Board of Health for the
Peterborough County-City Health Unit
AGENDA
Board of Health Meeting
Wednesday, June 10, 2015 - 4:45 p.m.
Council Chambers, City of Peterborough
500 George Street North, Peterborough

1. Call to Order

2. Confirmation of the Agenda

3. Declaration of Pecuniary Interest

4. Delegations and Presentations

4.1. **Introduction to the Climate Change Action Plan for the Greater Peterborough Area**
Jeff Garkowski, LURA Consultants

5. Confirmation of the Minutes of the Previous Meeting

5.1. **May 13, 2015**

6. Business Arising From the Minutes

7. Correspondence

8. New Business

8.1. **Staff Report: 2014/2015 Infant & Toddler and Development Program Audited Financial Statements and Transfer Payment Annual Reconciliation**
Larry Stinson, Interim Director, Corporate Services

8.2. **Staff Report: 2014/2015 Preschool Speech and Language Program Audited Financial Statements**
Larry Stinson, Interim Director, Corporate Services

8.3. **Staff Report: Guarding Minds at Work**
Dr. Rosana Pellizzari, Medical Officer of Health

8.4. **Committee Report: Governance**
Scott McDonald, Chair, Governance Committee

8.5. **Oral Report: Association of Local Public Health Agencies Annual General Meeting**
Kerri Davies, Board Member
Dr. Rosana Pellizzari, Medical Officer of Health

8.6. **Planning Session Follow-Up**
Dr. Rosana Pellizzari, Medical Officer of Health

9. In Camera to Discuss Confidential Personal and Property Matters

10. Motions for Open Session

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

September 9, 2015, 4:45 p.m.
Lower Hall, Administration Building
123 Paudash St., Hiawatha First Nation

12. 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.

Peterborough City-County Health Unit

Presentation to Board of Health

June 10, 2015

@sustainableptbo
#OURchange
Sustainable Peterborough
sustainablepeterborough.ca

sustainable Peterborough
Peterborough ECONOMIC DEVELOPMENT
Ontario Trillium Foundation / Fondation Trillium de l'Ontario
FCM FEDERATION OF CANADIAN MUNICIPALITIES / FÉDÉRATION CANADIENNE DES MUNICIPALITÉS

NOTICE: Proposed recommendations as noted within the posted agenda package may not be indicative of the final decision made by the Board of Health at the meeting. Should a member of the public or media outlet wish to confirm or clarify any Board position following the meeting, please contact the PCCHU Communications Supervisor or refer to the meeting summary issued shortly thereafter. Final motions are recorded in posted approved Minutes.

Our change

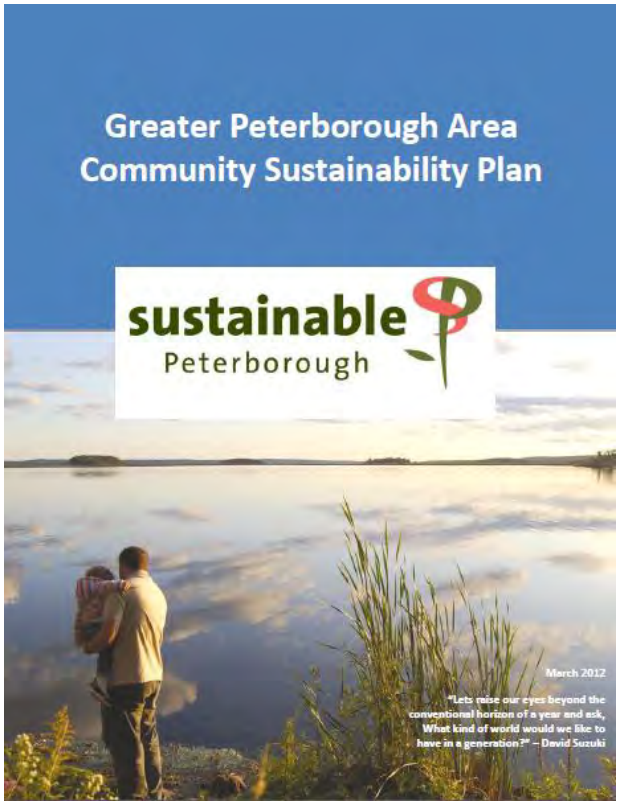
Agenda

- Welcome and Introductions
- Background and Project Overview
- Discussion on Public Health Impacts
- Questions
- Next Steps

SUSTAINABLE PETERBOROUGH

Our change

The Sustainability Story



A community sustainable project was initiated in 2010 by all 12 municipalities and First Nations within the Greater Peterborough Area.

The Peterborough Sustainability Plan was formally adopted by all partners April-May 2012.

SUSTAINABLE PETERBOROUGH

Our change

Sustainable Peterborough

- Community Collaboration
- Shared Vision and Goals
- Priority Actions
- Community Partnership
- Governance Structure
- Tracking and Reporting

SUSTAINABLE PETERBOROUGH

sustainable Peterborough

Caring communities balancing prosperity, well-being and nature.

We will reduce our contributions to climate change while increasing our ability to adapt to climate change conditions

SUSTAINABLE PETERBOROUGH

Our change

Priority Action

Become active members in the Partners for Climate Protection (PCP) Program to establish a baseline of greenhouse gas emissions with a corresponding plan for achieving a set target in emissions reductions

SUSTAINABLE PETERBOROUGH

Our change

FCM Partners for Climate Protection

1. Establish a GHG inventory and forecast
2. Set emission reduction targets
3. Develop a local action plan
4. Implement the local action plan
5. Monitor progress and report results

SUSTAINABLE PETERBOROUGH

Our change

Taking Action on Climate Change

Sustainable Peterborough is developing a **Climate Change Action Plan (CCAP)** for the Greater Peterborough Area to reduce local contributions to climate change and prepare the community for present and future changes.

Climate Change Action Plan

The CCAP will contain goals, actions and emission targets that fit with and address the needs of each local municipality and First Nation.

The overarching goal is to:

- Reduce our greenhouse gas emissions and use of fossil fuels;
- Lower our energy consumption;
- Reduce public health impacts; and
- Adapt to our changing climate.

SUSTAINABLE PETERBOROUGH

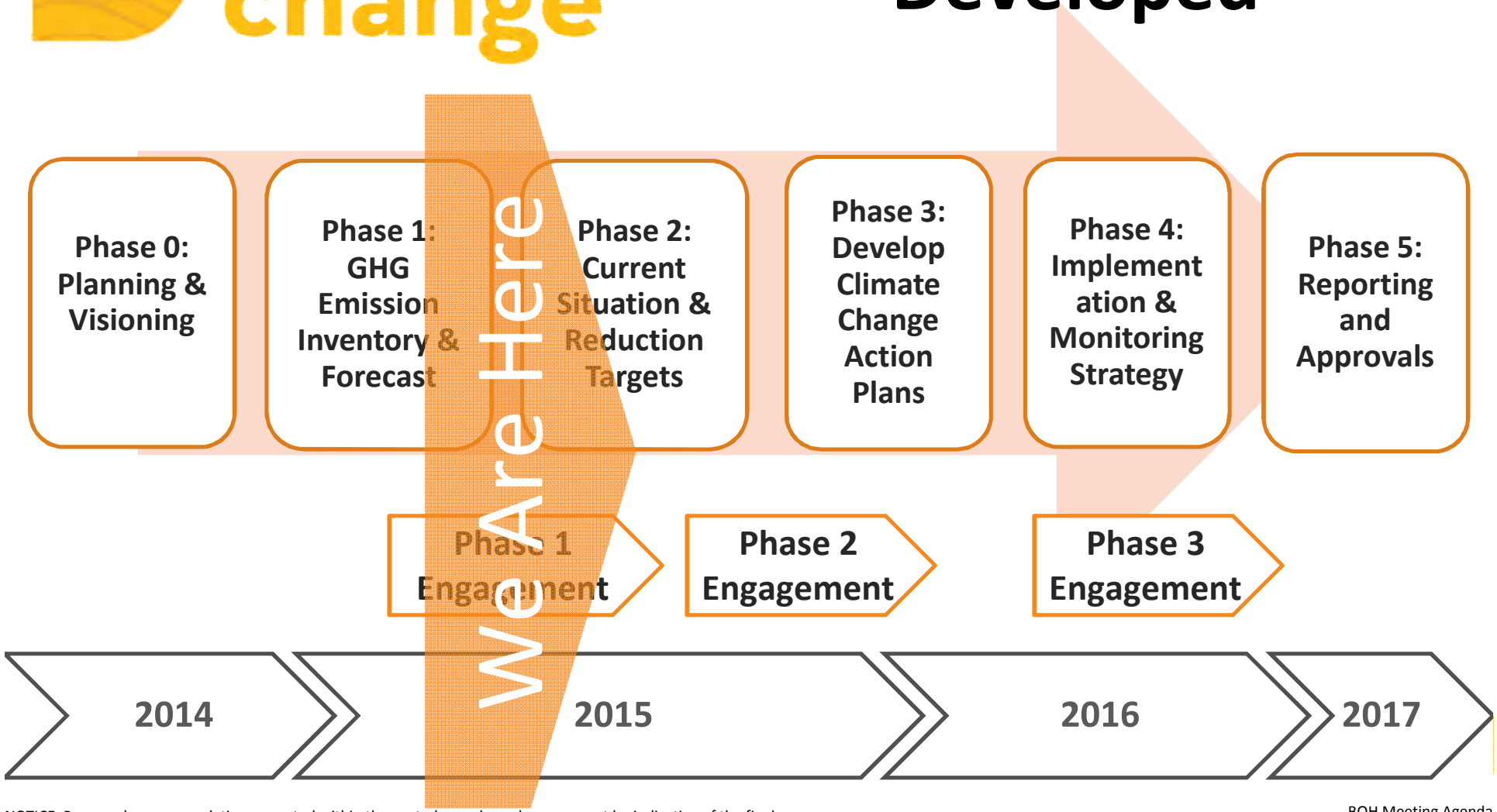
Our change

How it is Being Developed

SUSTAINABLE PETERBOROUGH

Our change

How it is Being Developed



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SUSTAINABLE PETERBOROUGH

Corporate and Community Sectors

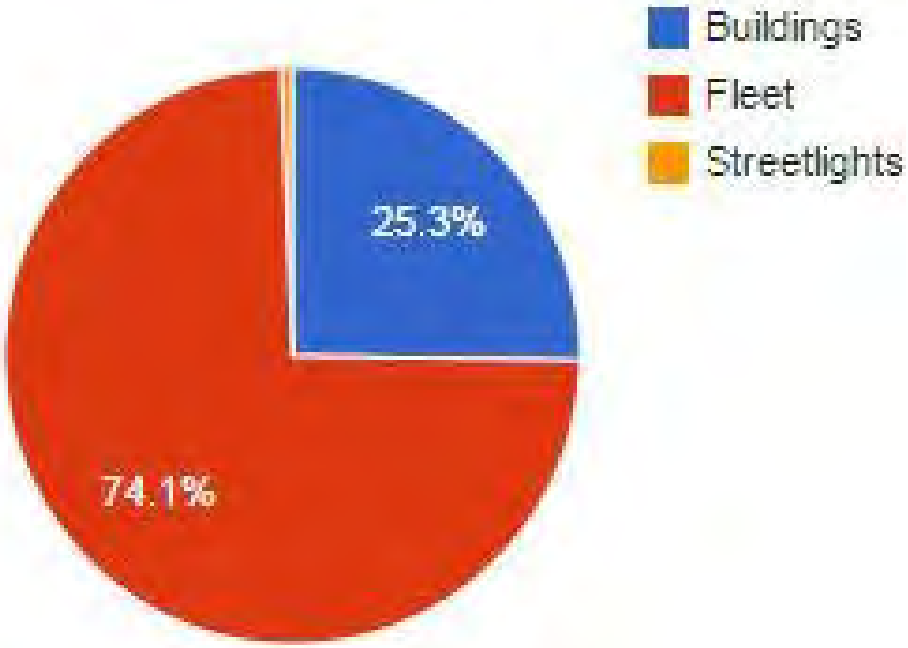
Municipal and First Nations Internal Operations	Community
Focus Areas - Buildings/Facilities - Fleet/Transportation - Corporate Policy - Infrastructure/Assets - Corporate Waste	**Focus Areas** - Land Use Planning - Transportation - Community Energy - Community Waste - Natural Assets & Water - Agriculture & Food - Economic & Business - People & Health

