively eliminate poverty, ensure all Canadians have a sufficient income to meet their basic needs, and live with dignity and to eliminate health inequities.

The Health Unit believes that eliminating poverty is an urgent public health and health equity issue, as well as a human rights and social justice issue. Research clearly indicates that people living in poverty are more likely to experience poorer health, have chronic health conditions, more injuries, and have a disability. Those living with low-income have a greater use of a variety of health care and social services and are more likely to live shorter lives.

The recent cancellation of the 3-year Basic Income Pilot Project will impact more than the 4,000 Ontarians who are currently committed to the Project. The research to be gleaned from this Project had the potential to impact the 1.7 million Ontarians who are living in poverty. In addition to the cancellation of the research project, the proposed cuts to the previously planned increase in social services rates (from 3% to 1.5%) and the 50% reduction in the amount of allowable earned income for those on social assistance are extremely concerning. These cuts directly contradict the significant volume of available evidence indicating that it is costlier, and socially unjust to keep people in the province living with inadequate income to meet their basic needs. As the Association of Local Public Health Agencies (alPHa), expressed in its August 2, 2018 letter to you, the Basic Income Pilot Project was based on a well thought out, researched proposal, which had received valuable input from over 35,000 Ontarians. To so abruptly cancel this Project undermines the investments made both financially and personally by many Ontario citizens. The unethical and unjust treatment of the participants from Lindsay, Hamilton-Brant, and Thunder Bay is unconscionable.

.../2

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Previous research on Basic Income Guarantee programs demonstrates substantial benefits such as decreased hospitalization rates, work-related injuries, emergency department visits and mental illness consultations. The Basic Income Guarantee (BIG) is considered by many economists and researchers as an economically sound and an effective policy option to reduce the number of programs and their associated costs, and to streamline the effort to tackle poverty. It is predicted that BIG will cost less than the current amounts spent on social programs, housing, justice and health care needs.

The Health Unit's position statement also acknowledges the success of existing guaranteed income supplement programs (Old Age Security and Guaranteed Income Supplements for seniors), which provide evidence of improved health status and quality of life for recipients.

Although the causes of poverty are complex, and a multipronged approach is required to improve health, the Basic Income Guarantee is one policy approach that could reduce the economic barriers to good health and ensure low-income individuals and families in Ontario have a sufficient income to meet their basic needs and live with dignity.

Continuation of the Basic Income Pilot Project would allow researchers to fully assess the impact of the Basic Income Guarantee on labour participation, health, social engagement, food security, housing stability and educational activities. We know through anecdotal reports from our staff, that participants in the Lindsay Pilot Project located in our Health Unit area, have already experienced benefits of BIG in terms of improved housing, ability to further education to improve employment opportunities, ability to purchase more nutritious food and reduced reliance on food banks.

The Health Unit therefore respectfully requests that the Basic Income Pilot Project be reinstated and allowed to be completed as originally planned. By completing the Project, the evidence obtained would then serve to guide further action for policies and programs to reduce poverty, thereby improving the health and well-being for all people in the Province of Ontario.

Yours truly

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

A. Lynn Noseworthy, MD, MHSc, FRCPC
Medical Officer of Health

ALN:kn

Attachment: Haliburton, Kawartha, Pine Ridge District Health Unit Position Statement-Basic Income Guarantee

Copy to: Hon. Doug Ford, Premier of Ontario
(via email) Hon. Christine Elliott, Minister of Health and Long-Term Care
Dr. David Williams, Chief Medical Officer of Health
Roselle Martino, Assistant Deputy Minister, Population and Public Health Branch
MPP Laurie Scott
MPP David Piccini
City of Kawartha Lakes
Haliburton County
Northumberland County
Central-East Local Health Integration Network
Loretta Ryan, Executive Director, Association of Local Public Health Agencies

…/3

Pegeen Walsh, Executive Director, Ontario Public Health Association
Ontario Boards of Health
Association of Municipalities of Ontario

HALIBURTON, KAWARTHA, PINE RIDGE DISTRICT HEALTH UNIT
BASIC INCOME GUARANTEE

Position Statement

It is the position of the Haliburton Kawartha Pine Ridge District Health Unit that eliminating poverty is an urgent health, human rights and social justice issue that requires action on the part of the municipal, provincial and federal governments. Basic income guarantee, which is an unconditional cash transfer from the government to citizens to provide a minimum annual income and is not tied to labour market participation, is an essential component of a strategy to effectively eliminate poverty, ensure all Canadians have a sufficient income to meet their basic needs, and live with dignity and to eliminate health inequities.

Backgrounder

Income has been identified as the most important determinant of health as it influences living conditions, physical and mental health and health-related behaviours including the quality of one's diet, extent of physical activity and tobacco use[1]. People living in poverty are more likely to experience poorer health, have two or more chronic conditions, have more injuries, be more likely to have a disability, use health care services more frequently and live shorter lives.

Based on the Low-Income Measure After Tax (LIM-AT), the incidence of low-income in 2013 was 13.5% for the Canadian population.[2] More specifically, 16.5% of children aged 17 and under lived in low income families and for children living in lone-parent families headed by a woman, the incidence rose to 42.6%.

