Board of Health for the
Peterborough County-City Health Unit
AGENDA
Board of Health Meeting
Wednesday, January 14, 2015 - 4:45 p.m.
Council Chambers, County Court House
470 Water Street, Peterborough

1. Call to Order

1.1. Welcome and Introductions
Dr. Rosana Pellizzari, Medical Officer of Health

2. Elections

2.1. Chairperson
2.2. Vice-Chairperson

3. Appointments to Committees

3.1. Governance
3.2. Property
3.3. Fundraising

4. Establishment of Date and Time of Regular Meetings

5. Establishment of Honourarium for 2015

6. Confirmation of the Agenda

7. Declaration of Pecuniary Interest

8. Delegations and Presentations

9. Confirmation of the Minutes of the Previous Meeting

9.1. **December 18, 2014**

10. Business Arising From the Minutes

10.1. **Remuneration of Board of Health Volunteers**

11. Correspondence

12. New Business

12.1. **Staff Report: Update on IARC Radiofrequency Monograph**
Donna Churipuy, Manager, Environmental Health Programs

12.2. **Staff Report: 2015 Cost-Shared Budget Approval**
Bob Dubay, Manager, Accounting Services

12.3. **Staff Report and Presentation: Low Income Dental Program Integration**
Sarah Tanner, Supervisor, Oral Health Programs
Presentation Link

12.4. **Staff Report: Vintners Quality Alliance Wines at Farmers' Markets**
Monique Beneteau, Health Promoter

12.5. **Committee Report: Property**
Dr. Rosana Pellizzari, Medical Officer of Health

13. In Camera to Discuss Confidential Personal and Property Matters

14. Motions for Open Session

15. Date, Time, and Place of the Next Meeting

February 11, 2015, 4:45 p.m.
Council Chambers, City Hall, 500 George St. N., Peterborough

16. Adjournment

ACCESSIBILITY INFORMATION: The Peterborough County-City Health Unit is committed to providing information in a format that meets your needs. To request this document in an alternate format, please call us at 705-743-1000.

To: All Members
Board of Health

From: Dr. Rosana Pellizzari, Medical Officer of Health

Subject: **Appointments to Board of Health Committees**

Date: January 14, 2015

The following information has been included for your reference:

- 2015 Board of Health Members
- 2014 Committee Appointments
- Committee Terms of Reference

2015 Board of Health
for the
Peterborough County-City Health Unit

Councillor Gary Baldwin, City of Peterborough

Councillor Henry Clarke, City of Peterborough

Mr. Gregory Connolley, Provincial Appointee

Ms. Kerri Davies, Provincial Appointee

Mayor John Fallis, County of Peterborough

Mr. Scott McDonald, Provincial Representative

Councillor Lesley Parnell, City of Peterborough

Councillor Trisha Shearer, Hiawatha First Nation Representative

Mayor Mary Smith, County of Peterborough

Chief Phyllis Williams, Curve Lake First Nation Representative

Mayor Rick Woodcock, County of Peterborough

Board of Health
for the
Peterborough County-City Health Unit
2014 Appointments to Committees

The Chairperson is an ex-officio member of all committees.

Governance:	Mr. Scott McDonald (Chair) Mayor Mary Smith Chief Phyllis Williams *Mr. Jim Embrey (resigned October 2014)* *Ms. Caroline MacIsaac (resigned November 2014)*
Property:	Councillor Henry Clarke Mr. Scott MacDonald Councillor Lesley Parnell Chief Phyllis Williams Mr. Andy Sharpe (Chair, community volunteer) Mr. David Watton (community volunteer)

Board of Health
for the
Peterborough County-City Health Unit
Committee Terms of Reference

1. Governance (hyperlink)

2. Property (hyperlink)

3. Fundraising

   The Board approved the establishment of this Committee in November 2014. There are currently no Terms of Reference for this Committee, Terms will be proposed to the Members at its first meeting where it will be refined, and then formally approved by the Board at a subsequent meeting.

   The Board's 2013-17 strategic plan states that "a fundraising strategy will be developed and led by the Board of Health", it is the hope that this Committee will fulfill that goal. Due to funding restrictions, and as noted at the November meeting, Ministry funds cannot be used to support this Committee (e.g. staff time) as it does not meet the requirement of delivering a health program/service, so this Committee and its work will be Member driven.

To: All Members
Board of Health

From: Dr. Rosana Pellizzari, Medical Officer of Health

Subject: **Establishment of Date and Time of Regular Meetings**

Date: January 14, 2015

Recommendation:

That the regular meetings for the Board of Health be held on the second Wednesday of each month (excluding July and August) starting at 4:45 p.m., or at the call of the Chairperson.

A listing of the Board of Health meeting dates with locations for 2015 is as follows:

Location: Council Chambers, County Court House, 470 Water Street
Date: January 14

Location: Council Chambers, City Hall, 500 George St. N.
Dates:
February 11
March 11
April 15*
June 10
October 14
November 11
December 9

Location: Council Chambers, Admin. Building, 22 Wiinookeedaa Rd., Curve Lake First Nation
Date: May 13

Location: Lower Hall, Admin. Building, 123 Paudash St., Hiawatha First Nation
Date: September 9

*3rd Wednesday of the month due to anticipated staff holidays.

Please note that staff are pursuing at least one meeting to be held in a Township location this year. Once confirmed, sufficient notice will be provided.

To: All Members
Board of Health

From: Dr. Rosana Pellizzari, Medical Officer of Health

Subject: **Establishment of Honourarium for 2015**

Date: January 14, 2015

Recommendation:

That the Board of Health for the Peterborough County-City Health Unit:

- receive the staff report, *Board Remuneration Review*, for information;
- approve an increase of $.75 to the current honourarium for 2015 representing a final amount of $146.36.

Please see the attached.

For your reference, please refer to the following Board policies and procedures:

Remuneration of Members, Policy (hyperlink)
Board Remuneration Review, Procedure (hyperlink)

Staff Report

Board Remuneration Review

Date:	January 14, 2015
To:	Board of Health
From:	Dr. Rosana Pellizzari, Medical Officer of Health

Original approved by	***Original approved by***
Rosana Pellizzari, M.D.	Brent Woodford, Director Corporate Services

Recommendations

That the Board of Health for the Peterborough County-City Health Unit:

- receive the staff report, *Board Remuneration Review*, for information;
- recommend an increase of $.75 to the current honourarium for 2015 representing a final amount of $146.36.

Financial Implications and Impact

City councillors are not entitled to receive the honourarium, however County councillors, First Nation Council Appointees and Provincial Appointees receive an hounourarium while on Health Unit business. The current honourarium is $145.61 so every 1% increase would amount to $1.46.

Decision History

With respect to honourarium increases, on March 13, 2013, the Board approved the following motion (M-13-43):

That the Board of Health for the Peterborough County-City Health Unit, starting this year, establish board member compensation in the future that is equal to staff increases or to the Consumer Price Index, whichever is lower.

On June 12, 2013, the Board approved a revision to the By-Law on remuneration requesting that:

The Board shall be provided with a recommendation from the Governance Committee on proposed adjustments or increases to support their decision.

Background

Policy requires the Board to confirm, at its first meeting of the year, which members shall be remunerated for attending meetings and determine the amount of the remuneration. Policy also requires Governance to review the Board honourarium rate at the end of each calendar year and that the Committee considers the increase granted to staff during the current year and to consider the Consumer Price Index (CPI) increase in making a recommendation.

For 2014 management and OPSEU were given a .5% increase in wages. We are currently negotiating with ONA and CUPE for increases of .5%. Benefit increases amounted to $2.98. "All in costs" amount to $.75 increase.

Rationale

The Board approved motion reads "*board member compensation in the future that is equal to staff increases or to the Consumer Price Index, whichever is lower."*

Strategic Direction

This will allow the Board to pursue its strategic direction of Quality and Performance.

Contact:

Brent Woodford
Director, Corporate Services
(705) 743-1000, ext. 231
bwoodford@pcchu.ca

Board of Health for the
Peterborough County-City Health Unit
MINUTES
Board of Health Meeting
December 18, 2014, 5:00 p.m.
City and County Rooms, 150 O'Carroll Avenue, Peterborough

In Attendance:

Board Members:	**Chief Phyllis Williams, Chair**
	Councillor Gary Baldwin
	Councillor Henry Clarke
	Mr. Gregory Connolley
	Ms. Kerri Davies
	Mayor John Fallis
	Mr. Scott McDonald (by telephone)
	Councillor Lesley Parnell
	Councillor Trisha Shearer (by telephone)
	Mayor Mary Smith
	Mayor Rick Woodcock
Staff:	**Dr. Rosana Pellizzari, Medical Officer of Health**
	Ms. Alida Tanna, Administrative Assistant, Recorder
	Mr. Larry Stinson, Director, Public Health Programs
	Mr. Brent Woodford, Director, Corporate Services
Guests:	**Mr. Peter Lawless, Legal Counsel, LLF Lawyers** (by telephone)
	Mr. Andrew Sharpe (by telephone)
Regrets:	**Ms. Natalie Garnett**

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1. Call to Order

Chief Williams, Chair, called the meeting to order at 4:59 p.m.

1.1. Announcement: Board of Health Membership Update

Chief Williams welcomed several new members to the Board:

- Mr. Gary Baldwin, Councillor, City of Peterborough
- Mr. Gregory Connolley, Provincial Appointee (term continues to November, 2017); and
- Mr. Rick Woodcock, Mayor, Township of North Kawartha

2. Confirmation of the Agenda

MOTION:
That the Agenda be approved as circulated.
Moved: Mayor Smith
Seconded: Councillor Parnell
Motion carried. (M-2014-144)

3. Declaration of Pecuniary Interest

Mr. Sharpe declared pecuniary interest relating to item 8.1, however, as a non-voting member, this declaration was of no consequence.

4. Delegations and Presentations

5. Confirmation of the Minutes of the Previous Meeting

5.1. November 12, 2014

MOTION:
That the minutes of the Board of Health meeting held on November 12, 2014, be approved as circulated.
Moved: Mayor Smith
Seconded: Councillor Parnell
Motion carried. (M-2014-145)

6. Business Arising From the Minutes

7. Correspondence

8. New Business

8.1. Staff Report: Community Member Appointment

Dr. Rosana Pellizzari, Medical Officer of Health

MOTION:
That the Board of Health for the Peterborough County-City Health Unit receive the staff report, Community Member Appointment, for information.
Moved: Councillor Shearer
Seconded: Mr. McDonald
Motion carried. (M-2014-146)

MOTION:
That the Board of Health for the Peterborough County-City Health Unit immediately appoint Andy Sharpe as a community member to the Property Committee to serve at the pleasure of the Board.
Moved: Councillor Parnell
Seconded: Councillor Clarke
Motion carried. (M-2014-147)

Councillor Parnell requested that the Board consider covering expenses for volunteer members.

MOTION:
That the Board of Health for the Peterborough County-City Health Unit refer the issue of expense reimbursement for volunteer members to the Governance Committee for further review.
Moved: Mayor Smith
Seconded: Councillor Parnell
Motion carried. (M-2014-148)

9. In Camera to Discuss Confidential Property Matters

MOTION:
That the Board of Health for the Peterborough County-City Health Unit go In Camera to discuss confidential personal and property matters.
Moved: Councillor Parnell
Seconded: Mayor Fallis
Motion carried. (M-2014-149)

MOTION:
That the Board of Health for the Peterborough County-City Health Unit rise from In Camera.
Moved: Councillor Clarke
Seconded: Mayor Fallis
Motion carried. (M-2014-150)

10. Motions from In Camera for Open Session

11. Date, Time, and Place of the Next Meeting

January 14, 2015, 4:45 p.m.
Council Chambers, County of Peterborough, 470 Water Street, Peterborough

12. Adjournment

MOTION:
That the meeting be adjourned.
Moved by: Councillor Clarke
Seconded by: Councillor Parnell
Motion carried. (M-2014-151)

The meeting was adjourned at 6:31 p.m.

Chairperson

Medical Officer of Health

To: All Members
Board of Health

From: Dr. Rosana Pellizzari, Medical Officer of Health

Subject: **Remuneration of Board of Health Volunteers**

Date: January 14, 2015

Recommendation:

That the Board of Health for the Peterborough County-City Health Unit:

- approve new policy 2-151, Remuneration of Board of Health Volunteers; and
- cover travel expenses for Mr. David Watton and Mr. Andrew Sharpe retroactive to January 1st, 2014.

At its December 18th meeting, the Board referred the matter of remuneration of volunteers to Board of Health Committees to the Governance Committee for further consideration.

The Governance Committee met later that evening and proposed the recommendations outlined above.

With respect to retroactive payment, Mr. Watton was appointed to the Property Committee as a volunteer in January 2014. Mileage incurred by Mr. Watton is quite minimal (less than $10.00). Mr. Sharpe would be reimbursed for mileage since his municipal appointment concluded as of November 30, 2014.

Board of Health

POLICY AND PROCEDURE

Section: Board of Health	**Number:** 2-151	**Title:** Remuneration of Board of Health Volunteers
Approved by: Board of Health		**Original Approved by Board of Health On** (YYYY-MM-DD)**:**
Signature:		**Author:** Director Corporate Services
Date (YYYY-MM-DD)**:**		
Reference:		

NOTE: This is a **CONTROLLED** document for internal use only, any document appearing in a paper form should **ALWAYS** be checked against the online version prior to use.

OBJECTIVE

The Board appreciates community members volunteering their time, wisdom and experience to help the organization achieve its mission and does not believe it appropriate for a volunteer to have to pay to generously give of their time when providing assistance to the Board.

POLICY

Volunteers on board of health Committees will be reimbursed for all "out-of-pocket" costs. Out-of-pocket costs include mileage, parking and any other expense the volunteer may incur while volunteering for the board of health. Mileage will be reimbursed at the current PCCHU rate.

PROCEDURE

Volunteers should advise the Administrative Assistant to the Medical Officer of Health of any expenses incurred, including the number of kilometers driven. Receipts should be submitted where available.

The Administrative Assistant will prepare the required cheque requisition for approval and payment.

Review/Revisions

On (YYYY-MM-DD)**:**
On (YYYY-MM-DD)**:**
On (YYYY-MM-DD)**:**
On (YYYY-MM-DD)**:**

To: All Members
Board of Health

From: Dr. Rosana Pellizzari, Medical Officer of Health

Subject: **Correspondence**

Date: January 14, 2015

Recommendation:

That the following documents be received for information and acted upon as deemed appropriate.

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1. Email dated November 24, 2014 from the Association of Local Public Health Agencies (alPHa) to Ontario Boards of Health regarding the Making Healthier Choices Act 2014.

2. Email dated November 28, 2014 from alPHa to Ontario Boards of Health regarding Community Water Fluoridation.

3. Letter dated November 28, 2014 from Dr. Pellizzari to the Hon. James Moore, Minister of Industry, regarding the reinstatement of the long-form census.

4. Letter dated December 3, 2014 from Dr. Pellizzari to Mr. Brian Parks, President Bridgenorth-Ennismore-Lakefield Rotary, regarding the 2014 Nutritious Food Basket report and request to present.
   - *Enclosures previously circulated (November Board report)*
   - *Similar requests were also made to the Rotary Club of Peterborough-Kawartha and the Rotary Club of Peterborough.*
   - *Presentation requests have been made to the Joint Services Steering Committee and City Council. County Council has not been approached since presentations have been arranged for each Township Council.*

5. Letter dated December 5, 2014 from the Ministry of Health and Long-Term Care to all Ontario Board of Health Chairs regarding the 2015 Public Health Funding and Accountability Indicators.

6. Email newsletter dated December 12, 2014 from alPHa sent to all Ontario Boards of Health and Public Health Units.

7. Letter dated December 22, 2014 to the Hon. Charles Sousa, Minister of Finance from the Board Chair regarding the 2014 Nutritious Food Basket report.

8. Letter dated December 22, 2014 to the Hon. Tracy MacCharles, Minister of Children and Youth Services/Responsible for Women's Issues from the Board Chair regarding an invitation to visit Peterborough.

9. Letter dated December 22, 2014 from the Hon. Tracy MacCharles, Minister of Children and Youth Services/Responsible for Women's Issues, in response to her initial letter dated November 6, 2014, regarding the Healthy Babies, Healthy Children program.

10. Email newsletter dated January 8, 2015 from alPHa sent to all Ontario Boards of Health and Public Health Units.

11. Resolutions/Letters from other local public health agencies (sorted by topic):

Community Water Fluoridation
- Windsor Essex

E-Cigarettes
- Simcoe Muskoka District
- Sudbury & District
- Timiskaming

Flavoured Tobacco
- Sudbury & District

Oral Health
- Algoma
- Haliburton, Kawartha, Pine Ridge
- Northwestern
- Sudbury & District

Reinstatement of the Long-Form Census
- Haliburton, Kawartha, Pine Ridge

From: allhealthunits-bounces@lists.alphaweb.org [mailto:allhealthunits-bounces@lists.alphaweb.org] **On Behalf Of** Gordon Fleming
Sent: November-24-14 4:37 PM
To: allhealthunits@lists.alphaweb.org
Subject: RE: [allhealthunits] Making Healthier Choices Act 2014

This message is in follow-up to the one I sent earlier today. The text of the Bill is now posted and you can read it and track progress using the following link:

http://www.ontla.on.ca/web/bills/bills_detail.do?locale=en&Intranet=&BillID=3080

From: allhealthunits-bounces@lists.alphaweb.org [mailto:allhealthunits-bounces@lists.alphaweb.org] **On Behalf Of** Gordon Fleming
Sent: Monday, November 24, 2014 10:23 AM
To: allhealthunits@lists.alphaweb.org
Subject: [allhealthunits] Making Healthier Choices Act 2014

ATTENTION
CHAIRS, BOARDS OF HEALTH
SENIOR MANAGERS, TOBACCO CONTROL PROGRAMS
SENIOR MANAGERS, HEALTHY EATING PROGRAMS
****

Hi All,

In case you are not aware, Associate Minister of Health and Long-Term Care Dipika Damerla announced some important public health measures today. Links to the Government announcement as well as alPHa's related action on these subjects are included here. alPHa will be writing new letters to the Minister once we have had the opportunity to examine these measures in more detail.

The Making Healthier Choices Act will contain three elements:

a. ***Legislation that will subject e-cigarettes to many of the same restrictions that are placed on tobacco.***

This will address part of alPHa's 2014 Resolution on the subject

A14-2 - E-Cigarettes

NOW THEREFORE BE IT RESOLVED that the Association of Local Public Health Agencies request Health Canada, the Ontario Ministry of Health and Long-Term Care and its stakeholders to provide for the public health, safety, and welfare of all Ontario residents by: ensuring manufacturing consistency of e-cigarettes; conducting research on the long-term health effects of e-cigarettes and exposure to second hand vapour; and regulating the promotion, sale and use of e-cigarettes in Ontario.

b. Menu Labelling Requirements

Our understanding is that these requirements are going forward as they were originally introduced prior to the spring 2014 dissolution of the Legislature. Please note that at the time, there was a similar Private Member's Bill being considered, and alPHa urged that the best elements of each be included in eventual legislation. We will be repeating that message as this new Bill makes its way through the legislative process.

alPHa Letter - Menu Labelling Bills

March 4 2014 alPHa letter to the Minister of Health and Long-Term Care and the NDP Health Critic regarding their respective menu labelling bills (149 and 162)

MOHLTC Reply - Menu Labelling Bills

April 15 2014 MOHLTC response to alPHa's March 4 2014 letter to the Minister of Health and Long-Term Care and the NDP Health Critic regarding their respective menu labelling bills (149 and 162).

c. A ban on flavoured tobacco products

alPHa has been active on this file as various Bills, both Government and Private Member, have been introduced at various times but not passed for various reasons. The latest includes some new elements, most notably the inclusion of menthol as a flavouring (it was exempt in most if not all of the previous versions). alPHa's responses to the earlier Bills is included here for your information.

alPHa Letter - Bill 66 Flavoured Tobacco

May 23 2012 Letter from alPHa President calling for passage of proposed amendments to the Smoke Free Ontario Act that would ban flavoured tobacco and prevent the introduction of new tobacco industry products to Ontario.

alPHa Letter - Smoke Free Ontario (Bill 131)

December 2 2013 letter from the alPHa President regarding the Province's recent announcements about strengthening the Smoke Free Ontario Act.

Please click here to read the Government announcement. We will provide links to the text of the Bill when it is introduced later today.

Gordon Fleming, B.A., BASc, CPHI(C)
Manager, Public Health Issues
Association of Local Public Health Agencies (alPHa)
2 Carlton Street, Suite 1306
Toronto, Ontario
(416) 595-0006, ext 23
(416) 595-0030 Fax

From: allhealthunits-bounces@lists.alphaweb.org [mailto:allhealthunits-bounces@lists.alphaweb.org] **On Behalf Of** Gordon Fleming
Sent: November-28-14 11:46 AM
To: allhealthunits@lists.alphaweb.org
Subject: [allhealthunits] MPP Resolution - Community Water Fluoridation

ATTENTION
CHAIRS, BOARDS OF HEALTH
SENIOR MANAGEMENT, ORAL HEALTH PROGRAMS
****

Hi All,

A Private Member's Motion regarding community water fluoridation was debated and passed yesterday in the Legislature, and you can read the transcript of the debate here (scroll down about 2/3 of the way down the page). Please note that this is NOT a piece of legislation, just a statement of opinion of the House on a matter.

Statements were made by MPPs from all parties, and each was strongly supportive of the motion. It is noteworthy that Monique Taylor (NDP, Hamilton Mountain) asked why MPP Delaney was introducing this as a motion without asking his Government to do anything about it.

We will incorporate this information into further advocacy around our alPHa Resolution A14-4, A Provincial Approach to Community Water Fluoridation.

Gordon Fleming, B.A., BASc, CPHI(C)
Manager, Public Health Issues
Association of Local Public Health Agencies (alPHa)
2 Carlton Street, Suite 1306
Toronto, Ontario
(416) 595-0006, ext 23
(416) 595-0030 Fax

Peterborough County-City
HEALTH UNIT
...because health matters!

November 28, 2014

Honourable James Moore
Minister of Industry
356 Confederation Building
House of Commons
Ottawa, ON K1A 0A6

Dear Minister Moore:

Re: Bill C-626, an Act to Amend the Statistics Act

As the Medical Officer of Health for the Peterborough County-City Health Unit, I am writing today to express our strong support for Private Member's Bill, C-626, which calls for the appointment of a Chief Statistician and the reinstatement of the mandatory Long-Form Census. Under the Ontario Public Health Standards we are mandated to undertake population health assessments and surveillance. We use that data routinely to understand population needs and to plan local health promotion and protection programs and services. For many years, the Long-Form Census provided the only source of detailed information on specific sub-populations, including those with special needs, those living in poverty and new immigrants with language barriers, among others.

In 2011, when the voluntary National Household Survey (NHS) replaced the Mandatory Long-Form Census, the reliability of the data was affected by low response rates both overall and within selected populations. This change is demonstrated by the main indicator used to assess the quality of the NHS data, the global non-response rate (GNR). For the National Household Survey, data for any geographic area with a GNR of greater than 50% have been suppressed. The Peterborough Census Metropolitan Area has one of the highest GNR's in Canada (36.3%). In four of our local municipalities the GNR exceeded 50%, and all of their individual results have been suppressed. Had the 2006 criteria for data suppression (GNR equal to or higher than 25%) been applied in 2011, no Peterborough data from the NHS would have been released. Our efforts to obtain information through other administrative sources of data, such as those derived from the annual tax file provided by the Canada Revenue Agency, have so far been unsuccessful.