SUSTAINABLE PETERBOROUGH

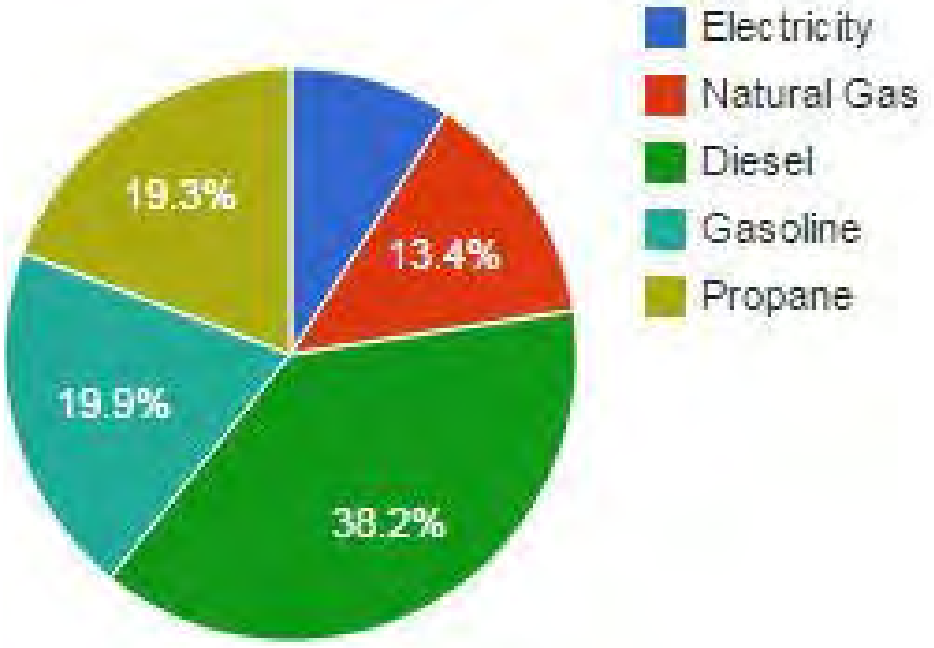
Our change

Example of Corporate Emission Inventory

GHG Emissions by Sector



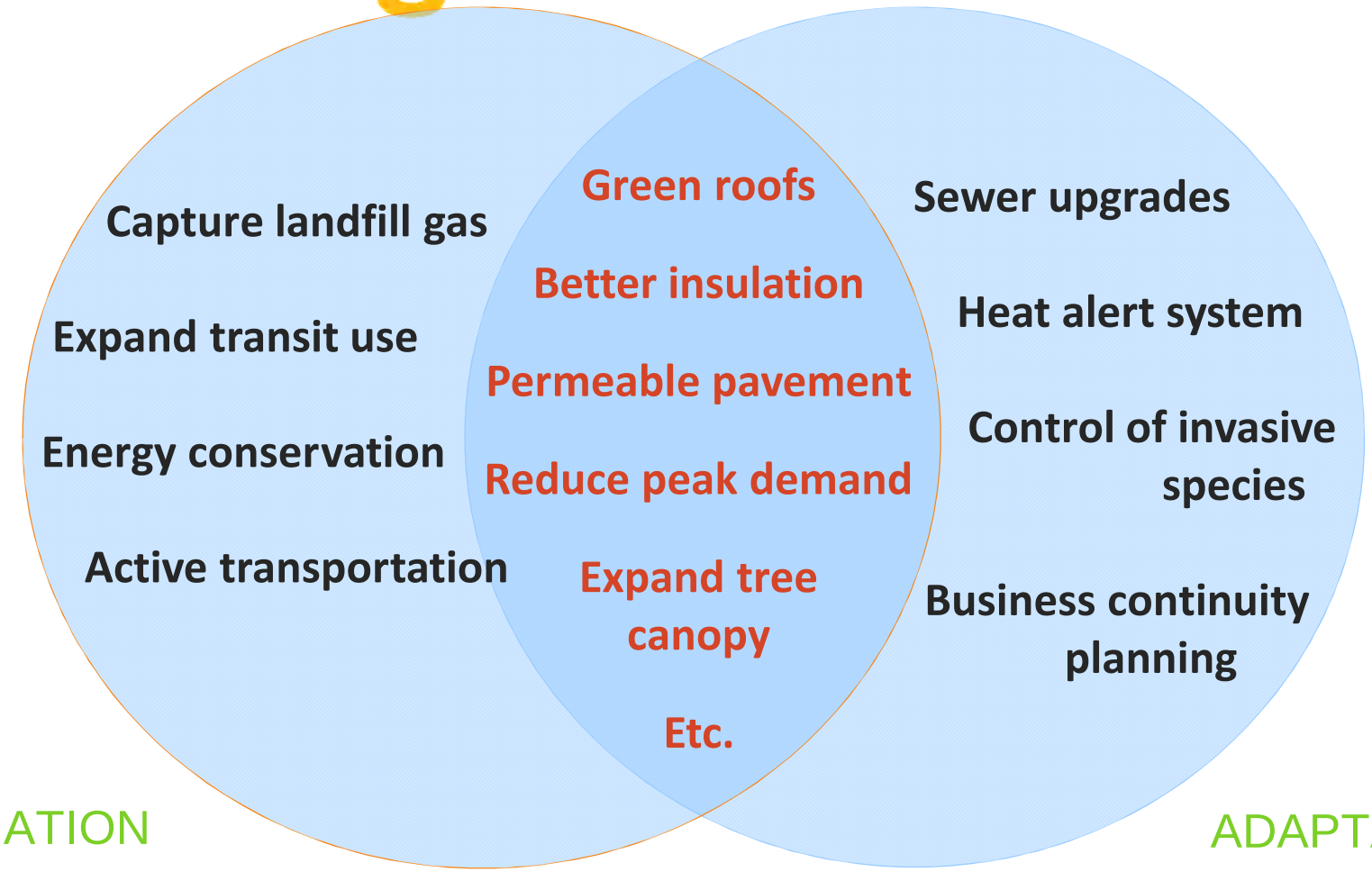
GHG Emissions by Source



SUSTAINABLE PETERBOROUGH

Our change

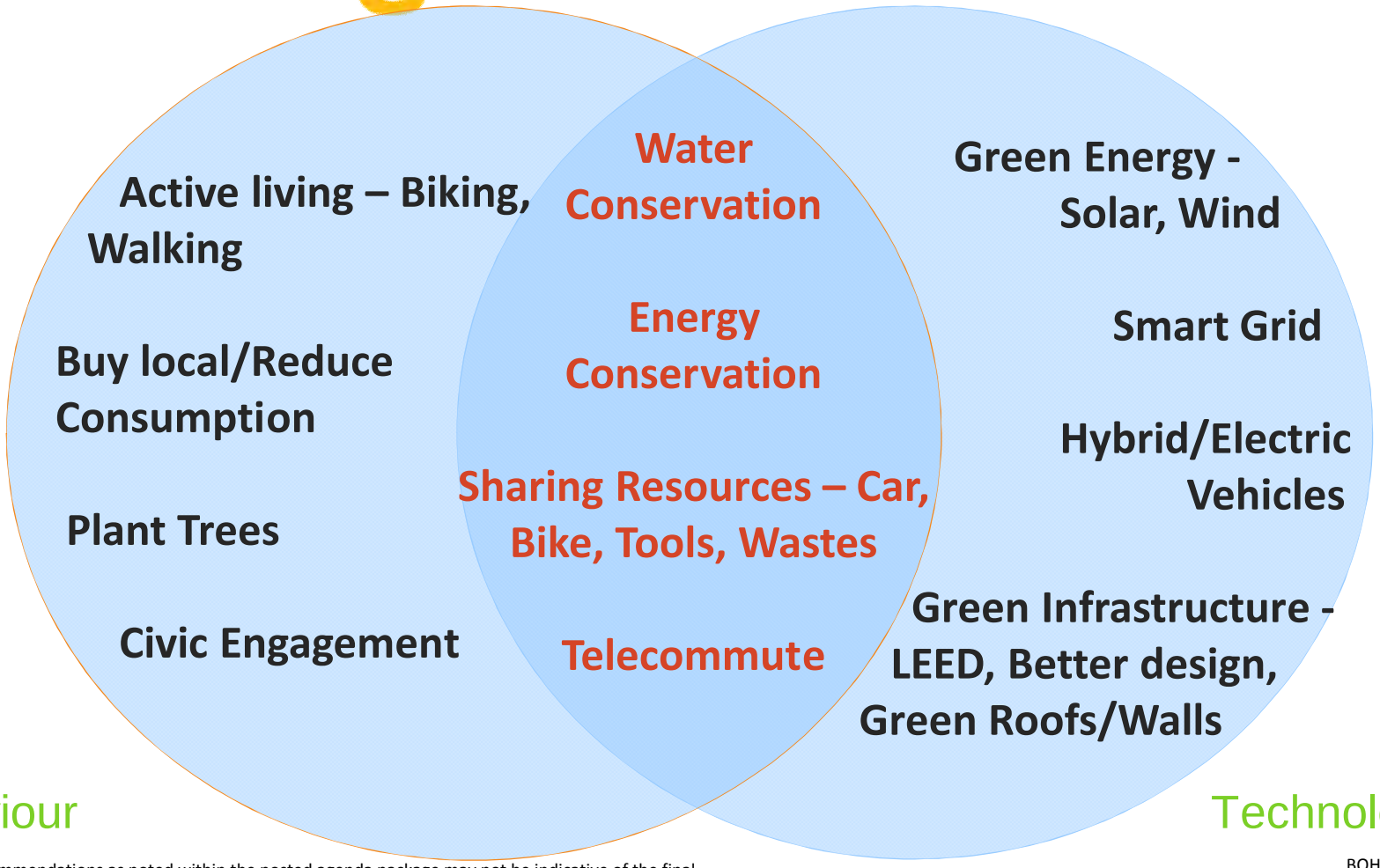
Mitigation & Adaptation



SUSTAINABLE PETERBOROUGH

Our change

Behaviour & Technology



SUSTAINABLE PETERBOROUGH

Climate Change Action Plan

How can climate change impact public health?

CLIMATE CHANGE **ACTION PLAN**

SUSTAINABLE PETERBOROUGH

Climate Change Action Plan

How and where have we experienced the impacts associated with climate change (personally or as a community)?

CLIMATE CHANGE **ACTION PLAN**

Our change

Climate Change Action Plan

Where do we anticipate the health impacts associated with climate change to be the most severe? Who is most vulnerable?

SUSTAINABLE PETERBOROUGH

Climate Change Action Plan

Who in our community is taking action on climate change from a public health perspective?

CLIMATE CHANGE **ACTION PLAN**

SUSTAINABLE PETERBOROUGH

Our change

Next Steps

- Completion of Community Baseline Inventories for Each Community
- Ongoing Community and Stakeholder Engagement
  - General Public & Community Stakeholders
  - Municipal Stakeholder Meetings
  - Task Forces
- Action Planning and Target Setting Initiating in the Fall

Stay Engaged!

Visit us at Pop-Up Climate Conversations

Share Your Ideas through Our Survey

Engage with Us Online

Website: www.sustainablepeterborough.ca
Twitter: @sustainableptbo #OURchange
Facebook: Sustainable Peterborough

Connect us with Local Organizations to Deliver a Climate Workshop

Sign up to Receive Our E-Newsletter

SUSTAINABLE PETERBOROUGH

Our change

Thank you!

Contact Information

Melanie Kawalec, Climate Action Plan Project Manager

City of Peterborough

705-742-7777 ext. 1441

climatechange@sustainablepeterborough.ca

Jeff Garkowski, Consulting Team Project Manager

LURA Consulting

416-644-1801

jgarkowski@lura.ca

LURA
LISTEN · UNDERSTAND · RELATE · ADVANCE

ICLEI Local Governments for Sustainability

GreenUP

CLIMATE CHANGE ACTION PLAN

Board of Health for the
Peterborough County-City Health Unit
DRAFT MINUTES
Board of Health Meeting
Wednesday, May 13, 2015 – 4:45 p.m.
Council Chambers, Administrative Building
22 Wiinookeedaa Road, Curve Lake First Nation

In Attendance:

Board Members:

Councillor Henry Clarke
Deputy Mayor John Fallis
Mayor Mary Smith
Mr. Gregory Connolley
Ms. Kerri Davies
Mayor Rick Woodcock
Councillor Gary Baldwin
Councillor Trisha Shearer (4:55 p.m.)
Mr. Andy Sharpe
Chief Phyllis Williams, Acting Chair

Staff: **Dr. Rosana Pellizzari, Medical Officer of Health**
Ms. Alida Tanna, Administrative Assistant
Mr. Larry Stinson, Interim Director, Corporate Services
Ms. Patti Fitzgerald, Acting Director, Public Health Programs
Ms. Natalie Garnett, Recorder

Regrets: **Councillor Lesley Parnell, Chair**
Mr. Scott McDonald, Vice Chair

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1. Opening Prayer

Mr. Keith Knott welcomed the Board of Health Members to Curve Lake First Nation and led the group in an opening prayer.

2. Call to Order

Chief Williams, Acting Chair called the meeting to order at 4:49 p.m.

3. Confirmation of the Agenda

MOTION:
That the Agenda be approved as circulated.
Moved: Councillor Clarke
Seconded: Mayor Smith
Motion carried. (M-2015-069)

4. Declaration of Pecuniary Interest

5. Delegations and Presentations

5.1. **Curve Lake First Nation Health and Family Services Update**
Crystal Cummings, Health and Family Services Manager at Curve Lake First Nation provided a power point presentation on Health and Family Services activities over the past year.

5.2. **Ontario's Approach to the Risk Categorization of Food Premises**
Atul Jain, Manager, Inspection Services updated the Board of Health on changes to the risk categorization of food premises.

6. Confirmation of the Minutes of the Previous Meeting

6.1. **April 15, 2015**

MOTION:
That the minutes of the Board of Health meeting held on April 15, 2015, be approved as circulated.
Moved: Ms. Davies
Seconded: Mayor Smith
Motion carried. (M-2015-070)

7. Business Arising From the Minutes

8. Correspondence

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

1. *Letter dated March 5, 2015 from MPP Laurie Scott, in response to Dr. Pellizzari's original letter dated February 4, 2015 regarding Low Income Dental Programs Integration.*

2. *Letter dated April 22, 2015 from the Central East Local Health Integration Network to Dr. Pellizzari regarding a recent presentation to the Board.*
3. *Email dated April 23, 2015 from the Association of Local Public health Agencies (alPHa) to all Ontario Boards of Health regarding the provincial budget.*
4. *Email newsletter dated April 29, 2015 from alPHa to all members.*
5. *Email dated May 4, 2015 from alPHa to all Ontario Board Chairs regarding the provincial Poverty Reduction Strategy.*
6. *Letter dated May 7, 2015 from the Chair to Prime Minister Harper and Minister Ambrose regarding the National Alcohol Strategy.*
7. *Resolutions/Letters from other local public health agencies:*
   Making Healthier Choices Act (Bill 45)
   Northwestern
   (This letter is endorsed by the Board of Health for the Peterborough City-County Health Unit and sent to Premier Wynne and Minister Damerla)

Moved: Ms. Davies
Seconded: Mayor Woodcock
Motion carried. (M-2015-071)

9. New Business

9.1. Staff Report: 2014 Audited Consolidated Financial Statements

Richard Steiginga and Gloria Raybone, Collins Barrow Chartered Accountants spoke to the 2014 Audited Consolidated Financial Statements.

MOTION:
That the Board of Health for the Peterborough County-City Health Unit approve the 2014 Auditor's Report of the Consolidated Financial Statements of the Peterborough County-City Health Unit, as prepared by Collins Barrow Chartered Accountants.
Moved: Mr. Sharpe
Seconded: Councillor Baldwin
Motion carried. (M-2015-072)

9.2. Staff Report: 2014 Annual Reconciliation Report with the Ministry of Health and Long-Term Care

Larry Stinson, Interim Director, Corporate Services provided an overview of the staff report.

MOTION:
That the Board of Health for the Peterborough County-City Health Unit receive the staff report, 2014 Annual Reconciliation Report with the Ministry of Health and Long-Term Care, for information.
Moved: Mayor Smith
Seconded: Councillor Baldwin
Motion carried. (M-2015-073)

9.3. **Staff Report: Q1 2015 Program Report**

Larry Stinson, Interim Director, Corporate Services provided a review of the Q1 2015 Program Report.

MOTION:
That the Board of Health for the Peterborough County-City Health Unit receive the staff report, Q1 2015 Program Report, for information.
Moved: Councillor Clarke
Seconded: Ms. Davies
Motion carried. (M-2015-074)

9.4 **Staff Report: Q1 2015 Corporate Services Report**

Larry Stinson, Interim Director, Corporate Services provided a review of the Q1 2015 Corporate Services Report.

MOTION:
That the Board of Health for the Peterborough County-City Health Unit receive the staff report, Q1 2015 Corporate Services Report, for information.
Moved: Deputy Mayor Fallis
Seconded: Mr. Connolley
Motion carried. (M-2015-075)

9.5 **Association of Local Public Health Agencies**

MOTION:
That the Board of Health for the Peterborough County-City Health Unit endorse the resolution as circulated for the Association of Local Public Health Agencies (alPHa) Resolutions Session on June 8, 2015.
Moved: Mayor Smith
Seconded: Ms. Davies
Motion carried. (M-2015-076)

MOTION:
That the Board of Health for the Peterborough County-City Health Unit approve the 2015-2016 annual membership fee for the Association of Local Public Health Agencies (alPHa) in the amount of $9,868.11.
Moved: Councillor Clarke
Seconded: Deputy Mayor Fallis
Motion carried. (M-2015-077)

The meeting recessed at 6:20 p.m. Mayor Smith left the meeting at 6:35 p.m. due to a previous commitment. The meeting reconvened at 6:39 p.m.