Locally in the Haliburton Kawartha Pine Ridge District Health Unit, in 2010, 12.7% of the population lived in low-income situations based on LIM-AT.[3] In terms of children under the age of 6 years, 21.8 % lived in low income families. [4]

Currently, households that rely on Ontario Works or Ontario Disability Support Programs as their primary source of income have income levels that are inadequate to meet core basic needs such as housing and food. According to a report on household food insecurity in Canada in 2012, 70% of households whose primary source of income was social assistance were food insecure.[5]

Over the past 20 years there have been tremendous changes in technology and globalization, which impacts job stability and security. Almost half of working adults are employed in precarious employment, which is part-time, seasonal or contract work that has little or no benefits and often pays low wages. Research shows that 70% of Canadians living in poverty are considered to be the working poor, which means they are employed but do not earn enough to make ends meet. [6]

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[1] In Focus The Social Determinants of Health, Epidemiology and Evaluation Services, Fall 2014 available from http://www.hkpr.on.ca/Portals/0/PDF%20Files/PDF%20-%20Epi/InFocus14-Web.pdf

[2] Statistics Canada Canadian Income Survey 2013 available from http://www.statcan.gc.ca/daily-quotidien/150708/dq150708b-eng.htm

[3] 2011 National Household Survey, Statistics Canada available from https://www12.statcan.gc.ca/nhs-enm/2011/dp-pd/prof/details/page.cfm?Lang=E&Geo1=HR&Code1=3535&Data=Count&SearchText=Haliburton,%20Kawartha,%20Pine%20Ridge%20District%20Health%20Unit&SearchType=Begins&SearchPR=01&A1=All&B1=All&GeoLevel=PR&GeoCode=3535&TABID=1

[4] Ibid

[5] Tarasuk, V., Mitchell, A., Dachner, N.,(2014) Household food insecurity in Canada, 2012 available from http://nutritionalsciences.lamp.utoronto.ca/wp-content/uploads/2014/05/Household_Food_Insecurity_in_Canada-2012_ENG.pdf

[6] Lewchuk, W. et al. It's More than Poverty: Employment Precarity and Household Well-being United Way Toronto-McMaster University Social Sciences, 2013. www.pepso.ca

Basic Income Guarantee

The causes of poverty are complex and a multipronged approach is required to eliminate poverty and to improve health and social equity for all. One component of a poverty reduction strategy is to provide a basic income guarantee (BIG). It is an unconditional income transfer from the government to individuals and families that is not tied to labour market participation.[7] The objective of a basic income guarantee is to provide a minimum annual income at a level that is sufficient to meet basic needs and allows individuals and families to live with dignity, regardless of work status.[8] Since research shows that basic income guarantee could have health promoting effects and reduce health and social inequities, it is considered to have merits as an effective policy option.

A basic income guarantee was piloted in Dauphin Manitoba from 1974-1979 to study the impact of a guaranteed income supplement. Research showed a number of substantial benefits including a decrease in hospitalization rates, which were 8.5% less when compared to the control group. There were fewer incidents of work-related injuries, fewer visits to the emergency department from motor vehicle accidents and domestic violence and there was a reduction in the rates of psychiatric hospitalizations and the number of mental illness consultations with health care professionals. The research also showed that teenagers and new mothers were the only populations to significantly work less. The study showed that more teenagers completed high school and new mothers extended their maternity leaves. Once the pilot finished and the cash transfers stopped, the number of teens not graduating from high school rose, returning to the previous rate that existed before the pilot.[9]

Currently in Canada, Old Age Security (OAS) and Guaranteed Income Supplements (GIS) are forms of guaranteed income supplement programs, which are income tested cash transfers for seniors at age 65 and older. Since their implementation, the incidence of poverty in seniors dropped substantially from 21.4% in 1980 to 5.2% in 2011. As a result, Canada has one of the lowest rates of seniors living in poverty in the world and the incidence of food insecurity is 50% less for those age 65 to 69 than for those age 60-64.[10]Similarly, other programs such as the Canadian Child Tax Benefit and National Child Benefit Supplement (which are tax free monthly payments for eligible families with children) have shown benefits in terms of improved math and reading skills and improved mental and physical health measures.[11]

Cost Considerations for a Basic Income Guarantee Program

It is widely agreed upon that the costs of poverty are very high. The total cost of poverty in Ontario is approximately $32.2-$38.3 billion dollars.[12] It is estimated that between $10.1 billion and $13.1 billion is spent on the social costs of poverty related to social assistance, housing and justice programs and health care costs associated with the effects of poverty. Lost opportunities for income tax revenue are estimated to be $4- $6.1 billion dollars and an additional $21.8-25.2 billion is attributed to lost productivity and revenue and intergenerational poverty low-income cycles.

Given the magnitude of the social and economic costs of poverty and the resources being spent on countering the negative effects of poverty, it is more prudent to spend those resources on prevention.

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[7] Pasma, C., and Mulvale, J. Income Security for all Canadians Understanding Guaranteed Income. Ottawa: Basic Income Earth Network Canada; 2009. Available from http://www.cpj.ca/files/docs/Income_Security_for_All_Canadians.pdf

[8] Ibid

[9] Forget, E. **The Town with No Poverty: Using Health Administration Data to Revisit Outcomes of a Canadian Guaranteed Annual Income Field Experiment 2011** available from http://nccdh.ca/images/uploads/comments/forget-cea_(2).pdf

[10] Hyndman, B., and Simon, l., Basic Income Guarantee Backgrounder October 2015 alPHA and OPHA available from ww.opha.on.ca/getmedia/bf22640d-120c-46db-ac69-315fb9aa3c7c/alPHa-OPHA-HEWG-Basic-Income-Backgrounder-Final-Oct-2015.pdf.aspx?ext=.pdf

[11] Ibid

[12] Laurie, N. **The cost of poverty: an analysis of the economic cost of poverty in Ontario.** Toronto Ontario Association of Food Banks, 2008. http://www.oafb.ca/assets/pdfs/CostofPoverty.pdf

The costs of a basic income guarantee program in contrast to the costs of social and private costs of poverty have yet to be extensively researched. Estimates from Queen's University and the University of Manitoba identify that the amount for a basic income guarantee program for all of Canada would cost between $40 and $58 billion. Considering the total costs of poverty for just Ontario, a basic income guarantee would be very achievable.[13]

Provincial and National Support for a Basic Income Guarantee Program

Support for the basic income guarantee program exists across the political spectrum including politicians from several provinces and municipalities, economists and the health and social service sectors. Many large associations have given formal expressions of support such as The Canadian Medical Association, the Association of Local Public Health Agencies and the Ontario Public Health Association, the Ontario Society of Nutrition Professionals in Public Health, the Canadian Association of Mental Health, the Canadian Association of Social Workers and many health units in Ontario. Citizen groups in communities across Canada have also been forming to express their support for this initiative.