The current situation makes it very challenging for us to provide evidence-informed population health programs and services at the local level. We urge you to support Bill C-626 and direct Statistics Canada to reinstate the mandatory Long Form census as a proven, cost-effective way to the meet the critical data needs of public health decision-makers.

10 Hospital Drive, Peterborough, ON K9J 8M1 P: (705) 743-1000 or 1-877-743-0101 F: (705) 743-2897 www.pcchu.ca

Sincerely,

Original signed by

Rosana Pellizzari, MD, MSc, CCFP, FRCPC
Medical Officer of Health, Peterborough County-City Health Unit

/at

cc. Chief Phyllis Williams, Chair, Board of Health, Peterborough County-City Health Unit
The Right Honourable Stephen Harper, Prime Minister
Ted Hsu, MP Kingston and the Islands
Hon. Rona Ambrose, Minister of Health
Hon. Andrew Scheer, Speaker of the House
Association of Local Public Health Units

10 Hospital Drive, Peterborough, ON K9J 8M1 P: (705) 743-1000 or 1-877-743-0101 F: (705) 743-2897 www.pcchu.ca

December 3, 2014

Mr. Brian Parks, President
Bridgenorth-Ennismore-Lakefield Rotary
PO Box 249
Bridgenorth, ON K0L 1H0

Dear Mr. Parks:

At the November 12, 2014 meeting of the Peterborough County-City Board of Health, a staff report on Food Insecurity in Peterborough was received. The report, along with the *2014 Limited Incomes: A Recipe of Hunger* report (attached) are based on the costing of a Nutritious Food Basket in our region and clearly demonstrate that poverty is the reason that people are going hungry in Peterborough.

The cost of a Nutritious Food Basket in Peterborough County and City for a reference family of 4 is $850 per month. The Nutritious Food Basket is Ontario's standardized costing tool, used by Health Units, to measure the cost of healthy eating according to Canada's Food Guide.

A single person whose source of income is Ontario Works can expect 94% of their income to cover rent, leaving insufficient funds for basic expenses including food. If this same person was to make food choices as outlined in the Nutritious Food Basket, they would be in a deficit of $245 each month after paying shelter costs and food. Minimum wage earners and households on fixed incomes have little, if any money left over to cover basic monthly expenses.

At the request of Councillor Lesley Parnell, I am writing to offer a presentation based on this information, to members of the Peterborough Rotary Club. We recognize your long history in supporting local school breakfast programs and food programs in our community. Both the Board of Health and the Peterborough Community Food Network recognize that now is the time for coordinated actions to support the most vulnerable in our community.

Sincerely,

Original signed by

Rosana Pellizzari, MS, MSc, CCFP, FRCPC
Medical Officer of Health, Peterborough County-City Health Unit
Chair, Peterborough Community Food Network

Encl.
/at

Ministry of Health and Long-Term Care

Public Health Standards, Practice and Accountability Branch

Public Health Division

393 University Avenue, 21st Floor
Toronto ON M7A 2S1
Telephone: 416 314-2130
Facsimile: 416 314-7078

Heath Promotion Division

Health Promotion Implementation Branch

777 Bay Street, Suite 702
Toronto ON M7A 1S5
Tel: 416-326-2044
Fax: 416-314-5497
TTY: 416-212-5723
TTY Toll Free: 1-866-263-1410
www.health.gov.on.ca

Ministère de la Santé et des Soins de longue durée

Direction des normes, des pratiques et de la responsabilisation en matière de santé publique

Division de la santé publique

393, avenue University, 21e étage
Toronto ON M7A 2S1
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Division de la Promotion de la santé

Direction des normes, des programmes et du développement communautaire

777, rue Bay, bureau 702
Toronto ON M7A 1S5
Tél: 416-326-2044
Téléc: 416-314-5497
ATS: 416-212-5723
ATS sans frais: 1-866-263-1410
www.health.gov.on.ca

Ontario

December 5, 2014

MEMORANDUM TO: Board of Health Chairs, Medical Officers of Health and Chief Executive Officers

RE: 2015 Public Health Funding and Accountability Agreement Indicators

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We are pleased to advise you that the ministry has finalized the performance indicators for the 2015 Public Health Funding and Accountability Agreement (please see Appendix A). A number of factors were considered in finalizing the indicators, including ministry priorities, current health unit performance, input received through the Indicator Development Task Group process, and feedback received from the health units through consultation processes in September 2013 and October 2014.

The ten 2014 health promotion indicators will continue in 2015.

There are some changes to the set of health protection indicators, including:

- A new indicator, "% of salmonellosis cases where one or more risk factor(s) other than 'Unknown' was entered into iPHIS";
- Immunization coverage indicators are being re-introduced following the roll-out of Panorama; and
- Some health protection indicators will only have targets set for those boards of health where there is opportunity for performance improvement.

…/2

Board of Health Chairs, Medical Officers of Health and Chief Executive Officers

In addition to the changes noted above, 2015 will be used as the baseline year for a new health protection indicator "% of confirmed gonorrhea cases treated according to recommended Ontario treatment guidelines". This 2015 baseline data will be collected in early 2016 as part of 2015 year-end reporting.

The ministry is also committed to working on developing new indicators. These can include specific indicators or areas of common interest that require further development prior to being considered for inclusion in Accountability Agreements. A list of these developmental indicators for 2015 can be found in Appendix B.

Further details on all indicators will be available in updated Technical Documents which will be posted on the DoN Performance Management Data Sharing Site and provided in a future communication prior to 2014 Year-End Data Collection.

If you have any questions, please send them to PHUIndicators@ontario.ca or contact us directly.

We look forward to continuing to work with you on implementation of the 2015 Public Health Funding and Accountability Agreement indicators.

Yours truly,

Original signed by

Paulina Salamo
Director (A)
Public Health Standards,
Practice & Accountability Branch
Public Health Division

Original signed by

Laura A. Pisko
Director
Health Promotion Implementation Branch
Health Promotion Division

Attachments

c: Roselle Martino, Executive Director, Public Health Division
Martha Greenberg, Assistant Deputy Minister, Acting, Health Promotion Division

APPENDIX A - 2015 PERFORMANCE INDICATORS

HEALTH PROMOTION INDICATORS	Current	New
% of population (19+) that exceeds the Low-Risk Alcohol Drinking Guidelines	•	
Fall-related emergency visits in older adults aged 65+	•	
% of youth (ages 12-18) who have never smoked a whole cigarette	•	
% of tobacco vendors in compliance with youth access legislation at the time of last inspection	•	
% of secondary schools inspected once per year for compliance with section 10 of the Smoke-Free Ontario Act (SFOA) †	•	
% of tobacco retailers inspected for compliance with section 3 of the Smoke-Free Ontario Act (SFOA)	•	
% of tobacco retailers inspected once per year for compliance with display, handling and promotion sections of the Smoke-Free Ontario Act (SFOA)	•	
Oral Health Assessment and Surveillance: % of all JK, SK and Grade 2 students screened in publicly funded schools	•	
Implementation status of NutriSTEP®	•	
Baby-Friendly Initiative (BFI) Status	•	

†Note that 2014 will be used as the baseline year for this indicator and that this baseline data will be collected as part of the 2014 year-end reporting.

HEALTH PROTECTION INDICATORS	Current	New
% of high-risk food premises inspected once every 4 months while in operation*	•	
% of moderate-risk food premises inspected once every 6 months while in operation	•	
% of Class A pools inspected while in operation*	•	
% of high-risk Small Drinking Water Systems (SDWS) inspections completed for those that are due for re-inspection*	•	
% of public spas inspected while in operation*	•	
% of personal services settings inspected annually	•	
% of suspected rabies exposures reported with investigation initiated within one day of public health unit notification	•	

HEALTH PROTECTION INDICATORS	Current	New
% of confirmed gonorrhea cases where initiation of follow-up occurred within two business days*	•	
% of confirmed iGAS cases where initiation of follow-up occurred on the same day as receipt of lab confirmation of a positive case*	•	
% of salmonellosis cases where one or more risk factor(s) other than “Unknown” was entered into iPHIS†		•
% of HPV vaccine wasted that is stored/administered by the public health unit	•	
% of influenza vaccine wasted that is stored/administered by the public health unit	•	
% of refrigerators storing publicly funded vaccines that have received a completed routine annual cold chain inspection	•	
% of school-aged children who have completed immunizations for hepatitis B	‡	
% of school-aged children who have completed immunizations for HPV	‡	
% of school-aged children who have completed immunizations for meningococcus	‡	

*Note that targets will be set for these indicators for those boards of health where there is opportunity for performance improvement.

†Note that 2014 will be used as the baseline year for this indicator and that this baseline data will be collected as part of the 2014 year-end reporting.

‡Note that these indicators are being re-introduced to the Public Health Funding and Accountability Agreements.

APPENDIX B - 2015 DEVELOPMENTAL INDICATORS

"Developmental Indicator" means a measure of performance or an area of common interest for creating a measure of performance that requires development due to factors such as, but not limited to: the need for new data collection, methodological refinement, testing, consultation or analysis of reliability, feasibility or data quality before being considered to be a Performance Indicator. Developmental Indicators do not have targets and will not be measured in 2015.

HEALTH PROMOTION DEVELOPMENTAL INDICATORS
Assess the effectiveness of public health unit partnerships regarding falls prevention: using a partnership evaluation tool
Track progression on local alcohol policy development: policies that create or enhance safe and supportive environments
Tobacco Prevention: Level of Achievement of Tobacco Use Prevention in Secondary School: progress towards implementation of tobacco-free living initiatives within secondary schools
Obesity Prevention: Policy & Environmental Support Status: healthy eating and physical activity policy development and the creation of supportive environments that will help to reduce childhood obesity
Growth and Development – Parent access to the Nipissing District Developmental Screen™: promotion and implementation of healthy growth and development screen

HEALTH PROTECTION DEVELOPMENTAL INDICATORS
Presence of a certified food handler (CFH) in high-risk food service premises
% of respiratory infection outbreaks in institutions entered into iPHIS where all four required ministry policy questions are 100% complete
Completion of ISPA assessments for 7 and 17 year olds
Vaccine wastage from all sources
Adverse Events Following Immunization (AEFIs) Education and Reporting

From: info@alphaweb.org [mailto:info@alphaweb.org]
Sent: December-12-14 10:37 AM
To: Alida Tanna
Subject: alPHa Information Break - Dec. 12, 2014

alPHa
Association of Local
PUBLIC HEALTH
Agencies

Information Break

December 12, 2014

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

Municipal Primer on Public Health

Next week alPHa will be sending a primer on public health to all successful candidates in the October 2014 municipal election. The two-page primer highlights the need to focus on health, briefly explains what is population health, and summarizes the role and responsibilities of a board of health. A copy of the primer will be made available on the alPHa website at www.alphaweb.org

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NDP Speak Out Against Cuts to Children's Preventive Dental Programs

In a December 8 news conference, MPP France Gélinas, NDP health and long-term care critic, warned the province of the Ontario government's removal of preventive dental services for low-income children under the Ontario Public Health Standards (OPHS). Health units would no longer be mandated to provide basic teeth cleaning and check-ups to this vulnerable group beginning August 2015. The change, she noted, would leave tens of thousands of children at risk of poorer oral health. This message is in line with alPHa's 2014 resolution which calls on the

government to maintain preventive dental programs in the OPHS.
Read the NDP news release here
Read alPHa's resolution A14-8 Maintaining Preventive Dental Services in the Ontario Public Health Standards (OPHS) here

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Private Member's Motion on Fluoridation

On November 27, a Private Member's Motion regarding community water fluoridation was debated and passed in the Ontario Legislature. The Motion calls on the House to express an opinion that "water fluoridation promotes good health, and the optimal concentration of fluoride in drinking water is essential to the health of Ontarians by minimizing tooth decay, and helping restore tooth enamel." Although not a piece of legislation, the Motion received support from MPPs from all political parties. alPHa will be using this information for further advocacy on its resolution that supports community water fluoridation across the province.
Read the transcript of the debate here (scroll down 2/3 of the page)
Read alPHa's resolution A14-4, A Provincial Approach to Community Water Fluoridation here

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Upcoming alPHa Events

February 5, 2015 - Boards of Health Section Meeting and Orientation Session (full day), Novotel Toronto Centre, 45 The Esplanade, Downtown Toronto. Registration coming soon!

February 6, 2015 - Public Health Administrative Assistants' Conference (full day), Novotel Toronto Centre, 45 The Esplanade, Downtown Toronto. Registration coming soon!

February 6, 2015 - COMOH Section Meeting, Novotel Toronto Centre, 45 The Esplanade, Downtown Toronto

June 7-9, 2015 - alPHa Annual Conference and AGM, Marriott Ottawa, 100 Kent Street, Ottawa

Contact: Karen Reece, karen@alphaweb.org, 416-595-0006 ext 24

Change in alPHa Symposiums

Results from our recent member survey indicated support for changes to member networking and learning opportunities. As

part of its new strategic direction, alPHa will no longer be holding its two-day Fall and Winter Symposiums each year, beginning Fall 2014. Instead, business meetings for COMOH and the Boards of Health (BOH) Section and other events will be scheduled in consultation with alPHa's member groups. alPHa will continue to hold its Annual Conference and AGM in early June.

Peterborough County-City
HEALTH UNIT
...because health matters!

December 22, 2014

The Honourable Charles Sousa
Minister of Finance
7 Queen's Park Crescent, 7th floor
Toronto, ON M7A 1Y7

Dear Minister Sousa:

Re: Results of 2014 Nutritious Food Basket for Peterborough County-City Health Unit

As the Minister of Finance, we are writing to you to ensure that poverty reduction remains a high priority for the government. The enclosed results of our 2014 Nutritious Food Basket assessment for the Peterborough County-City Health Unit were presented at the November 12, 2014, Board of Health Meeting, and released to the public, raising the concern that local poverty and food insecurity rates in our community continue to rise. There is an urgent need to address the economic barriers that people living with low incomes experience in accessing healthy food.

The cost of the Nutritious Food Basket in Peterborough City and County in, 2014, for a reference family of four is $196.32 per week or $850.07 per month. The items include nutritious foods based on the four food groups in Canada's Food Guide. There has been a 7.6% increase in local food costs since 2012 and a 14.6% increase in food costs since 2010. Despite the increasing costs of food, the real issue is that incomes are too low and many individuals and family just do not have enough money to pay for their basic needs including shelter and healthy food. This issue poses serious health risks for the public health of our community.

A single person whose source of income is Ontario Works can expect to use 94% of their income to cover rent, making it impossible to afford other basic expenses, such as nutritious food. Based on the Nutritious Food Basket calculation, a single man would need to spend 40% of his total income to eat nutritiously. To cover the cost of shelter and a healthy diet, they would be in a deficit of $245 each month.

We are aware that the government is taking steps to reduce poverty and we welcome the initiatives outlined in *Realizing our Potential: Ontario's Poverty Reduction Strategy 2014-19*. The new poverty reduction strategy is encouraging: however it lacks clean targets and timelines. We would encourage the Province of Ontario to introduce clear implementation and investment plans to ensure the goals of the new strategy are achieved.

We particularly urge the government to increase basic social assistance rates to an amount that is adequate to cover basic living expenses including the cost of healthy eating. This should begin with an immediate increase of $100 a month to those relying on Ontario Works and the

Ontario Disability Support Program. These necessary increases will allow low-income individuals and families to afford to eat healthier foods. Ultimately, this can reduce lifestyle related chronic diseases and higher healthcare costs.

Your urgent attention is required to ensure people living with low incomes have access to healthy food.

Yours in health,

Original signed by

Chief Phyllis Williams
Chair, Board of Health
Peterborough County-City Health Unit

/at
Encl.

cc: Hon. Deb Matthews, Minister Responsible for the Poverty Reduction Strategy/ Deputy Premier
Association of Municipalities of Ontario
Ontario Boards of Health
Association of Local Public Health Agencies

Peterborough County-City
HEALTH UNIT
...because health matters!

December 22, 2014

Hon. Tracy MacCharles
Ministry of Children and Youth Services/
Ministry Responsible for Women's Issues
56 Wellesley Street West, 14th Floor
Toronto, ON M5S 2S3

Dear Minister MacCharles,

It was a pleasure to meet with you at the AMO conference in London earlier this year. Our board of health and county representatives appreciated having the opportunity to express our concerns about provincial funding for Healthy Babies Healthy Children, a program that is extremely valued here in our community. At that time, you expressed an interest in coming to Peterborough and we believe we have identified the perfect opportunity for you to visit.

Peterborough's Food For Kids is a strong and vibrant coalition that is able to rally the support of thousands of volunteers and local donors. Through provincial enhancement funds from the Ministry, two additional schools in Peterborough will be "regionally designated" in January 2015 to receive extra money to run their school nutrition programs. Schools will be chosen based on a variety of factors, and will be ones that currently run a program but will have the funding they receive enhanced to be at a provincially designated level (around 15% of program costs). Perhaps you might be interested in visiting one of these schools to highlight the new funding increase? We see it as a great opportunity to showcase what is already happening.

Depending which schools are chosen to receive this extra funding, we propose visiting one "designated" school to see a program and it's volunteers in action, and then visiting a second school (one we would choose with an exemplary program) to see another model in action (e.g., "Grab & Go", "Bin" model, or "Sit & Serve" breakfast). We would hope that you could be present in the morning, between 8:00 and 9:15 a.m. in order to coincide with the serving of breakfast/morning meal. The date itself is flexible, as long as it's a school day. We understand that the selected schools will receive the additional funding in early February so perhaps that timing could be considered?

The YWCA would also like to invite you to visit their Crossroads shelter, because it really is a state of the art design, and the Ministry made a very important contribution to its development. This would also be an opportunity to learn firsthand about Peterborough's "START", a unique Violence Against Women Hub, which provides one stop service to women newly disclosing violence and abuse, bringing 6 - 8 service providers together one day a week, allowing the woman to personally learn about and meet agency staff whose help she will need, all in one day. In addition, you would probably be very interested in knowing more about the

public health-YWCA partnership in community food programs, and how we see food linked to the issues of Violence Against Women and women and children in poverty.

It would be an honour to host you here in Peterborough. In addition to the School Nutrition program and the YWCA, we would be happy to showcase any of the programs, such as Healthy Babies, Healthy Children, that you oversee and fund. We look forward to hearing from you.

Yours in health,

Original signed by

Chief Phyllis Williams
Chair, Board of Health
Peterborough County-City Health Unit

/at

cc: Lynn Zimmer, Executive Director, YWCA Peterborough Haliburton
Brenda Dales, Chair, Food For Kids Peterborough and County

cc'd. KAREN C.

Ministry of Children and Youth Services

Minister's Office

56 Wellesley Street West
14th Floor
Toronto ON M5S 2S3
Tel.: 416 212-7432
Fax: 416 212-7431

Ministère des Services à l'enfance et à la jeunesse

Bureau de la ministre

56, rue Wellesley Ouest
14e étage
Toronto ON M5S 2S3
Tél. : 416 212-7432
Téléc. : 416 212-7431

Ontario

DEC 2 2 2014

CSS5111C-2014-2400

Chief Phyllis Williams
Chair, Board of Health
Peterborough County-City Health Unit
10 Hospital Drive
Peterborough, Ontario
K9J 8M1

Dear Chief Williams:

Thank you for your letter regarding funding for Peterborough County-City Health Unit's Healthy Babies Healthy Children program. I appreciate the opportunity to respond and provide you with some information.

As you are aware, healthy child development programs, funded by the Ministry of Children and Youth Services, are important components to helping children reach their full potential in Ontario. Despite a very challenging economic climate over the last decade, significant enhancements have been introduced to strengthen the Healthy Babies Healthy Children program. These included the introduction of a new protocol, including investments in province-wide education and training to practitioners in order to enhance home visiting outcomes. This also included additional funding for liaison nurses in support of a streamlined screening process designed to get vulnerable families into services more quickly. These investments represent a renewed focus on early identification and intervention for vulnerable families.

Additionally, the ministry has worked with Public Health Ontario over the last year on a process for evaluating the implementation of the new protocol. This provided information on families identified with risk and not identified with risk. It also provided information on facilitators and barriers to implementation, and the degree to which the program change goals were met. Public Health Ontario has presented its provincial findings at the Healthy Babies Healthy Children Directors and Managers meeting in May 2014 and is currently delivering individual reports to each health unit. I would like to thank Peterborough County-City Health Unit for its active involvement in all aspects of the evaluation.

.../cont'd

Based on the findings of the evaluation and ongoing work with our Healthy Babies Healthy Children Advisory Committee, we look forward to continued partnerships with public health units to fully implement all aspects of the renewed Healthy Babies Healthy Children program.

We appreciate that the health unit has had to make some challenging decisions and will consider supporting these decisions in the future through various methods, including the soon to be launched continuous quality improvement process. This new approach to program management will enable health units to use program data in support of service delivery decisions and consider small quality improvement initiatives that can impact overall program outcomes.

Again, thank you for writing and for your continued partnership and engagement in helping improve the health and well-being of children and families in Ontario.

Sincerely,

Tracy MacCharles
Minister

From: info@alphaweb.org [mailto:info@alphaweb.org]
Sent: January-08-15 12:42 PM
To: Alida Tanna
Subject: alPHa Information Break - Jan. 8, 2015

alPHa
Association of Local
PUBLIC HEALTH
Agencies

Information Break

January 8, 2015

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

Ontario Liberals Passed Nine Bills in Most Recent Session

Premier Kathleen Wynne's government has passed nine bills since July 2014 to improve the quality of life for Ontarians, according to a December 11 news release. The house is presently on winter break and will hold public pre-budget consultations around the province from January 19 to 30 before resuming in February.
Read the December 11 news release here

Board of Health Vacancies on alPHa Board

alPHa is currently looking to fill two board of health representative vacancies on its 2014-

2015 Board of Directors, one each from the Central West region and Southwest region. Interested candidates should contact alPHa's Susan Lee at susan@alphaweb.org for further information.

Board of Health Governance Toolkit

alPHa has released its *Governance Toolkit for Ontario Boards of Health* in an effort to assist board of health members and their work. The toolkit contains practical tools and templates on a variety of governance-related subjects and is a companion document to alPHa's *Orientation Manual for Board of Health Members*. An online version of the Governance Toolkit is under development.
Click here to view the BOH governance toolkit

Municipal Flyer on Public Health

In December alPHa sent a public health flyer to successful candidates in the October 2014 municipal election as local governments are getting re-established following the election and some candidates are being assigned to boards of health. The flyer highlights the unique role municipal members play in shaping the conditions for their communities' health as well as the role of the board of health and public health unit. The flyer has received positive feedback from recipients across the province.
Read alPHa's municipal information flyer here

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alPHa Website Feature: Current Consultations

alPHa's website keeps a running tab on current public consultations. The Ministry of Environment and Climate Change is presently seeking input into its *Technical Discussion Paper on Proposed Ontario Drinking Water Quality Standards*. The deadline to respond is February 16.

Click here to learn more and provide your input

Upcoming alPHa Events

February 5, 2015 - Boards of Health Orientation Session (full day), Novotel Toronto Centre, 45 The Esplanade, Downtown Toronto. Click here to register.