10. <u>In Camera to Discuss Confidential Property Matters</u>

MOTION:
That the Board of Health for the Peterborough County-City Health Unit go In Camera to discuss confidential property matters at 6:40 p.m.
Moved: Mr. Sharpe
Seconded: Deputy Mayor Fallis
Motion carried. (M-2015-078)

MOTION:
That the Board of Health for the Peterborough County-City Health Unit rise from In Camera at 7:30 p.m.
Moved: Councillor Clarke
Seconded: Deputy Mayor Fallis
Motion carried. (M-2015-079)

11. <u>Motions from In Camera for Open Session</u>

12. <u>Date, Time, and Place of the Next Meeting</u>

June 10, 2015 – Council Chambers, City Hall, 500 George Street North, Peterborough, 4:45 p.m.

13. <u>Adjournment</u>

MOTION:
That the meeting be adjourned.
Moved by: Councillor Baldwin
Seconded by: Mr. Connolley
Motion carried. (M-2015-080)

The meeting was adjourned at 7:37 p.m.

Chairperson

Medical Officer of Health

To: All Members
Board of Health

From: Dr. Rosana Pellizzari, Medical Officer of Health

Subject: **Correspondence**

Date: June 10, 2015

Recommendation:

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

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1. Email dated May 13, 2015 from the Association of Local Public Health Agencies (alPHa) to all to all Ontario Boards of Health regarding the Board of Health Section Agenda for June 9, 2015.

2. Letter dated May 14, 2015 from the Board Chair to Minister MacCharles regarding funding for the Healthy Babies, Healthy Children program.

3. Letter dated May 14, 2015 from the Board Chair to Premier Wynne and Minister Damerla regarding Bill 45, Making Healthier Choices Act.

4. Letter dated May 20, 2015 from Premier Wynne, in response to the Board Chair's letter dated May 14, 2015, regarding Bill 45, Making Healthier Choices Act.

5. Letter dated May 27, 2015 from Victoria McPhail to Dr. Pellizzari, copied to the Board, regarding PCCHU employee Cathy Basterfield and the Infant and Toddler Development Program. *(included with permission from the sender)*

6. Email dated June 1, 2015 from alPHa to all Ontario Medical Officers / Association Medical Officers of Health regarding the Board of Health Section agenda for June 9, 2015.

7. Resolutions/Letters from other local public health agencies:

    - Alcohol Availability
      Sudbury and District

- Basic Income Guarantee
  Simcoe Muskoka

- Smoke-Free Multi-Unit Housing
  Perth

From: allhealthunits-bounces@lists.alphaweb.org [mailto:allhealthunits-bounces@lists.alphaweb.org] **On Behalf Of** Linda Stewart
Sent: May-13-15 1:54 PM
To: 'All Health Units'
Subject: [allhealthunits] alPHa BOH Section Agenda - June 9, 2015

Please forward to All Board of Health Members

Dear BOH Member,

The next alPHa Boards of Health Section meeting is on the last day of alPHa's 2015 Annual Conference and Annual General Meeting. The theme of the conference is Rethinking Public Health and it is taking place at the Ottawa Marriott Hotel. The conference includes a welcome reception and the alPHa Distinguished Service Awards Dinner.

Attached is the agenda for the BOH Section meeting that will be held in Ottawa on Tuesday, June 9, 2015 from 8:30 AM to Noon. If you haven't already, you can register for the full conference, AGM and BOH Section meeting at this link. The link will also take you to information about the conference hotel and instructions for booking your stay.

Looking forward to seeing you in June.

Linda

Linda Stewart
Executive Director

Association of Local Public Health Agencies (alPHa)
2 Carlton Street, Suite 1306
Toronto, ON M5B 1J3
Tel: (416) 595-0006 ext. 22
Fax: (416) 595-0030
linda@alphaweb.org

For scheduling, please contact Karen Reece, Administrative Assistant, at karen@alphaweb.org or call 416-595-0006 ext 24.

For more information visit our web site: http://www.alphaweb.org

alPHa
Association of Local PUBLIC HEALTH Agencies

2 Carlton Street, Suite 1306
Toronto ON M5B 1J3
Tel: (416) 595-0006
www.alphaweb.org

Providing leadership in public health management

To All Members of Ontario Boards of Health

Dear Board of Health Member: May 12, 2015

I am contacting you to provide you with the latest information about the Boards of Health Section meeting that is being hosted by the Association of Local Public Health Agencies.

If you are serving on a Board of Health for the first time, this may be your first alPHa Boards of Health Section meeting. As a member of a board of health, you are automatically a member of alPHa's Board of Health Section. The Section is made up of individuals like you who sit on boards of health in Ontario. Working with the Board of Health Section Executive, alPHa provides opportunities for board of health members to meet face-to-face, learn together and discuss topics important to your role in public health.

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Hoping to see you there,

Linda Stewart,
Executive Director

Attachments

The Association of Local Public Health Agencies (alPHa) is a non-profit organization that provides leadership to Ontario's boards of health and public health units. The Association works with governments and other health organizations, to advocate for a strong and effective public health system in the province, as well as public health policies, programs and services that benefit all Ontarians.

alPHa
Association of Local PUBLIC HEALTH Agencies

2 Carlton Street, Suite 1306
Toronto ON M5B 1J3
Tel: (416) 595-0006
www.alphaweb.org

Providing leadership in public health management

To All Members of Ontario Boards of Health

AGENDA

Boards of Health Section Meeting

Tuesday, June 9, 2015 • 8:30 AM – 12:00 PM
North Victoria Ballroom, Ottawa Marriott Hotel, 100 Kent Street

CHAIR: Lorne Coe, Durham Region

7:00	Registration and Continental Breakfast
8:30 – 8:45	**Welcome and Introductions** *This is an opportunity for new and returning members of boards of health across Ontario to say hello.*
8:45 – 8:50	**Section Business** *Approval of Minutes from June 3, 2014 Meeting*
8:50 – 10:30	**Food Insecurity Workshop** *Gain an understanding of this important public health problem and possible policy solutions through an interactive learning experience.* ***Speaker:*** ***Valerie Tarasuk, Department of Nutritional Sciences, University of Toronto***
10:30 – 11:00	**BREAK**
11:00 – 11:30	**Update** *Update from alPHa about activities since the last meeting.* ***Speaker:*** ***Linda Stewart, Executive Director, alPHa***
11:30 – 12:00	**Section Elections** *4 regions will be electing representatives:* - *Eastern* - *Central West* - *South West* - *North East*
12:00	**Meeting Adjourns**
12:00 – 1:00	**LUNCH** (provided)

Workshop Speaker Biography

Dr. Valerie Tarasuk is a professor in the Department of Nutritional Sciences and the Dalla Lana School of Public Health at the University of Toronto. She is the Principal Investigator in the PROOF research program, which is an interdisciplinary, internationally-based group investigating the attributes of effective policy approaches to improve household food insecurity in Canada. PROOF`s work is demonstrating the sensitivity of households' food security to policy decisions related to income and housing affordability. For example, Newfoundland and Labrador`s multi-pronged, aggressive poverty reduction strategy has reduced food insecurity among social assistance recipients in that province. The guaranteed annual incomes currently provided to Canadian seniors also appear to protect this population subgroup from food insecurity. Most recently, PROOF has quantified the health care costs associated with food insecurity in Ontario, suggesting that policy interventions designed to reduce food insecurity can be expected to reduce public health expenditures in health care and improve overall health.

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

May 14, 2015

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,

In follow-up to our letter of November 6, 2014, we wish to bring you up to date with the current status of our Healthy Babies, Healthy Children (HBHC) program. You may recall that we expressed our continued concern regarding insufficient funding of the Healthy Babies, Healthy Children (HBHC) program and, as a consequence, an adverse impact on service delivery. This concern is shared widely by our municipal political representatives, many of whom met with you last August at the AMO Conference.

The Board of Health approved the budget for the HBHC program at the April Board Meeting. This program is funded 100% by the Ministry of Children and Youth Services and has not seen an increase since 2007, despite our continue efforts to advocate for the increases needed to maintain appropriate levels of service. This continued funding shortfall has led to an erosion of staffing levels, which to-date has been managed mainly by gapping and attrition.

Unfortunately, this year our only method for balancing the budget is a staff reduction. We were forced to decrease the Family Home Visitor complement in this program by 0.8 full-time equivalent (FTE). In addition, we are leaving a one FTE vacancy in our Public Health Nurse complement unfilled as a result of a maternity leave of absence. The program's materials and supplies budget has also been reduced. We are very concerned that the ongoing erosion of this program, given the decreased provincial funding, will compromise this very important service and potentially undermine its ability to identify and support young children and their families. We know that we are not alone in this and that many boards of health find themselves in similar situations. We urge your government to provide the funding required to keep HBHC viable and effective in our communities throughout the province.

Our invitation to Peterborough to see our community programs in action and to engage in discussion as to how our budgetary concerns may be alleviated still stands. We would welcome you to come and see how valuable HBHC is, as well as the wonderful work being done in the school nutrition programs. We would be happy to work with your staff to make arrangements to visit public health, as well as our local YWCA here in Peterborough if this is of interest to you.

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

Councillor Lesley Parnell
Chair, Board of Health
Peterborough County-City Health Unit

/at

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

May 14, 2015

The Honourable Kathleen Wynne
Premier of Ontario
Room 281, Queen's Park
Toronto, ON M7A 1A1
Sent via E-mail: premier@ontario.ca

Dear Premier Wynne:

At its meeting held May 13, 2015, the Board of Health for the Peterborough County-City Health Unit considered correspondence from the Northwestern Health Unit (NWHU) regarding "Bill 45, Making Healthier Choices Act", urging the provincial government to amend Bill 45 to include sodium labelling and to allow for municipal by-laws to address additional nutrition information beyond sodium and calories.

The Board of Health for the Peterborough County-City Health Unit resolved as follows:

WHEREAS, menu labelling legislation is an important step towards creating healthier and more transparent food environments for Ontario's families; and

WHEREAS, Canadian are eating out more than ever before, and people of all ages and income levels are eating out; and

WHEREAS, eating away from home is associated with excessive intakes of calories, sodium and fat among children and adults; and

WHEREAS, the average sodium intake of all ages of Canadian children exceeds the tolerable upper limit established by the Institute of Medicine (IOM); and

WHEREAS, menu labelling provides an opportunity to help prevent these children from joining the Canadian average of consuming double the recommended amount of sodium; and

WHEREAS, menu labelling provides an opportunity to help prevent these children from joining the 90% of Canadians who develop hypertension as they age, and the 1.3 million Canadians who are living with cardiovascular disease; and

WHEREAS, Canadians strongly support disclosure of calories and sodium values and of a panel of about 3,000 Canadians, 75% would like to see calories on the menu, while 71% want sodium; and

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

WHEREAS, listing nutrition information along with contextual or interpretive nutrition information on restaurant menus helps consumers select healthier choices, and

WHEREAS, the Board of Health for the Peterborough County-City Health Unit support menu labelling that includes both calories and sodium as a population health strategy that assists consumers to make informed and healthier food choices, as outlined in the position statement of the Ontario Society of Nutrition Professionals in Public Health, Serving up Nutrition Information in Ontario Restaurants: A Position Paper;

NOW THEREFORE BE IT RESOLVED THAT the Board of Health for the Peterborough County City Health Unit urges the provincial government to amend the "Bill 45, Making Healthier Choices Act" to:

1. Include sodium labelling; and
2. Provide reference values; and
3. Allow for municipal bylaws to address additional nutrition information beyond sodium and calories

FURTHERMORE BE IT RESOLVED THAT, copies of the letter regarding Bill 45 be forwarded to the Premier of Ontario, the Associate Minister of Health and Long-Term Care (Long-Term Care and Wellness), local members of Provincial Parliament (MPP), the Ontario Society of Nutrition Professionals in Public Health, Ontario Boards of Health and the Association of Local Public Health Agencies for their information and support.

We thank you for your consideration and look forward to your response.

Sincerely

Original signed by

Lesley Parnell
Chair, Board of Health

/at

c: Hon. Dipika Damerla, Associate Minister of Health and Long-Term Care (Long-Term Care and Wellness)
Jeff Leal, MPP Peterborough
Laurie Scott, MPP Haliburton-Kawartha Lakes-Brock
Ontario Society of Nutrition Professionals in Public Health
Ontario Boards of Health
Association of Local Public Health Agencies

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The Premier of Ontario

Legislative Building, Queen's Park
Toronto, Ontario M7A 1A1

Ontario

La première ministre de l'Ontario

Édifice de l'Assemblée législative, Queen's Park
Toronto (Ontario) M7A 1A1

May 20, 2015

Lesley Parnell
Chair, Board of Health
Peterborough County-City Health Unit
10 Hospital Drive
Peterborough, Ontario
K9J 8M1

Dear Lesley Parnell:

Thank you for your letter in which you set out the board's resolution regarding Bill 45, Making Healthier Choices Act, 2014. I appreciate your keeping me informed of the board's activities.

I note that you have sent a copy of the board's resolution to my colleague the Honourable Dipika Damerla, Associate Minister of Health and Long-Term Care (Long-Term Care and Wellness). I trust that she will also take the board's views into consideration.

Thank you again for the information.

Sincerely,

Kathleen Wynne
Premier

c: The Honourable Dipika Damerla

TORONTO 2015
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Ontario
HOST PROVINCE
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Dr. Rosana Pellizzari, Medical Officer of Health
Peterborough City-County Health Unit
10 Hospital Drive, Peterborough, ON K9J 8M1

cc: Board of Health, PCCHU
cc: Larry Stinson, Director, Public Health Programs
cc: Karen Chomniak, Manager Family Health Programs
cc: Cathy Basterfield, Infant Toddler Development Worker

May 27, 2015

Dear Dr. Pellizzari,

My name is Victoria McPhail and I am a stay-at-home mother to two beautiful children, Emily (5) and Mason (2). My husband, Mike, and I, with our kids, are blessed to call the city of Peterborough our home. My daughter, Emily, born March 22, 2010, has a rare brain disorder.

5 years ago, following Emily's birth, I was referred to the Infant Toddler Development Program at the PCCHU. We were still learning about Emily's condition, Agenesis of the Corpus Callosum, and were learning how to be new parents at the same time. Cathy Basterfield, an Infant Toddler Development Worker at the PCCHU, visited our home for our first appointment on May 12, 2010 and has since become one of the most valued people on Emily's medical team.

Described by the American National Organization for Disorders of the Corpus Callosum (NODCC), callosal disorders are "conditions in which the corpus callosum does not develop in a typical manner... Disorders of the corpus callosum are not illnesses or diseases, but abnormalities of brain structure. Many people with these conditions are healthy. However, other individuals with disorders of the corpus callosum do require medical intervention due to seizures and/or other medical problems they have in addition to the disorder of the corpus callosum." Emily has complete Agenesis of the Corpus Callosum whereby the corpus callosum has failed to develop. Dysgenesis can also occur where the corpus callosum can be partially apparent or is apparent but malformed. DCC's often present with a variety of symptoms and challenges, similar to autism where children and adults with the disorder can be said to be on 'a spectrum'. Emily currently has no apparent symptoms or medical problems associated to ACC, which was verified by ultrasound and fetal MRI at Mount Sinai's Special Pregnancy Program and Sick Kids in Toronto in January 2010.