This past winter the Ontario provincial government embraced the opportunity to engage in the needed research to provide a clearer understanding of the implications and outcomes of the basic income guarantee program. By conducting a pilot study of the program, evidence will be gathered to determine if this is a more efficient manner of delivering income support, if it strengthens engagement in the labour force and if savings are achieved in areas such as the health care and justice systems. In 2016, the Ontario provincial government will work with researchers, communities and stakeholders to develop and implement a basic income guarantee pilot study.

HALIBURTON KAWARTHA PINE RIDGE DISTRICT HEALTH UNIT
RESOLUTION ON BASIC INCOME GUARANTEE

WHEREAS addressing the social determinants of health and reducing health inequities are fundamental to the work of public health in Ontario; and

WHEREAS the Haliburton Kawartha Pine Ridge District Health Unit's strategic direction is to address the social determinants of health and health equity; and

WHEREAS income is recognized as the most important determinant of health and health inequities; and

WHEREAS 12.7% of the population in the Haliburton Kawartha Pine Ridge District live in low income circumstances based on the Low-Income After-Tax (2011 National Household Survey, Statistics Canada); and

WHEREAS low income and income inequality have well-established, strong relationships with a wide range of adverse health and social outcomes as well as lower life expectancy; and

WHEREAS income insecurity continues to rise in Ontario and Canada as a result of an increase in precarious employment and an increasing number of working-age adults who rely on employment that pays low wages; and

WHEREAS existing federal and provincial income security programs are insufficient to ensure that all Canadians have adequate and equitable access to the social determinants of health (e.g., food, shelter, education); and

WHEREAS a basic income guarantee, which is an unconditional cash transfer from the government to citizens to provide a minimum annual income and is not tied to labour market participation, has the potential to ensure all Canadians have a sufficient income to meet basic needs and to live with dignity; and

[13] Roos, N., and Forget, E. **"The time for a guaranteed annual income might finally have come."** The Globe and Mail, August 4, 2015. Available at http://www.theglobeandmail.com/report-on-business/rob-commentary/the-time-for-a-guaranteed-annual-income-might-finally-have-come/article25819266/

WHEREAS a basic income guarantee resembles existing income security supplements currently in place for Canadian seniors and children, which have contributed to improved health status and quality of life in these age groups; and

WHEREAS a pilot project of basic income for working age adults conducted in Dauphin Manitoba in the 1970s, indicates that the provision of a basic income guarantee can reduce poverty and income insecurity, improve physical and mental health and educational outcomes, and enable people to pursue educational and occupational opportunities relevant to them and their families; and

WHEREAS the concept of a basic income guarantee has received support from the health and social sectors including the Canadian Public Health Association (CPHA), the Canadian Medical Association (CMA), the Canadian Association of Social Workers, the Association of Local Public Health Agencies (alPHa) and the Ontario Public Health Association (OPHA), the Ontario Society of Nutritional Professionals in Public Health and the Ontario Mental Health and Addictions Alliance as a means to alleviate poverty and improve health outcomes of low income Canadians; and

WHEREAS there is growing support from economists, political affiliations and other sectors across Canada for a basic income guarantee;

NOW THEREFORE BE IT RESOLVED THAT the Haliburton Kawartha Pine Ridge District Health Unit Board of Health endorse a position statement of a basic income guarantee;

AND FURTHER that the Haliburton Kawartha Pine Ridge District Health Unit Board of Health join alPHa and OPHA in requesting that the federal Ministers of Employment, Workforce Development and Labour, Families, Children and Social Development, Finance and Health, as well as the Ontario Ministers Responsible for the Poverty Reduction Strategy, Community and Social Services, Children and Youth Services, Finance and Health and Long-Term Care, prioritize joint federal-provincial consideration and investigation into a basic income guarantee as a policy option for reducing poverty and income insecurity;

AND FURTHER that the Prime Minister, the Premier of Ontario, the Chief Public Health Officer, the Chief Medical Officer of Health for Ontario, the Ontario Public Health Association, the Canadian Public Health Association, the Association of Local Public Health Agencies, the Ontario Boards of Health, the Federation of Canadian Municipalities, the Association of Municipalities of Ontario, MP Kim Rudd, MP Jamie Schmale, MPP Lou Rinaldi and MPP Laurie Scott as well as the City of Kawartha Lakes, the County of Haliburton and Northumberland County be so advised.

Public Health
Santé publique
SUDBURY & DISTRICTS

August 3, 2018

VIA EMAIL

The Honourable Doug Ford
Premier of Ontario
premier@ontario.ca

The Honourable Lisa MacLeod
Minister of Children, Community and Social Services
mcssinfo.css@ontario.ca

The Honourable Christine Elliott
Minister of Health and Long-Term Care
ccu.moh@ontario.ca

Dear Premier Ford and Ministers MacLeod and Elliott:

Re: Ontario Basic Income Research Project and the Reduction in the Scheduled Social Assistance Rate Increase

I am writing on behalf of the Board of Health for Public Health Sudbury & Districts to express deep concern regarding the recent announcements to reduce important supports to Ontario's most vulnerable citizens. These announcements include the termination of the Basic Income Research Project and the reduction in the scheduled social assistance rate Increase.