February 6, 2015 - Public Health Administrative Assistants' Conference (full day), Novotel Toronto Centre, 45 The Esplanade, Downtown Toronto. Program information coming soon! Click here to register.

February 6, 2015 - COMOH Section Meeting, Novotel Toronto Centre, 45 The Esplanade, Downtown Toronto. Session open to COMOH members only. Click here to register.

June 7-9, 2015 - alPHa Annual Conference and AGM, Marriott Ottawa, 100 Kent Street, Ottawa

Contact: Karen Reece, karen@alphaweb.org, 416-595-0006 ext 24

Change in alPHa Symposiums

Results from our member survey in 2013 indicated support for changes to member networking and learning opportunities. As part of its new strategic direction, alPHa will no longer be holding its two-day Fall and Winter Symposiums each year, beginning Fall 2014. Instead, business meetings for COMOH and the Boards of Health (BOH) Section and other events will be scheduled in consultation with alPHa's member groups. alPHa will continue to hold its Annual Conference and AGM in early June.

December 18, 2014

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

Dear Dr. Hoskins:

On December 18, 2014, the Windsor-Essex County Health Unit Board of Health passed the following resolution regarding community water fluoridation:

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

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

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

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

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

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

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

Continued to page 2

WINDSOR-ESSEX COUNTY HEALTH unit
Bureau de santé de Windsor-comté d'Essex

519-258-2146
1-800-265-5822
www.wechu.org

WINDSOR 1005 Ouellette Avenue, Windsor, ON N9A 4J8
ESSEX 360 Fairview Avenue West, Suite 215, Essex, ON N8M 3G4
LEAMINGTON 215 Talbot Street East, Leamington, ON N8H 3X5

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

Yours very truly,

Gary McNamara
Chair, Board of Health

Dr. Gary M. Kirk
Associate Medical Officer of Health and CEO

F:\Administration\Committees\Board\Letters\Board Resolutions\2014 Resolution Letters\CWF letter to Dr Hoskins-Dec 18 2014.docx

cc: Board Members, Windsor-Essex Board of Health
Local MPPs
Mary Brennan, Director, Council Services (distribution to County Councillors)
Becky Murray, City Council Services (distribution to City Councillors)
Ms. Monika Turner, Director of Policy, AMO
Dr. David Mowat, Interim Chief Medical Officer of Health
The Honourable Tracy MacCharles, Minister of Children and Youth Services
Dr. Jerry Smith, President, Ontario Dental Association
Dr. Charles Frank and Dr. Lesli Hapak, Board Members, Ontario Dental Association
Dr. Matt Duronio, President, Essex County Dental Society
Dr. Peter Cooney, Canadian Oral Health Advisor, Public Health Agency of Canada
Dr. Haider Hasnan, President, Essex County Medical Society
Dr. Peter Donnelly, President and CEO, Public Health Ontario
Ontario Association of Public Health Dentistry
Ms. Sue Makin, President, The Ontario Public Health Association
Ms. Amy MacDonald, Co-Chair, Ontario Society of Nutrition Professionals in Public Health
Mr. Gordon Fleming, Manager of Public Health Issues, alPHa
Mr. Adam Vasey, Director, Pathway to Potential
Ontario Boards of Health

simcoe muskoka
DISTRICT HEALTH UNIT

November 19, 2014

Health Products and Food Branch Inspectorate
Director General, Health Products and Food Branch Inspectorate
3rd Floor, Graham Spry Building
250 Lanark Avenue
Ottawa, Ontario
K1A 0K9

Dear Director General, Health Products and Food Branch Inspectorate:

As you know, the use and availability of electronic cigarettes is booming and their use is rapidly gaining popularity among youth and young adults in Ontario and nationally. A 2014 study by Czoli, Hammond, and White of Canadian youth and young adults age 16-30 years, found that close to half of respondents (43.4%) had seen e-cigarettes advertised or for sale and a total of 16.1% reported trying an e-cigarette.

E-cigarettes that do not contain nicotine and do not make a health claim can be imported, advertised or sold in Canada without restrictions. However, e-cigarettes that contain nicotine or that make a health claim are regulated under the Food and Drugs Act and accordingly, require market authorization by Health Canada prior to being imported, advertised or sold in Canada. No such e-cigarettes have market authorization. Nevertheless, e-cigarettes with nicotine continue to be easy to obtain in Canada, whether through corner stores, dedicated retailers or online. Lack of enforcement of current legislation impacts significantly on this widespread availability.

No formal safety requirements exist regarding product development, ingredient disclosure, nicotine levels, product safety, or packaging, creating an environment where unregulated, unproven, and potentially unsafe products are widely available posing tremendous health risks to consumers. E-cigarettes are also not subject to the packaging, labelling, advertising, promotion and sponsorship restrictions that apply to traditional cigarettes and other tobacco products therefore e-cigarettes are increasingly being marketed to youth and young adults through product flavouring, celebrity endorsements, event sponsorship and free product offers.

The main areas of concern regarding e-cigarettes include the possibility that children (non-smokers) will initiate nicotine use with electronic cigarettes and once addicted to nicotine will switch to cigarette smoking, and the possibility that everything that makes electronic cigarettes attractive to smokers may enhance the attractiveness of smoking itself and perpetuate the smoking epidemic. Also noteworthy is the current trend by some smokers to use electronic cigarettes to cut down rather than quit smoking conventional cigarettes (“dual use”), leading to suggestions that electronic cigarettes may act to prolong cigarette smoking rather than support cessation efforts carrying far greater health benefits.

The wide availability, countertop displays, advertising and promotion of electronic cigarettes confuses the public about the existing laws and undermines the denormalization of tobacco use to date. The more visible smoking behaviour becomes, the more socially acceptable it

appears. It is discouraging to see the significant health benefits provided by years of tobacco control eroded by the proliferation of electronic cigarette use and availability.

The Board of Health, for the Simcoe Muskoka District Health Unit, respectfully recommends that Health Canada:

a. enforce current legislation regarding the sale and promotion of nicotine containing e-cigarettes;
b. enforce current prohibitions on e-cigarettes making a health claim without appropriate assessment, evaluation and market authorization; and
c. monitor and conduct research on adverse health effects of e-cigarette use and second-hand exposure.

We look forward to your leadership on this emerging issue in tobacco control.

Sincerely,

ORIGINAL SIGNED BY

Barry Ward
Chair, Board of Health
Simcoe Muskoka District Health Unit

c. Dr. David Mowat, Interim Chief Medical Officer of Health
Association of Local Public Health Agencies
All Ontario Boards of Health
Local M.P.s for Simcoe Muskoka

simcoe muskoka
DISTRICT HEALTH UNIT

November 19, 2014

The Honourable Rona Ambrose, P.C., M.P.
Federal Minister of Health
Health Canada
Brooke Claxton Building, Tunney's Pasture
Postal Locator: 0906C
Ottawa, Ontario K1A 0K9

Dear Minister Ambrose:

The use and availability of electronic cigarettes is booming and their use is rapidly gaining popularity among youth and young adults in Canada. A 2014 study by Czoli, Hammond, and White of Canadian youth and young adults age 16-30 years, found that close to half of respondents (43.4%) had seen e-cigarettes advertised or for sale and a total of 16.1% reported trying an e-cigarette.

In Canada, e-cigarettes that contain nicotine or that make a health claim are regulated under the Food and Drugs Act and accordingly, require market authorization by Health Canada prior to being imported, advertised or sold in Canada. No such e-cigarettes have market authorization. Nevertheless, e-cigarettes with nicotine continue to be easy to obtain in Canada, whether through corner stores, dedicated retailers and online. E-cigarettes that do not contain nicotine and do not make a health claim can be imported, advertised or sold in Canada without restrictions.

No formal safety requirements exist regarding product development, ingredient disclosure, nicotine levels, product safety, or packaging. Creating an environment where unregulated, unproven, and potentially unsafe products are widely available posing tremendous health risks to consumers. E-cigarettes are also not subject to the packaging, labelling, advertising, promotion and sponsorship restrictions that apply to traditional cigarettes and other tobacco products therefore e-cigarettes are increasingly being marketed to youth and young adults through product flavouring, celebrity endorsements, event sponsorship and free product offers.

The main areas of concern regarding e-cigarettes include the possibility that children (non-smokers) will initiate nicotine use with electronic cigarettes and once addicted to nicotine will switch to cigarette smoking, and the possibility that everything that makes electronic cigarettes attractive to smokers may enhance the attractiveness of smoking itself and perpetuate the smoking epidemic. Also noteworthy is the current trend by some smokers to use electronic cigarettes to cut down rather than quit smoking conventional cigarettes (“dual use”), leading to suggestions that electronic cigarettes may act to prolong cigarette smoking rather than support cessation efforts carrying far greater health benefits.

The wide availability, countertop displays, stores specifically established to sell these products, advertising and promotion of electronic cigarettes confuses the public about the existing laws and undermines the denormalization of tobacco use to date. The more visible smoking

behaviour becomes, the more socially acceptable it appears, particularly to youth. It is discouraging to see the significant health benefits provided by years of tobacco control potentially eroded by the proliferation of electronic cigarette use and availability.

The Board of Health for the Simcoe Muskoka District Health Unit respectfully recommends that Health Canada amend federal legislation to:

a. regulate all e-cigarettes, cartridges and liquids to ensure manufacturing consistency and accurate labelling;
b. require that e-cigarette liquids are sold in child-proof bottles; and
c. restrict e-cigarette marketing, advertising and promotion, consistent with the existing tobacco legislation.

We look forward to your leadership on this emerging issue in tobacco control.

Sincerely,

ORIGINAL SIGNED BY

Barry Ward
Chair, Board of Health
Simcoe Muskoka District Health Unit

c. Dr. Eric Hoskins, Ontario Minister of Health and Long-Term Care
Hon. Dipika Damerla, Associate Minister of Health and Long-Term Care
Dr. David Mowat, Interim Chief Medical Officer of Health
Association of Local Public Health Agencies
All Ontario Boards of Health
Local M.P.s for Simcoe Muskoka

simcoe muskoka
DISTRICT HEALTH UNIT

November 19, 2014

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

Dear Minister Hoskins:

The use and availability of electronic cigarettes is booming and their use is rapidly gaining popularity among youth and young adults. The 2013 Ontario Student Drug Use and Health Survey found that 15 % of high school students had tried an electronic cigarette.

Electronic cigarettes do not currently fall under the definition of smoking or holding lit tobacco under the Smoke-Free Ontario Act (SFOA). Legally, this means that electronic cigarettes could be used in enclosed public places and workplaces or in other places where smoking is prohibited. Permitting the use of electronic cigarettes indoors, in places where smoking is banned under the Smoke-Free Ontario Act (SFOA) or existing bylaws can create enforcement challenges and undermine the work that has been done in tobacco control thus far.

Electronic cigarettes are also not subject to the prohibitions under the Smoke-Free Ontario Act (SFOA) that restrict sales to minors, as well as the display, advertising or promotion of conventional tobacco products, therefore electronic cigarettes can be displayed, advertised, promoted and sold anywhere, anyway to anyone of any age. Currently electronic cigarettes using liquids in a variety of youth friendly flavours can be found on retailer countertops and in stores specifically established to sell this product.

The main areas of concern regarding e-cigarettes include the possibility that children (non-smokers) will initiate nicotine use with electronic cigarettes and once addicted to nicotine will switch to cigarette smoking, and the possibility that everything that makes electronic cigarettes attractive to smokers may enhance the attractiveness of smoking itself and perpetuate the smoking epidemic. Also noteworthy is the current trend by some smokers to use electronic cigarettes to cut down rather than quit smoking conventional cigarettes (“dual use”), leading to suggestions that electronic cigarettes may act to prolong cigarette smoking rather than support cessation efforts carrying far greater health benefits.

The Board of Health, for the Simcoe Muskoka District Health Unit, respectfully recommends that the Smoke Free Ontario Act and Regulations be amended to:
a. prohibit electronic cigarette use wherever smoking is prohibited;
b. prohibit sales of flavoured electronic cigarette products; and
c. prohibit electronic cigarette displays in retail stores; and
d. restrict sales of electronic cigarettes to minors.

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

The accomplishments of the Ministry of Health and Long-term Care under the Smoke-free Ontario Act are significant and we look forward to your leadership on this emerging issue in tobacco control.

Sincerely,

ORIGINAL SIGNED BY

Barry Ward
Chair, Board of Health
Simcoe Muskoka District Health Unit

c. Hon. Dipika Damerla, Associate Minister of Health and Long-Term Care
Dr. David Mowat, Interim Chief Medical Officer of Health
Association of Local Public Health Agencies
All Ontario Boards of Health
Ontario Public Health Agency
Local M.P.P.s for Simcoe Muskoka
North Simcoe Muskoka and Central LHINs

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November 7, 2014

VIA ELECTRONIC MAIL

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

The Honourable Liz Sandals
Minister of Education
22nd Floor, Mowat Block
900 Bay Street
Toronto, ON M7A 1L2

Dear Ministers:

Re: Support for Regulation on the manufacture, sale, promotion, display, and use of e-cigarettes and prohibiting the use of e-cigarettes on school property

At its meeting on October 16, 2014, the Sudbury & District Board of Health considered the issue of e-cigarettes in the context of our ongoing concerns about smoking rates, particularly among youth. I am pleased to share with you the related Board resolution. Motion #57-14 calls for regulation of the manufacture, sale, promotion, display, and use of e-cigarettes and prohibition of the use of e-cigarettes on school property:

WHEREAS electronic cigarettes (e-cigarettes) mimic the appearance, use, and sometimes the taste of a cigarette and some use cartridges which contain nicotine, an addictive substance; and

WHEREAS e-cigarettes that contain nicotine or make a health claim are illegal in Canada however there is no legislation that regulates the sale and use of e-cigarettes that do not contain nicotine or make health claims; and

WHEREAS e-cigarettes could have potential as a cessation aid, there is limited data on their overall effectiveness to do so. Health Canada and the World Health Organization advise against the use of e-cigarettes, due to uncertainty around their safety, quality, and efficacy as a smoking cessation aid; and

WHEREAS e-cigarettes may undermine current tobacco control efforts by re-normalizing smoking behaviour and becoming a gateway to cigarette smoking by youth; and

THEREFORE BE IT RESOLVED that the Sudbury & District Board of Health support the efforts of alPHa, Ontario Boards of Health and other public health agencies and provincial organizations and strongly recommend implementation of federal regulations on the manufacturing and quality of e-cigarettes, the promotion, display and sale of e-cigarettes to minors, and the use of e-cigarettes in workplaces and public places; and

FURTHER THAT the Sudbury & District Board of Health recommend prohibiting the use of e-cigarettes on school property; and

FURTHER THAT this motion be forwarded to Health Canada, the Honourable Rona Ambrose, MP, local MPs, alPHa and Ontario Boards of Health.

It is the Board's hope that you will seriously consider the aspects of this important health issue that fall within provincial jurisdiction.

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

Sincerely,

Penny Sutcliffe, MD, MHSc, FRCPC
Medical Officer of Health

cc: Joe Cimino, Member of Provincial Parliament, Sudbury
France Gélinas, Member of Provincial Parliament, Nickel Belt
Michael Mantha, Member of Provincial Parliament, Algoma-Manitoulin
John Vanthof, Member of Provincial Parliament, Timiskaming-Cochrane
Linda Stewart, Executive Director, Association of Local Public Health Agencies
Pegeen Walsh, Executive Director, Ontario Public Health Association
Ontario Boards of Health

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November 25, 2014

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

Dear Premier:

The Board of Health for Timiskaming Health Unit recently passed the enclosed resolution, Regulating the Manufacture, Sale, Promotion, Display, and Use of E-Cigarettes, at their November 5th, 2014 meeting.

We sincerely hope you will support us in our efforts to encourage local government, businesses and organizations to prohibit e-cigarettes use wherever tobacco smoking is prohibited by provincial or municipal law.

Sincerely,

Carman Kidd
Board of Health Chairperson

Marlene Spruyt
Medical Officer of Health/Chief Executive Officer

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RESOLUTION

Date:	November 5th, 2014
Resolution #:	**02-2014**
Title:	**Regulating the Manufacture, Sale, Promotion, Display, and Use of E-Cigarettes**
MOVED BY:	Mike McArthur
SECONDED BY:	Jamie Morrow

At its November 5th, 2014 meeting, the Timiskaming Board of Health passed the following resolution

Whereas as outlined in the Toronto Public Health Position Statement on Electronic Cigarettes (August 1, 2014), e-cigarette use in Canada is a public health concern for the following reasons:

- there is emerging evidence of health and safety risks associated with e-cigarette devices, vaping, and exposure to second-hand vapour;
- quality control and manufacturing standards for e-cigarettes are lacking;
- youth use of e-cigarettes could lead to smoking initiation and consequently nicotine addiction; and
- e-cigarette use may impair efforts to denormalize all smoking behaviour and promote a smoke-free lifestyle to children, youth and current or former smokers who are trying to quit.

Therefore be it resolved that the Timiskaming Health Unit supports Toronto Public Health recommendations that federal and provincial government subject electronic cigarettes (with or without nicotine) to the following:

i. prohibit e-cigarette use wherever smoking is prohibited through the Smoke-Free Ontario Act;
ii. prohibit sales of flavoured e-cigarette products as has been proposed for tobacco products;
iii. prohibit e-cigarette sales to minors (people under age 19);
iv. E-cigarettes should be subject to restrictions on marketing, promotion, retail displays, and advertising;
v. E-cigarette devices, cartridges and liquids should be subjected to strict consumer safety standards including ensuring manufacturing consistency, regulating the maximum quantity/dosage of nicotine they contain, stipulating labelling and reporting requirements and requiring that e-liquid is sold in child-proof bottles; and
vi. research on the long-term health effects of e-cigarettes and exposure to second hand vapour.

Furthermore be it resolved that until these recommendations are implemented, the Timiskaming Health Unit encourages local government, businesses and organizations to adopt similar policies regarding the use of e-cigarettes on their property. These internal policies should prohibit e-cigarette use (vaping) wherever tobacco smoking is prohibited by provincial or municipal law including:

- in indoor public places and workplaces, such as restaurants, stores, universities and colleges, offices, hospitals and common areas of residential buildings;
- on indoor or outdoor school property; and
- within a specified distance of an entrance or exit of any building that is used by the public.

Businesses and organizations are invited to contact the THU for assistance in developing a local policy that addresses e-cigarette use.

AND FURTHER that the Premier of Ontario, the Chief Medical Officer of Health, Ontario Public Health Association, Prime Minister of Canada, Chief Public Health Officer of Canada, Federal Minister of Health, and Ontario's Minister of Health and Long-Term Care as well as local municipalities, hospitals, boards of education, restaurants and workplaces be so advised.

X Carried
☐ Defeated

Chair - Board of Health

Copy to: Ms. Kathleen Wynne, Premier of Ontario
Dr. David Mowat, Chief Medical Officer of Health
Mr. Stephen Harper, Prime Minister of Canada
Dr. Gregory Taylor, Chief Public Health of Canada
Ms. Rona Ambrose, Federal Minister of Health
Dr. Eric Hoskins, Minister of Health and Long-Term Care
Ms. Pegeen Walsh, Executive Director - OPHA
Local Municipalities
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November 7, 2014

VIA ELECTRONIC MAIL

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

Dear Minister:

Re: Support for Ontario's Doctors Call on Government to Bring Back Flavoured-tobacco Legislation including a Ban on Menthol Cigarettes

At its meeting on October 16, 2014, the Sudbury & District Board of Health passed the following motion #62-14 Flavoured Tobacco Menthol:

WHEREAS in 2013, approximately 5.6% of students in Grades 7 to 12 in the Sudbury & District Health Unit (SDH) area reported having smoked cigarettes daily in the past year (3.4% Ontario); and

WHEREAS the overall prevalence of smoking in the SDHU area is significantly higher than that for the province (26.4% versus 19.2%, daily or occasional smokers of ages 12 and over, 2011-2012); and

WHEREAS 1 in 4 Ontario youth in Grades 9-12 who report smoking, say they smoked menthol cigarettes; and

WHEREAS evidence suggests that at least some of the youth smoking menthol cigarettes choose to do so because they didn't like the flavour of regular cigarettes; and

WHEREAS the United States Food and Drug Administration determined that while menthol in cigarettes is not a toxic ingredient, menthol makes already toxic cigarettes more appealing cigarettes, and is therefore a public health risk above that seen with non-menthol cigarettes, and

WHEREAS the Sudbury & District Board of Health has a longstanding history of action and advocacy to prevent tobacco use and promote tobacco use cessation, and

THEREFORE BE IT RESOLVED that the Sudbury & District Board of Health strongly endorse the Ontario Medical Association's call on government to re-introduce tobacco legislation banning candy and fruit flavoured cigarettes while adding to it a ban on the sale of menthol cigarettes and tobacco products; and

FURTHER that this motion be shared with appropriate local, public health and government partners.

It is the Board's hope that you will consider this motion as you strategize to further prevent tobacco use, particularly among youth. The Board of Health's work to promote and protect health at the local level is greatly facilitated by strong public health action at the provincial government level.

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

Sincerely,

Penny Sutcliffe, MD, MHSc, FRCPC
Medical Officer of Health

cc: Joe Cimino, Member of Provincial Parliament, Sudbury
France Gélinas, Member of Provincial Parliament, Nickel Belt
Michael Mantha, Member of Provincial Parliament, Algoma-Manitoulin
John Vanthof, Member of Provincial Parliament, Timiskaming-Cochrane
Linda Stewart, Executive Director, Association of Local Public Health Agencies
Pegeen Walsh, Executive Director, Ontario Public Health Association
Ontario Medical Association
Ontario Boards of Health

Algoma
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Dr. Kimberley Barker, MD CCFP MPH FRCPC
Medical Officer of Health
www.algomapublichealth.com

November 13, 2014

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

Dear Hon. Minister Hoskins:

To ensure equitable access for all children within the District of Algoma, the Board of Health has passed the attached resolution that recommends the Ministry of Health and Long-Term Care considers maintaining preventive oral health services within the Ontario Public Health Standards.

If preventive services are removed from the Ontario Public Health Standards, it is estimated that 843 children in the Algoma District will no longer qualify for these services. The Board of Health urges the province to take positive action to meet the needs of our population with respect to these crucial services.

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

Sincerely,

Dr. Kimberley Barker, MD CCFP MPH FRCPC
Medical Officer of Health

Attachment

KB/cl

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Algoma
PUBLIC HEALTH
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RESOLUTION NO. 101

DATE: October 15, 2014

MOVED: Tom Farquhar

SECONDED: Janet Blake

Re: Maintaining Preventive Dental Services and Urgent Care Programs in the Ontario Public Health Standards

WHEREAS in August 2015, the Ministry of Health and Long-Term Care will integrate six publicly funded dental programs into one common program. This new program will have a family financial means test to determine eligibility; it will no longer consider oral health needs; and

WHEREAS under the new program the Preventive Oral Health Services and the Children in Need of Treatment Standard will be removed from the Ontario Public Health Standards, 2008; and

WHEREAS the current programs Children In Need of Treatment (CINOT), CINOT Expansion and Preventive Services considers dental need and financial hardship; and

WHEREAS Children that do not meet the financial eligibility will no longer qualify to receive preventive services, resulting in the exclusion of approximately 843 children in the Algoma District; and

WHEREAS the impact may cause a financial hardship for low income families in our area who may no longer qualify for dental services and will have to pay out of pocket for these services. This will create barriers and health inequities for the children of Algoma; and

WHEREAS children with unmet dental needs will be at risk of falling into system gaps, which can lead to more extensive and costly dental treatment and put children's overall health at risk; and

THEREFORE BE IT RESOLVED THAT the current eligibility for preventive dental services under the Ontario Public Health Standards and access to one full course of treatment for children with urgent dental needs be maintained in order to ensure equitable access to preventive oral health services for all children;

FURTHERMORE THAT copies of this resolution be forwarded to the Minister of Health and Long Term Care, local municipalities and all Ontario Boards of Health.