I am writing to you because I feel Cathy needs to be commended particularly for her commitment to Emily's success and potential. As Emily's condition is relatively unknown and thus unexplored by the medical team in Peterborough, as well as elsewhere in Ontario and Canada, I find I am most often the one educating her doctors and therapists on treatments or routines I think she should undergo. Of the many people whom I have provided information regarding Disorders of the Corpus Callosum, no one else but Cathy has demonstrated a level of interest or persistence in following Emily's progress.

Emily is doing far better than we ever could have imagined from the time we were given her diagnosis in utero, and if you met her, you would witness a vibrant, friendly, affectionate and ambitious little girl who loves her city and all it has to offer and explore. There is no evidence of her diagnosis thus far, and while we continue to follow the research on DCC and monitor and evaluate her progress through that lens, we celebrate her achievements all the more. However, because of her success, she has been discharged from numerous other therapies - while we would have loved to continue with several of them since we do not know when, if ever, there will be a time when Emily's needs will become much more evident, we understand this is often not possible due to heavy caseloads. Other programs in the city have been at a loss as to what to do with our family, and unwilling to do the research to see where they could offer service or support. This is added to the fact that for the time being we have decided to homeschool Emily to provide her with one-on-one teaching and support, and we as a result are not shared services as those children in a typical classroom or school environment. Under normal circumstances, we would have been discharged from ITDP by now. Cathy has offered, with support of her management team, to continue to offer us assistance in navigating the preschool and kindergarten years, so that we can continue to provide Emily with resources that will help her maximize her potential. What were originally bi-weekly visits from Cathy are now quarterly discussions where we review Emily's progress and share ideas, education strategies, relevant activities or research initiatives that could be helpful to us at home. Right now our biggest concern for Emily is how and when to share her diagnosis with her, and Cathy has been an great help to us in offering different approaches to address this.

I cannot thank Cathy enough for the encouragement and support she has offered to me and our family over the past five years. She continues to inform herself and research options that may be beneficial for me to explore in educating and aiding Emily as she grows, despite the fact that Emily is at an age that is, as Cathy states "beyond her scope" and she is unsure whether she is of any help to us. She is more than helpful, and one of the best supports I have had thus far as a parent. Cathy has been a friend, team mate, coach, sounding board, and one of Emily's biggest fans. Her great level of professionalism coupled with enormous compassion for families should be commended. I trust you value Cathy as a member of the PCCHU team as much as I do.

I would also like to thank Karen Chomniak for agreeing to continue Cathy's visits to us beyond the usual years attended to by the Infant Toddler Development Program in Peterborough. Thank you to the PCCHU and the Board of Health for continuing the ITDP. It has been an invaluable resource to our family, and one of the many reasons why we feel privileged to call Peterborough home.

Sincerely,

Victoria McPhail

From: COMOH Listserv **On Behalf Of** Susan Lee
Sent: June-01-15 5:06 PM
To: COMOH
Subject: [comoh] Late Resolutions for Possible Consideration at 2015 alPHa Resolutions Session

To All MOHs and AMOHs,

Attached are the late resolutions for consideration at the alPHa Annual General Meeting-Resolutions Session on Monday, June 8th at the Marriott Ottawa in Ottawa, Ontario. Please note these may or may not get discussed at the session, subject to the rules governing late resolutions (i.e. time permitting and a 2/3 majority vote to debate them).

We are nevertheless circulating this package prior to the conference for your information. It is our hope that you and your board of health / health and social service committee members will review the contents in advance of June 8th. Please ensure that a copy of the attached is distributed to the following individuals:

- Chair, Board of Health or Health & Social Services Committee;
- Members of the Board of Health / Health & Social Service Committee;
- Health Unit staff attending the June 8th Resolutions Session

Also, please be reminded that in order to vote on the resolutions, voting members must be registered. We'd prefer if this could be done prior to the conference, so if your health unit hasn't yet registered, please complete and return the attached form by June 4th.

Thanks in advance.

Susan

Susan Lee
Manager, Administrative & Association Services
Association of Local Public Health Agencies (alPHa)
2 Carlton Street, Suite 1306
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LATE RESOLUTIONS

FOR CONSIDERATION AT 2015 RESOLUTIONS SESSION

The five (5) late resolutions on the following pages are provided for your information.

Please be reminded of alPHa's policy on late resolutions:

> ***Late Resolutions.*** *Submissions received after the 45 day advance date will NOT be reviewed by the Executive Committee, but may still be introduced from the floor as Late Resolutions, subject to rules governing them (e.g., time permitting and a 2/3 majority vote to debate them).*
>
> *Late resolutions must be provided to the meeting Chairperson in writing. The Chairperson will first determine if there is time to consider any late resolutions. The resolutions will be read aloud or displayed as quickly as possible to the membership present and the membership will be asked to vote on whether or not to proceed with a debate and vote. If a two-thirds vote is not achieved, then the late resolution will not be dealt with any further at the meeting. The Minutes will reflect that the resolution was brought forward and denied.*

DRAFT alPHa RESOLUTION A15-2 (LATE)

TITLE: **National Universal Pharmacare Program**

SPONSOR: **Haliburton Kawartha Pine Ridge District Health Unit**

WHEREAS the World Health Organization's Right to Health, which includes essential drugs in the core content of minimum rights and the state is obligated to fulfill the rights; and

WHEREAS in 1964 a national universal pharmacare program to cover the costs of outpatient prescription medications was recommended be included in the national Medicare system by the Royal Commission on Health Services; in 1997 the National Forum on Health recommended a universal first dollar pharmacare program; and in 2002 the Romanow Commission recommended catastrophic drug coverage as a first step towards a pharmacare program and still the Government of Canada has not included pharmacare under the *Canada Health Act*; and

WHEREAS Canada is the only Organization for Economic Co-operation and Development (OECD) country with a universal public health care system that does not provide coverage for prescription medications; and

WHEREAS Canadians pay among the highest per capita spending on prescription drugs of the OECD countries; and

WHEREAS the ability to fill a prescription for medication depends on whether and to what extent a person has access to either a private or public insurance plan or if an individual is able to pay out of pocket if a person has no insurance plan; and

WHEREAS 1 in 10 Canadians are unable to fill a prescription because of cost, which in turn compromises the ability to reach optimal level of health and can drive up health care costs in other areas including more physician visits and hospitalizations; and

WHEREAS the current system is a combination of private and public insurance plans that are expensive, not sustainable and inequitable; and

WHEREAS the Government of Canada has a responsibility under the *Canada Health Act* to protect, promote and restore physical and mental well-being of persons and enable reasonable access to health care services without causing barriers, including financial barriers; and

WHEREAS a national, universal pharmacare program would enable all Canadians access to quality, safe and cost effective medications, improve health outcomes and generate cost savings;

NOW THEREFORE BE IT RESOLVED that the Association of Local Public Health Agencies (alPHa) urges the Government of Canada to move forward with the development and implementation of a national, universal pharmacare program;

AND FURTHER that the Association of Local Public Health Agencies (alPHa) advises the Prime Minister of Canada of this resolution and copies the Ministers of Finance Canada and Health Canada, the Chief Public Health Officer, Leader of the Opposition, Leader of the Liberal Party, Premier of Ontario, Ministers of Finance and Health and Long-Term Care and the Chief Medical Officer of Health;

AND FURTHER that the following organizations be copied and asked for their support: Canadian Medical Association, Canadian Nurses Association, Canadian Pharmacists Association, Canadian Life and Health Insurance Association, Ontario Medical Association, and the Registered Nurses Association of Ontario.

DRAFT alPHa RESOLUTION A15-3 (LATE)

TITLE: **Amending Public Pools Regulation 565**

SPONSOR: **Association of Supervisors of Public Health Inspectors of Ontario**

WHEREAS swimming pools, spas, wading pools and splash pads have been implicated in drownings, fatal and near-fatal injuries and water-borne illness including gastrointestinal disease and skin infections and;

WHEREAS recent waterborne outbreaks have been documented where parasites, for which conventional disinfection is ineffective, have been identified as the causative organism; and

WHEREAS proper filtration and the use of ultra-violet light could provide the necessary protection for public pool users but neither is currently required in legislation; and

WHEREAS drowning is considered to be the second leading cause of preventable death in Canada among children; and

WHEREAS the Office of the Chief Coroner of Ontario of has recommended the implementation of admission standards for public swimming pools to improve surveillance over activities of young children in order to prevent drowning fatalities of young children in public swimming pools; and

WHEREAS the existing enforcement strategies available to public health staff for non-critical regulatory infractions in public pools are unwieldy, time-consuming and not cost-effective; and

WHEREAS this deficiency could be rectified by the provision of short-form wording and set fines; and

WHEREAS existing regulations do not apply to facilities such as wading pools and splash pads ; and

WHEREAS Ontario Regulation 565 (Public Pools) was enacted in 1990 and its requirements have not substantially changed since then;

NOW THEREFORE BE IT RESOLVED that the Association of Local Public Health Agencies (alPHa) request that the Ministry of Health and Long-Term Care undertake a review of Ontario Regulation 565 and introduce such amendments as are necessary to address the deficiencies identified in this motion.

Backgrounders attached – see next 3 pages

BACKGROUNDER: A15-3

alPHa Resolution

Amending Public Pools Regulation 565

Backgrounder

- **Ontario Regulation 565 (Public Pools) was enacted 25 years ago and since that time substantial changes have occurred in the recreational water field precipitating the need for changes in the legislation.**
- **Recent waterborne outbreaks have been documented where parasites, for which conventional disinfection is ineffective, have been identified as the causative organism. Proper filtration and the use of ultra-violet light could provide the necessary protection but neither is required in the existing legislation.**
- **Following a 2009 inquest, the Office of the Chief Coroner of Ontario recommended that a provincial swimming pool bather admission standard be incorporated into Ontario Regulation 565 but this has never been implemented.**
- **At that time, the Office of the Chief Coroner also recommended that "short form wording" should be provided to allow for improved enforcement of the regulation. This remains outstanding but if introduced, would be expected to be more cost-effective for public health units and result in improved compliance with the regulation.**
- **Wading pools, splash pads and receiving basins for water slides have increased in popularity in recent years but do not fall within the scope of the current legislation.**
- **In 2008, an Ontario Public Health Association resolution requested the Ministry of Health and Long-term Care to amend the regulation to include "splash pads receiving basins and other like forms of wet recreation."**
- **In January, 2013, the Chair of the Council of Ontario Medical Officers of Health and the president of the Association of Supervisors of Public Health Inspectors of Ontario jointly wrote to the Chief Medical Officer of Health for Ontario requesting a review of Ontario Regulation 565 (see attached).**

ASPHIO
The Association of Supervisors of Public Health Inspectors of Ontario (Incorporated 1982)

Council of Medical Officers of Health of Ontario

Dr. Arlene King
Chief Medical Officer of Health
Public Health Division
Ministry of Health and Long-Term Care
11th Floor, Hepburn Block
Queen's Park
Toronto, ON
M7A 1R3

Dear Dr. King,

Subject: **Public Pools Regulation 565 (amended to O.Reg. 270/99)**

The Council of Ontario Medical Officers of Health and the Association of Supervisors of Public Health Inspectors of Ontario request a review of Ontario Regulation 565 (Public Pools). Significant waterborne outbreaks and recent drownings in Ontario clearly illustrate the deficiencies of the current regulation.

Since the last amendment in 1999, there have been a number of substantial changes in recreational water practices including technology, public expectations and laboratory analysis capabilities that permit improved detection of pathogens, both in people and in the water. For example, recent documented waterborne outbreaks involving parasites, for which conventional disinfection is ineffective, have been identified as the causative organism. Proper filtration and the use of ultra-violet light could provide the necessary protection for public pool users but neither is currently required in legislation.

Furthermore, the current regulation does not incorporate admission standards recommended by the office of the Chief Coroner; neither does it have short form wording or set fines associated with it. The existing enforcement strategies available to public health staff for non-critical regulatory infractions in public pools are unwieldy, time consuming and are not cost-effective. With the advent of inspection disclosure sites, there is a compelling need for a prompt and efficacious process to address repeated non-compliance in order to maintain public confidence.

It should also be noted that the conventional, rectangular swimming pool is increasingly being replaced by more complex designs which may be aesthetically

pleasing but can also present safety challenges by inadvertently creating blind spots for lifeguards or producing glare on the water surface through the increased use of glass in construction and the provision of enclosed observation areas**.** The foregoing is just one example of technology outpacing regulation and is provides an illustration of the need for regulatory review and amendment.

COMOH and ASPHIO both believe that a review and update of the existing legislation should be implemented. We look forward to a positive response and to working with the Ministry of Health and Long-Term Care to support regulatory change.

Yours truly,

Dr. Valerie Jaeger, MD, PHD, MPH,
Council of Ontario Medical Officers of Health

Chris Beveridge, CD, BA, BASc, CPHI©
President, Association of Supervisors of Public Health Inspectors of Ontario

cc Dr. Robin Williams, Associate Chief Medical Officer of Health
Ms, Nina Aaron, Director, Public Health Protection and Promotion Branch
Mr. Tony Amalfa, Manager, Environmental Health, Public Health Protection and Promotion Branch

DRAFT alPHa RESOLUTION A15-4 (LATE)

TITLE: **Public Health Support for a Basic Income Guarantee**

SPONSOR: **Simcoe Muskoka District Health Unit**

WHEREAS low income, and high income inequality, have well-established, strong relationships with a range of adverse health outcomes; and

WHEREAS 1,745,900 Ontarians, or 13.9% of the population, live in low income according to the 2011 National Household Survey after-tax low-income measure; and

WHEREAS income inequality continues to increase in Ontario and Canada; and

WHEREAS current income security programs by provincial and federal governments have not proved sufficient to ensure adequate, secure income for all; and

WHEREAS a basic income guarantee – a cash transfer from government to citizens not tied to labour market participation - ensures everyone an income sufficient to meet basic needs and live with dignity, regardless of work status; and

WHEREAS basic income resembles income guarantees currently provided in Canada for seniors and children, which have contributed to health improvements in those age groups; and

WHEREAS there was an encouraging pilot project of basic income for working age adults conducted jointly by the Government of Manitoba and the Government of Canada in Dauphin, Manitoba in the 1970s, which demonstrated several improved health and educational outcomes; and

WHEREAS a basic income guarantee can reduce poverty and income insecurity, and enable people to pursue educational, occupational, social and health opportunities relevant to them and their family; and

WHEREAS the idea of a basic income guarantee has garnered expressions of support from the Canadian Medical Association and the Alberta Public Health Association as a means of improving health and food security for low income Canadians; and

WHEREAS there is momentum growing across Canada from various sectors and political backgrounds for a basic income guarantee;

NOW THEREFORE BE IT RESOLVED THAT the Association of Local Public Health Agencies (alPHa) endorse the concept of a basic income guarantee**;**

AND FURTHER THAT alPHa request that the federal Ministers of Employment and Social Development, Labour, and Health, as well as the Ontario Ministers Responsible for the Poverty Reduction Strategy,

Labour, Children and Youth Services, and Health and Long-Term Care, prioritize joint federal-provincial consideration and investigation into a basic income guarantee, as a policy option for reducing poverty and income insecurity and for providing opportunities for those in low income;

AND FURTHER that the Prime Minister, the Premier of Ontario, the Chief Public Health Officer, the Chief Medical Officer of Health for Ontario, the Canadian Public Health Association, the Ontario Public Health Association, the Federation of Canadian Municipalities, and the Association of Municipalities of Ontario be so advised.