The Board of Health for Public Health Sudbury & Districts cares deeply about vulnerable Ontarians and supports measures to support health equity through critical financial policies. The Board has previously called for provincial and federal levels of government to pursue a basic income guarantee policy and to increase social assistance rates to reflect the actual cost of nutritious food and adequate housing (Board motions #43-15 and #50-16).

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There is considerable research that clearly shows that people with lower incomes experience higher burdens of adverse health and social outcomes compared with people of higher incomes. This includes morbidity and/or mortality from chronic and infectious disease, mental illness, and infant mortality, amongst others.[i]. There is a corresponding financial burden to the health care system. A recent report from the Public Health Agency of Canada estimates that socio-economic inequalities cost the health care system $6.2 billion annually, with Canadians in the lowest income bracket accounting for 60% (or $3.7 billion) of those costs.[i]

It is with deep regret that we learned of your government's recent announcements and we respectfully urge you to reconsider these important supports to vulnerable Ontarians. In line with our own strategic priority of decreasing health inequities and striving for equitable opportunities for health, we would very much welcome the opportunity to engage in dialogue with you on this important health matter.

Yours sincerely,

René Lapierre
Chair
Board of Health for Public Health Sudbury & Districts

Cc: Jamie West, Member of Provincial Parliament, Sudbury
France Gélinas, Member of Provincial Parliament Nickel Belt
Michael Mantha, Member of Provincial Parliament, Algoma- Manitoulin
Dr. David Williams, Chief Medical Officer of Health
Helen Angus, Deputy Minister, Ministry of Health and Long-term Care
All Ontario Boards of Health

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[i] Auger, N and Alix, C. (2016). Income, Income Distribution, and Health in Canada. In Raphael, D. (Eds), Social Determinants of Health (p. 90-109), 3rd edition. Toronto: Canadian Scholars Press Inc.

[i] Public Health Agency of Canada. The direct economic burden of socioeconomic health inequalities in Canada: an analysis of health care costs by income level. Ottawa: Public Health Agency of Canada; 2016 [Accessed 2016 Dec 28]. Retrieved from http://vibrantcanada.ca/files/the_direct_economic_burden_-_feb_2016_16_0.pdf.

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August 8, 2018

VIA EMAIL

Honourable Doug Ford
Premier of Ontario
Premier@ontario.ca

Honourable Lisa MacLeod
Minister of Children, Community and Social Services
lisa.macleodco@pc.ola.org

Honourable Christine Elliott
Minister of Health and Long-Term Care
christine.elliott@pc.ola.org

Dear Premier Ford and Minsters MacLeod and Elliott:

Re: Basic Income Research Project and Social Assistance Rate Reduction and Reform

On behalf of the Timiskaming Health Unit (THU), I am writing to express our concerns with the recent announcements to reduce income supports to Ontario's most vulnerable citizens. These announcements include stopping the Basic Income Research Project and the reduction in the scheduled social assistance rate increase.

There is substantial evidence that demonstrates the powerful relationship between income and health and social outcomes. Those with lower incomes experience higher burden of adverse outcomes compared to those with higher income. The effects of low income and of income inequality perpetuated by the current system may be felt more severely in northern areas of the province such as Timiskaming, where the median income is lower than the provincial average, a greater proportion of the population lives in low income, and access to health and social services may be more limited.[1]

Reducing the negative impact of income and income inequalities is fundamental to the work of public health. The Board of Health for the Timiskaming Health Unit has previously called for and expressed support for a basic income guarantee policy and social assistance rates that reflect the actual cost of basic needs.

As such, we request that you:

- **Reconsider the decision to cancel the basic income pilot**. The basic income pilot was based on sound research, considerable public consultation, and expressed support from all provincial political parties. The basic income pilot should be maintained and evaluated at the end of its three-year duration as planned before decisions are made as to its effectiveness and viability.

- **Maintain the planned increase to social assistance rates and consider social assistance reform as an investment in society rather than a cost to society**. Current social assistance rates are insufficient as highlighted by a public health campaign on food insecurity – No Money for Food is Cent$less.[2] Studies have shown that investing to eliminate poverty costs less than allowing it to persist.[3] Investing to eliminate poverty saves money spent on treating the consequences of poverty in all sectors of government.

- **Act on the recommendations from the "Income Security: A Roadmap for Change" report**. The Roadmap promotes taking a fundamentally different approach to income security—putting people's dignity, their needs, and their rights at the centre of the system.[4] The changes proposed in this report would have a significant impact on income and health.

It is with grave concern that we learned of your governments recent announcements and we urge you to reconsider these important supports. Furthermore, as your government undertakes an accelerated plan to reform Social Assistance we ask you to consider the points above to make the most of the opportunity for the people of Ontario.

Sincerely,

Carman Kidd, Chair
Board of Health for Timiskaming Health Unit

cc: John Vanthof, Member of Provincial Parliament, Timiskaming-Cochrane
Dr. David Williams, Chief Medical Officer of Health
Helen Angus, Deputy Minister, Ministry of Health and Long-Term Care
All Ontario Boards of Health

References

1. Statistics Canada. 2017. Timiskaming Health Unit, [Health region, December 2017], Ontario and Ontario [Province] (table). Census Profile. 2016 Census. Statistics Canada Catalogue no. 98-316-X2016001. Ottawa. Released November 29, 2017. https://www12.statcan.gc.ca/census-recensement/2016/dp-pd/prof/index.cfm?Lang=E (accessed July 24, 2018).
2. Ontario Dietitians in Public Health. *No Money fo Food is Cent$less.* Accessed August 8 2018: https://www.odph.ca/centsless
3. National Council of Welfare. *The Dollars and Sense of Solving Poverty*. Ottawa, Ontario: Her Majesty the Queen in Right of Canada; 2011.
4. Income Security Reform Working Group, First Nations Income Security Reform Working Group, Urban Indigenous Table on Income Security Reform. *Income Security: A Roadmap for Change*. Toronto, Ontario; 2017.