CARRIED: Chair's Signature

Chair: Marchy Bruni
Vice-chair: Janet Blake
Robert Ambeault
Carmen Bondy
John Currie
Brenda Davies
Tom Farquhar
Debbie Kirby
Karen Marinich
Gordon Post
Ron Rody

HALIBURTON, KAWARTHA, PINE RIDGE DISTRICT HEALTH UNIT
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November 20, 2014

The Honorable Dr. Eric Hoskins
Minister of Health and Long-Term Care
Hepburn Block, 10th Floor
80 Grosvenor Street
Toronto, ON M7A2C4

Dear Minister Hoskins:

Re: Maintaining preventive dental services in the Ontario Public Health Standards (OPHS) and one full course of dental care for children with urgent dental needs

In December 2013 the Ministry of Health and Long-Term Care (MOHLTC) announced its plans to integrate the six provincially-funded oral health programs for children and youth by August 2015. The integration of these programs into one basket of services will streamline administration and delivery of services, with the intention of reducing confusion for families looking to access dental care.

As part of the integration however, the MOHLTC plans to remove clinical preventive oral health services performed by health unit staff from the OPHS. In addition, the integration would also mean that some children with urgent dental conditions would no longer be eligible for one full course of dental treatment to restore dental health, as they currently are through the Children In Need of Treatment program.

Caries rates have shown to be on the rise for preschool aged children and within the Haliburton Kawartha Pine Ridge District (HKPR) Health Unit area with total decay rates of junior and senior kindergarten students increasing from 34% to 37% in the last three school years. Dental infection if left untreated, can negatively affect a child's sleep, nutritional intake, speech development, self-esteem, learning at school and overall quality of life. In the HKPR area the need for access to preventive services is further compounded by the fact that there is no fluoride in the drinking water.

The removal of preventive services, which has been shown to be highly effective in reducing caries rates among children from the OPHS, and the new financial cut offs for children at high risk of dental disease who previously had access to preventive clinics and CINOT, creates a new service gap that will result in an oral health disparity for these vulnerable children. This is

contrary to the Ontario Public Health mandate that generally takes on a universal, population-based approach and does not screen out clients based on financial status.
These changes would mean that as of August 2015, only children whose families can establish financial eligibility for the new integrated program would be eligible to receive publicaly-funded preventive dental services; and any child with urgent dental needs whose family does not qualify financially for the new program *may* have access to dental treatment that would only address his/her specific problem. The concern is that these changes will lead to less children accessing preventive oral health services, more children living with dental problems, and ultimately a decline in the oral health of children in Ontario.

As such, please find enclosed the resolution backgrounder and motion endorsed by the Haliburton, Kawartha, Pine Ridge District Health Unit Board of Health at its October 16, 2014 board meeting. While HKPR recognizes and supports the integration of provincially-funded children's dental programs, we urge you to reconsider the removal of Oral Health Preventive Services from the OPHS and maintain access to one full course of treatment and prevention for children with urgent dental conditions.

Sincerely,

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

Mark Lovshin, Chair, Board of Health

cc: The Honorable Liz Sandals, Minister of Education
The Honorable Tracy MacCharles, Minister of Children and Youth Services
Ontario Boards of Health
Dr. Arthur Worth, President, Ontario Dental Association
Dr. Peter Cooney, Canadian Oral Health Advisor, Public Health Agency of Canada
Dr. Peter Donnelly, President and CEO, Public Health Ontario
Dr. Maria VanHarten, President, Ontario Association of Public Health Dentistry
Ms. Pegeen Walsh, Executive Director, The Ontario Public Health Association
Ms. Linda Stewart, Executive Director, Association of Local Public Health Agencies

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Haliburton, Kawartha, Pine Ridge District Health Unit

Board of Health

Resolution Recommendation

2014 November 20

Issue: Impact of the removal of preventive dental services from the OPHS and loss of full dental care for children with urgent dental needs

In December 2013 the Ministry of Health and Long-Term Care (MOHLTC) announced its plans to raise the financial eligibility threshold for the Healthy Smiles Ontario (HSO) program starting this past April 2014 and integrate the six provincially funded oral health programs for children and youth by August 2015. The integration of these programs into one basket of services will streamline administration and delivery of services, with the intention of reducing confusion for families looking to access dental care[1-3].

As part of the integration, the MOHLTC plans to remove clinical preventive oral health services performed by health unit staff from the Ontario Public Health Standards (OPHS). The current protocol states "the board of health shall provide or ensure the provision of the essential clinical preventive oral health services at least annually in accordance with the Preventive Oral Health Services Protocol, 2008"[4]. Preventive services include: professionally applied topical fluoride, pit and fissure sealants and scaling.

Currently, the Children In Need of Treatment (CINOT) program, provides children with an urgent dental condition one full course of treatment to restore dental health. This eligibility would be lost for some children with the new integrated program.

These changes would mean that, as of August 2015, only children whose families can establish financial eligibility for the new integrated program would be eligible to receive publically funded preventive dental services; and any child with urgent dental needs whose family does not qualify financially for the new program *may* have access to dental treatment that would only address his/her specific problem. The concern is that these changes will lead to less children accessing preventive oral health services, more children living with dental problems, and ultimately a decline in the oral health of children in Ontario.

Background

The proposed changes

On December 16, 2013, the MOHLTC announced its plan to raise the current income eligibility threshold for HSO starting in April 2014. The threshold would vary according to the number of children in the family. At this time the government also stated its intention to integrate the

following provincially funded dental programs for children and youth by August 2015: Children In Need of Treatment (CINOT), HSO, Ontario Works, Ontario Disability Support Program, Assistance for Children with Severe Disabilities and preventive services under the OPHS[1].

To summarize, the following is a list of the proposed changes that will take place according to the MOHLTC[2]:

1. Administration and eligibility determination for the new dental program will be centralized and contracted out;
2. The new dental program will be 100% funded by the Province;
3. Local Public health units will no longer be mandated under OPHS to provide prevention services to children and youth*;
4. Prevention services will be included in the basket of services of the new dental program so only children who are financially eligible for the new provincially funded treatment program will be eligible for publicly funded dental prevention services; and
5. It is being proposed that children who have urgent dental needs, i.e. pain, infection, abscess, broken teeth, etc., and whose families cannot meet/establish financial eligibility for the new provincial dental program will no longer be eligible to get one course of treatment and prevention to restore them to health, as they currently are through the CINOT program. Instead they may only be eligible for treatment to address the urgent/emergency condition.

* Under the current standards, children aged 17 and under are eligible to receive public health delivered preventive services if they meet specific clinical criteria, have no dental coverage, meet the financial criteria of Low Income Cut Off (LICO) + 20% or under (as noted in the OPHS) and are unable to obtain preventive care due to cost. Ontario health units are required to conduct oral health assessment and surveillance. During oral health screening Registered Dental Hygienists determine if children are dentally eligible for any or all of the three mandated services under the Preventive Services Protocol.

What the proposed changes would mean

Of great concern is change #3 that involves removing preventive services from the OPHS. To date, preventive services including professionally applied topical fluoride, pit and fissure sealants and scaling have been available to all children with an identified need. If this change is moved forward than only children and teens whose families meet the eligibility requirements for the HSO program will be eligible for the following preventive services:

- **Professionally applied topical fluoride** – A caries-inhibiting procedure that is associated with a 46 per cent reduction in decayed , missing and filled tooth surfaces[5].
- **Pit and fissure sealants** – A plastic coating applied to molar teeth, which has proven to be a highly effective preventive treatment. After placement of sealants the reduction of

caries incidence in children and adolescents range from 86 % at one year, 78.6% at 2 years and 58.6% at 4 years[5].

- **Scaling** – The removal of hard deposits from teeth (calculus) to reduce inflammation and possible destruction of soft tissues and the supporting structures of the teeth.

Another concern is change #5 above. Currently, families qualify for CINOT if they have an urgent dental need and the family states that they do not have dental insurance and cannot afford to pay for dental care. CINOT will treat a child's urgent problem and provide his/her with one full course of dental treatment and preventive care to restore his/her dental health. If the change regarding children with urgent needs occurs, children with serious dental concerns whose families do not qualify financially for the new integrated program *may* have access to dental care to treat only their urgent dental need.

Why there is a need for preventive care for children

Dental caries is the most common chronic disease to affect children, more common than asthma[5]. Fifty-seven percent of 6-11 year olds and 59% of 12-19 year olds have experienced decay[6]. Caries rates are increasing for preschool aged children[7]. This increase has occurred in our health unit area with school screening reports from the past three school years showing total decay rates of junior and senior kindergarten students going from 34.5% in 2011/2012, 36.5% in 2012/2013 to 37% in 2013/2014[8].

Dental infection if left untreated, can negatively affect a child's sleep, nutritional intake, speech development, self-esteem, learning at school and overall quality of life. In the HKPR District Health Unit area the need for access to preventive services is further compounded by the fact that there is no fluoride in the drinking water.

The removal of preventive services from the OPHS and the new financial cut offs for children at high risk of dental disease who previously had access to preventive clinics and CINOT, creates a new service gap that will result in an oral health disparity for these vulnerable children. This is contrary to the Ontario Public Health mandate that generally takes on a universal, population based approach and does not screen out clients based on financial status[3]. An objective of the Child Health program in the OPHS is to reduce the prevalence of dental disease in children and youth. The most effective and economical way to do this is to provide this population with access to preventive oral health services and in urgent cases a full course of dental care, to restore them back to dental health.

Recommendations

1. That the Board of Health send a letter to the Ontario Premier and Minister of Health and Long-Term Care calling for the Province of Ontario to retain the Preventive Oral Health Services Protocol in the 2008 Ontario Public Health Standards and maintain access to one full course of treatment and prevention for children with urgent dental conditions.

2. That a copy of the letter sent to the Ontario Premier and Minister of Health and Long-Term Care be sent to the Minister of Education, the Minister of Children and Youth Services, Ontario Boards of Health, and to the following organizations: Ontario Dental Association, Public Health Agency of Canada, Public Health Ontario, Ontario Association of Public Health Dentistry, The Ontario Public Health Association, Association of Local Public Health Agencies.

References

1. Ministry of Health and Long Term Care Memorandum to Medical Officers of Health, Boards of Health and CEOs, December 16, 2013
2. Toronto Public Health, Impact of Removing Clinical Preventive Oral Health Services from Ontario Public Health Standards, August 1, 2014
3. Simcoe Muskoka District Health Unit 2014 Resolution and Briefing Note
4. MOHLTC, Ontario Public Health Standards, Child Health- Protocol- Preventive Dental Services, 2008, Queens Park Printer
5. More Than Just Cavities Report, A Report by Ontario's Chief Medical Officer of Health, April 2012
6. Canadian Health Measures Survey, Oral Health Report 2010
7. Oral Health Care for Children, A Position Statment, Anne Rowan-Legg; Canadian Paediatric Society Community Paediatrics Committee, *Paediatr Child Health* 18(1):37-43
8. Oral Health Information Support System DMF Report, Haliburton-Kawartha-Pine Ridge, JK & SK, 2011-2012, 2012-2013, & 2013-2014.

Board of Health for the Haliburton, Kawartha, Pine Ridge District Health Unit

Resolution: Retain the Preventative Oral Health Services Protocol in the OPHS and maintain access to one full course of treatment and prevention for children with urgent dental conditions.

WHEREAS Dental caries is the most common chronic disease to affect children, more common than asthma and if left untreated, can negatively affect a child's sleep, nutritional intake, speech development, self-esteem, learning at school and overall quality of life; and

WHEREAS caries rates are increasing for preschool aged children and the overall decay rates of JK and SK children in the HKPR area has risen from 34.5% in 2011/2012, 36.5% in 2012/2013 to 37% in 2013/2014; and

WHEREAS the preventive oral health services (fluoride varnish, pit and fissure sealants and scaling) offered by public health staff have been shown to be highly effective in reducing the caries rates of children; and

WHEREAS the Ministry of Health and Long Term Care (MOHLTC) plans to integrate the provincially funded dental programs for children and youth in August 2015 that will involve the removal of preventive dental services from the 2008 Ontario Public Health Standards (OPHS) protocol; and

WHEREAS as of August 2015 only children who are financially eligible based on the new Healthy Smiles Ontario (HSO) program cut-off will be eligible for public health preventive oral health services; and

WHEREAS in HKPR families with 2 children that used to qualify for preventive services under the OPHS will no longer qualify based on the new financial cut off set by the new program; and

WHEREAS the new program *may* only provide treatment for the urgent dental condition rather than a full course of treatment and prevention for children with urgent dental needs whose families cannot afford care (as has been allowed with the Children In Need of Treatment program); and

WHEREAS the need for universal access to preventive oral health services for vulnerable children is compounded by the fact that locally there is no fluoride in the water; and

WHEREAS the proposed changes are contrary to the Ontario Public Health mandate that generally takes on a universal, population based approach and does not screen out clients based on financial status, which will result in the exclusion of a significant population of vulnerable children and ultimately a decrease in the oral health of children locally and across the province.

THEREFORE BE IT RESOLVED THAT the Haliburton, Kawartha, Pine Ridge, District Health Unit Board of Health write to the Ontario Premier and the Minister of Health and Long-Term

Care to urge them to maintain progress toward universal publicly funded children's dental care in the new integrated dental services program by:

a) Maintaining current eligibility for preventive dental services under the Ontario Public Health Standards; and
b) Maintaining access to one full course of treatment for children with urgent dental conditions, and

THAT a copy of this letter sent to the Ontario Premier and Minister of Health and Long-Term Care be sent to the Minister of Education, the Minister of Children and Youth Services, Ontario Boards of Health, and to the following organizations: Ontario Dental Association, Public Health Agency of Canada, Public Health Ontario, Ontario Association of Public Health Dentistry, The Ontario Public Health Association, Association of Local Public Health Agencies.

Northwestern Health Unit
www.nwhu.on.ca

210 First Street North
Kenora, ON P9N 2K4

November 21, 2014

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

Dear Minister Hoskins,

The Board of Health of Northwestern Health Unit commends you for taking steps to improve the health of vulnerable Ontarians under the Ontario Poverty Reduction Strategy.

We wish to bring to your attention some of the unintended consequences for our region, of your proposed changes to the publicly funded oral health programs and services.

Children in northwestern Ontario have twice the dental decay rates as their southern counterparts, due to difficulty in accessing services because of lack of providers, and geographic and socio-economic barriers[i] .

In 2013 over 4,000 children of the working poor received dental preventive or treatment services under provincial dental programs in our region. Unfortunately, under the proposed eligibility criteria for the new integrated provincial program, Healthy Smiles Ontario 2 (HSO 2), less than 80 of these children will be eligible for services. This means that 49 of every 50 children (3,920 out of 4,000) who were previously seen will now be excluded from the proposed HSO 2 program.

As an internationally known and respected pediatric physician who is recognized for the work you have done for vulnerable populations, we ask that you work with us to continue to provide service to vulnerable children in northern Ontario.

The enclosed Board of Health Resolution, approved at the Board's meeting held November 21, 2014, urges you to reconsider the closure of these very worthwhile preventive and treatment program components for our most vulnerable children, and to allow them to continue as subcomponents for the new HSO 2 program.

Sincerely,

Julie Roy

Julie Roy
Chair, Board of Health for Northwestern Health Unit roy.julie@nwhu.on.ca

Encl.

/2

c: Honourable Kathleen Wynne, Premier of Ontario
Dr. David Mowat, Chief Medical Officer of Health
Sarah Campbell, MPP (Kenora, Rainy River)
Bill Mauro, MPP (Thunder Bay, Atikokan)
Association of Local Public Health Agencies (alPHa)
Ontario Boards of Health
Association of Municipalities of Ontario (AMO)
Northwestern Health Unit obligated municipalities
School Boards of Northwestern Health Unit catchment
North West Local Health Integration Network (LHIN)
Rainy River District Social Services Administration Board (RRDSSAB)
Kenora District Services Board (KDSB)
Kenora Rainy River Dental Society (KRRDS)
Dr. Alex Hukowich, Acting Medical Officer of Health, Northwestern Health Unit
Mark Perrault, Chief Executive Officer
Dr. Peter Cooney, Dental Consultant
Dawn Sauvé, Dental Health Manager

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[i] Ito, D. Summary of 2009-10 and 2010-11 oral health screening: Results from participating Ontario health units, Ontario Association of Public Health Dentistry, 2012.

Northwestern Health Unit
www.nwhu.on.ca

NORTHWESTERN HEALTH UNIT
BOARD OF HEALTH

No. 118 -2014 MOTION/RESOLUTION

Moved by .....

Seconded by .....

Ensuring Continued Oral Health Access for 4,000 Local Children in Need of Preventive Services or With Urgent Dental Needs

WHEREAS[1] oral health is inextricably linked to overall health, and dental caries is the most common chronic childhood disease in children and adolescents: five times more common than asthma; one of the main reasons preschool children receive a general anaesthetic; the second most expensive disease category in Canada; and

WHEREAS the Ontario Public Health Standards have mandated that all children in need of preventive oral health services and treatment receive essential care; and

WHEREAS[2] preschool and school-based preventive programs and urgent care referrals are highly effective interventions; and

WHEREAS[3] children in northern Ontario have twice the dental decay rates as their southern counterparts, due to difficulty in accessing services because of lack of providers and geographic, cultural and socio-economic barriers; and

WHEREAS only less than 80 of the 4,000 children of the working poor seen in 2013 in this area will meet the financial criteria for the proposed new Healthy Smiles Ontario 2 (HSO 2) program and only a small number will be eligible for preventive and treatment services, therefore resulting in exclusion of a significant population of vulnerable children and adolescents; and

WHEREAS the financial restriction under the new HSO 2 program will not fully support preventive services or a full course of treatment services for the other 3,920 children in need; and

WHEREAS this reduced access to preventive and treatment services will leave more children at risk of developing dental disease, resulting in increased need for publicly-funded more expensive emergency dental care and increased visits to non-dental urgent care providers such as physicians' offices and emergency departments;

NOW THEREFORE BE IT RESOLVED THAT the Ministry of Health and Long-Term Care maintains the current eligibility criteria, and continue to support current levels of funding provided through general program and Healthy Smiles Ontario budgets at our local level; and

/2

Northwestern Health Unit
www.nwhu.on.ca

NORTHWESTERN HEALTH UNIT
BOARD OF HEALTH

No. 118 -2014 MOTION/RESOLUTION

FURTHERMORE BE IT RESOLVED THAT the eligibility criteria for the proposed preventive and emergency programs that will replace Children in Need of Treatment (CINOT) and CINOT Expansion and Preventive Dental Services programs consider dental needs and financial hardship in order to maintain and ensure equitable access to oral health preventive and treatment services for all children.

AND THAT this Resolution be sent to the Minister of Health and Long-Term Care, and copied to the Premier of Ontario and the Chief Medical Officer of Health; and that copies be forwarded to regional members of provincial parliament, Association of Local Public Health Agencies (alPHa), Ontario Boards of Health, Northwestern Health Unit obligated municipalities, Association of Municipalities of Ontario, School Boards of Northwestern Health Unit catchment, North West Local Health Integration Network, Rainy River District Social Services Administration Board, Kenora District Services Board, and Kenora Rainy River Dental Society for their information and support.

References

[1]Health Canada, 2010. *Canadian Health Measures Survey (CHMS), Oral Health Statistics 2007-2009.* Retrieved from: http://www.hc-sc.gc.ca/hl-vs/pubs/oral-bucco/fact-fiche-oral-bucco-stat-eng.php

[2]Oral *Health – More Than Just Cavities, April 2012,* Chief Medical Officer of Health, Dr. Arlene King's Report. Retrieved from: http://www.health.gov.on.ca/en/common/ministry/publications/reports/oral_health/oral_health.pdf

[3]Ito, D. Summary of 2009-10 and 2010-11 oral health screening: Results from participating Ontario health units, Ontario Association of Public Health Dentistry, 2012.

	Yea	Nay	Abstained	Disclosure of Interest
J. Albanese				
C. Baron				
J. Belluz				
D. Brown				
S. MacKinnon				
J. Roy				
P. Ryan				
T. Sachowski				
S. Smith				
D. Squires				
B. Thompson				

Date November 21, 2014

Chair Julie Roy

Sudbury & District
Health Unit
Service de santé publique

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🖷 : 705.522.5182

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Sudbury ON P3C 1S8
☎ : 705.522.9200
🖷 : 705.677.9611

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

Espanola
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🖷 : 705.869.5583

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

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

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1.866.522.9200

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November 7, 2014

VIA ELECTRONIC MAIL

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

Dear Minister Hoskins:

Re: Publically Funded Dental Services

At its meeting on October 16, 2014, the Sudbury & District Board of Health carried the following resolution #59-14:

WHEREAS, income has a significant impact on the frequency of dental visits resulting in those living in poverty or low income households to visit the dentist less often or not at all; and

WHEREAS, in the past school year, 1 in 3 elementary school age children, in the Sudbury & District, had received dental treatment or were in need of dental treatment; and

WHEREAS, a much lower percentage (45%) of low-income individuals living in Sudbury reported having dental insurance compared to middle/upper income individuals (72%); and

WHEREAS, the proposed Integrated Dental program, to be launched by the Ministry of Health and Long-Term care in August 2015, will require families to meet a financial means test in order to qualify for services thereby preventing a large number of children, who currently receive services, from receiving care in the Sudbury & District Health Unit catchment; and

WHEREAS, the current Children In Need of Treatment (CINOT), expanded CINOT and OPHS Preventive Services Protocol for preventive services consider dental need and financial hardship which allows a greater number of low income children to qualify for services;

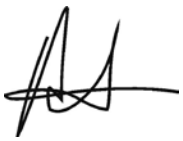
THEREFORE BE IT RESOLVED THAT the Board of Health for the Sudbury & District Health Unit support the board correspondence related to oral health programing urging the Ministry of Health and Long-Term Care to:

1) ***Adequately fund the "emergency" program, that has been proposed by the Ministry, in order to meet the utilization rate of the current needs based treatment programs (CINOT and expanded CINOT) and ensure this program is based on comprehensive dental needs; and***

2) ***Maintain clinical preventive oral health service in the Ontario Public Health Standards and appropriately fund these requirements.***

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

Yours sincerely,



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

cc: Association of Local Public Health Agencies
Association of Municipalities of Ontario
Ontario Boards of Health

November 20, 2014

The Right Honourable Stephen Harper
Prime Minister of Canada
Langevin Building
80 Wellington St
Ottawa ON K1A 0A2

Dear Sir

The Board of Health for the Haliburton, Kawartha, Pine Ridge District Health Unit wishes to express its strong support for the Private Members Bill C-626, which calls for the appointment of a Chief Statistician and the reinstatement of the mandatory Long-Form Census.