Backgrounder attached – see next 9 pages

BACKGROUNDER – A15-4

Basic Income Guarantee:
Backgrounder for alPHa Resolution, June 2015

What is a basic income guarantee?

Basic income guarantee (BIG), also known as a guaranteed annual income, is a cash transfer from government to citizens not tied to labour market participation (Pasma and Mulvale, 2009; Basic Income Canada Network, 2015). It ensures income at a level sufficient to meet basic needs and live with dignity, regardless of work status (Basic Income Canada Network, 2015). Basic income is premised on the vision of universal income security through ensuring that everyone receives a modest, but adequate income (Pasma and Mulvale, 2009).

What are the key policy options for providing a basic income guarantee?

There are essentially two basic models, with some degree of variance, for providing a basic income guarantee. These are the negative income tax model and the universal demogrant model (Pasma and Mulvale, 2009).

Originally proposed by the American economist, Milton Freidman, the **negative income tax** model (NIT) relies on the tax system as the vehicle for administering a basic income guarantee. It consists of three basic elements: the benefit level, the reduction rate and the break- even level. The benefit level is the maximum benefit payable to any individual. The reduction rate is the amount by which the benefit is decreased for additional household income exceeding the benefit rate or maximum allowable level. The break-even level is the amount of income at which the reduction rate is 100%, meaning that those above the break-even level receive no benefit.

The **universal demogrant (UD) model**, by contrast, entails the provision of a regular payment to every citizen. While the UD payment itself is exempt from taxation, all additional income is taxable. In practice, this means that high income citizens pay the UD benefit back through their taxes.

Is one policy option better than the other? What are the relative advantages of NIT vs UD?

Each model has its strengths. For example, the NIT is viewed as maintaining a work incentive since the benefit is not eliminated entirely as additional income is received, while the UD model

is viewed as less stigmatizing - as everyone receives the benefit through a direct payment - and more effective for increasing social cohesion (Pasma and Mulvale, 2009).

However, for any basic income model, the detailed decision making on benefit levels and tax rates will determine how effective the policy actually is in reducing poverty (Yalnizyan, 2013).

What is the history of basic income policies in Canada?

A form of guaranteed income for Canadian seniors was established in 1967, with the introduction of the Old Age Security (OAS) and Guaranteed Income Supplement (GIS) programs (Basic Income Canada Network, 2015). As a result, Canada has one of the lowest rates of seniors' poverty in the world. When low-income Canadians leave the workforce after turning 65, their poverty level drops substantially: statistics show that the rate of Canadians experiencing food insecurity is fifty percent less among those aged 65 to 69 than it is among those aged 60 to 64 (Emery, Fleisch and McIntyre, 2013).

Similarly, the Canadian Child Tax Benefit (CCTB), including the National Child Benefit Supplement and the Child Disability Benefit, provides universal monthly benefits to parents of children under 18 years to assist with the costs of raising children. Benefits are rated according to the number of children and reduced at a certain income threshold. An examination of this program has found that it leads to improved outcomes for children, both in terms of math and reading skills, and in terms of mental and physical health measures (Milligan and Stabile, 2011).

In the 1970s, the federal government launched a national review of social policy with the aim of developing a program to ensure an adequate minimum income for all Canadians. As part of this review, Manitoba agreed to serve as the pilot site for a federally funded basic income experiment.

This initiative, commonly known as **Mincome**, was launched in Dauphin, Manitoba in 1974. Mincome compared low-income families enrolled in the experiment with a control group that did not receive the Mincome benefits. Three income support levels up to a maximum of $5,800 ($29,069.00 in 2015 dollars) for a family of four were tested, with adjustments for family size and structure (Hum and Simpson, 2001). These amounts were increased annually throughout the duration of the program due to the high rates of inflation throughout the latter half of the 1970s. Three tax back rates were then applied to all income the families received above the Mincome benefit rate: 35, 50 and 75 percent.

The Mincome pilot was terminated without a final evaluation report in 1979. A retrospective evaluation conducted by Evelyn Forget, an economist at the University of Manitoba, was published in 2011. Forget found that the disincentive to work, a key concern expressed about a basic income guarantee, was minimal as only new mothers and teenagers worked substantially less during Mincome. Mothers with newborns stopped working because they wanted to stay at home longer with their babies, and teenagers worked less because they weren't under as much pressure to support their families. The latter trend resulted in more teenagers graduating high school. Moreover, recipients who continued to work had more opportunities to choose what type of work they did. Forget also found unanticipated associations between Mincome and positive health outcomes. Over the duration of Mincome, hospital visits dropped by 8.5 percent, with fewer incidents of work-related injuries, and fewer emergency room visits from motor vehicle accidents and domestic violence. Additionally, there were reductions in the rates of psychiatric hospitalization and the number of mental illness-related consultations with health professionals (Forget, 2011).

Basic income has also had a long history outside of Canada. For example, in the US, the Office of Economic Opportunity conducted four basic income experiments from 1968-1976, and Alaska has had its Permanent Fund Dividend program in place since 1982, which pays small but impactful basic income payments to all residents annually (Forget, 2011; Pasma, 2014). Successful programs and pilots have also been conducted in Brazil, India, and Namibia (Pasma, 2014).

What are the key potential benefits of a basic income guarantee?

Basic income has supporters from across the political spectrum since, depending on how it is provided, it can achieve a range of policy objectives. There are a number of economic, social, and health-related arguments favouring basic income:

Economics – A basic income guarantee has the potential to alleviate or even eliminate poverty. This is a powerful rationale, in current times of growing economic inequality and persistent poverty in the setting of rich countries (Young and Mulvale, 2009).

Over the past two decades, technological change and globalization have changed the nature of job opportunities available to Canadians since the Second World War, resulting in fewer opportunities for secure, permanent jobs paying living wages. These trends have forced an increasing number of working age adults to rely on **precarious employment:** poorly paid, part-time seasonal or casual jobs with no benefits or job security (Seth, 2014). The number of Canadians dependent on precarious employment has been steadily increasing. For example, a

joint 2013 study from the United Way and McMaster University found that almost half the adult workforce in Southern Ontario have jobs that could be characterized as precarious employment (Lewchuk et al., 2013).

A basic income guarantee can buffer the effects of precarious employment by providing a form of 'disaster insurance' that protects people from slipping into poverty during challenging times, and going without necessities such as adequate food or shelter (Emery, Fleisch and McIntyre, 2013).

Health and Social - Given that basic income is designed primarily to bring individuals out of poverty, it has the potential to reduce the substantial, long-term social consequences of poverty, including higher crime rates and fewer students achieving success in the educational system (Basic Income Canada Network, 2015).

With the well-established relationship between low income and morbidity and mortality from a wide range of causes, it could reasonably be anticipated that a basic income guarantee would have important health-promoting effects at the individual level (Forget, 2011). Moreover, if basic income is able to reduce income inequalities within a jurisdiction through greater redistribution, it could contribute to health improvements across the population, given that a multi-country analysis of data conducted by Wilkinson and Pickett (2009) found that countries with higher rates of income inequality had correspondingly higher levels of health and social problems across all income levels, including lower life expectancy, math and literacy scores, and trust, and higher levels of obesity, mental illness, and violence.

Forget's study of the Mincome pilot did, as already noted, demonstrate some of these health and social impacts of basic income (Forget, 2011), despite the limitations on what could be measured retrospectively. As well, the health effects of Canada's guaranteed income programs for seniors have been notable, with the rate of food insecurity declining substantially and self-reported physical and mental health improving markedly, after low income Canadians move from low-wage, insecure employment to a guaranteed income at the age of 65 (Emery, Fleisch and McIntyre, 2013).

Basic income also promotes greater equality of opportunity, or economic democracy (Young and Mulvale, 2009; Pasma and Mulvale, 2009). A guaranteed income, at an adequate level, provides people the autonomy to manage their own circumstances, such as recovering from financial setbacks, balance shifting employment and family care needs, recovering from illness or injury, or seeking more education, retraining, or novel job opportunities, all with some

degree of security (Basic Income Canada Network, 2015). Parents who have grown up without much opportunity can also choose to save and plan for a different future for their children.

Further, guaranteed income is a simpler, more transparent approach to social assistance than the current system, and extends protection to those who are currently not covered or poorly covered (Pasma and Mulvale, 2009). As well, the universality and conditionality of guaranteed income makes the traditional scrutiny of social assistance recipients unnecessary, avoiding the stress and the discouragement of work effort that can be associated (Young and Mulvale, 2009; Basic Income Canada Network, 2015).

How much would a basic income program cost and how would it align with other social programs?

The direct costs of a basic income program would vary substantially depending on the model and assumptions made, but either way estimates demonstrate that it would represent a very significant public expenditure (Young and Mulvale, 2009). However, even conservative estimates of the indirect costs of poverty (e.g., through health care, remedial education, crime, social programs, and lost productivity) can be higher than the costs of alleviating poverty in Canada (Basic Income Canada Network, 2015). In Ontario alone, the indirect costs of poverty have been estimated at $32.2 - $38.3 billion in 2007 dollars, or 5.5% - 6.6% of Ontario's then GDP (Laurie, 2008). In addition, it has been argued that the environmental costs of premising income support and economic redistribution on economic expansion and growth is no longer feasible (Young and Mulvale, 2009). Factoring in such costs of *not* having a guaranteed income scheme are important components of the affordability and feasibility discussion.

A basic income guarantee is meant to strengthen and augment, rather than displace, other public services such as health care, education, child care, and supports for First Nations, Inuit and Metis communities, newcomers, and people with disabilities. It can also complement existing income security measures, and some of these supports may be less required over time as a basic income is transitioned in (Basic Income Canada Network, 2015).

What are the jurisdictional issues (i.e., federal vs provincial) around the implementation of a basic income guarantee?

With respect to basic income, jurisdictional issues between the federal and provincial levels of government are not entirely clear. While provinces bear constitutional responsibility for the payment of social assistance to individuals, federal spending power extends to payments to individuals as well as conditional and unconditional grants to provinces that could potentially

be used to fund a basic income guarantee (Stilborn, 1997). In practice, however, it is likely necessary that the provinces and federal government reach an agreement on how to fund and deliver a basic income guarantee. Such an agreement is needed to ensure that social programs do not disappear in some parts of Canada but not in others. In addition, if the federal government assumes full or partial responsibility for funding basic income, provinces would have increased revenues which could either be utilized as their share of a basic income guarantee funding or for other provincial programs (Pasma and Mulvale, 2009).

Which political parties and other groups are in support a basic income guarantee?

As was noted previously, support for basic income guarantee spans the political spectrum. As of 2015, two federal political parties - the Liberal Party of Canada and the Green Party of Canada - have passed resolutions supporting a basic income guarantee in the form of basic income supplements (see links to resolutions in references). In the Conservative Party, former Senator Hugh Segal has publicly called for a guaranteed annual income for several decades. In 2008, Senator Segal introduced a notice of motion in the Senate calling for a study on the feasibility of guaranteed annual income as a means of reducing poverty (Pasma and Mulvale, 2009).

There have also been expressions of support from politicians from several provinces and municipalities. In a unanimous show of support leading up to PEI's May 2015 election, leaders from the PC, Liberal, NDP and Green parties each expressed a commitment to exploring a basic income guarantee program for PEI, such as in the form of a multi-year demonstration project (Burge, 2015). At the municipal level, at a May 2015 national poverty reduction summit Mayor Naheed Nenshi of Calgary committed to take a leadership role in striving for a guaranteed annual income, and encouraged other mayors to do the same (Benns, 2015).

Further, there have been recent formal expressions of support for basic income from the Canadian Medical Association, the Alberta Public Health Association, and the Canadian Association of Social Workers (Canadian Medical Association, 2013; Alberta Public Health Association, 2014; Drover et al, 2014). The Canadian Public Health Association is also examining the issue (Personal communication with Ian Culbert, Executive Director, March 20, 2015). Beyond the health and social sectors, a non-governmental organization by the name of Basic Income Canada Network is now dedicated to achieving a basic income guarantee in Canada, and several citizen groups are forming across Ontario and Canada in support of this issue.

References

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DRAFT alPHa RESOLUTION A15-5 (LATE)

TITLE: **Provincial Availability of Naloxone**

SPONSOR: **Windsor-Essex County Board of Health**

WHEREAS approximately 50,000 Ontarians are addicted to opioids; and

WHEREAS opioids may cause fatal overdoses if taken incorrectly; and

WHEREAS 5,935 fatal opioid-related overdoses occur in Ontario between 1991 and 2010; and

WHEREAS opioid-related overdoses account for 12.1% of the deaths among 25-34 year olds and rose from 3.3% of the deaths to 12.1% of the deaths of that population from 1991-2010; and

WHEREAS a harm reduction program to address opioid overdoses is consistent with the requirements of the Ontario Public Health Standards to prevent substance misuse; and

WHEREAS naloxone is a medication that can reverse the symptoms of an opioid overdose, potentially reducing harm; and

WHEREAS naloxone is a medication without additive or abusive properties and has no "street" value; and

WHEREAS several Ontario Public Health Units have successfully implemented their own local naloxone programs, effectively reversing opioid overdoses; and

WHEREAS the provincial Expert Working Group on Narcotic Addiction has recommended that the ministry "increase and sustain the availability of naloxone overdose prevention kits and harm reduction information via public health units across the province"; and

WHEREAS current naloxone reductions programs, including those at Public Health Units, are limited in their service to at-risk populations by the types of programs – Public Health Units that manage a core needle Exchange program (NEP), community-based organizations that have been contracted by Public Health Units to manage an NEP, and Ministry-funded Hepatitis C Teams – as well which clients they can serve, i.e., those currently enrolled in an NEP;

Continued on next page

NOW THEREFORE BE IT RESOLVED that the Association of Local Public Health Agencies requests that the Ministry of Health and Long-Term Care develop and implement a provincial Naloxone Strategy that would include and expand the Naloxone Distribution Program to:

- Not-for-profit agencies, Emergency Departments, Correctional Facilities, Paramedics/Emergency Medical Technicians, and organizations that service individuals at risk of opioid overdose,
- Individuals that support and/or care for individuals at risk of opioid overdose, and
- Any individual living in Ontario that is 16 years of age and older and dependent on opioids;

AND FURTHER that the Premier of Ontario, the Minister of Health and Long-Term Care, the Associate Minister of Health and Long-Term Care, the Chief Medical Officer of Health for Ontario, Public Health Ontario, the Centre for Addiction and Mental Health, the College of Physicians and Surgeons of Ontario, the Ontario Public Health Association, and the Association of Municipalities of Ontario, the Expert Working Group on Narcotic Addition and the Municipal Drug Strategy Co-ordinator's Network of Ontario be so advised.

Backgrounder attached – see next 5 pages

BACKGROUNDER – A15-5

Provincial Naloxone Program: Backgrounder for alPHa Resolution, June 2015

Naloxone programs: The need

Opioids are prescription pain medications (e.g., morphine, oxycodone, and fentanyl) that can be addictive and, if taken in high doses, fatal. Between 1991 and 2010, 5,935 opioid-related fatal overdoses occurred in Ontario. The annual number of deaths rose over that period from 127 deaths in 1991 to 550 deaths in 2010.