Sent via email: lisa.macleodco@pc.ola.org

August 1, 2018

Honourable Minister Lisa MacLeod
Minister of Children, Community and Social Services
80 Grosvenor Street, 6th Floor, Hepburn Block
Ministry of Community and Social Services
Toronto, ON M7A 1E9

Dear Minister MacLeod:

On behalf of the Simcoe Muskoka District Health Unit (SMDHU) Board of Health, I am writing to convey our profound disappointment at your recent announcement of your intentions to cancel the Ontario Basic Income Pilot, and to urge you to reconsider this decision. Your government's change in direction from your pre-election indications of continuing the pilot will leave the more than 4000 pilot participants facing extremely challenging circumstances, which is an unethical approach to a scientific endeavor. This pilot is recognized throughout our province and internationally as a pivotal opportunity to study the impact of basic income on a range of economic, social, and health outcomes in modern day Ontario. With the extent of the societal impact of poverty, income inequality, and growing precarious employment, basic income is widely recognized as a key policy avenue for exploration to help address these issues. A great deal of time and resources have already been invested in effectively planning and beginning to implement this pilot; we feel it would be a substantial waste to terminate it so prematurely, without the opportunity to first learn from it.

SMDHU has been a vocal proponent of the basic income concept since 2015. Among other actions, we sponsored a resolution at the Association of Local Public Health Agencies (alPHa) general meeting in May 2015, endorsing the concept of basic income and requesting that the provincial and federal governments jointly consider and investigate a basic income guarantee as a policy option for reducing poverty and income insecurity, available at this link. The full backgrounder informing this resolution, and a related resolution for the Ontario Public Health Association, is available at this link. In June 2016, SMDHU's Board of Health endorsed the Responses to Food Insecurity Position Statement of the Ontario Society of Nutrition Professionals in Public Health. This statement recognizes the strong link between poverty and food insecurity and urges the investigation of a basic income for reducing these phenomena. SMDHU's Board of Health has also written on several occasions to the previous provincial government, including to provide input into the design of the basic income pilot and to acknowledge the scientifically and socially sound approach to the design decisions.

Our support of basic income is informed by evidence of the powerful link between income and health. Twelve per cent of the population of Simcoe Muskoka live in low income. Those living with a lower income in our region are at far greater risk of experiencing a lower life expectancy -- two and a half years less for females and five years less for males, compared to those with the highest income. Moreover, the prevalence of self-reported chronic diseases, such as diabetes and heart disease, are one and a half to two times higher for those living in low income compared to their higher income counterparts in our region.

In the immediate future, we also strongly urge the Province to maintain the planned increase to social assistance rates. Current rates are highly insufficient to afford basic needs, including rent and nutritious food. The need for increased social assistance rates, as well as continuing the basic income pilot and creating policies that encourage good jobs with regular hours and benefits, is highlighted in SMDHU's campaign on food insecurity: No Money for Food is Cent$less.

Ontario has the opportunity to continue its basic income pilot and to learn if, in fact, this policy option will help to provide people in poverty and precarious employment with greater opportunity - to live with dignity, to experience improved physical and mental health, and to fully participate in and contribute to society. We urge your government to maintain this pilot and its planned evaluation, so that future generations may benefit from this learning.

Sincerely,

ORIGINAL Signed By:

Scott Warnock
Board of Health Chair
Simcoe Muskoka District Health Unit

SW:LS:cm

cc: Honourable Doug Ford, Premier of Ontario
Honourable Christine Elliott, Minister of Health and Long-Term Care
Dr. David Williams, Chief Medical Officer of Health
Roselle Martino, Assistant Deputy Minister, Population and Public Health Division
Loretta Ryan, Executive Director, Association of Local Public Health Agencies
Pegeen Walsh, Executive Director, Ontario Public Health Association
MPPs Simcoe and Muskoka
Mayors and Councils of Simcoe and Muskoka
North Simcoe Muskoka and Central Local Health Integration Network

Peterborough Public Health

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

August 3, 2018

The Honourable Lisa MacLeod
Minister of Children, Community and Social Services
80 Grosvenor Street, 6th Floor, Hepburn Block
Ministry of Community and Social Services
Toronto, ON M7A 1E9
Sent via email: lisa.macleodco@pc.ola.org

Dear Minister MacLeod:

I am writing on behalf of the Board of Health for Peterborough Public Health to urge you to reconsider the recent decision to cancel the Ontario Basic Income Pilot Project. We feel strongly that the Pilot Project offers a well-designed, cost-effective and unique opportunity to determine the contribution of a Basic Income to improving a range of economic, social and health outcomes in Ontario. The 4,000 pilot participants, including 2,000 participants in our neighbouring community of Lindsay, have entered into significant future commitments since the launch of the project, and in good faith have agreed to provide important data on the impact of this poverty reduction approach. We feel it is ethically essential to honour the promise of a full pilot program to them.

Peterborough Public Health has actively supported the concept of the basic income guarantee for many years. In September, 2015, our Board urged the provincial government to undertake a Basic Income initiative in order to address extensive health inequities in our province. Dr. Salvaterra, the Medical Officer of Health, has provided public information and support for the concept in local media. Public health staff also participate in the local Basic Income Peterborough Network. The Network has hosted a number of public education events, including an event featuring Dr. Evelyn Forget to share her analysis of the basic income project in Dauphin Manitoba, which predated the Ontario pilot.