In 2010, numerous organizations throughout Canada, including our Health Unit (copy enclosed), expressed grave concerns about the cancellation of the mandatory Long-Form Census and replacing it with the voluntary household survey. The concerns that were felt at the time regarding the decreased validity and reliability of a voluntary survey, especially for smaller population areas have been proven to be legitimate. Through known biases and a steady decrease in participation rates, the voluntary National Household Survey (NHS) has not produced the quality of data required by our Health Unit. As stated in chapter one of the National Household Survey User Guide, "The objective of the NHS is to provide data for small geographic areas and small populations groups."[i] However, the global non-response rate, an indicator of data quality, has indicated that there is too great a risk of non-response bias and as a result, higher risk of inaccuracy for many communities across the country.

The work of Public Health is evidence–based. We utilize data routinely for population health assessment, program and service planning, program evaluation and the identification of priority populations for public health interventions. The voluntary NHS, which replaced the mandatory Long-Form Census for 2011 produced data for our Health Unit's jurisdiction (Northumberland County, City of Kawartha Lakes and Haliburton County) that have questionable reliability and validity with limited generalizability. With a number of higher risk (or marginalized) populations less likely to complete a voluntary census, the NHS also limits our ability to accurately report on priority populations and potential areas in need of service. We were unable to compare data from the many years of previous censuses to the 2011 NHS. We have had to use the reliable and valid eight year old data from the 2006 Census to plan public health programs and services and prepare reports and supporting documents.

It is imperative to the work of public health that the quality of data produced through the Long-Form Census be restored.

We ask that the Private Members Bill C-626, An Act to amend the Statistics Act (appointment of Chief Statistician and the reinstatement of the Long-Form Census) be supported for referral to the Standing Committee on Industry, Science and Technology.

Sincerely,

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

Mark Lovshin, Chair, Board of Health

[i] National Household Survey User Guide. Available from http://www12.statcan.gc.ca/nhs-enm/2011/ref/nhs-enm_guide/index-eng.cfm. Accessed on November 17, 2014.

c.c. The Honourable James Moore, Minister of Industry, Canada
The Honourable Rona Ambrose, Minister of Health, Canada
The Honourable Thomas Mulcair, Leader of the Opposition
The Honourable Justin Trudeau, Leader of the Liberal Party
The Honourable Kathleen Wynne, Premier of Ontario
The Honourable Dr. Eric Hoskins, Minister of Health and Long-Term Care
Rick Norlock, MP, Northumberland, Quinte-West
Barry Devolin, MP, Haliburton, Kawartha Lakes, Brock
Lou Rinaldi, MPP, Northumberland, Quinte-West
Laurie Scott, MPP, Haliburton, Kawartha Lakes, Brock
Municipalities of Haliburton, CKL and Northumberland (upper and lower tier)
Ontario Boards of Health

Encl.

HKPR Haliburton, Kawartha, Pine Ridge District Health Unit

October 4, 2010

The Right Honourable Stephen Harper
Prime Minister of Canada
Langevin Building
80 Wellington St
Ottawa ON K1A 0A2

Dear Sir

The Board of Health for the Haliburton, Kawartha, Pine Ridge District Health Unit wishes to express its concern and disagreement with your Government's decision to eliminate the mandatory long-form census and replace it with a voluntary household survey.

The Board is concerned that a voluntary household survey will result in response bias thereby generating inaccurate data, higher costs, inability to compare data over time, and inaccessible data at the local level.

The detail contained in the long-form census is vital in order for health unit staff across Ontario to tailor programs and services to meet local needs, to address the determinants of health and to reduce health inequalities, as mandated by the *Ontario Public Health Standards 2008.* The current long-form census data are comprehensive and verifiable and are collected using consistent methodology. The citizenship, languages, education, employment, mobility, occupation and income information in particular, assist us in identifying priority populations so that our plans may focus on those most in need. Further, continued use of the long-form census will provide the data needed to evaluate and compare the changes in the health status of our residents, resultant of our programs and services, enabling us to modify those programs and services as needs are identified.

We ask that you reverse this decision and reinstate the mandatory long-form questionnaire as part of the 2011 Canadian Census and all future Canadian Censuses.

Sincerely

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

Original signed by

Mark Lovshin
Chair, Board of Health

YOUR HEALTH PARTNER FOR LIFE!

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Fax: (905) 885-9551

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Toll-free: 1-866-888-HKPR (4577)
Website: www.hkpr.on.ca

c.c. The Honourable Tony Clement, Minister of Industry, Canada
The Honourable Leona Aglukkaq, Minister of Health, Canada
The Honourable Michael Ignatieff, Leader of the Opposition
The Honourable Gilles Duceppe, Leader of the Bloc Quebecois
The Honourable Jack Layton, Leader of the New Democratic Party
The Honourable Dalton McGuinty, Premier of Ontario
The Honourable Deb Matthews, Minister of Health and Long-Term Care
The Honourable Leona Dombrowsky, Minister of Education
The Honourable Madeleine Meilleur, Minister of Community and Social Services
Rick Norlock, MP, Northumberland, Quinte-West
Barry Devolin, MP, Haliburton, Kawartha Lakes, Brock
Lou Rinaldi, MPP, Northumberland, Quinte-West
Rick Johnson, MPP, Haliburton, Kawartha Lakes, Brock
Municipalities of Haliburton, CKL and Northumberland (upper and lower tier)
Local School Boards
Linda Stewart, Association of Local Public Health Agencies
Ontario Boards of Health

Staff Report

Update on IARC Radiofrequency Monograph

Date:	January 14, 2015
To:	Board of Health
From:	Dr. Rosana Pellizzari, Medical Officer of Health

Original approved by	***Original approved by***
Rosana Pellizzari, M.D.	Donna Churipuy, Manager

Recommendations

That the Board of Health for the Peterborough County-City Health Unit receive the staff report, *Update on IARC Radiofrequency Monograph,* for information.

Financial Implications and Impact

There are no financial implications arising from this report.

Decision History

In May 2008, the Board of Health received a staff report outlining the potential health impacts of exposure to radiofrequencies.

In June 2011, the Board of Health requested that a staff report be prepared addressing the health and safety concerns related to wireless technology.

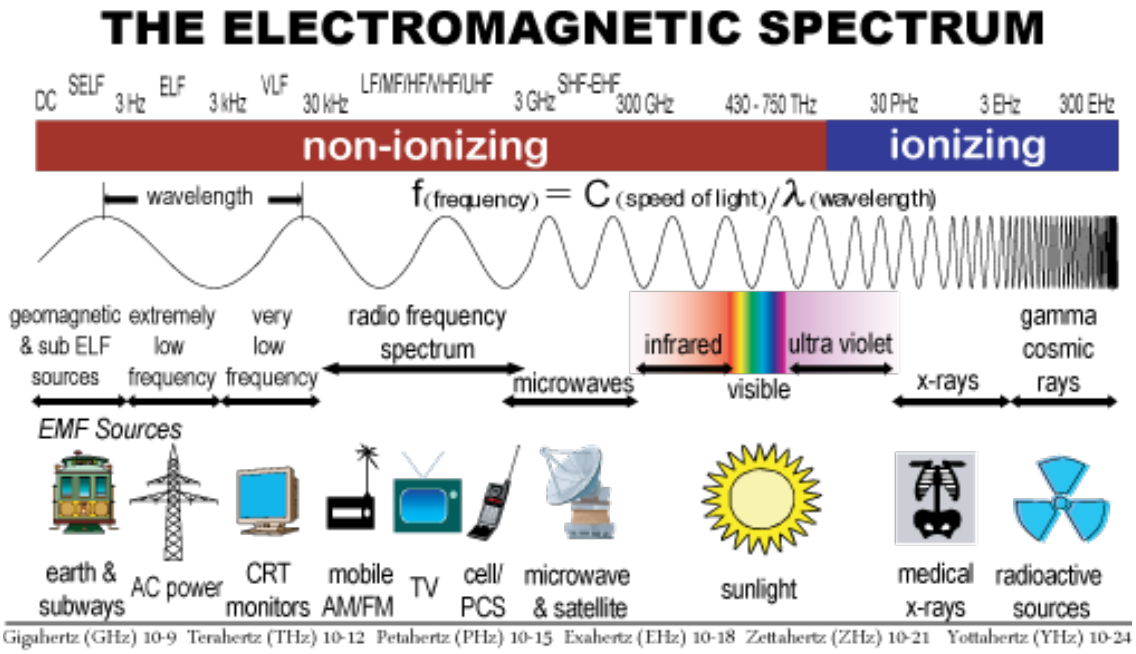
In March 2012, Deputy Mayor Sharpe informed the Board of Health that two delegations had been declined; both requests were related to wireless technologies. It was decided that the Board would defer any further delegations on this item until a report was received from Public Health Ontario. One request was referred to internal staff; a meeting had already taken place with the individual.

In October 2012, the Board of Health received a staff report summarizing the results of the radiofrequency (RF) survey conducted by Public Health Ontario in the City of Peterborough. As a result a number of delegation requests were received. Those delegation requests were declined by the Chair on the basis that we were still awaiting the report from PHO.

Background

Radiofrequencies (RF) are a band of fields found in the electromagnetic spectrum ranging from 30 kHz to 300 GHz. People are exposed to both natural and anthropogenic sources of RF. RF are widely used in everyday life including cellphones, television, radio, wireless technologies and radar however hand-held devices such as cellphones are the dominant source of exposure to the general public. Figure 1 below shows the RF bands, together with the range of frequencies used for other applications, including telecommunications, industry and medicine.

Figure 1



During the past few years, Peterborough area residents have expressed concern about the potential health effects, including risk for cancer, of exposure to radiofrequencies from wireless technologies and cell phone towers.

In 2011, the International Agency for Research on Cancer (IARC) classified RF as “possibly carcinogenic” to humans. In April 2013, the monograph reviewing the data to determine if RF changes the incidence of cancer among humans was released. The IARC monograph concludes that personal devices are the most common source of RF exposure to the general population. The use of personal devices has increased over the last few decades; however, the amount of RF emitted by individual devices has decreased and the manner in which the devices are used

has changed such that the methodology of previous research studies is less applicable to the current use of the personal devices. For example, hands-free devices and texting are more common now than during the period the research was conducted thereby changing the degree and location of exposure.

IARC Monographs identify environmental and lifestyle causes of cancer in people. They identify agents that are capable of: causing cancer; reducing the time period from exposure to the agent to the development of symptoms; and increasing the severity of cancer. The monographs do not assess the potency of the hazard nor provide a quantitative risk assessment. They also do not assess for other health impacts. IARC considered three types of exposures to RF: exposure from personal devices; occupational exposure; and environmental exposure.

Shortly after the release of the monograph, several public health units requested that Public Health Ontario (PHO) summarize the scope, process and findings of the Monograph, and the studies used to reach their conclusions. On October 14, 2014, PHO released the attached *IARC Radiofrequency Monograph Overview (Overview)*.

Not all of the questions raised about the safety of exposure for radiofrequencies have yet been completely answered. The *Overview* states that research studies currently underway may answer some of the outstanding concerns about the exposure of children to radiofrequencies from cell phones. To date, results of the scientific studies suggest that exposure to radiofrequencies from other sources does not cause cancer. In the *Overview,* PHO concludes that "application of the IARC classification to policy decisions is challenging" as a similar rating was given to high voltage transmission lines and "does not provide a clear scientific answer as to whether either of these exposures are carcinogenic." Ongoing research may alleviate the uncertainty surrounding the safety of radiofrequencies however; in the meantime, precautionary use of cell phones held in the traditional manner beside an ear may be warranted.

Rationale

The *Overview* describes the process used by IARC to evaluate agents and classify their carcinogenicity. It also discusses the changes that have occurred in cellphone use, cellphone technology, and current exposures from hand held devices. It states, "Use of personal devices results in exposures orders of magnitude greater than from sources in the community, including outdoor sources such as cellphone base stations and broadcast antennas, and indoor sources such as cordless phone base stations and wireless internet routers." The highest typical personal exposure to RF is from the use of a mobile phone close to the head. The power density from mobile phones is typically 1-5 mW/cm^2 whereas the power density from a WiFi laptop is 0.004 mW/cm^2. Mobile phone base stations have a power density of 0.000005–0.002 mW/cm^2 10s to a few thousand feet from the base station.

The *Overview* reviews the challenges associated with the studies used by the IARC Working Group including problems with the exposure assessments and the fact that many studies rely on self-reported use of devices. The *Overview* also reviews changes in trends including that fact that text messaging is a much more common use of hand held devices which results in a decreased exposure to the head to the user. The *Overview* summarizes the types of studies and results reviewed by IARC. Ecological, time-trend analyses, a single cohort study and seven case-control studies (including the INTERPHONE study) were considered which can show association however cannot prove causality. Cellphone use among long-term users carries the greatest risk and is associated with increased risk of gliomas. There was no clear association of occupational exposure to RF and brain cancer. Studies of environmental exposures also did not demonstrate increased risk of brain tumours from environmental exposure to RF. Studies of carcinogenicity from RF radiation in experimental animals were inconclusive and genotoxic studies had mixed results. Research has not yet demonstrated possible mechanisms by which RF could induce cancer.

PHO reported that it is difficult to come to a conclusive interpretation of the evidence because of conflicting results from studies worldwide and the limitations associated with epidemiological studies. Environmental exposures contribute very little to overall exposure. Findings from the INTERPHONE and Hardell group case-controls studies demonstrate increased likelihood of glioma among the heaviest cellphone users, but are not designed to show causality. Personal devices when used close to the body are the most important source of exposure therefore they may be the greatest contributor to risk of cancer. The IARC classification of 'possibly carcinogenic' does not "provide a clear scientific answer to whether these exposures are carcinogenic."

Strategic Direction

This report applies to the Board of Health strategic direction of *Community-Centred Focus*.

Contact:

Donna Churipuy, Manager
Environmental Health Programs
(705) 743-1000, ext. 218
dchuripuy@pcchu.ca

Attachments:

Attachment A – IARC Radiofrequency Monograph Overview

References:

BC Centre for Disease Control & National Collaborating Centre for Environmental Health (2013). *Radiofrequency Toolkit for Environmental Health Practitioners.* Accessed on December 23,

2014 http://www.bccdc.ca/NR/rdonlyres/9AE4404B-67FF-411E-81B1-4DB75846BF2F/0/RadiofrequencyToolkit_v5_26032014.pdf

Oda, Joanna, Copes, Ray (October 2014). IARC Radiofrequency Monograph Overview. Public Health Ontario.

Public Health Ontario
PARTNERS FOR HEALTH

Santé publique Ontario
PARTENAIRES POUR LA SANTÉ

IARC Radiofrequency Monograph Overview

Request prepared by: Joanna Oda MD, Public Health and Preventive Medicine Resident
Ray Copes MD, MSc, Chief, Environmental and Occupational Health
Public Health Ontario

Date: October 2014

Contact information: eoh@oahpp.ca

Executive Summary

Prepared at the request of several health units, this document summarizes the scope, process and findings of the Monograph, and the studies the Working Group used to reach their conclusions. The Working Group categorized radiofrequency as Group 2B, possibly carcinogenic to humans, based on limited evidence in humans and animals.

Conclusive interpretation of the existing evidence is difficult due to conflicting results and the inherent limitations of epidemiological studies. The lack of positive findings in several well-conducted long-term animal exposure studies is reassuring, as are the time-trend analyses demonstrating no increase in the incidence of brain tumours despite an increase in the use of RF emitting devices.

However, the findings of both the INTERPHONE and the Hardell group case-control studies demonstrating an increased odds ratio for glioma amongst the heaviest cellphone users cannot be easily dismissed. Epidemiological studies are limited by the relatively small number of people with prolonged exposure included in the studies published to date.

Mechanistic research has been limited by poor reporting of exposure conditions and difficulty controlling for the thermal effects of RF. Future research will be challenged by accurate exposure assessment as technologies continue to evolve, changing the way humans are exposed and the types of RF they are exposed to.

There has been a great deal of interest and concern about the potential health effects of RF and its carcinogenic effects in particular. The IARC Monograph reinforces messages that personal devices are the dominant source of RF exposure to the general public. Use of these devices has increased substantially over the last several decades. At the same time, advances in technology have reduced the amount of RF emitted by an individual device during a given task. Use of hands-free devices, which move the antenna away from the body, does reduce exposure to the head, but may increase exposure

to other body parts. Ongoing studies such as MOBI-KIDS, a case-control study of young people with brain tumours and COSMOS, a European cohort study, may help to answer some outstanding questions.

Application of the IARC classification to policy decisions is challenging. The rating of "possibly carcinogenic" is the same rating that has been applied to the magnetic fields associated with high voltage transmission lines and does not provide a clear scientific answer as to whether either of these exposures are carcinogenic. The approach to dealing with both these hazards will rely on the degree of precaution that policy-makers choose to apply to the existing evidence and its residual uncertainty, as well as the assessment of societal benefits associated with their sources.

Introduction

Radiofrequency electromagnetic fields (RF) are a band in the electromagnetic spectrum with frequencies ranging from 30 kHz to 300 GHz. RF is widely used in a variety of communication technologies, including cellphones, conventional television, radio and wireless internet technology. The rapid increase in cellphone use and related infrastructure (e.g. base towers) has led to concerns about the potential health effects of RF, including whether or not it is capable of causing cancer in humans.

In 2011, the International Agency for Research on Cancer (IARC) classified RF as "possibly carcinogenic" to humans (Group 2B). The associated IARC Monograph was released in April 2013 (1). This document summarizes the scope, process and findings of the Monograph, and the studies the Working Group used to reach their conclusions.

IARC Monographs

SCOPE OF IARC MONOGRAPHS

IARC is an agency of the World Health Organization (WHO). IARC's Monograph program aims to identify environmental and lifestyle causes of cancer in humans. Each monograph reviews all available data to determine if the agent in question "alters the age-specific incidence of cancer in humans". Monographs identify cancer "hazards", that is, agents capable of causing cancer, reducing its latency or increasing its severity. Monographs do not provide an assessment of hazard potency or provide a quantitative assessment of cancer risk at current exposure levels. Working Groups may evaluate dose-response data, if it is available, in the process of assessing the evidence for causation. Monographs limit their scope to the question of carcinogenicity and do not evaluate other potential health effects.

MONOGRAPH PROCESS, TERMS AND CATEGORIES

Monographs are prepared by the Working Group, which consists of members selected for their knowledge and experience and the absence of conflicts of interest. Members have usually published significant research on the agent in question. Others may participate in meetings and offer expertise and information, but do not play a role in data evaluation or drafting of the Monograph.

The Working Group reviews all pertinent studies, including data on exposure to human populations, cancer studies in humans and experimental animals and mechanistic studies. Consideration is limited to reports that have been published or accepted for publication and are publicly available. Studies found to be inadequate or irrelevant may not be used in the final assessment of the evidence; the reasons for doing so are given in the text.

IARC uses standard terms to characterize the weight of the evidence for carcinogenicity of an agent in humans and experimental animals. Evidence is categorized as either “sufficient”, “limited”, “inadequate” or “suggesting lack of carcinogenicity”. Evidence of carcinogenicity is deemed “sufficient” in humans if a causal relationship has been established and chance, bias and confounding can be confidently ruled out. Evidence that is deemed "sufficient" identifies at least one target organ or tissue where increased cancer risk was observed, though others may exist. Evidence is deemed “limited” if a positive association between exposure and cancer is found and a “causal interpretation” is considered credible by the Working Group, but chance, bias and confounding cannot be ruled out. Evidence is “inadequate” if the studies considered are of insufficient quality or power and a causal conclusion cannot be made. Evidence is classified as “suggesting lack of carcinogenicity” only if there are several well-designed, adequately powered studies, with appropriate follow-up periods that cover the full range of possible exposures humans encounter, and the studies consistently show no positive association. Confidence intervals must be narrow, and bias and confounding can be confidently ruled out.

Similar language is used to describe cancer studies in animals. “Sufficient” evidence in experimental animals requires an increase in the incidence of neoplasm in two or more species of animals. If limited to one species, evidence may still be deemed sufficient if similar findings are found in two or more independent studies. Evidence is considered “limited” if it is restricted to a single experiment; there are concerns about the design or conduct of existing studies; exposure is associated with an increase in benign neoplasms only, or its promoting activity is limited to a narrow range of sites. Evidence is “inadequate” if existing studies cannot be interpreted due to qualitative or quantitative limitations or is absent all together. Evidence “suggesting lack of carcinogenicity” in experimental animals is always limited to the species and exposure conditions (e.g. level of exposure, age at exposure) studied.

In addition to studies in humans and animals, the Working Group considers evidence of carcinogenic mechanism and other relevant data. This includes data on tumour pathology, metabolism, toxicokinetics, and gene expression. Mechanistic data linking an agent to a carcinogenic effect is described as “weak”, “moderate” or “strong”. Unlike the definitions for carcinogenicity in humans and animals, the definitions of “weak”, “moderate” and “strong” are not explicitly defined. Studies demonstrating the effect in exposed humans are considered the strongest evidence. Evidence of effect in experimental animals is strengthened when similar mechanisms are known to have an effect in humans.

The evidence is assessed and categorized into one of five standard groups used by IARC. The decision is heavily influenced by the categorization of the human, experimental animal and mechanistic evidence (see Table 1). IARC notes that this categorization is a scientific judgement and that the criteria outlined “cannot encompass all of the factors that may be relevant to an evaluation”. Thus, agents may be assigned to higher or lower categories “than a strict interpretation of these criteria would indicate”.

- **Group 1: The agent is carcinogenic to humans**: Agents for which there is sufficient evidence of carcinogenicity in humans are placed in this category. Under some circumstances, agents for which there is less than sufficient evidence (i.e. limited or inadequate) of carcinogenicity in humans but sufficient evidence in experimental animals and strong evidence of a relevant carcinogenic mechanism will also be placed in this category.

- **Group 2A: The agent is probably carcinogenic to humans**: Agents may be categorized in Group 2A for three reasons: when there is limited evidence in humans and sufficient evidence in experimental animals; when there is inadequate evidence in humans and sufficient evidence in animals with strong mechanistic evidence; or when the agent belongs to a class of agents for which one or more members have been classified as Group 1 or 2A and there is evidence the agent in question has similar mechanistic effects.

- **Group 2B: The agent is possibly carcinogenic to humans:** This category is used for agents with limited evidence in humans and less than sufficient evidence in animals. In some cases, agents may have inadequate evidence of carcinogenicity in humans and sufficient evidence in animals or mechanistic evidence. An agent may be classified here based solely on strong mechanistic data. There is no quantitative difference between Group 2A and 2B. The terms "probably" and "possibly" indicate a higher level of evidence for Group 2A than 2B.

- **Group 3: The agent is not classifiable as to its carcinogenicity to humans**: Agents may be placed in this category for several reasons. The evidence may be inadequate in humans and inadequate or limited in experimental animals. Agents with inadequate evidence in humans and sufficient evidence in animals may be placed in this category if there is strong evidence that the carcinogenic mechanism is not present in humans. Agents that do not fall into any other category are also placed here. Group 3 often indicates that further research is needed.

- **Group 4: The agent is probably not carcinogenic to humans:** This category is reserved for agents with evidence suggesting lack of carcinogenicity in humans and experimental animals. It is worth noting that only a single agent has been placed in this category: caprolactam in 1987.