As a cause of death among 25-34 year olds, opioid-related deaths rose from 3.3% in 1991 to 12.1% in 2010. From 1991 to 2010, the annual years of life lost due to premature deaths involving opioids tripled from 7,006 to 21,927 (Gomes et al, 2014). About 1 out of 170 deaths in Ontario is now related to opioid overdose.

Other costs are high as well. In the United States, in 2009, total costs for opioid-related poisoning were estimated at approximately $20.4 billion with indirect costs constituting 89% of the total. Direct medical costs were approximately $2.2 billion. Emergency department costs and inpatient costs were estimated to be $800 million and $1.3 billion, respectively. Absenteeism costs were $335 million and lost future earnings due to mortality were $18.2 billion (Inocencio et al, 2013).

Naloxone is a medication that can reverse the symptoms of an opioid overdose. Naloxone has no addictive properties and no abuse potential. As a consequence, it has no street value.

Approximately 50,000 individuals in Ontario are addicted to opioids (Ministry of Health and Long Term Care (MOHLTC) 2012). Ontario Public Health Unit's and Boards of Health have a mandate to "reduce the frequency, severity, and impact of preventable injury and of substance misuse" (Ontario Public Health Standards). Naloxone training and distribution is an effective strategy to fulfil this mandate.

Utilization of naloxone is similar in many ways to that of epinephrine. It can be prescribed for at risk patients as an intramuscular injection, just as epinephrine auto-injectors are prescribed to patients at risk for anaphylaxis. It can be carried by the at-risk patient for use in a life-threatening emergency, and is often administered by a bystander rather than self-administered by the patient.

History of provincial naloxone and opioid overdose prevention programs in Ontario

In March 2012, the MOHLTC convened an Expert Working Group on Narcotic Addiction (EWGNA) to provide advice to the government on strengthening addiction services. In its final report, EWGNA recommended that the ministry "increase and sustain the availability of naloxone overdose prevention kits and harm reduction information via public health units across the province." On October 4, 2013, the MOHLTC, consistent with the advice of the EWGNA, introduced a Provincial Naloxone Distribution Program. This allowed eligible agencies -- Public Health Units (PHU) that manage a core Needle Exchange Program (NEP); Community-based organizations that have been contracted by the local Public Health Unit to manage a core NEP; and, Ministry funded Hepatitis C Teams -- to begin ordering naloxone for distribution directly through the Ontario Government Pharmaceutical and Medical Supply Service (OGPMSS). Overdose prevention kit supplies, as well as relevant training materials were made available through the Ontario Harm Reduction Distribution Program (OHRDP) of the Kingston Community Health Centres.

Currently there are many communities in Ontario, including Windsor-Essex County, that are actively engaged in naloxone distribution through the current provincial program

Limitations of the current MOHLTC Provincial Naloxone Distribution Program:

The current provincial naloxone program severely limits the number and nature of clients that are able to receive this medication. Currently, only eligible agencies, which include Public Health Units that manage a core NEP, community-based organizations that have been contracted by the local PHU's to manage a core NEP, and Ministry-funded Hepatitis C Teams, have the ability to receive naloxone through MOHLTC programming at no cost. These agencies are then further limited to only provide naloxone to those who are existing NEP clients. Unfortunately, only a fraction of high-risk patients attend needle distribution programs. The Centre for Addiction and Mental Health (CAMH) estimates that about 25% of opioid dependent individuals attend a methadone clinic. Additionally, many addicted patients take prescription opioids orally and are not willing to travel to a PHU or harm reduction program to get naloxone and the associated training. Other at-risk populations that are not currently reached by the Ontario program include those who have been untreated for opioid addiction and individuals recently released from prison. The current program model does not allow naloxone access among these groups of clients and many others, and without change, will continue to limit the level of positive impact the program can have on overdose reversal rates.

Other limiting factors that are present as a result of the current program framework include:

- Challenges related to client recruitment –a limited number of users will travel to a PHU or harm reduction program to get naloxone
- Limited PHU capacity - PHUs can only distribute naloxone through their own staff and this may cause long delays in access or a slower rate of service delivery

Recommendations to enhance the Provincial Naloxone Distribution Program:

In order to adequately address the challenges associated with the program model the following is recommended:

1. Eliminate the current restrictive agency eligibility requirements and expand programming opportunities to additional agencies working with individuals identified to be at-risk for opioid overdose. In addition to the list of current eligible agencies, not-for-profit agencies, emergency departments, correctional facilities, paramedics/emergency medical technicians, and organizations that service individuals at risk of opioid overdose have personnel in places where the presence of naloxone could have a significant impact on decreasing the loss of life. The 2014 World Health Organization's (WHO) report entitled "Substance Use: Community management of opioid overdose" indicates that a key group of individuals likely to witness overdoses are people working with people who use drugs. They include trained health professionals and first responders, such as ambulance, police, fire and drug-treatment workers as well as outreach workers. Changing the distribution model to accommodate additional agencies could be done either directly, by offering the naloxone and kit materials to additional parties in the same manner as those currently eligible, or it could be indirectly through a train-the-trainer model with PHUs (i.e., PHU staff provide training session to new agency staff and provide naloxone kits to each individual to administer to their own at-risk clients if the need arose).
2. Naloxone and the associated training should be made available to any individuals that support and/or care for individuals at risk of opioid overdose. The 2014 WHO report "Substance Use: Community management of opioid overdose" indicates that most opioid overdoses occur in private homes, and most of these are witnessed by close friends, a partner or family members. Changing programming this way would allow for naloxone to be handled in a similar manner as epinephrine, a medication that is used similarly.
3. Naloxone and the associated training should be made available to any individual living in Ontario that is 16 years of age and older and dependent on opioids. This will create opportunities for other at-risk patients, as noted previously, who are not integrated into an NEP to receive this important training and medication.

Key benefits of recommended program expansion:

The main benefit of an expanded provincial naloxone program is increased and sustained availability of naloxone to those at risk. By increasing the number of trained and ready to assist individuals, naloxone will be more readily available to everyone who may benefit from it.

Over time, this enhanced overdose prevention strategy and model can decrease the number of opioid overdose deaths in Ontario. This is evidenced by evaluations of similar community based naloxone programs in the United States over the last ten years. In North Carolina, a mortality study of their program found that before (2009) and after (2011) implementation overdose rates dropped from 46.6 per 100,000 to 29.0 per 100,000. (Albert et al., 2011). Additional evaluations of similar programs show high survival rates among individuals administered naloxone by bystanders in the community (Bennet, 2011).

In addition, moving to a community-based model in Ontario will create an opportunity to develop or strengthen current community agency relationships among harm reduction networks. In Windsor-Essex County, there have been several key community agencies that have expressed an interest in hosting naloxone distribution services but have been unable to do so because of cost. By making these organizations eligible we will be able to collaboratively create more supportive local environments. Strong community collaboration can lead to the development of more effective local strategies to not only reduce opioid overdose related deaths but also lead to the development of more effective treatment strategies to help those at risk.

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DRAFT alPHa RESOLUTION A15-6 (LATE)

TITLE: **Physical Literacy in Educational and Childcare Settings**

SPONSOR: **Chatham-Kent Board of Health**

WHEREAS less than 10% of Canadian children and youth are meeting minimum recommendations for physical activity and more than one-third were considered overweight or obese in 2009-2011; and

WHEREAS physical inactivity is linked to a number of preventable chronic diseases and is associated with increasing healthcare costs; and

WHEREAS individuals who are physically literate have the knowledge, skills, and attitudes to lead physically active lives; and

WHEREAS the Ontario Ministry of Education is provincially mandated to oversee both publicly-funded education and licensed childcare settings; and

WHEREAS physical literacy is a clearly stated outcome objective of the Health and Physical Education Curriculum, yet it is not currently measured; and

WHEREAS principals report that delivery of the Health and Physical Education curriculum varies significantly depending on the expertise and comfort level of the teacher; and

WHEREAS only 19.9% of Ontario Elementary Schools have a full or part-time specialist teacher assigned to teach health and physical education; and

WHEREAS neither the Ministry of Education nor School Boards currently ensure every child receives 20 minutes of sustained daily physical activity.

NOW THEREFORE BE IT RESOLVED that the Association of Local Public Health Agencies request the Ontario Ministry of Education and its stakeholders to provide for the public health, safety, and welfare of all Ontario residents by enhancing the development of physical literacy in educational and childcare settings through:

1. Adopting a mandatory assessment of physical literacy for elementary and secondary students across the province;

2. Ensuring that quality daily health and physical education programming is delivered by health and physical education specialists in all Ontario elementary and secondary schools;

3. Evaluating compliance and enforcing the Daily Physical Activity (Policy/Program Memorandum No. 138) requirement;

4. Providing ongoing staff training related to physical literacy for all teachers, early childhood educators, and childcare providers;

5. Strengthening the Day Nurseries Act/Child Care and Early Years Act to promote and support physical literacy development in licensed childcare settings; and

6. Making health and physical education credits a mandatory requirement for grades 9-12.

Backgrounder attached – see next 3 pages

BACKGROUNDER: A15-5

In 2011, the Ontario Society of Physical Activity Promoters in Public Health (OSPAPPH) membership survey identified physical literacy as a key priority for their health units in assisting to address physical inactivity. Through consultation with its membership, the Program Consultation and Training Centre, and various stakeholders, OSPAPPH developed a key message document and the proposed six policy recommendations to enhance development of physical literacy in educational and childcare settings.

Sixteen Medical Officers of Health, twelve Boards of Health, and one Family Health Division, representing 20 different Health Units have previously endorsed these policy recommendations. Eight endorsements were also received from several key national and provincial organizations including the Canadian Society of Exercise Physiology (CSEP), the Ontario Health and Physical Education Association (OPHEA), Canadian Diabetes Association, Health Nexus, Canadian Sport for Life Society, Niagara Sports Commission, ParticipACTION, and the Healthy Active Living and Obesity Research Institute. These recommendations were also supported by the Ontario Collaborative Group on Healthy Eating and Physical Activity (OCGHEPA).

Physical literacy is the gateway to physical activity and provides the foundation for an active life. By definition*; individuals who are physically literate move with competence and confidence in a wide variety of physical activities in multiple environments that benefit the healthy development of the whole person*[1]*;*

- *Physically literate individuals consistently develop the motivation and ability to understand, communicate, apply, and analyze different forms of movement*[1]*.*
- *They are able to demonstrate a variety of movements confidently, competently, creatively and strategically across a wide range of health-related physical activities.*[1]
- *These skills enable individuals to make healthy, active choices that are both beneficial to and respectful of their whole self, others, and their environment.*[1]

Many children today lack the basic skills, knowledge, and behaviours needed to live healthy, active lifestyles as shown by the startling rates of inactivity, obesity, and decreased fitness.[2] Currently, less than 10% of Canadian children and youth and only 15% of adults get the minimal requirement of daily physical activity to achieve health benefits.[3,4] Physical inactivity is attributed to 15-39% of chronic disease cases including seven heart disease, stroke, colon cancer, breast cancer, hypertension, type 2 diabetes, and osteoporosis. The total economic burden of physical inactivity in Canada is estimated at $6.8 billion.[5]

Participation in regular physical activity has also been directly correlated to improved academic performance, positive self-concept, psychological well-being, and reduced anxiety and depression.[6,7]

The Ontario Ministry of Education has a vital role to play in ensuring the development of physical literacy in children and youth and must ensure that educational and childcare environments are conducive to physical literacy development**.** Physical literacy is stated as a main goal of the revised elementary Health and Physical Education Curriculum[8] yet it is currently not measured. Principals report that delivery of the Health and Physical Education curriculum varies significantly depending on the expertise and comfort level of the teacher.[9]

Research supports that physical education specialists are the preferred teachers of physical education in school settings. Compared to generalist teachers, qualified Health and Physical

Education specialist teachers, trained in physical education, generally provide more time to develop skills, more opportunities for moderate to vigorous physical activity, and use more optimal teaching practices.[10]

In 2004, Ontario's Chief Medical Officer of Health Report recommended that schools and school boards establish the foundation for lifelong physical activity by ensuring that physical education is taught by teachers trained in physical education.[11]

According to the Ontario School Information System (Ministry of Education), in 2012/2013 only 19.9% of Ontario's publicly funded elementary schools had either a full or part-time health and physical education specialist teacher.[12]

Policy/Program Memorandum No.138 of the Ministry of Education states that School Boards must ensure that all elementary students have a minimum of sustained 20 minutes of moderate to vigorous physical activity each school day during instructional time, and that School Boards will monitor the implementation of this policy.[13] However, the 2013 Auditor General report on Ontario's Healthy Schools Strategy found that neither the Ministry of Education nor school boards monitor schools to ensure this requirement is achieved.[14]

A recent study of more than 1000 Greater Toronto Area students found that fewer than half of participating children were provided with Daily Physical Activity every day, and not a single child engaged in sustained moderate to vigorous activity for twenty minutes or more.[15]

Current language under section 53 (4b) of the Day Nurseries Act only specifies that children who attend child care for six or more hours per day receive two hours of outdoor play (weather permitting) and that they be provided with active and quiet time, group and individual activities, and activities designed to promote gross and fine motor skills, language and cognitive, social and emotional development.[16] These deficiencies need to be addressed in the new Child Care and Early Years Act.

Currently, only one Health and Physical Education credit is required to receive a Secondary School Diploma. In 2012/2013, just over 87% of grade 9 students in Ontario earned a health and physical education credit compared to only 26% of students in grade 12.[12] Additional credits would not only ensure all students receive physical education but would also provide them with instruction in all other areas of the health and physical education curriculum of public health importance important including nutrition, alcohol and substance misuse, sexual health, mental health, personal safety and injury prevention.

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May 11, 2015

VIA EMAIL

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

Dear Premier Wynne:

Re: Increasing Alcohol Availability in Ontario

The proposed measures for increasing alcohol availability to Ontarians in local supermarkets through the Liquor Modernization Project is of grave concern. As an organization, the Sudbury & District Board of Health believes that government decisions regarding alcohol should be made within the broader context of its known and measurable societal harms, negative economic impacts, and risks to the public's health and community safety. At the April 16, 2015 meeting, the Board passed motion 08-15:

WHEREAS alcohol is the second leading cause of death, disease, and disability in Canada and causally linked to over 60 diseases and injuries; and

WHEREAS 84% of SDHU adults (78% Ontario-wide) and 43% of SDHU teens aged 12-18 reported consuming alcohol in the last 12 months; and 27% of SDHU current drinkers over 12 years reported episodes of heavy drinking (five or more drinks on one occasion at least once monthly); and

WHEREAS the Regulatory Modernization in Ontario's Beverage Alcohol Industry initiative (2014), through the Ministry of Finance and the Alcohol Gaming Commission of Ontario, has increased alcohol availability in Ontario through initiatives including VQA wine in Farmers' Markets, LCBO Express Kiosks, support to industry, increased hours of sale and removal of special event and festival restrictions; and

WHEREAS the privatization of alcohol sales would set a precedent for further privatization across multiple venues throughout Ontario, such as the Government's currently proposed expansion of beverage alcohol in local supermarkets; and

WHEREAS alcohol is no ordinary commodity and decisions about its promotion and availability should be made within the broader context of alcohol's known negative societal, economic and health risks; and

WHEREAS local boards of health are required under the Ontario Public Health Standards to develop health promotion and protection strategies to mitigate against the risks of alcohol consumption and boards are held accountable under MOHLTC Accountability Agreements for reporting on local alcohol consumption rates;

THEREFORE BE IT RESOLVED THAT the Sudbury & District Board of Health endorse the correspondence from the Association of Local Public Health Agencies to Government Ministers and the Premier – while also informing the Premier of our serious concerns regarding the proposal for the increased availability of alcohol through VQA wine in Farmers' Markets, LCBO Express Kiosks, and the privatization of the sale of beverage alcohol through initiatives such as local supermarkets; and

FURTHER THAT the Sudbury & District Board of Health share these concerns and inform the community by means of an open letter; and

FURTHER THAT copies of this motion and subsequent correspondence to the community and Premier be forwarded to local Members of Provincial Parliament, Ministers of Health and Long-Term Care, Economic Development, Finance, Agriculture, Food and Rural Affairs; the Attorney General, Chief Medical Officer of Health, Assistant Deputy Ministers, Ontario Boards of Health, Constituent Municipalities, and Ontario Public Health Association.