There is an abundance of evidence on the powerful link between income and health, which is supported by data from our local community. Fifteen per cent of the population of Peterborough City and County live in low income. Those living with a lower income in our community are more likely to die earlier than people who are better off financially – females in the highest income group live eight years longer than those in the lowest income group, while males in the highest income group live fourteen years longer than males in the lowest income group. Similarly, individuals living with the lowest incomes have higher rates of chronic disease. Self-reported diabetes in Peterborough among adults aged 50+ in the lowest income group (18%) is more than double that of the highest income group (8%).

It has also been well documented that food insecurity is closely related to poorer health outcomes and higher health care costs. The most recent edition of the Peterborough Limited Incomes/Nutritious Food Basket Report reported that 16.5% of people in Peterborough City and County experience food insecurity. The Report clearly demonstrates that incomes from current social assistance programs and minimum wages from often precarious employment, are insufficient to meet people's basic needs. A Basic Income Guarantee has the potential to dramatically reduce food insecurity in our communities.

Previous research has shown that improved health outcomes are obtained when people receive a liveable basic income. Residents of Dauphin, Manitoba, for instance, saw an 8.5% reduction in hospitalization rates (primarily due to fewer accident and injury hospitalizations and fewer hospitalizations due to mental health issues). These improvements are direly needed in our current situation of significant health inequities.

We firmly believe that the Ontario Basic Income Pilot Project has enormous potential to inform the development of an effective income support system which will directly impact a wide range of key determinants of health and health outcomes. We ask that you allow the pilot and its planned evaluation to proceed as planned and fulfill its considerable potential.

Sincerely,

Original signed by

Councillor Henry Clarke,
Chair, Board of Health

/ag

cc: Honourable Doug Ford, Premier of Ontario
Honourable Christine Elliott, Minister of Health and Long-Term Care
Dr. David Williams, Chief Medical Officer of Health
Roselle Martino, Assistant Deputy Minister, Population and Public Health Division
Loretta Ryan, Executive Director, Association of Local Public Health Agencies
Pegeen Walsh, Executive Director, Ontario Public Health Association
MPP David Piccini
MPP Laurie Scott
MPP Dave Smith
Central-East Local Health Integration Network
Ontario Boards of Health

July 27, 2018

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

Dear Premier Ford;

Re: Implementation of Smoke-Free Ontario Act 2017

The Board of Health for the Grey Bruce Health Unit urgently requests the provincial government proceed with the immediate implementation of the Smoke-Free Ontario Act 2017.

This legislation is an important component of an over-all strategy that aims to substantially reduce the negative health impacts from tobacco use as it addresses electronic cigarettes (e-cigarettes) and other emerging products.

These new products were not part of the smoking milieu at the time of the development of the existing Smoke-Free Ontario Act, and therefore not adequately recognized in the regulatory framework. The Electronic Cigarettes Act provides some level of mitigation, but does not fully address the use of e-cigarettes in public places and workplaces and the display and promotion of e-cigarettes in retail settings. Also of note, the evidence is unclear as to the value of e-cigarettes to support cessation while there is evidence they can act as a gateway for young people to engage in tobacco smoking (Public Health Ontario, 2016).

Currently, no legislation addresses the use of smoking or vaping of medical cannabis in public places and enclosed places. This normalizes the use of such products to youth and young adults and exposes all Ontarians to the harms of second-hand smoke and vapour.

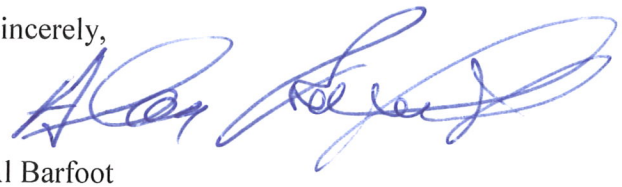
A consolidated approach, as taken by the Smoke-Free Ontario Act 2017, provides the best means to address many of these outstanding issues.

Grey and Bruce Counties adopted smoke-free bylaws several years before the province introduced the Smoke Free Ontario Act. Our experience has seen a reduction in youth smoking rates. Today, an estimated 98% of 12 to 18 year-olds in Grey Bruce have never smoked a whole cigarette, up from 67% in 2000 (Canadian Community Health Survey, 2015/16).

We also note that support for smoke free outdoor spaces in Grey Bruce is at an all-time high - ranging from 72% - 92% (Grey Bruce Health Unit 2014).

We welcome the enactment of an enhanced and consolidated Smoke Free Ontario Act 2017 and the important benefits it will provide to protect the health of all Ontarians.

Sincerely,



Al Barfoot
Chair, Board of Health for the Grey Bruce Health Unit

Cc: Christine Elliott, Minister of Health and Long-Term Care
Bill Walker, Member of Provincial Parliament, Bruce Grey Owen Sound
Lisa Thompson, Member of Provincial Parliament, Huron Bruce
Jim Wilson, Member of Provincial Parliament, Simcoe Grey
All Ontario Boards of Health
Association of Local Public Health Agencies
Dr. David Williams, Chief Medical Officer of Health

Public Health
Santé publique
SUDBURY & DISTRICTS

July 3, 2018

VIA EMAIL

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

Dear Premier Ford:

Re: *Smoke-Free Ontario Act, 2017*

I am writing to share that the Board of Health for Public Health Sudbury & Districts is a longstanding proponent and partner in provincial measures to control tobacco. It is thus with deep regret that we learned of the government's decision to delay the implementation the *Smoke-Free Ontario Act, 2017* (the Act), and we urge you to immediately reconsider this decision.