Table 1: Overall evaluation of carcinogenicity (excludes Group 4)

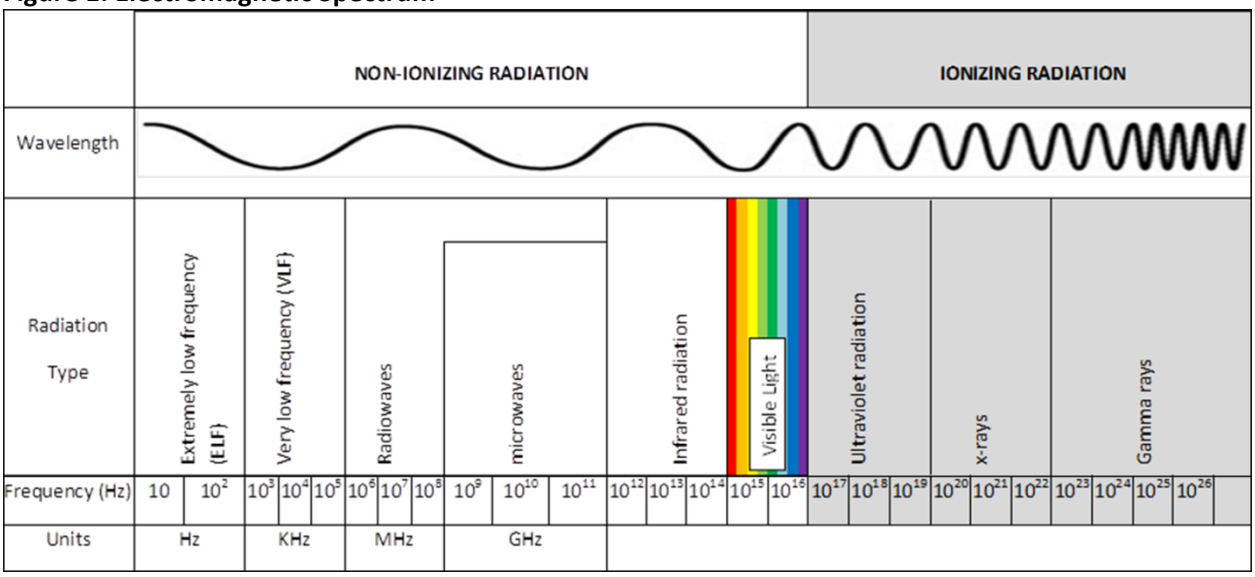
		Strength of evidence of carcinogenicity in humans		
		Sufficient	Limited	Inadequate
Strength of evidence of carcinogenicity in animals	Sufficient	Group 1	Group 2A Group 1 if strong evidence mechanism operates in humans	Group 2B Group 2A if strong evidence mechanism operates in humans Group 3 if strong evidence mechanism does not operate in humans
	Limited	Group 1	Group 2B Group 2A if agent belongs to class with members in Group 1 or 2A	Group 3 Group 2B (if strong mechanistic evidence)
	Inadequate	Group 1	Group 2B Group 2A if agent belongs to class with members in Group 1 or 2A	Group 3 Group 2B (if strong mechanistic evidence)

Radiofrequency Monograph Summary

EXPOSURE DATA

Electromagnetic radiation is the energy carried by electric and magnetic fields. Radiofrequency electromagnetic radiation (RF) is a band of the electromagnetic spectrum with frequencies ranging between 30 kHz and 300 GHz and wavelengths ranging from 10 km to 1 mm (see Figure 1). Sources emit RF which interacts with the body, creating induced electric and magnetic fields, most commonly measured by the specific energy absorption rate (SAR) in watts per kilogram (W/kg). The SAR is most heavily influenced by distance from the source and the source's power density (measured in W/m2); power density decreases as an inverse square of distance. However, factors such as posture relative to the source and properties of the tissue exposed mean that a single source may have varying effects in different areas of the body, with local hot-spots.

Figure 1: Electromagnetic Spectrum



Humans are exposed to both natural and human-made sources of RF. Natural sources of electromagnetic radiation, including RF, tend to have a broader range of frequencies than human-made sources. The Earth and living tissue also emit RF: at ground level, the Earth has a power density of 1.3mW/m2; the average human body has a power density of 2.5mW/m2. Only a small portion of solar and cosmic radiation is in the RF range. At the surface of the Earth, the power density of RF from the sun and sky is about 3µW/m2, or 1000 times less than the RF emitted by the Earth itself.

Anthropogenic RF fields are used in a wide variety of telecommunication technologies including television and radio broadcast signals, cellphones and related infrastructure. The Working Group identified anthropogenic sources as the dominant source of exposure to the general public and distinguished between three types of sources: personal devices, occupational sources and environmental exposure.

The dominant sources of human exposure are hand-held devices used in close proximity to the body, such as cellphones. Based on testing to ensure regulation compliance, typical cellphones induce SARs between 0.4 and 1.6 W/kg. However, these measures are based on cellphones operating at their maximum power, at which cellphones rarely operate. The actual SAR induced by holding a cellphone to the ear depends on the relative position of the antenna to the head, the quality of the link between the base station and the phone (poorer connections result in more power being emitted) and the properties of the ear, skull and brain. Models of adult and child heads demonstrate that certain regions of children's brains may be exposed to SARs two times greater than adults, due to their closer proximity to the surface of the head. SARs may be up to ten times greater in the bone marrow of children's skulls compared to adults.

Though cellphone use has greatly increased, advances in cellphone technology have resulted in changes in how their power emissions interact with users. Older, analogue phones tended to be larger and emitted more RF energy than newer digital phones. New cellphones are programed with power-saving algorithms decreasing the amount of power emitted to the minimum required, depending on the strength of the connection with the base station. Text messaging and hands-free headsets reduce the exposure of the head to RF, while potentially increasing exposure to other parts of the body. The Working Group noted the difficulties these changes present when evaluating studies conducted prior to 2004, before these changes became commonplace.

There are numerous commercial applications of RF that may result in occupational exposure including industrial induction and dielectric heating, medical technology (such as magnetic resonance imaging, diathermy and surgical cautery), communication technology, and security and navigational applications (such as radar and whole-body security scanners). Many of these applications operate at power levels substantially higher than those emitted by personal devices; however, due to the positioning of the operators, energy deposition in the whole body may occur rather than being concentrated in the head, as is seen with cellphone use. Actual exposures can vary significantly depending on the technology, tasks being performed and the presence of other RF emitting equipment in the workspace. Operators of induction and dielectric heaters have the highest reported exposures with whole-body SARs up to 2W/kg and heating effects experienced by workers are not uncommon.

Use of personal devices results in exposures orders of magnitude greater than from sources in the community, including outdoor sources such as cellphone base stations and broadcast antennas, and indoor sources such as cordless phone base stations and wireless internet routers. Studies from Austria, Germany and the Netherlands have demonstrated wide variations in electrical field strengths in both indoor and outdoor settings and a poor correlation with distance to source. Distance from cellphone base stations is a poor proxy for exposure due to variations in antenna directionality, shielding and scattering by the intervening environment.

Tissue heating is the most well established effect of RF exposure and current international guidelines from the International Commission on Non-Ionizing Radiation Protection (ICNIRP) and the Institute of Electrical and Electronic Engineers (IEEE) are based on preventing tissue heating. Temperature rises of more than 1°C are found to occur at whole-body SAR of 4 W/kg for 30 minutes. Both ICNIRP and IEEE distinguish between two settings. ICNIRP distinguishes between the workers and the general public. IEEE distinguishes between controlled settings, subject to safety controls and programs and uncontrolled environments, accessible to the general public. Both organizations apply a safety factor of 10 to the first

tier and a safety factor of 50 to the second, limiting exposure to SARs of 0.4 W/kg and 0.08 W/kg, respectively. Many nations base their exposure guidelines on either the ICNIRP or IEEE.

CANCER IN HUMANS

The Working Group considered three categories of human exposure to RF:

1) Exposure from use of personal devices
2) Occupational exposure
3) Environmental exposure

EXPOSURE FROM PERSONAL DEVICES

The Working Group noted several challenges common to most studies. Exposure assessment remains problematic. Many studies rely on self-reported use of personal devices or subscription data; many studies are unable to account for sources of RF other than cellphones. Advances in technology, including the replacement of analogue phones with digital phones, the increasing use of text messaging and hands-free devices all decrease exposure to the head. Cellphones are the most widely studied source of RF exposure in the general public, but did not become widely used until the mid-1990s in most industrial countries, resulting in few participants with prolonged exposure.

The Working Group was most influenced by studies of cellphone users. Ecological, time-trend analyses, a single cohort study and seven case-control studies (including the INTERPHONE study) were considered. Time-trend analyses comparing measures of cellphone use (usually the number of subscriptions) and disease indicators (usually the incidence of cancer) have been conducted in New Zealand, the Scandinavian countries, the United Kingdom, the United States, Switzerland and Israel. A significant increase in cellphone subscriptions is universally reported, with some countries showing increases beginning in the early 1990s (e.g. Sweden), while others are delayed until the 2000s (e.g. the United States). Parallel increases in the rates of brain tumours have not been found. The Working Group notes that such findings argue against RF having a "promptly acting and powerful carcinogenic effect," however, it does not exclude the possibility of an effect that is manifested decades after first use or an increased risk to a small proportion of the population.

Only one cohort study of the general population was identified (2). This Danish retrospective cohort study used subscriber information from two private cellphone providers from 1982 to 1995. Subscribers were linked to the Danish Cancer Registry and expected rates were based on the rates from the entire Danish population. The latest publication included outcomes up to 2002. Subscribers had a median of eight years of subscription. For the main cancers of interest, standard incidence rates (SIR) were close to the null value (see Table 2). Other findings of note include acoustic neuroma occurring on both sides with relatively similar rates and no change over time, despite 35% of Danes reporting a preference for cellphone use on the left side, 53% reporting a preference for the right and 13% reporting no preference. Acoustic neuromas were not larger in long-time subscribers compared to short-term subscribers (mean diameter 14.6mm versus 15.9 mm, respectively).

Table 2. Results of Danish Cohort Study

Total n=420 095; 357 553 men, 62 542 women. Follow up time: 1982-2002. NR=not reported

Cancer Site	Exposure Groups	Number of cases/deaths	Relative Risk (95% confidence interval)
All cancers	Ever subscribed	14,291	0.95 (0.93-0.97)
	Men	11,802	0.93 (0.92-0.95)
	Women	2,447	1.03 (0.99-1.07)
Brain, CNS	Ever subscribed	580	0.97 (NR)
	Men	491	0.96 (0.87-1.05)
	Women	89	1.03 (0.82-1.26)
Glioma	Ever subscribed	257	1.01 (0.89-1.14)
Glioma, temporal lobe	Ever subscribed	54	1.21 (0.91-1.58)
Glioma, parietal lobe	Ever subscribed	21	0.58 (0.36-0.89)
Meningioma	Ever subscribed	68	0.86 (0.67-1.09)
Nerve sheath tumours	Ever subscribed	32	0.73 (0.50-1.03)

Unfortunately, the Danish cohort study is limited by its use of subscription data as a marker of cellphone use and RF exposure, which likely results in a substantial amount of misclassification. The authors note that self-reported usage from the Danish participants of the INTERPHONE study demonstrated that 39% of subscribers were in fact not the actual cellphone users associated with the subscription and 16% of non-subscribers reported regular use of a cellphone. This would both decrease the power of the study and bias it towards the null. Males and persons with higher socioeconomic status were overrepresented in the exposed cohort.

Five case-control studies, including the INTERPHONE study and a series of papers from a Swedish group led by Hardell, were considered. Three of these published between 2000 and 2002 were considered uninformative as more than half of the control participants had never used a cell phone (3-5). Two others were also considered uninformative due to small numbers and unclear exposure assessments (6,7).

The international, multi-centre INTERPHONE study, coordinated by IARC is the largest study to date assessing the association between cellphone use and brain tumours, including glioma, acoustic neuroma and meningioma. The Working Group considered the pooled results rather than individual centre publications (8). A total of 2,708 cases of glioma and 2,972 controls were included in the study, however, only 252 cases and 232 controls had at least 10 years of exposure prior to the reference date. Participants (or proxy if the participant was too ill or had died) responded to a computer-assisted personal interview. The questionnaire covered demographic factors, cellphone use, other wireless

communication use and possible risk modifiers, such as hands-free devices and side of use. Participation rates were relatively low (64% among cases and 53% among controls).

Several analytic approaches were taken and are summarized in the table below. Comparing regular users (defined as at least one call per week for six months or more) to never users, a protective odds ratio of 0.81 was found (95% CI 0.70-0.94). This was seen across study centres. Using cumulative call time as a risk factor, ORs were again less than one except in the highest 10% of users, 1.4 (95% CI 1.03-1.89) compared to never regular users. When cumulative use was collapsed to greater than five hours compared to less than five hours, the OR increase to 1.38 (95% CI 1.02-1.87). The temporal lobe receives the greatest exposure compared to other regions of the brain during cellphone use. For cases in the highest use category, cases with gliomas in the temporal lobe had increased ORs (OR 1.87, 95% CI 1.09-3.22) compared to parietal and frontal lobe tumours (OR 1.25 95% CI 0.81-1.91) and tumours in other locations (OR 0.91 95% CI 0.33-2.51).

For meningioma, participation rates were also low, but higher for cases at 78%; 53% for controls. Odds ratios were consistently below unity, both comparing never regular users and regular users and deciles of cumulative call time.

Table 3. Summary results of INTERPHONE Study (2010)

Tumour Type	Exposure Groups	Exposed Cases	Odds Ratio (95% confidence interval)
	Never regular use	1,042	1.0 (ref)
	Regular use	1,666	0.81 (0.70-0.94)
	Cumulative call time (without hands free), hrs		
	<5	141	0.70 (0.52-0.94)
Glioma	5-12.9	145	0.71 (0.53-0.94)
Cases = 2,708	13-30.9	189	1.05 (0.79-1.38)
Controls = 2,972	31-60.9	144	0.74 (0.55-0.98)
	61-114.9	171	0.81 (0.61-1.08)
	115-199.9	160	0.73 (0.54-0.98)
	200-359.9	158	0.76 (0.57-1.01)
	360-734.9	189	0.82 (0.62-1.08)
	735-1,639.9	159	0.71 (0.53-0.96)
	>= 1,640	210	1.40 (1.03-1.89)

Tumour Type	Exposure Groups	Exposed Cases	Odds Ratio (95% confidence interval)
	Never regular use	1,147	1.00
	Regular use	1,262	0.79 (0.68-0.91)
	Cumulative call time (without hands free), hrs		
	<5	160	0.90 (0.69-1.18)
Meningioma	5-12.9	142	0.82 (0.61-1.10)
Cases = 2,409	13-30.9	144	0.69 (0.52-0.91)
Controls = 2,662	31-60.9	122	0.69 (0.51-0.94)
	61-114.9	129	0.75 (0.55-1.00)
	115-199.9	96	0.69 (0.50-0.96)
	200-359.9	108	0.71 (0.510.98)
	360-734.9	123	0.90 (0.66-1.23)
	735-1,639.9	108	0.76 (0.54-1.08)
	>= 1,640	130	1.15 (0.81-1.62)

Other case-control studies were published by Hardell. This series of studies represents the ongoing collection of case and control data from Swedish populations. Analogue phone use began in Sweden in the early 1980s, allowing for assessment of longer-term exposure. The Working Group focused on the latest pooled analysis, published in 2011 for glioma (9) and 2006 for meningioma (10). The database included 1,148 cases and 2,438 controls ascertained between 1997 and 2003, including 123 cases and 106 controls with more than 10 years of use. Results are summarized in the table below. Participation rates were considerably higher than in the INTERPHONE study at 85% for cases and 84% for controls. Unlike the INTERPHONE study, the Hardell group found increased odds ratios for glioma, among people who had ever used a cellphone compared to those who never used, 1.3 (95% CI 1.1 – 1.6) and increasing odds ratios with increasing time since start of use and cumulative call time. Similar to INTERPHONE findings, meningioma risk was not increased with increasing cumulative use, however there were few cases in the higher exposure levels. The increased OR of 1.4 (95% CI 1.0-1.8) reached statistical significance for ipsilateral use of digital phones, but not for analogue phones, 1.3 (95% CI 0.9-2.0).

Table 4. Summary of results from Hardell Group

Tumour Site	Exposure Groups	Exposed Cases	Odds Ratio (95% CI)
Glioma Cases= 1,148 Controls=2,438	< 1 year of use		(ref)
	Ever used	529	1.3 (1.1-1.6)
	Time since start of use (yr)		
	>1-5	250	1.1 (0.9-1.4)
	5-10	156	1.3 (1.0-1.6)
	>10	123	2.5 (1.8-3.3)
	Cumulative call time, hrs		
	1-1,000	427	1.2 (1.03-1.5)
	1,001-2,000	44	1.8 (1.2-2.8)
	>2,000	58	3.2 (2.0-5.1)
Meningioma Cases=916 Controls=2,162	Never use	455	(ref)
	Cumulative use, analogue phone, hrs		
	1-500	99	1.3 (1.0-1.7)
	501-1,000	8	1.1 (0.5-2.6)
	>1,000	6	1.4 (0.5-3.8)
	Cumulative use, digital, hrs		
	1-500	268	1.1 (0.9-1.3)
	501-1,000	18	1.0 (0.6-1.8)
	>1,000	9	0.7 (0.3-1.4)

The Swedish studies and INTERPHONE were considered to be the most robust evidence available to the Working Group, shared similar designs and limitations. The Working Group concluded that the results "could not be dismissed as reflecting bias alone, and that a causal interpretation was possible."

OCCUPATIONAL EXPOSURE

Sources of occupational exposure are found in a wide variety of industries including military and security (e.g. radar, walkie-talkie devices), radio and television antenna maintenance workers, and welding and plastics manufacturing (e.g. dielectric sealing and heating equipment). The Working Group limited consideration to studies that specifically addressed exposure to RF radiation, excluding those involving exposure to magnetic fields and extremely low-frequency fields.

Eighteen studies were reviewed by the Working Group, eight case-control studies and ten cohorts. Exposure assessments were limited to the use of job titles and rarely involved actual measurements of the workplace to confirm exposure. Four case control studies examined the association between occupational exposures and brain cancer and tended to find statistically insignificant increases, but were unable to control for other exposures in the occupational setting, including known carcinogens such as ionizing radiation. The importance of this to the final results was highlighted by Thomas et al.(11) who found a statistically significant increased OR of 1.7 (95% CI 1.1-2.7) among electric and electronics workers. However, after removing participants exposed to soldering fumes, this decreased to 1.4 (95% CI 0.7-3.1). Overall, the Working Group concluded, “there is no clear indication of an association of occupational exposure to RF radiation with risk of cancer of the brain.”

ENVIRONMENTAL EXPOSURES

The Working Group identified seven ecological studies assessing the association between RF transmitting antennas, including both cellphone base stations and radio transmitters. The ecological studies compared incidences of cancer variations based on geographic distance from the antenna. These studies did not demonstrate an increased risk with closer proximity, but had few cases. As discussed in the Exposure Data section, distance from an antenna is a poor surrogate for exposure and a large amount of misclassification is likely.

Three case-control studies also relied on geographic distance from an antenna, using home address or self-reported proximity of their residence (7,16,17). A fourth case-control study by Schuz et al. (18) used the German participants of INTERPHONE and examined if there was an increased risk of glioma or meningioma associated with placement of a cordless phone base station within three metres of the bed. No increased risk was found; however, very few participants were considered exposed: of the 2,241 cases and controls only 18 met criteria for exposure. Like the occupational studies, the Working Group considered these studies insufficient and concluded, “these studies provide no indication that environmental exposure to RF radiation increases the risk of brain tumours”.

CANCER IN EXPERIMENTAL ANIMALS

The Working Group reviewed four classes of animal studies: 1) bioassays of standard-bred animals; 2) bioassays of tumour-prone animals; 3) effects on animals following tumour induction and 4) co-carcinogenesis studies. The Working Group commented on several study design challenges presented by animal studies not usually seen with other chemical or physical agents, such as accurately measuring and reporting exposure, which depends heavily on the animals’ size and position in relation to the source. Due to these challenges, estimates of SAR are usually for the whole body rather than specific

organs or tissues. Restraints can be used to ensure uniform exposure, but limits on the time animals are ethically permitted to be restrained limits the amount of time animals are exposed to RF. Thermal effects of RF may be seen at levels lower than in humans and many studies used SAR values at levels below the maximum tolerated dose.

The Working Group examined seven long-term (two years) bioassays in standard bred animals, two in mice and five in rats. Six of these studies were well designed, using restraints to ensure consistent exposure and sham control groups as comparators (19-24). Histology was performed on all specimens. These studies used varying exposure conditions ranging from 1 to 21.5 hours per day over the course of the animals' lives. Five of these studies found no difference in life span or incidence of neoplasm between exposed and control groups. Chou et al. (21), the only study to use pulsed RF waves found a statistically significant increase in the total number of malignant tumours (5% versus 18%), by pooling non-significant changes in incidence at several tumour sites. The Working Group concluded that "the results of the 2-year cancer bioassays provided no evidence that long-term exposure to RF radiation increases the incidence of any benign or malignant neoplasm in standard-bred mice or rats."

Twelve studies using cancer-prone animals, using four different models, were considered. Two studies had positive results. The Eμ-Pim1-transgenic mouse is prone to lymphoma. A 1997 study (25) found a 2.4-fold increase in the incidence of lymphoma in mice exposed to pulsed GSM RF fields (900 MHz) for two 30 minute intervals per day, with an average SAR of 0.13-1.4 W/kg. Two later studies in 2002 (19) and 2007 (26) failed to replicate these results, despite including experimental groups exposed to average SARs of 2.0 and 4.0 W/kg. Three other studies using the AKR mouse model of lymphoma did not show a significant difference between exposure and control groups (27-29).

The second positive animal study used a mouse model for breast cancer, the C3H/HeA and exposed animals to 450 MHz for two hours per day, six days per week and average SARs over 6 to 8 W/kg (30). Increased incidence and earlier onset of mammary tumours was observed in the exposed group, though no histopathology was performed and detection was limited to palpation only. Two similar studies (31,32) failed to confirm this finding, but used lower SARs (1.0 W/kg). A single study (33) using a mouse model of brain cancer, the Patched1, did not find an increase in incidence, but exposed animals for a short period of time early in life (two 30 minute intervals per day for five days, starting on the second day of life). Based on these studies, the Working Group concluded that “the results of these studies do not support the hypothesis that the incidence of tumours in the brain or lymphoid tissue would increase as a result of exposure to RF radiation.”

Radiofrequency energy's effect on cancer promotion following tumour induction has been studied in animal models of neoplasm in lymphoid tissue, mammary glands, brain and skin. Of the sixteen studies, the single lymphoma model was negative. Four studies used Sprague-Dawley rats exposed to 7, 12-dimethybenz(a)anthracene (DMBA) to induce mammary tumours. One of these studies showed an increase in incidence in the group exposed to the highest amount (SAR of 4.0 W/kg) compared to the sham exposed, however this rate was similar to the cage controlled group. The three negative studies used similar protocols and failed to show an increase. Five studies examining the effect of RF following skin tumour induction did not show an increase in incidence or size of tumours. Six studies used N-ethyl-N-nitrosourea (ENU) in rats and examined the effect of RF on CNS tumour development. All were negative.