The current health care costs, enforcement, and other social costs related to alcohol misuse are estimated to be over $5 billion a year.[i] However, in 2013–2014, the beverage alcohol sector only contributed approximately $3 billion to the Ontario government.

When moving forward with the modernization initiatives, we urge you and your government to consider the health and wellness of the population and the potentially devastating consequences of increased availability of alcohol. The proposed private models of delivery and sales must include significant management and control from the LCBO, including training and responsible sale practices. We encourage your government to include best practices such as training staff, setting limits to hours of sale, product marketing and advertising, and ensuring separate retail and cash register areas.

We strongly recommend the province undertake a detailed analysis of the health and social impacts, including direct and indirect costs related to the proposed changes to Ontario's beverage alcohol retailing system.

The Board of Health continues to welcome the opportunity to collaborate with you on these important health concerns.

Sincerely,

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

cc: Hon. Charles Sousa, Minister of Finance
Hon. Dr. Eric Hoskins, Minister, Health and Long-Term Care
Hon. Dipika Damerla, Associate Minister, Health and Long-Term Care
Hon. Brad Duguid, Minister, Economic Development, Employment and Infrastructure
Hon. Jeff Leal, Minister, Agriculture, Food and Rural Affairs
Hon. Madeleine Meilleur, Attorney General
Hon. France Gelinas, Member of Provincial Parliament, Nickle Belt
Hon. Michael Mantha, Member of Provincial Parliament, Algoma Manitoulin
Hon. Glenn Thibeault, Member of Provincial Parliament, Sudbury
Dr. David Mowat, Chief Medical Officer of Health (Acting)
Dr. Bob Bell, Deputy Minister, Health and Long-term Care
Martha Greenberg, Assistant Deputy Minister (A), Health and Long-Term Care
Roselle Martino, Executive Director, Public Health, Health and Long-Term Care
Sharon Lee Smith, Associate Deputy Minister, Policy and Transformation
Linda Stewart, Executive Director Association of Local Public Health Agencies
Pegeen Walsh, Executive Director, Ontario Public Health Association

[i] Rehm, J., et al. (2006). *The Cost of Substance Abuse in Canada 2002 – Highlights*. Canadian Centre on Substance Abuse

simcoe muskoka
DISTRICT HEALTH UNIT

May 28, 2015

The Honourable Pierre Poilievre
Minister of Employment and
Social Development
House of Commons
Ottawa, Ontario K1A 0A6

The Honourable Kellie K. Leitch
Minister of Labour
Ministry of Labour
House of Commons
Ottawa, ON K1A 0A6

The Honourable Rona Ambrose
Minister of Health
Ministry of Health
House of Commons
Ottawa, ON
K1A 0A6

The Honourable Kevin Daniel Flynn
Minister of Labour
Ministry of Labour
14th Floor
400 University Avenue
Toronto, ON M7A 1T7

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

The Honourable Tracy MacCharles
Minister of Children and Youth Services
Ministry of Children and Youth Services
14th Floor
56 Wellesley Street West
Toronto, ON M5S 2S3

The Honourable Deborah Matthews
Minister Responsible for the
Poverty Reduction Strategy
Room 4320, 4th Floor, Whitney Block
99 Wellesley Street West
Toronto, ON M7A 1W3

Dear Minister Poilievre, Minister Leitch, Minister Ambrose, Minister Flynn, Minister Hoskins, Minister MacCharles, and Minister Matthews:

Re: Public health support for a basic income guarantee

On behalf of the Simcoe Muskoka District Health Unit's Board of Health, I am writing today to express our strong support for joint federal-provincial (Ontario) consideration for and investigation into a basic income guarantee for Ontarians and all Canadians.

Several reports in recent years have described the extent of poverty and growing income inequality in Ontario and Canada.[1,2] From a public health perspective, there is a strong literature base demonstrating the relationship between both low absolute income, and the extent of income inequality in a society, and a range of adverse health and social outcomes. This includes morbidity and/or mortality from chronic and infectious disease, mental illness, and infant mortality, amongst others.[3] Given that 56 000 people (or more than 11% of the population) in Simcoe and Muskoka live in low income situations based on the after-tax low-income (2011 National Household Survey, Statistics Canada), the avoidable burden of disease from low income and income inequalities is substantial.

In response to these key social and public health challenges, a growing number of individuals and organizations in the health, economics, social, and political sectors have proposed the introduction of a basic income guarantee for all Canadians, also known as guaranteed annual income. A basic income guarantee ensures everyone an income sufficient to meet basic needs and live with dignity, regardless of work status. It can be achieved through a range of policy approaches.

Basic income is a concept that has been examined and debated for decades, including through pilot projects in the United States, Canada, and other countries more recently.[4,5] As you may be aware, Mincome, in particular, was an encouraging pilot project of basic income for working age adults conducted jointly by the Government of Manitoba and the Government of Canada in the 1970s, which demonstrated several improved health and educational outcomes.[4] Basic income also resembles income guarantees currently provided in Canada for seniors and children, which have contributed to health and social improvements in those age groups. [6,7]

In addition to providing an effective policy response to poverty and inequality, a basic income guarantee would be a key societal support in the face of rising precarious employment in Canada. Given the trend towards fewer opportunities for secure, permanent jobs, providing living wages and benefits, a basic income guarantee could help buffer the effects of precarious employment by providing a form of 'disaster insurance' that protects people from slipping into poverty during challenging times.[6]

There has been recent support for a basic income guarantee from the Canadian Medical Association, the Alberta Public Health Association, and the Canadian Association of Social Workers. The Canadian Public Health Association is also examining the issue. Beyond the health and social sectors, a non-governmental organization by the name of Basic Income Canada Network is now dedicated to achieving a basic income guarantee in Canada, and several citizen groups are forming across Ontario and Canada in support of this issue.

Advocating for improved income security policies is supportive of the Simcoe Muskoka District Health Unit's strategic direction on the Determinants of Health, which requires the health unit to 'Address the factors that create inequities in overall health and improve the quality of life for populations at risk of poor health outcomes'.

We urge you to undertake a joint federal-provincial investigation into a basic income guarantee in order to address the extensive health inequities in Canada, which are both highly concerning and largely preventable.

Sincerely,

Barry Ward
Chair, Board of Health

c. The Right Honourable Steven Harper, Prime Minister of Canada
The Honourable Kathleen Wynne, Premier of Ontario
Dr. David Mowat, Ontario Chief Medical Officer of Health
Linda Stewart, Association of Local Public Health Agencies
Pegeen Walsh, Ontario Public Health Association
Ontario Boards of Health
Simcoe Muskoka Members of Parliament
Simcoe Muskoka Members of Provincial Parliament
North Simcoe Muskoka and Central Local Health Integration Network
Gary McNamara, President, Association of Municipalities Ontario
Brock Carlton, Chief Executive Officer, Federation of Canadian Municipalities
Simcoe Muskoka Municipalities

References

1. Canadian Index of Wellbeing. How are Ontarians Really Doing?: A Provincial Report on Ontario Wellbeing. Waterloo, ON: Canadian Index of Wellbeing and University of Waterloo, 2014.
2. Conference Board of Canada. How Canada Performs: A Report Card on Canada. 2013. Accessed April 27, 2015. http://www.conferenceboard.ca/hcp/details/society/income-inequality.aspx
3. Auger, N and Alix, C. Income, Income Distribution, and Health in Canada. In: Raphael, D (Ed). Social Determinants of Health, 2nd edition. Toronto: Canadian Scholars Press Inc, 2009.
4. Forget, E. The Town with No Poverty: The Health Effects of a Canadian Guaranteed Annual Income Field Experiment. Canadian Public Policy xxxvii(3) 283-306, 2011. http://utpjournals.metapress.com/content/xj02804571g71382/fulltext.pdf
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6. Emery, J.C.H., Fleisch, V.C., and McIntyre, L. How a Basic income guarantee Could Put Food Banks Out of Business. University of Calgary School of Public Policy Research Papers 6 (37), 2013. http://www.policyschool.ucalgary.ca/sites/default/files/research/emery-foodbankfinal.pdf
7. Milligan, K., and Stabile, M. “Do Child Tax Benefits Affect the Well-Being of Children? Evidence from Canadian Child Benefit Expansions”. American Economic Journal: Economic Policy 3(3): 175-205, 2011.

Perth District Health Unit
653 West Gore Street
Stratford, Ontario N5A 1L4
519-271-7600 Fax 519-271-2195
www.pdhu.on.ca

May 19, 2015

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

Dear Minister Hoskins,

The Perth District Health Unit Board recently considered a request for action for Smoke-free Multi-unit Housing. The following resolution was passed at the March 18, 2015 meeting:

That the Board endorse the following actions and policies to reduce the exposure of second-hand smoke in multi-unit housing:

- **encourage all landlords and property owners of multi-unit housing to voluntarily adopt no-smoking policies in their rental units or properties;**
- **advocate that all future private sector rental properties and buildings developed in Ontario should be smoke-free from the onset;**
- **encourage public/social housing providers to voluntarily adopt no-smoking policies in their units and/or properties;**
- **advocate that all future public/social housing developments in Ontario should be smoke-free from the onset.**
- **encourage the Ontario Ministry of Housing to develop government policy and programs to facilitate the provision of smoke-free housing.**

Carried

Yours truly,

Dr. Miriam Klassen
Medical Officer of Health

c. Minister of Housing and Municipal Affairs (minister.mah@ontario.ca)
alPHa (by email)
Ontario Health Units (by email)
Perth County Municipalities (by email)

Staff Report

2014/2015 Infant & Toddler and Development Program Audited Financial Statements and Transfer Payment Annual Reconciliation

Date:	June 10, 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, Accounting Manager

Recommendations

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

- receive the staff report, 2014/2015 Infant & Toddler and Development Program (ITDP) Audited Financial Statements and Transfer Payment Annual Reconciliation, for information;
- approve the 2014/2015 ITDP Audited Financial Statements in the amount of $247,535; and
- approve the 2014/2015 ITDP Annual Program Expenditure Reconciliation.

Financial Implications and Impact

The Board of Health is required by contract with the Ministry of Children and Youth Services to provide the Ministry with the 2014/2015 Infant & Toddler Development Audited Financial Statements.

The Province also requires that the Annual Program Expenditure Reconciliation be Certified by the Medical Officer of Health that the Annual Expenditure Reconciliation is true, correct and agrees with the books and records of the organization. The Chairperson of the Board must Certify that the Annual Program Expenditure Reconciliation and Certification by the Medical Officer of Health was received by the Board of Health.

Decision History

The Board of Health approved the 2014/2015 budget request to the province of $242,423 on April 9, 2014.

As directed by the Board of Health, the budget reflects the actual occupancy costs and a more reasonable recovery of costs to administer the program. Operating costs continue to be limited to the approved funding level of $242,423. There have been no funding increases to the program since 2003. To balance the budget in 2014/15 the board approved $2,544 of other health unit funds to be used. These funds were set aside for the program in prior years. The 2014/15 budget reflects a reduction of .3 FTE Secretary and a .1 FTE reduction to Infant Development Workers.

Background

The Infant & Toddler Development Program is supposed to be funded 100% by the Ministry of Community and Social Services. The Infant & Toddler Development program budget year began April 1, 2014 and ends March 31, 2015. The total funding allocation from the Ministry for the current year was $242,423. The operating budget has been fixed at $242,423 with no increases since 2002/2003. Deferred income from the City of Peterborough Best Start Program has been used for several years now to balance the budget.

Rationale

The audited expenditures for the year totalled $247,535 are higher than the approved budget due to additional staff time in the program this year. Additional funding in the amount of $5,112 required to balance the budget as the result of staffing levels slightly above the approved budget.

A copy of the draft Auditors Report and Financial Statements are attached. The Audited Financial Statements are drafted in accordance with Generally Accepted Accounting Principles.

A copy of Annual Program Expenditure Reconciliation is attached.

Strategic Direction

This will assist the Board in meeting the strategic directions of Community-Centred Focus and Quality and Performance, by meeting the needs of priority populations and delivering programs that have demonstrated value.

The Board of Health will need to continue to work with the Ministry of Community and Social Services to secure additional funding to support the on-going operations of the Infant & Toddler Development Program.

Contact:

Bob Dubay, Accounting Manager
Corporate Services
(705) 743-1000, ext. 286
bdubay@pcchu.ca

Attachments:

Attachment A – Draft Auditors Report and Financial Statements, Infant & Toddler Development Program
Attachment B – Draft Annual Program Expenditure Reconciliation, Infant & Toddler Development Program

PETERBOROUGH COUNTY-CITY HEALTH UNIT

INFANT TODDLER DEVELOPMENT PROGRAM

STATEMENT OF REVENUES AND EXPENSES

FOR THE YEAR ENDED MARCH 31, 2015

INDEPENDENT AUDITORS' REPORT

To The Members Of The Board Of Health Of The Peterborough County-City Health Unit

Report on the Financial Statement

We have audited the accompanying statement of revenues and expenses of the Peterborough County-City Health Unit – Infant Toddler Development Program for the year ended March 31, 2015, and a summary of significant accounting policies and other explanatory information.

Management's Responsibility for the Financial Statement

Management is responsible for the preparation and fair presentation of this financial statement in accordance with Canadian Public Sector Accounting Standards, and for such internal controls as management determines are necessary to enable the preparation of this financial statement that is free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on the financial statement based on our audit. We conducted our audit in accordance with Canadian generally accepted auditing standards. Those standards require that we comply with ethical requirements and plan and perform the audit to obtain reasonable assurance about whether this financial statement is free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in this financial statement. The procedures selected depend on the auditors' judgment, including the assessment of the risks of material misstatement of this financial statement, whether due to fraud or error. In making those risk assessments, the auditor considers internal controls relevant to the entity's preparation and fair presentation of this financial statement in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal controls. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by management, as well as evaluating the overall presentation of this financial statement.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, this financial statement presents fairly, in all material respects, the revenues and expenses of the Peterborough County-City Health Unit – Infant Toddler Development Program as at March 31, 2015 in accordance with Canadian Public Sector Accounting Standards.