We urge the Government of Ontario to implement the *Smoke-Free Ontario Act, 2017* without delay so all Ontarians can benefit from reduced risks of illness and death associated with tobacco, vapour, and cannabis use. All are essential components of the modernized Smoke-Free Ontario Strategy that aims to drastically reduce tobacco use by 2035, further protecting health and reducing healthcare costs.

The Board of Health supports the modernization of the Smoke-Free Ontario Strategy in "*Smoke-Free Ontario the Next Chapter-2018 for a Healthier Ontario*", and recognizes that a comprehensive strategy includes a regulatory framework that aligns vaping restrictions with restrictions on tobacco. Furthermore, the Board of Health recognizes the importance of taking a public health approach to the legalization of cannabis with the inclusion of marijuana/cannabis (medical and recreational) as a prescribed product or substance under the *Smoke-Free Ontario Act*, knowing that further regulation of cannabis would come through the *Cannabis Act, 2017*.

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phsd.ca

Public Health Sudbury & Districts is eager to take on its responsibilities under the Act to further protect the public from tobacco, vapour, and cannabis, as provided for under the modernized legislation. We welcome the opportunity to dialogue further on this important measure to protect the health of all Ontarians.

Yours Sincerely,

René Lapierre
Board of Health Chair

cc: Christine Elliott, Minister of Health and Long-Term Care
Jamie West, Member of Provincial Parliament, Sudbury
France Gélinas, Member of Provincial Parliament, Nickel Belt
Michael Mantha, Member of Provincial Parliament, Algoma-Manitoulin
All Ontario Boards of Health
Loretta Ryan, Association of Local Public Health Agencies
Dr. David Williams, Chief Medical Officer of Health
Dr. Penny Sutcliffe, Medical Officer of Health and Chief Executive Officer, Public Health Sudbury & Districts

July 20, 2018

The Honourable Christine Elliott
Minister of Health and Long-Term Care
Deputy Premier
80 Grosvenor Street, 10th Floor, Hepburn Block
Toronto, Ontario M7A 1E9

Dear Minister Elliott,

On behalf of the Board of Health of the Middlesex-London Health Unit, congratulations on your appointment as the Minister of Health and Long-Term Care. We look forward to our continued partnership with the Ontario Government as we work together to tackle complex issues of public health concern.

Even though great gains have been made in tobacco control and the rate of smoking is declining, tobacco remains the leading cause of preventable disease and death in the province of Ontario. According to the *Canadian Substance Use Costs and Harms Study* released in June 2018, substance use costs the Canadian economy $38.4 billion, or almost $1,100 for every person in Canada, with tobacco use alone contributing to 31.2% ($12.0 billion) of these costs, second only to alcohol ($14.6 billion or 38.1%).

The healthcare burden associated with tobacco remains high; in 2014, substance use-related healthcare costs amounted to $11.1 billion in Canada, with tobacco use contributing to 53.1% ($5.9 billion) of these costs. The Middlesex-London Health Unit and its Board of Health looks forward to working under the leadership of the Ontario Government to address the harms from tobacco use and the growing use, availability and promotion of other inhaled products and other emerging nicotine products, like cannabis, heat-not-burn tobacco, shisha and electronic cigarettes (e-cigarettes or vapour products).

At its July 19th meeting, the Board of Health reconfirmed its commitment to tobacco control as a top public health priority. The Board of Health understands that the provincial government wishes to re-examine the evidence related to vaping as a cessation tool, and that the enactment of the *Smoke-Free Ontario Act 2017 (SFOA 2017)* has been suspended. Further research is needed to fully understand the impacts of e-cigarettes on tobacco use initiation and smoking cessation, and the health impacts from second-hand exposure. It is critical that any policy framework that allows vaping as a cessation tool include safeguards to prevent youth uptake.

Research has confirmed that that use among youth of products such as e-cigarettes increases the likelihood of youth smoking tobacco, potentially leading to a lifetime of smoking cigarettes, with all of the risk that this entails. Legislation that prohibits the use of vaping products in the same public locations where smoking tobacco is already restricted can help reduce this risk.

Regardless of any changes to vaping provisions, other aspects of *SFOA 2017* are important and worthy of note. The consolidation of the Electronic Cigarettes Act with the Smoke-Free Ontario Act creates the legislative framework that will be a crucial tool for any tobacco control strategy. The prohibition of displays included in the legislation is also important, with research evidence indicating that such measures help reduce youth initiation.

The Board of Health of the Middlesex-London Health Unit remains committed to working in partnership with the Ontario Government to tackle the burden of tobacco and nicotine addiction. The public health community and its institutions and agencies, including local public health agencies, the seven Tobacco Control Area Networks, Public Health Ontario, the Ontario Tobacco Research Unit, and the non-governmental organizations, have expertise and institutional history that will be crucial during current and future reviews of tobacco control strategy development.

The public health community looks forward to the opportunity to share their expertise and experience, working together under the leadership of the Ministry of Health and Long-Term Care, to create a healthier, more productive population with enhanced quality of life and reduced health care costs.

Sincerely,

Joanne Vanderheyden, Chair
Middlesex-London Board of Health

Attachment: Report No. 048-18 "*Provincial Government Suspends the Enactment of the Smoke-Free Ontario Act 2017"*

cc by email: The Honourable Doug Ford, Premier of Ontario
The Honourable Monte McNaughton, Minister of Infrastructure, MPP Lambton-Kent-Middlesex
The Honourable Jeff Yurek, Minister of Natural Resources and Forestry, MPP Elgin-Middlesex-London
Teresa Armstrong, MPP London-Fanshawe
Terence Kernaghan, MPP London North Centre
Peggy Sattler, MPP London West
Helen Angus, Deputy Minister, Health and Long-Term Care
Sharon Lee Smith, Associate Deputy Minister, Policy and Transformation
Roselle Martino, Assistant Deputy Minister, Population and Public Health Division
Dr. David Williams, Chief Medical Officer of Health
The Association of Local Public Health Agencies
Ontario Boards of Health