Six co-carcinogenesis studies were evaluated. Four of these studies demonstrated significant increases in neoplasm incidence in the exposed groups, however two (30,34) were described by the working group as "poorly presented" and "difficult to interpret." One of them did not include a concurrent sham control group. The other two positive studies used novel experimental models for hazard identification and their concordance with human carcinogenesis is unknown. One exposed Wistar rats to the known mutagen 3-chloro-4-(dichloromethyl)-5-hydroxy-2(5H)-furanone (MX), a water disinfection by-product. An increased incidence in vascular tumours was seen in the group exposed to an SAR of 0.9 W/kg; this was statistically significant in comparison to the sham exposed control but not the cage control group (35). Another study treated pregnant B6C3F1 mice with ENU (36). The experimental group was exposed to RF in utero and throughout life (1966 MHz, 20 hours per day, 7 days per week). Increases in bronchiolo-alveolar carcinoma and hepatocellular adenoma were observed. Despite the methodological limitations of these studies, the Working Group considered these studies as providing some support for the carcinogenicity of RF in animal models.

The Working Group concluded that there was limited evidence of carcinogenicity from RF radiation in experimental animals, based primarily on a positive study in a mouse model of breast cancer and positive results in several co-carcinogenesis studies.

MECHANISTIC AND OTHER RELEVANT DATA

Studies with endpoints related to carcinogenic mechanisms were evaluated, including genotoxicity, gene expression, and effects on the immune system. Effects on the blood-brain barrier were also considered.

Genotoxic effects were explored in studies using cells collected from exposed humans and experimental animals – in vitro studies of human and mammalian cells exposed to RF. Some of these explored co-exposures, looking at the interaction between RF and another known genotoxin.

Genotoxic studies were conducted using peripheral blood lymphocytes taken from humans who had been exposed to RF occupationally, and to mobile phones. Seventeen studies of occupational exposures were examined. Peripheral lymphocytes were examined for differences in the rate of chromosomal abnormalities between exposed workers (e.g. radar maintenance workers, air traffic control personnel) and a control group (usually office staff at the same workplace). Six of these were published from the same Croatian research group and it is unclear if the same subjects were studied. Results were mixed with 10 studies reporting an increased rate in exposed groups; however, sample sizes were small, ranging from 6 to 50 subjects, limiting statistical analysis. Five of the six larger studies, with more than 40 participants, reported no difference between groups. Exposure assessments were universally poor.

The Working Group considered five studies comparing peripheral lymphocytes and three studies using buccal cells of mobile phone users compared to non-users. Seven of these studies showed increased rates of chromosomal abnormalities in users compared to non-users. However, commonly considered confounders, such as age, smoking and alcohol use were not controlled for, and the buccal cell studies examined fewer than the 2,000 cells recommended for such studies. Due to these methodologic flaws, though there were several positive studies for genotoxicity, the Working Group concluded the available evidence was not strong enough to draw conclusions about RF's ability to damage genes in humans.

In vivo studies of experimental animals were conducted mostly in rats and mice. Approximately half of the studies reviewed by the Working Group were limited by the exposure system (some consisting simply of placing a mobile phone under the animals' cage) or exposures sufficient to likely cause thermal effects or too low to pose a challenge to the animals. The studies of sufficient quality did not show a consistent pattern, some with findings in direct contradiction despite similar protocols.

Similarly, in vitro studies of human and other mammalian cells exposed to RF were of varied quality. The Working Group attributed the positive findings of many to thermal effects based on the reported exposure levels. Exposures to RF in the non-thermal range generally gave negative results. There were a few remaining studies showing positive results at non-thermal levels, but were not replicated in later studies. The Working Group concluded that there was weak evidence that RF radiation is genotoxic and no evidence for mutagenicity.

The Working Group reviewed studies that explored RF's effect on the immune system in human subjects, experimental animals and human cells, exposed in vitro. The human studies examined concentrations of immunoglobulins and changes in lymphocyte counts in participants exposed to RF occupationally (e.g. radar operators, diathermy equipment users). Similar to the human genotoxic studies, sample sizes were small and were unable to control for common confounders such as age and smoking.

Studies examining immune cells taken from experimental animals exposed to RF were similarly inconsistent in their results, even among experiments with similar protocols. Several studies indicate that a variety of shifts (both increases and decreases) in the number of lymphocytes and other cells may be observed after exposure to RF, however the relevance to carcinogenicity is unknown. Overall, the evidence was considered insufficient to draw a conclusion on the effect of RF on the immune function as it relates to carcinogenesis.

The Working Group considered 84 studies on RF's effect on gene and protein expression. A single pilot study in exposed humans was identified; the remainder were conducted in exposed animals or human cells exposed in vitro. The in vivo animal studies used a variety of models and outcomes, but did not evaluate proteins known to be important for the initiation and development of cancer in humans. Reporting of exposure conditions was often poor.

Heat-shock proteins are a family of proteins found in all cell types and their overexpression has been associated with poor prognostics for certain cancers. The Working Group considered a 2005 review paper on the effect of RF on HSP expression and 22 recent in vitro studies of human cells using HSP gene expression as an outcome. The majority of these studies found no evidence that RF caused an increased expression of HSP genes or proteins. The few studies that did demonstrate a positive association have not been successfully replicated.

There have been consistent reports from one laboratory of evidence of increased permeability in the blood-brain barrier following RF exposure in rats. Increased permeability could potentially allow the passage of brain carcinogens. However, these have not been replicated in four similar studies, using either continuous or pulsed RF radiation. The Working Group concluded that the evidence does not support the hypothesis that non-thermal doses of RF increase the permeability of the blood-brain barrier.

Overall, the Working Group considered the evidence was weak for possible mechanisms by which RF could induce cancer.

Overall Evaluation

The Working Group categorized radiofrequency as Group 2B, possibly carcinogenic to humans based on limited evidence in humans and animals. The Monograph identifies personal devices, used close to the body, as the most important sources of RF exposure in the general public. Environmental exposures, such as cellphone towers, contribute little to total personal exposure. High-powered RF equipment, such as dielectric heaters, can be a source of significant occupational exposures for operators. In these cases, whole body exposure may be greater than the general public, but with less energy deposition in the head and brain.

Conclusive interpretation of the existing evidence is difficult due to conflicting results and the inherent limitations of epidemiological studies. The lack of positive findings in several well-conducted long-term animal exposure studies is reassuring, as are the time-trend analyses demonstrating a lack of increase in the incidence of brain tumours despite increasing use of RF emitting devices. However, the findings of both the INTERPHONE and the Hardell group case-control studies demonstrating an increased odds ratio for glioma amongst the heaviest cellphone users cannot be easily dismissed. Epidemiological studies are limited by the relatively small number of people with prolonged exposure included in the studies published to date. Mechanistic research has been limited by poor reporting of exposure conditions and difficulty controlling for the thermal effects of RF. Future research will be challenged by accurate exposure assessment as technologies continue to evolve, changing the way humans are exposed and the types of RF they are exposed to.

There has been a great deal of interest and concern about the potential health effects of RF and its carcinogenic effects in particular. The IARC Monograph reinforces messages that the dominant source of RF exposure to the general public is personal devices. Use of these devices has increased substantially over the last several decades. At the same time, advances in technology have reduced the amount of RF emitted by individual devices during a given task. Use of hands-free devices, which move the antenna away from the body, does reduce exposure to the head, but may increase exposure to other body parts. Ongoing studies such as MOBI-KIDS, a case-control study of young people with brain tumours (37) and COSMOS,(38) a European cohort study may help to answer some outstanding questions.

Application of the IARC classification to policy decisions is challenging. The rating as “possibly carcinogenic” is the same as has been applied to the magnetic fields associated with high voltage transmission lines and does not, in either case, provide a clear scientific answer as to whether these exposures are carcinogenic. The approach to dealing with both these hazards will rely on the degree of precaution that policy-makers choose to apply to the existing evidence and its residual uncertainty as well as the assessment of societal benefits associated with their sources.

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Staff Report

2015 Cost-Shared Budget Approval

Date:	January 14, 2015
To:	Board of Health
From:	Dr. Rosana Pellizzari, Medical Officer of Health

Original approved by	***Original approved by***
Rosana Pellizzari, M.D.	Bob Dubay, Manager Finance

Recommendations

That the Board of Health for the Peterborough County-City Health Unit approve:

- the 2015 cost-shared budget for public health programs and services in the amount of $7,626,546; and
- the additional budget for annual anticipated occupancy costs and mortgage payments required to operate King Street in the amount of $520,000;

This brings the total 2015 cost-shared budget for public health programs and services, excluding one-time costs, to $8,146,546.

Financial Implications and Impact

This budget includes most cost-shared budgets funded by the Ministry of Health and Long-Term Care (MOHLTC) as well as City, County and First Nations, but does not include other programs and services of the Health Unit funded 100% MOHLTC or by other Ministries of the Province.

Budgeting is simply putting dollar figures to plans. Many assumptions go into the formulation of the budget for the purposes of determining costs.

The most significant factor in the calculation of the cost-shared budgets is the cost of wages and benefits. Whatever is settled for 2014 and 2015 in the collective agreements will have a

significant impact on the 2015 budget. This budget is based on the Board's current bargaining position for both years.

The second most significant assumption is the increase in funding required from our funding partners. We have informed the City and County that they can expect just under a 3% increase plus their share of anticipated increase in occupancy and mortgage costs required by the move to King Street.

Excluding the increased occupancy and mortgage requirements, discussed later in this section, the following outlines the range of deficit we can expect based on the potential Provincial increases:

Provincial

Funding	Deficit
0%	-174,871
1%	-119,370
1.5%	- 91,621
2.0%	- 63,869
2.99%	slight deficit (as explained below)

The additional annual increase in occupancy and mortgage costs required to afford the King Street property is $520,000. While we will not require this amount to be flowed until the date of sale, it is imperative that we have the annual budget approval amount to secure the mortgage funding. The anticipated additional costs are as follows:

Additional Operational Expenses – King Street

Maintenance	125,578
Cleaning	81,975
Utilities	98,544
Insurance	15,470
Grounds and exterior	10,900
Share of building Insurance	23,109
Condo Management fee	20,494
Capital reserve	50,000
Mortgage payment	185,956
Total additional costs	612,026
Less: Reallocation of O'Carroll rent	-103,273
Net Increase in cost	**508,753**
Additional Funding Required	**520,000**
Surplus Funding	**11,247**

The small income is required to meet the Debt Service Coverage Ratio of the Mortgage lender.

One other item is that many of the funds that we use to access for programs such as “Come Cook with Us”, “Nobody’s Perfect” parenting and many other programs are, as of 2014, now only available through program reserves. In 2015, the budget has been drafted with a planned small deficit of $14,429 to use up some of the accumulated program reserves. Program reserves are funds set aside for these programs. Some of these funds were received as donations which Canada Revenue expects us to use within a two year window.

Decision History

The Health Protection and Promotion Act section 72(1) states that the budget for public health programs and services is the responsibility of the obligated municipalities. In 2004, the provincial government announced, “the Ministry will review Board of Health-approved budgets in relation to guidelines and approve its share according to the following” funding ratio “75% province, 25% municipalities”.

The 2015 budget is prepared on the basis of 75% funding grant from the MOHLTC, and 25% from the County of Peterborough, City of Peterborough, Curve Lake First Nation and Hiawatha First Nation. The County of Peterborough, City of Peterborough fund the Health Unit based on census population data. The Curve Lake First Nation and Hiawatha First Nation contribute based on funding agreements with the Board of Health.

On December 11, 2013 the Board approved the 2014 cost shared budget in the amount of $7,454,137, an overall 3.16% budget cost increase however the province only approved a 2% increase in funding. The impact of not being in receipt of the amount requested in 2014 has necessarily affected the amount we are requesting in 2015.

The City and County of Peterborough and First Nations of Curve Lake and Hiawatha have been approached by senior management to fund their share of Occupancy costs for the Board of Health pending the successful completion of a new building purchase. In 2013 and 2014 the annual amount for occupancy costs approved by the Board for a new building was $277,000. However the Board has not received written approval of this request from any of the funding partners. This amount is considerably lower than the current budget request. A large part of the difference is that the original plan was to buy the entire building and rent out excess space. The profit on the rents would have reduced the funding partners’ required contributions. However the risk of not renting the excess space and the potential for serious financial impact was much greater. The current plan has no opportunity to offset occupancy and mortgage costs, but also eliminates the risk. The annual amount required to meet the income requirements to secure a mortgage from Infrastructure Ontario is $520,000.

Background

Historical Ministry approvals have been:

	Increase
Increase in 2014 over 2013	2.00%
Increase in 2013 over 2012	2.00%
Increase in 2012 over 2011	1.62%
Increase in 2011 over 2010	2.85%
Increase in 2010 over 2009	3.0%

For the 2015 budget the following assumptions have been made:

1) Additional occupancy and mortgage costs will be required to facilitate a move;
2) Contract settlements will not exceed the Board's current wage position;
3) There will be no new Pay Equity adjustments;
4) No allowance has been made to deal with non-union compensation report;
5) General inflation will be 1%;
6) There will be no significant change in Influenza, HPV or Meningitis C rates;
7) There will be no significant changes to operating plans which will increase or decrease costs;
8) The budget assumes that the Board will tender non statutory benefits and save $48,000;
9) A full-time Human Resources position started January 1, 2015 funded from part of the savings of not replacing an administrative assistant position and through savings from tendering liability insurance $17,000 and remainder from tendering non statutory benefits;
10) There is no allowance for, but there is a limited risk that there may be costs associated with Provinces planned changes to Dental programs;
11) Allocation of local contributions between the City and County are based on published 2011 population census data and First Nation contributions are an estimate of per capita cost based on population data provided by the First Nations; and
12) Local reserves will be used to offset the difference in First Nation provided population versus census data.

Rationale

Under the *Ontario Public Health Standards*, the Board is required to approve an annual budget that does not forecast an unfunded deficit. The planned 2015 budgeted deficit will be funded by program reserves.

Strategic Direction

The proposed budget allows the Board to address all its strategic priorities.

Contact:

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Attachments: Attachment A – 2015 Cost-Share Budget and King Street Operating/Move Costs

PETERBOROUGH COUNTY CITY HEALTH UNIT **Draft January 5, 2015**

DRAFT 2015 PUBLIC HEALTH (Including SDW & Enhanced CINOT) BUDGETS – Operations Only

See additional pages for additional Costs King St.

		2015 Budget	2014 Budget	Change	% Increase
	EXPENDITURES				
1	Salaries and wages	5,276,715	5,186,171	90,544	1.75%
2	Employee benefits	1,438,639	1,398,290	40,349	2.89%
	% benefits of salary and wages	27.96%	26.96%		
3	Staff Education	5,050	5,000	50	1.00%
4	Staff Training	31,199	30,890	309	1.00%
5	Board Training and Employee Recognition	44,801	41,753	3,048	7.30%
6	Travel	77,636	83,636	-6,000	-7.17%
7	Building Occupancy	292,690	237,977	54,713	22.99%
8	Office Expenses, Printing, Postage	34,480	33,148	1,331	4.02%
9	Materials, Supplies	391,786	332,462	59,325	17.84%
10	Office Equipment	12,462	7,388	5,074	68.68%
11	Professional and Purchased Services	349,143	335,290	13,853	4.13%
12	Communication costs	122,572	121,359	1,214	1.00%
13	Information and Information Technology Equipment	57,431	56,862	569	1.00%
	EXPENDITURES	**8,136,619**	**7,872,240**	**264,377**	**3.36%**
	FEES & OTHER REVENUES				
14	Expenditure Recoveries Flu, HPV, MenC	21,335	37,300	-15,965	-42.80%
15	Expenditure Recoveries & Offset Revenues	488,738	378,788	109,949	29.03%
	FEES & OTHER REVENUES	**510,073**	**416,088**	**93,984**	**22.59%**
	NET EXPENDITURES - Cost Shared Budget	**7,626,546**	**7,456,152**	**170,394**	**2.29%**
	PARTNER CONTRIBUTIONS – 2014				
16	Ministry of Health & Long-Term Care	5,701,656	5,538,277	163,379	2.95%
17	County of Peterborough	780,042	757,659	22,383	2.95%
18	City of Peterborough	1,118,199	1,086,142	32,057	2.95%
19	Curve Lake First Nation	9,236	8,977	259	2.89%
20	Hiawatha First Nation	2,984	2,900	84	2.90%
21	Local Reserves needed to match Province	0	7,530	-7,530	-100.00%
	FUNDING PARTNER CONTRIBUTIONS	**7,612,117**	**7,401,485**	**210,632**	**2.85%**
Planned Deficit to be funded from Program reserves		**-14,429**			

Salary & Benefit Assumptions

1 ONA & CUPE agreement increases October 1, 2014 & October 1, 2015 as per Executive
2 OPSEU and Non Union increases April 1, 2014 & April 1, 2015 per contract
3 OMERS rates are known, YMPE is estimate
4 All other benefits are based on estimated rate increases to 2014 rates
5 No allowance for salary adjustments such as 2015 Pay Equity or Non Union compensation review
6 Full-time Human Resources position started January 1, 2015 funded from part of the savings of not replacing an administrative assistant position and through savings from tendering liability insurance $17,000 and remainder from tendering non statutory benefits.

Other Assumptions

Budget includes Cost-shared: Manadatory prgs, CINOT, cost shared SDW and Flu, HPV and Men C activities.

Allows for 1% inflation in 2015.

Assumes province will continue funding 100% of enhanced MOH salary - currently there is no agreement.

Assumes no significant change to HPV or MenC immunization levels.

Budget does not consider any significant changes to operational plans which could increase or decrease costs.

Allocation of local contributions between City and County based on published 2011 population census data.

First Nation allocations are estimate of per-capita cost based on band provided population number.

The budget assumes that the Board will tender non statutory benefits and save $48,000

Increases to Materials & Supplies and Purchased Services are offset by increased revenues (lines 9 & 15).

Board memberships increased for ALPHA rate increase (line 5). Required ergonomic costs (line 10).

There is a limited risk that there may be costs associated with Provinces planned changes to Dental programs.

Assumes building repairs will be needed before transfer of 10 Hospital drive to purchaser (line 7).

Increases to Professional Fees for additional Sexual Health clinics and legal fees (line 11).

PETERBOROUGH COUNTY CITY HEALTH UNIT **Draft Jan 5, 2015**

DRAFT 2015 PUBLIC HEALTH BUDGET – Additional operating costs King Street

		2015 Budget	2014 Budget	Change
	EXPENDITURES			
1	Occupancy and Mortgage costs	520,000	0	520,000
	EXPENDITURES	**520,000**	**0**	**520,000**
	PARTNER CONTRIBUTIONS – 2015			
2	Ministry of Health (Cost Shared Programs)	390,000	0	390,000
3	County of Peterborough	52,870	0	52,870
4	City of Peterborough	75,817	0	75,817
5	Curve Lake First Nation	626	0	626
6	Hiawatha First Nation	202	0	202
7	Local Reserves needed to match Provincial funding	485	0	485
	FUNDING PARTNER CONTRIBUTIONS	**520,000**	**0**	**520,000**

Additional Operational Expenses - King Street

Maintenance	125,578
Cleaning	81,975
Utilities	98,544
Grounds and Exterior	10,900
Share of building Insurance	23,109
Management Fee	20,494
Capital Reserve	50,000
Insurance	15,470
Mortgage Payment	185,956
	612,026
Less: Reallocation of O'Carrol rent	-103,273
Net increase in annual cost	508,753
Additional Funding above	520,000
Surplus Funding	**11,247** **Income required by Debt Service Coverage Ratio**

PETERBOROUGH COUNTY CITY HEALTH UNIT
DRAFT 2015 PUBLIC HEALTH - One Time move costs

One-time move, furniture and Renovation costs are still expected to cost the City $261,666
Previously the City has considered spreading over 3 years.

	PETERBOROUGH COUNTY CITY HEALTH UNIT		**Draft Jan 5, 2015**	
	DRAFT 2015 PUBLIC HEALTH BUDGET – Related to Building and Move			
		2015	**2014**	
		Budget	**Budget**	**Change**
	EXPENDITURES			
2	Anticipated one-time Move\Capital costs	1,794,690	0	1,794,690
	EXPENDITURES	**1,794,690**	**0**	**1,794,690**
	PARTNER CONTRIBUTIONS – 2015			
3	Ministry of Health (Cost Shared Programs)	1,346,018	0	1,346,018
4	County of Peterborough	182,475	0	182,475
5	City of Peterborough	261,666	0	261,666
6	Curve Lake First Nation	2,161	0	2,161
7	Hiawatha First Nation	698	0	698
8	Local Reserves needed to match Provincial funding	1,672	0	1,672
	FUNDING PARTNER CONTRIBUTIONS	**1,794,690**	**0**	**1,794,690**

Staff Report

Low Income Dental Program Integration

Date:	January 14, 2015
To:	Board of Health
From:	Dr. Rosana Pellizzari, Medical Officer of Health

Original approved by	***Original approved by***
Rosana Pellizzari, M.D.	Sarah Tanner, Supervisor

Recommendations

That the Board of Health for the Peterborough County-City Health Unit:

- receive the staff report, *Low Income Dental Program Integration*, for information; and
- send a letter to the Ontario Premier and Minister of Health and Long-Term Care calling for the Province of Ontario to retain the Preventive Oral Health Services Protocol in the 2008 Ontario Public Health Standards, and maintain access to treatment and prevention services for children with urgent dental conditions.

Financial Implications and Impact

Financial implications are not known at this time.

The 2014 Financial Planning, Accountability and User Guide for Program-Based Grants for Mandatory and Related Public Health Programs and Services contains specific wording related to funding Children In Need of Treatment (CINOT) and CINOT Expansion: "The Children In Need Of Treatment Expansion Program provides coverage for basic dental care for children 14 through 17 years of age in addition to general anaesthetic coverage for children 5 through 13 years of age. Boards of health must be in compliance with the Ontario Public Health Standards (OPHS) and the CINOT Protocol."[1] 2015 guidelines are not yet available to public health units.

Decision History

The Board of Health has not previously made a decision with regards to this matter.

Background

On December 16, 2013, the Ministry of Health and Long-Term Care announced its plan to raise the current income eligibility threshold for Healthy Smiles Ontario (HSO) starting in April 2014 in order to include more low-income families. The threshold would vary according to the number of children in the family. At this time the government also stated its intention to integrate the following provincially funded dental programs for children and youth by August 2015: CINOT, HSO, Ontario Works, Ontario Disability Support Program, Assistance for Children with Severe Disabilities and preventive services under the Ontario Public Health Standards.[2]

The proposed changes to integrate the six current programs into one low-income dental program means that:

1. Administration and eligibility determination for the new dental program will be centralized and contracted out to a third party;
2. The new dental program will be 100% funded by the Province;
3. Local public health units will no longer be mandated under the OPHS to provide prevention services to children and youth*;
4. Prevention services will be included in the basket of services of the new dental program so only children who are financially eligible for the new provincially funded treatment program will be eligible for publicly funded dental prevention services; and,
5. It is being proposed that children may only be eligible for treatment to address an urgent/emergency condition (i.e., pain, infection, abscess, broken teeth). Those families who cannot meet/establish financial eligibility for the new provincial dental program will no longer be eligible to get one course of treatment and prevention to restore them to health, as they currently are through the CINOT program.