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 048-18

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health / CEO

DATE: 2018 July 19

SMOKING STRATEGY DEVELOPMENTS RE: *SMOKE-FREE ONTARIO ACT, 2017*

Recommendation

It is recommended that the Board of Health:

1. ***Receive Report No. 048-18 "Smoking Strategy Developments Re: Smoke-Free Ontario Act, 2017" for information; and,***
2. ***Send a letter, attached as Appendix A, to the Ontario Government expressing MLHU's ongoing commitment to address the burden of tobacco and nicotine addiction, and to encourage continued engagement of the public health community in current and future reviews of tobacco control policy and provincial tobacco strategy development.***

Key Points

- The *Smoke-free Ontario Act, 2017*, scheduled to come into effect on July 1st, 2018, was suspended by the Ontario Government to re-examine the evidence related to vaping as a cessation tool.
- Despite the advancements that have been made in tobacco control, the *Canadian Substance Use Costs and Harms Study*, released in June 2018, calculated that substance use costs the Canadian economy $38.4 billion a year, with tobacco use alone contributing to 31.2% ($12.0 billion) of these costs, second only to alcohol ($14.6 billion or 38.1%).
- New ways of consuming tobacco and nicotine continue to emerge, strengthening the need for sustained and innovative public health action.
- Participation of the public health community, including local public health agencies, Public Health Ontario, Tobacco Control Area Networks, the Ontario Tobacco Research Unit, and non-governmental organizations, will allow decisions to reflect the best available evidence, and keep a focus on health.

Background

At the June Board of the Health meeting, Report No. 038-18 *"The Enactment of the Smoke-Free Ontario Act 2017",* outlined how the *Smoke-free Ontario Act 2017* (*SFOA 2017*) intended to protect young people from marketing and advertising tactics used by the vapour product industry to recruit new users, by applying similar restrictions that have been in place for tobacco products since 2008. In addition, the *SFOA 2017* intended to protect Ontarians from second-hand smoke and vapour by prohibiting the use of e-cigarettes, and the smoking and vaping of medical cannabis in places where smoking tobacco was already prohibited, and in a few additional public spaces of public concern. The *SFOA 2017*, scheduled to come into effect on July 1st, 2018, would have repealed the existing *Smoke-Free Ontario Act (SFOA)* and *Electronic Cigarettes Act, 2015 (ECA),* and replaced them with a single legislative framework.

Enactment of *SFOA 2017* Delayed for Further Analysis

Implementation of *SFOA 2017* has been suspended by the Ontario Government to allow for re-examination of the evidence related to vaping as a cessation tool. All proposed changes under the *Act* are on hold, including: the consolidation of the two *Acts* into a single legislative framework; restrictions on locations of

use of vaping products; and, restrictions on the display, promotion and advertising of vapour products. The Ministry of Health and Long-Term Care has committed to consulting with the public health community, experts, the public and the vapour product industry to re-examine the evidence related to vaping as a cessation aid to ensure that any changes are in the best interests to protect Ontarian's health and safety.

Regardless of any changes to vaping provisions, other aspects of SFOA 2017 are important and worthy of note. The consolidation of the Electronic Cigarettes Act with the Smoke-Free Ontario Act creates the legislative framework that will be a crucial tool for any tobacco control strategy. The prohibition of displays included in the legislation is also important, with research evidence indicating that such measures help reduce youth initiation.

The Cost of Substance Use in Canada and the Need for a Sustained Strategy

Released on June 26th, 2018, the *Canadian Substance Use Costs and Harms Study* provides compelling, up-to-date evidence that reinforces the need for a sustained, innovative tobacco control strategy that is responsive to expanding markets and product availability. Produced by the Canadian Centre on Substance Use and Addiction and the University of Victoria's Canadian Institute for Substance Use Research, the study examined the costs and harms associated with substance use.

In 2014, substance use cost the Canadian economy $38.4 billion, or almost $1,100 for every person in Canada; alcohol ($14.6 billion) and tobacco use ($12.0 billion) together contributed 70% of these costs. Substance use-related healthcare costs in 2014 amounted to $11.1 billion in Canada, with alcohol and tobacco use contributing over 90% of these costs.

The advancements that have been made in tobacco control in Ontario since 2006 have led to decreased smoking of tobacco products; however, the burden of tobacco addiction remains substantial. E-cigarettes, though sometimes marketed as a cessation device, have been shown to increase youth initiation of cigarette smoking. Policies are required to ensure that only smokers use e-cigarettes, and that prohibitions on their use in public places, like tobacco smoking prohibitions, are in place to help to prevent youth uptake. The enactment of legislation that prohibits the use of vapour products in the same public locations where smoking tobacco is already restricted is an important public health measure that may warrant consideration.

Due to the harms of tobacco and nicotine addiction, and the growing use, availability and promotion of other inhaled products and other emerging nicotine products, including cannabis, heat-not-burn tobacco, shisha and e-cigarette products, tobacco control remains a public health priority. Innovative approaches are urgently needed to motivate the two million Ontarians who use tobacco to quit and stay quit. Youth uptake is another crucial area that requires innovation, with the use of products that generate addiction to nicotine becoming more common among youth.

The Middlesex-London Health Unit remains committed to working in partnership with the Ontario Government to address the burden of tobacco and nicotine addiction. The public health community and its institutions and agencies, including local public health agencies, the seven Tobacco Control Area Networks, Public Health Ontario, the Ontario Tobacco Research Unit, and the non-governmental organizations, have expertise and institutional history that will be crucial during current and future reviews of tobacco control strategy development.

This report was prepared by the Healthy Living Division.

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