***To date, preventive services including professionally applied topical fluoride, pit and fissure sealants and scaling have been available to all children with an identified need. The new program would mean that only children and teens whose families meet the eligibility requirements for in the new integrated program will be eligible for the following preventive services:*

- *Professionally applied topical fluoride – A caries-inhibiting procedure that is associated with a 46% reduction in decayed, missing and filled tooth surfaces.[3]*
- *Pit and fissure sealants – A plastic coating applied to molar teeth, which has proven to be a highly effective preventive treatment. After placement of sealants, the reduction of cavities incidence in children and adolescents range from 86% at one year, 78.6% at 2 years and 58.6% at 4 years.[4]*
- *Scaling – The removal of hard deposits from teeth (calculus) to reduce inflammation and possible destruction of soft tissues and the supporting structures of the teeth.*

Dental infection, if left untreated, can negatively affect a child's sleep, nutritional intake, speech development, self-esteem, learning at school and overall quality of life. In Peterborough, fluoride is added only to the City water system and we do not know the levels present in the rural areas.

Dental decay remains the most common chronic disease to affect children, more common than asthma.[5] 31% of all day surgeries for pre-school children are for Early Childhood Tooth Decay (ECTD). In Ontario, 18.4 children per 1000 children had day surgery for ECTD in 2011/12.[6] In the 2011/12 school year, 41% of children screened in Peterborough area schools had tooth decay and 270 children were identified with "urgent needs".[7]

Rationale

The removal of preventive services from the OPHS and the new financial eligibility for children at high risk of dental disease (who previously had access to preventive clinics and CINOT) would create a new service gap that will result in an oral health disparity for vulnerable children. Ontario's boards of health utilize a population-based approach to oral health which does not screen out clients based on financial status.[8] An objective of the Child Health program in the OPHS is to reduce the prevalence of dental disease in children and youth. Ensuring access to preventive oral health services and, in urgent cases, a full course of dental care is the most fiscally responsible and efficient way to ensure that children are able to return to, and retain optimum oral health.

Strategic Direction

This staff report supports the following Board of Health strategic directions:

- **Community-Centred Focus:** The Oral Health programs at PCCHU starts with the priorities of the community – screening, advising, advocating for access to preventive and treatment services. The Community Dental Health Centre and the Mobile Dental Health Centre are designed to promote access to services and be visible, active community partners.

- **Determinants of Health and Health Equity:** Promoting optimum oral health and responding to the needs of the individual are central to Oral Health Programs. Accessibility to professional, no-cost to the client services which are promoted through our community partners and networks are the foundation of the model with outreach to rural and vulnerable communities.

Contact:

Sarah Tanner, Supervisor
Oral Health Programs
(705) 743-1000, ext. 207
stanner@pcchu.ca

References:

1. The 2014 Financial Planning, Accountability and User Guide for Program-Based Grants for Mandatory and Related Public Health Programs and Services - Policy and Guidelines page 10**.**

2. Toronto Public Health, Impact of Removing Clinical Preventive Oral Health Services from Ontario Public Health Standards, August 1, 2014.

3. Canadian Institute of Health Information 2013 – Oral Health Report.

4. MOHLTC, Ontario Public Health Standards, Child Health- Protocol- Preventive Dental Services, 2008, Queens Park Printer.

5. Peterborough County-City Health Unit. Oral Health In Peterborough. December 2013.

6. Canadian Institute of Health Information 2013 – Oral Health Report.

7. Peterborough County-City Health Unit. Oral Health In Peterborough. December 2013.

8. Canadian Institute of Health Information 2013 – Oral Health Report.

Update on Low Income Dental Integration Project

Sarah Tanner, Supervisor
Oral Health Program

January 14, 2015

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Background

- In October 2013, Cabinet directed the Ministry of Health and Long-Term Care to implement an integrated dental program for children and youth from low-income families. Current benefits and programs to be integrated include:
  - dental benefits for children under Ontario Works*;
  - dental benefits for children under the Ontario Disability Support Plan;
  - dental benefits for children under the Assistance for Children with Severe Disabilities program;
  - Children In Need Of Treatment program;
  - Healthy Smiles Ontario program; and
  - Preventive oral health services within the *Ontario Public Health Standards, 2008.*

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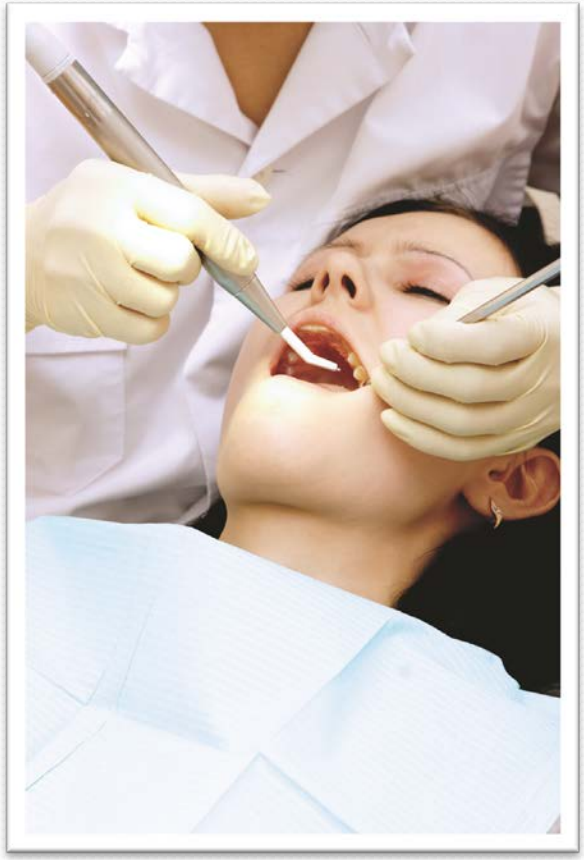
Current State

- **Currently services are provided through a confusing patchwork for clients**

- A patchwork of oral health programs and/or benefits with varying eligibility criteria, enrollment processes, delivery partners, service



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Intended future state

- **Healthy Smiles Ontario II**

- A new 100% provincially funded health program with an evidence-informed service schedule; supported by centralized enrollment, eligibility adjudication and claims management.

- More children are eligible as a result of a change to the income eligibility threshold which also adjusts for family size (the first change was implemented as of April 1, 2014).

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Implementation

- **Implementation Technical Advisory Committee (ITAC):** co-chaired by Dr. Andrea Feller, Laura Pisko and Liz Walker

- **Service Schedule Review Expert Panel** created, co-chaired by Dr. Carlos Quiñonez, University of Toronto and Dr. Paul Allison, Dean of Dentistry, McGill University - As part of the Service Schedule Review, **the Expert Panel** will solicit submissions from stakeholder organizations and delivery partners, including public health units, as well as program clients.

Procurement

- A Fairness Commissioner has been secured to provide independent advice to the ministry during the procurement process to ensure that it is done as fairly as possible

- A conflict of interest (COI) process is also being instituted that requires all external stakeholders to declare any real or potential COI prior to any discussion with the ministry regarding the new program.

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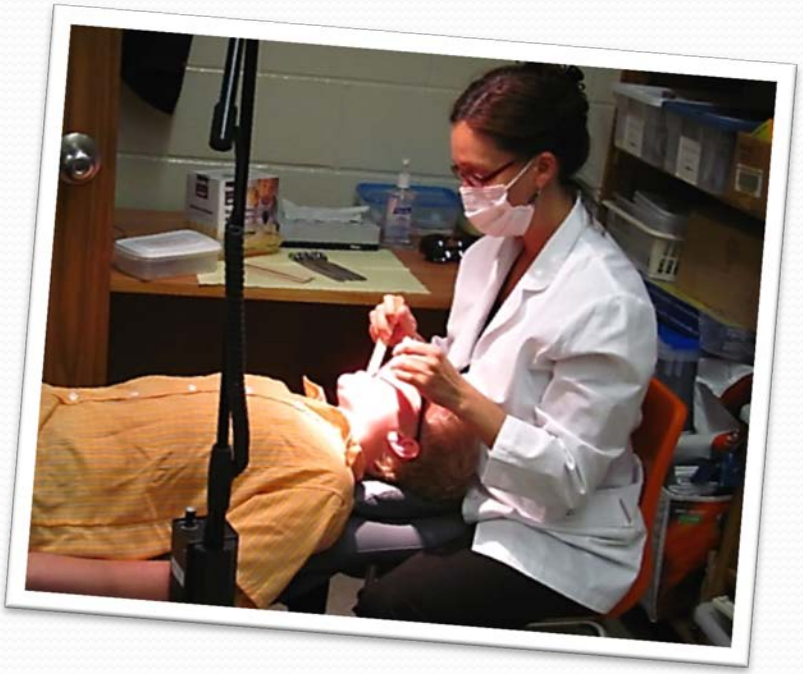
Program design

- A role for public health units will continue and include activities such as oral health promotion, surveillance/screening, support to the client journey, and other activities

- There have been discussions on preventive services in the future state and options on the approach to preventive services are currently being developed for consideration



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Outreach

- Engagement/outreach approaches are underway including the Implementation Technical Advisory Committee (ITAC), the Service Schedule Review Expert Panel and the Key Stakeholders' Table

- Engagement of social assistance delivery agents will be led by the Ministry of Community and Social Services (MCSS) and will seek advice regarding the inclusion of social assistance clients in the new program, as well as related programmatic considerations

Transition

- Options are being developed for transitioning existing HSO clients into the integrated program, including a [potential] one-time data feed from OHISS to the future program administrator
  - Privacy and data sharing implications of this option are still being considered

- The funding approach [for PHUs] for 2015 is under discussion, but will likely include a transition period prior to the implementation of a funding model for the integrated program

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QUESTIONS?

Staff Report

Vintners Quality Alliance (VQA) Wines at Farmers' Markets

Date:	January 14, 2015	
To:	Board of Health	
From:	Dr. Rosana Pellizzari, Medical Officer of Health	
Original approved by		***Original approved by***
Rosana Pellizzari, M.D.		Monique Beneteau, Health Promoter

Recommendations

That the Board of Health for the Peterborough County-City Health Unit:

- receive the staff report, *Vintners Quality Alliance (VQA) Wines at Farmers' Markets,* for information;
- send a letter to all municipalities in the City and County of Peterborough encouraging them to formally opt out of the VQA Wines at Farmers' Markets pilot project or, if they choose to participate, to adopt harm reduction strategies to reduce the effects of the availability and accessibility of alcohol; and
- send a letter to all farmers' markets in the City and County of Peterborough encouraging them to decline the participation of VQA wineries at their markets or, if they choose to allow their participation, to adopt and enforce harm reduction strategies.

Financial Implications and Impact

There are no financial implications arising from this report.

Decision History

The Board of Health has not previously made a decision with regards to this matter.

Background

The Ontario Ministry of Finance held consultation sessions in February 2014 with key stakeholders around the province to discuss the idea of making the sale of VQA (Vintners' Quality Alliance) wines available at farmers' markets. The government's objective, as stated in the presentation, is to support the Ontario wine industry and is part of their plan to modernize alcohol laws in the province.

In addition to the consultation sessions, individuals were invited to share their thoughts regarding the "proposal to amend Regulation 720 (Manufacturers' Licences) under the Liquor Licence Act" through the government's on-line Regulatory Registry. A number of agencies opposing this initiative submitted letters which included the Centre for Addiction and Mental Health (CAMH), the Ontario Public Health Association (OPHA), the Association of Local Public Health Agencies (alPHa), and the Alcohol Management in Municipalities Work Group. The greatest concerns focused on ever-expanding availability and accessibility of alcoholic beverages resulting in overconsumption and negative health consequences.

The government implemented a pilot farmer's market project on May 1, 2014 and it will be evaluated in winter 2015. At that time, it is possible that the initiative would expand to include Ontario craft brewers and distillers.

According to the provincial government, there are approximately 140 VQA wineries in Ontario who qualify to participate in this initiative and approximately 320 farmers' markets. If wineries choose to participate, they apply to the Alcohol and Gaming Commission of Ontario (AGCO) for "'occasional extensions' of on-site winery retail stores (WRS)."[1] The application process can be found on the AGCO website at http://www.agco.on.ca/en/whatwedo/farmers_market.aspx. This site also includes a list of the wineries that have applied for an expansion of their licenses as well as the farmers' markets where wine may be sold. The provincial government is also assisting in promoting locations via a map on the Ministry of Agriculture, Food and Rural Services website: http://www.ontario.ca/travel-and-recreation/buy-ontario-wine-local-farmers-market. In the Peterborough area, the Peterborough Downtown Farmers' Market and Lakefield Farmers' Market are listed on the map. According to a presentation by the AGCO at the Countermeasures XX Conference in November 2014, 75 wineries (mostly small and medium size) participated at least one day and 135 farmers' markets participated, some just once or twice and others every week. The greatest compliance issues with the Liquor License Act have revolved around inadequate advance notice of when and where sales were happening and sampling (i.e., people consuming alcohol beyond the boundaries of the booth).

Municipalities can opt out of this program "by providing the Registrar of the AGCO with a notice of objection to the sale of VQA wines at farmers' markets in their jurisdiction."[2] In addition, farmers' markets can decline requests from wineries.

[1] Government of Ontario. (February 2014). *VQA Wine at Farmers' Markets* presentation, slide 4.
[2] Ibid., slide 6.

Recognizing that the initiative is underway and that municipalities and farmers' markets are now allowing wineries to sell their products, the Ontario Public Health Association (OPHA) intends to distribute a letter to all municipalities detailing the public health concerns regarding the health and social implications of having alcohol available at farmers' markets. The letter, expected in late winter 2015, will include an attachment outlining a number of harm reduction strategies that can be adopted in order to avert any serious negative consequences. The latest version of the proposed handout can be found appended to this report.

Rationale

The research is very clear that the more alcohol is available and accessible via more outlets, extended hours, and lower prices, the greater the consumption rates. The evidence also shows that higher consumption rates results in greater health and social consequences related to injuries, chronic disease, Fetal Alcohol Spectrum Disorder and violence and crime.[3]

The Health Unit's 2011 report, *Report on Alcohol Use in Peterborough City and County: Recommendations for a Healthier and Safer Community*[4], showed that individuals in the City, County and First Nations of Peterborough are already consuming alcohol at higher rates than the provincial average. The report stated:

> "Unfortunately, over a third of Peterborough adults drink in excess of established low risk drinking guidelines - a rate higher than the Ontario average. Peterborough drinkers also engage in binge drinking at rates 9% higher than the provincial average, ranking 9th highest in the province (amongst 36 health units). Since 2001, the prevalence of heavy drinking amongst adults has been steadily increasing in Peterborough and at a slightly faster rate than provincial estimates." (p. 7)

The AGCO regulations not only allow wineries at farmers' markets to sell alcohol during the normal operating hours of the market but also allow for sampling. These rules mean that individuals could be consuming and acquiring alcohol as early as 6 a.m. Unless harm reduction strategies are adopted, these regulations will contribute to increased access and availability of alcohol.

Farmers' markets have traditionally been an event for families to visit together. Having alcohol promoted through attractive displays and patrons sampling wine in the presence of young children and youth contributes to the normalization of alcohol use in our community. To have alcohol available for sale and sampling beside produce, meat and other goods implies that alcohol is a commodity like any other when, in fact, it can carry serious health and social consequences.

[3] Peterborough County-City Health Unit. (2011). Report on Alcohol Use in Peterborough City and County: Recommendations for a Healthier and Safer Community.
[4] Ibid., p. 7

Research shows that the most effective strategies for mitigating the risks due to alcohol must be comprehensive in nature.[5] For this reason, the Peterborough County-City Health Unit intends to identify and meet with staff of those municipalities where farmers' markets are situated in an effort to explain our concerns and to emphasize the need to mitigate harms. Health unit staff will also discuss our concerns directly with the farmers' markets in the area.

It is important to note that there has been a certain tension between competing demands within the government. On the one hand, the Ministry of Health and Long-Term Care (MOHLTC) has mandated public health to reduce alcohol consumption rates through the accountability agreement. At the same time, the provincial government is relaxing alcohol controls thereby making alcohol more available and accessible (e.g, farmers' markets, retail outlets). The Council of Ontario Medical Officers of Health (COMOH) expressed to the MOHLTC its frustration with this contradiction. Subsequently, health units received correspondence from the Ministry indicating that the performance indicator in the Accountability Agreement regarding the Low Risk Alcohol Drinking Guidelines (LRADG) has moved to the "monitoring" category. In other words, we are not obligated to meet this indicator at this time.

Strategic Direction

This report addresses the Health Unit's *Community-Centred Focus*. In collaboration with local and provincial partners, we are working toward minimizing the health and social risks associated with alcohol consumption.

Contact:

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Community Health Team
(705) 743-1000, ext. 309
mbeneteau@pcchu.ca

References:

Government of Ontario. (February 2014). *VQA Wine at Farmers' Markets* presentation.
Peterborough County-City Health Unit (2011). *Report on Alcohol Use in Peterborough City and County: Recommendations for a Healthier and Safer Community*.

Attachments:

Attachment A – Handout: Harm Reduction Strategies for VQA Wine Sales at Farmers' Markets

[5] Locally Driven Collaborative Project – Cycle 2. (2014). *Addressing alcohol consumption and alcohol-related harms at the local level.*
http://www.oninjuryresources.ca/downloads/workgroups/ldcpalcohol/LDCP_report_rev_Oct_14_6.pdf

Harm Reduction Strategies for the Ontario VQA Wine at Farmers' Markets pilot program

1. **Limit alcohol availability**
   Rationale: Research has repeatedly demonstrated that as alcohol becomes more available in a community, levels of drinking and alcohol-related harms increase. Evidence shows that controls on hours, days and locations of sale can effectively limit and prevent these impacts.[i]

Actions you can take:

- Align VQA stall hours with the on-site wine retail start time of 9:00 am. Place conditions on the timing of sales and sampling to reflect the specific nature of the market and its surrounding community.
- Decide which farmers' markets on municipal property may or may not be appropriate for participation in the pilot.
- Limit the number or proportion of booths dedicated to VQA wine sales and set a limit on stalls allowed to provide alcohol samples.
- Ensure warehousing of wine at or near the market does not occur. Report lack of compliance to the AGCO.

2. **Ensure responsible sale and promotion of alcohol to protect children and youth and to encourage moderate drinking**
   Rationale: Exposure to advertising shapes youths' attitudes to alcohol, influences the age an adolescent starts drinking, and leads to heavier drinking amongst those who already drink. Additionally, maintaining a certain level of pricing is one of the most effective means to reduce alcohol consumption in the general population and minimize alcohol-related harm.

Actions you can take:

- Choose to opt out of selling alcohol at markets that attract a high attendance of youth and young children.
- If participating in the pilot, confine alcohol sale and sampling to a designated area.
- Ensure VQA wine sales at farmers' markets conform to existing rules around alcohol marketing and advertising, particularly constraints around advertising of price and multi-unit discounts, such as 2-for-1 deals.[1]

3. Foster safety and reduce liability

Rationale: Depending on the location, organizing groups and/or municipalities can be held liable should there be an alcohol-related incident arising from the sale and/or sampling of alcohol. The insurance provider may require additional risk-reduction measures**.** Keeping VQA wine sales and sampling separate from other goods may facilitate the regulation and control of alcohol. Information and/or signs posted about low-risk drinking allow consumers to make informed decisions about alcohol.

Actions you can take:

- If permitted, ensure wine sampling complies with appropriate sampling guidelines**.** Consider establishing local sampling guidelines similar to the Toronto Farmers' Market Network.[ii] These measures include:
  - ensuring food is available and sample portion sizes are minimal (i.e., less than 60 ml/2 oz. for wine);
  - limiting the number of samples per customer;
  - not allowing customers to take samples outside the designated area;
  - charging a nominal fee for samples on a cost recovery basis;
  - posting or providing information on the low-risk alcohol drinking guidelines[iii], the risks of alcohol during pregnancy[iv] and prevention of drinking and driving.
- Consider making it a requirement that wineries provide proof that staff is Smart Serve trained.
- Ensure Farmers' markets on municipal property comply with local municipal alcohol policies.

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i Babor, Thomas, et al. (2010). Alcohol: No Ordinary Commodity- research and public policy 2nd edition. Oxford University Press, Oxford New York.

[ii] As posted on the City of Toronto website for the July 2, 2014 Executive Committee meeting—Attachment 3.See http://app.toronto.ca/tmmis/viewAgendaItemHistory.do?item=2014.EX43.12.

[iii] For more information on the guidelines, visit: http://www.ccsa.ca/Resource%20Library/2012-Canada-Low-Risk-Alcohol-Drinking-Guidelines-Brochure-en.pdf

[iv] See http://www.agco.on.ca/pdfs/en/warnsign_clr.pdf.

To: All Members
Board of Health

From: Dr. Rosana Pellizzari, Medical Officer of Health

Subject: **Committee Report: Property**

Date: January 14, 2015

The Property Committee met last on December 12, 2014. At that meeting, the Committee requested that the following items come forward to the Board of Health for information. Supporting documentation has been included (and linked) where available.

1. Property Committee Meeting Minutes, November 10, 2014

Recommendation:

That the Board of Health for the Peterborough County-City Health Unit receive for information, meeting minutes of the Property Committee for November 10, 2014.

Board of Health for the
Peterborough County-City Health Unit
MINUTES
Property Committee Meeting
Monday, November 10, 2014
Board Room, 10 Hospital Drive, Peterborough

Present:	**Councillor Henry Clarke (by teleconference)** **Councillor Lesley Parnell** **Deputy Mayor Andy Sharpe, Chair** **Mr. Scott McDonald (by teleconference)** **Mr. David Watton (by teleconference)**
Regrets:	**Chief Phyllis Williams**
Staff:	**Dr. Rosana Pellizzari, Medical Officer of Health** **Mr. Brent Woodford, Director, Corporate Services** **Ms. Natalie Garnett, Recorder**
Guests:	**Dennis O'Connell, Independent Project Managers (by teleconference)** **Daniel Giddings, Independent Project Managers (by teleconference)** **Bob Pakenham, Solicitor, LLF Lawyers**

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1. Call to Order

Deputy Mayor Sharpe called the meeting to order at 12:00 p.m.

2. Confirmation of the Agenda

MOTION:
That the Agenda be accepted as circulated.
Moved: Councillor Parnell
Seconded: Mr. McDonald
Motion carried. (M-2014-18-PR)

3. Declaration of Pecuniary Interest

There were no declarations of Pecuniary Interest.

4. Delegations and Presentations

5. Confirmation of Minutes of the Previous Meeting

MOTION:
That the Property Committee Meeting minutes for April 9 and June 11, 2014 be approved.
Moved by: Councillor Parnell
Seconded by: Councillor Clarke
Motion carried. (M-2014-19-PR)

6. Business Arising from the Minutes

7. Correspondence

8. New Business

9. In Camera to Discuss Confidential Property Matters

MOTION:
That the Property Committee go in Camera to discuss confidential property matters.
Moved by: Councillor Parnell
Seconded by: Mr. Watton
Motion carried. (M-2014-20-PR)

MOTION:
That the Property Committee Meeting rise from in Camera at 12:50 pm.
Moved by: Councillor Parnell
Seconded by: Councillor Clarke
Motion carried. (M-2014-21-PR)

10. Motions from In Camera for Open Session

11. Date, Time and Place of the Next Meeting

At the call of the Chair.

12. Adjournment

MOTION:
That the Property Committee meeting be adjourned.

Moved by: Councillor Parnell

Seconded by: Mr. Watton
Motion carried. (M-2014-22-PR)

The meeting was adjourned at 12:51 p.m.

Chairperson

Medical Officer of Health