Chartered Professional Accountants
Peterborough, Ontario
June 10, 2015

PETERBOROUGH COUNTY-CITY HEALTH UNIT
INFANT TODDLER DEVELOPMENT PROGRAM

STATEMENT OF REVENUES AND EXPENSES
For The Year Ended March 31, 2015

	Budget 2015 $ (Unaudited)	Actual 2015 $	Actual 2014 $
Revenues			
Ministry of Community and Social Services/Ministry of Children and Youth Services grant	242,423	242,423	242,423
City of Peterborough - Best Start	2,544	2,664	3,480
Other revenue	-	2,448	-
	244,967	247,535	245,903
Expenses			
Personal Services Expenses			
Salaries and wages	150,929	152,952	167,246
Employee benefits	42,260	44,057	45,613
	193,189	197,009	212,859
Other Operating Expenses			
Audit and legal	1,900	1,600	1,600
Rent and utilities	15,396	15,396	5,725
Materials and supplies	2,500	2,042	2,305
Office supplies, postage and advertising	1,740	1,849	1,688
Staff education and training	1,000	70	294
Travel	5,000	5,327	4,677
Allocated administration	24,242	24,242	16,755
	51,778	50,526	33,044
	244,967	247,535	245,903
Amount due to Province of Ontario	-	**-**	**-**

The accompanying notes are an integral part of this financial statement.

PETERBOROUGH COUNTY-CITY HEALTH UNIT
INFANT TODDLER DEVELOPMENT PROGRAM

NOTES TO THE FINANCIAL STATEMENT
For The Year Ended March 31, 2015

NOTE 1: SIGNIFICANT ACCOUNTING POLICIES

The statement of revenues and expenses of the Infant Toddler Development Program of the Peterborough County-City Health Unit has been prepared in accordance with the standards in the Chartered Professional Accountants Canada Public Sector Accounting (PSA) handbook. The more significant accounting policies are summarized below:

Accounting Entity

This financial statement comprises all of the activities for which the Infant Toddler Development Program of the Peterborough County-City Health Unit is legally accountable. The funding and financial reporting requirements of this program are separate and apart from the other functions of the Health Unit.

Tangible Capital Assets

Tangible capital assets are recorded at cost which includes all amounts that are directly attributable to acquisition, construction developments or betterment of the asset. The Infant Toddler Development Program has no significant capital assets.

Operating Grants

The Infant Toddler Development Program claims each year from the Ministry of Community and Social Services and the Ministry of Children and Youth Services grants equivalent to its net allowable operating costs. While these claims for allowable operating costs are recorded as revenue in the current year, the reimbursement for these costs is dependent ultimately upon their acceptance by the funders of the program.

Budget Data

Budget data is compiled from the budget approved by the Board of Health, with subsequent adjustments. Budget data is not subject to audit.

Recognition of Revenues and Expenses

Revenues and expenses are reported on the accrual basis of accounting. The accrual basis of accounting recognizes revenues as they become available and measurable, expenses are recognized as they are incurred and measurable as a result of receipt of goods and services and the creation of a legal obligation to pay.

Use of Estimates

The preparation of financial statements in compliance with Canadian Public Sector Accounting Standards requires management to make estimates and assumptions that affect the reported amounts of revenues and expenses during the year. Actual results could differ from the estimates, the impact of which would be recorded in future periods.

PETERBOROUGH COUNTY-CITY HEALTH UNIT
INFANT TODDLER DEVELOPMENT PROGRAM

NOTES TO THE FINANCIAL STATEMENT
For The Year Ended March 31, 2015

NOTE 2: PENSION PLAN

Certain employees of the Infant Toddler Development Program are eligible to be members of the Ontario Municipal Employees Retirement Fund which is a multi-employer final average pay contributor pension plan. Employer contributions made to the Fund during the year amounted to $13,707 (2014 - $14,473). These amounts are included in employee benefits expense in the statement of revenues and expenses.

TRANSFER PAYMENT ANNUAL RECONCILIATION

SECTION IV: AUDITED FINANCIAL STATEMENT RECONCILIATION

SERVICE PROVIDER / DELIVERY AGENT:	Peterborough County-City Health Unit
FOR THE YEAR ENDED:	March 31, 2015
SERVICE CONTRACT/CFSA APPROVAL NUMBER:	C-23673 - 4

LINE				
400	**TOTAL GROSS REVENUES PER AUDITED FINANCIAL STATEMENTS**		$	247,535
401	**LESS: Non Funded Ministry (MCYS) Revenue (i.e. funding from other sources not related to ministry services**		$	-
402	**Adjustments for Revenues from Ministry Funding calculation**			
403	Less:	Non Retainable Revenues		
404		Specify (e.g. Expenditure Recoveries)	$	-
405		Specify (e.g. Offsetting Revenues)	$	5,112
406		Specify (e.g. Specific Operating Donations)	$	-
407		Specify (e.g. Inter-Agency Chargebacks)	$	-
408	Less:	Amortization of Deferred Revenue	$	-
409	Less:	Other (specify)_____	$	-
410	Less:	Other (specify)_____	$	-
		Subtotal	$	5,112
411	Add:	One-Time Capital Expenditures Approved & not included in Revenue	$	-
412	Add:	Other (specify)_____	$	-
413	Add:	Other (specify)_____	$	-
414		**Subtotal**	$	-
415	**Total Revenue Reported (Line 400 - Line401 - Line 404 to Line 410 + Line 414)**		$	**242,423**
420	**Total Approved Ministry Funding (Total of LINE 223)** *(Lines 415 and 420 should equal)*		$	**242,423**
440	**TOTAL GROSS EXPENDITURES PER AUDITED FINANCIAL STATEMENTS**		$	247,535
441	**LESS: Non Funded Ministry (MCSS) Expenditures (i.e. expenditures from other services not related to ministry services)**		$	-
442	**Adjustments for Inadmissible Expenditures related to Ministry Funded Programs**			
443	Less:	Accruals (Payables greater than 30 day i.e. Vacation/Sick Accrual)	$	-
444	Less:	Appropriations	$	-
445	Less:	Amortization on Capital Assets	$	-
446	Less:	Donations to Individuals or Organizations	$	-
447	Less:	Fundraising Costs	$	-
448	Less:	Loans to Clients or Staff	$	-
449	Less:	Retainer Fees	$	-
450	Less:	Provisions for Bad Debt	$	-
451	Less:	In Kind	$	-
452	Less:	Other (specify)_____		
453	Less:	Other (specify)_____	$	-
		Subtotal	$	-
	LESS: Other Adjustments			
455	Less:	Expenditure Recoveries/ Offsetting Revenues	$	-
456	Less:	Other - City of Peterborough - Best Start and deferred revenue	$	5,112
457	Less:	Other (specify)_____	$	-
		Subtotal	$	**5,112**
460	**ADD: Adjustments for Admissible Expenditures, attach prior approval documentation**			
461	Add:	One-Time Capital Expenditures Approved & Capitalized	$	-
462	Add:	Other (specify)_____	$	-
463	Add:	Other (specify)_____	$	-
		Subtotal	$	-
475	**Total Ministry (MCYS) Eligible Expenditures reported in the Audited Financial Statements**		$	**242,423**
480	**Total Eligible Expenditures (Total of LINE 269)**		$	**242,423**
490	**Variance**		$	-

Variance Explanation:

491	**Retained Earning**	$	-
492	**Total Assets**	$	-
493	**Total Debt**	$	-

(Please attach additional sheets if necessary or if the space is insufficient to complete the above reconciliation)

TRANSFER PAYMENT ANNUAL RECONCILIATION

SECTION I: SUMMARY, CERTIFICATION and VERIFICATION

SERVICE PROVIDER / DELIVERY AGENT: Peterborough County-City Health Unit

FOR THE YEAR ENDED: March 31, 2015

SERVICE CONTRACT/CFSA APPROVAL NUMBER: C-23673 - 4

PART A: SUMMARY

LINE	SERVICES		Executive and Allotment Control	Total Eligible Expenditures (pending final Ministry review and approval)	Total Approved Ministry Funding	Summary of Revised Ministry Funding after Financial Flexibility (pending final Ministry review and approval)
100	Detail Code #	Service (Detail Code) Name				
101	A476	Infant Development	CYSEX034-AL09	$ 242,423	$ 242,423	$ 242,423
102	0			$ -	$ -	$ -
103	0			$ -	$ -	$ -
104	0			$ -	$ -	$ -
105	0			$ -	$ -	$ -
106	0			$ -	$ -	$ -
107	0			$ -	$ -	$ -
108	0			$ -	$ -	$ -
109	0			$ -	$ -	$ -
110	0			$ -	$ -	$ -
111	0			$ -	$ -	$ -
112	0			$ -	$ -	$ -
113	0			$ -	$ -	$ -
114	0			$ -	$ -	$ -
115	0			$ -	$ -	$ -
116	0			$ -	$ -	$ -
117	0			$ -	$ -	$ -
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133	0			$ -	$ -	$ -
134	0			$ -	$ -	$ -
135	0			$ -	$ -	$ -
136	0			$ -	$ -	$ -
137	0			$ -	$ -	$ -
138	0			$ -	$ -	$ -
139	0			$ -	$ -	$ -
140	0			$ -	$ -	$ -
141	0			$ -	$ -	$ -
142	0			$ -	$ -	$ -
TOTAL				$ 242,423	$ 242,423	$ 242,423

PART B: CERTIFICATION BY SERVICE PROVIDER / DELIVERY AGENT AUTHORITY

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

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

Dr. Rosana Pellizzari

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

Medical Officer of Health

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

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

PART C: VERIFICATION BY THE BOARD OF DIRECTORS

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

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

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

Signature

Lesley Parnell

Name of Chairperson or Designate

Chair

Title

Staff Report

2014/2015 Preschool Speech and Language Program Audited Financial Statements

Date:	June 10, 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, Accounting Manager

Recommendations

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

- receive the staff report, *2014/2015 Preschool Speech and Language Program Audited Financial Statements,* for information; and
- approve the 2014/2015 Preschool Speech and Language Program Audited Financial Statements.

Financial Implications and Impact

To submit the 2014/2015 Preschool Speech and Language Audited Financial Statements to the Board for approval in accordance with the agreement between the Five Counties Children's Centre and the Peterborough County-City Health Unit.

Decision History

The Board of Health is required by the agreement with the Five Counties Children's Centre to approve the Audited Financial Statements.

Background

The Preschool Speech and Language Program (PSLP) fiscal period began April 1, 2014 and ended March 31, 2015 and is funded 100% by a grant from the Five Counties Children's Centre.

The Preschool Speech and Language Program is a regional partnership with the Five Counties Children's Centre (5CCC), the Haliburton, Kawartha, Pine Ridge District Health Unit (HKPR) and the Peterborough County-City Health Unit. Funds from the Ministry of Children and Youth Services are provided to 5CCC which in turn provides funds to help support our Health Unit's Family HEALTHline and other activities. Parents may phone in to receive information on speech and language screening and referrals to community agencies. Health promotion activities (media events, posters and pamphlets, displays, etc.) are jointly developed with Haliburton, Kawartha, Pine Ridge District Health Unit.

Rationale

The funding from the Five Counties Children Centre provides funding to support the Health Unit's Family HEALTHline. The total revenue and expenditures for the fiscal period ending March 31, 2015 was $12,670.

A copy of the draft Auditors Report and Financial Statements are attached. The Audited Financial Statements are drafted in accordance with Generally Accepted Accounting Principles.

Strategic Direction

Continued participation in the regional Preschool Speech and Language Program (PSLP) supports the Board's strategic direction of *Community-Centred Focus* and will enable the Board of Health to work strategically with the Five Counties Children Centre and other partnerships throughout the regional PSLP Network to ensure that local health needs for parents of young children are identified and assessed.

Contact:

Bob Dubay, Accounting Manager
Corporate Services
(705) 743-1000, ext. 286
bdubay@pcchu.ca

Attachments:

Attachment A – Draft Auditors Report and Financial Statements, Preschool Speech and Language Program

PETERBOROUGH COUNTY-CITY HEALTH UNIT

PRESCHOOL SPEECH AND LANGUAGE PROGRAM

STATEMENT OF REVENUE AND EXPENSES

FOR THE YEAR ENDED MARCH 31, 2015

INDEPENDENT AUDITORS' REPORT

To The Members Of The Board Of Health Of The Peterborough County-City Health Unit

Report on the Financial Statement

We have audited the accompanying statement of revenue and expenses of the Peterborough County-City Health Unit – Preschool Speech and Language Program for the year ended March 31, 2015, and a summary of significant accounting policies and other explanatory information.

Management's Responsibility for the Financial Statement

Management is responsible for the preparation and fair presentation of this financial statement in accordance with Canadian Public Sector Accounting Standards, and for such internal controls as management determines are necessary to enable the preparation of this financial statement that is free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on the financial statement based on our audit. We conducted our audit in accordance with Canadian generally accepted auditing standards. Those standards require that we comply with ethical requirements and plan and perform the audit to obtain reasonable assurance about whether this financial statement is free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in this financial statement. The procedures selected depend on the auditors' judgment, including the assessment of the risks of material misstatement of this financial statement, whether due to fraud or error. In making those risk assessments, the auditor considers internal controls relevant to the entity's preparation and fair presentation of this financial statement in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal controls. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by management, as well as evaluating the overall presentation of this financial statement.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, this financial statement presents fairly, in all material respects, the revenue and expenses of the Peterborough County-City Health Unit – Preschool Speech and Language Program as at March 31, 2015 in accordance with Canadian Public Sector Accounting Standards.

Chartered Professional Accountants
Peterborough, Ontario
June 10, 2015

PETERBOROUGH COUNTY-CITY HEALTH UNIT
PRESCHOOL SPEECH AND LANGUAGE PROGRAM

STATEMENT OF REVENUE AND EXPENSES
For The Year Ended March 31, 2015

	Budget 2015 $ (Unaudited)	Actual 2015 $	Actual 2014 $
Revenue			
Five Counties Children's Centre grant	12,670	12,670	12,670
	12,670	12,670	12,670
Expenses			
Personal Services Expenses			
Salaries and wages	8,396	8,396	8,365
Employee benefits	2,074	2,074	2,055
Phone line support	1,250	1,250	1,250
	11,720	11,720	11,670
Other Operating Expenses			
Rent	420	420	420
Audit	530	530	580
	950	950	1,000
	12,670	12,670	12,670
Excess Of Revenue Over Expenses For The Year	-	-	-

The accompanying note is an integral part of this financial statement.

PETERBOROUGH COUNTY-CITY HEALTH UNIT
PRESCHOOL SPEECH AND LANGUAGE PROGRAM

NOTE TO THE FINANCIAL STATEMENT
For The Year Ended March 31, 2015

NOTE 1: SIGNIFICANT ACCOUNTING POLICIES

The statement of revenue and expenses of the Preschool Speech and Language Program of the Peterborough County-City Health Unit has been prepared in accordance with the standards in the Chartered Professional Accountants Canada Public Sector Accounting (PSA) handbook. The more significant accounting policies are summarized below:

Accounting Entity

This financial statement comprises all of the activities for which the Preschool Speech and Language Program of the Peterborough County-City Health Unit is legally accountable. The funding and financial reporting requirements of this program are separate and apart from the other functions of the Health Unit.

Tangible Capital Assets

Tangible capital assets are recorded at cost which includes all amounts that are directly attributable to acquisition, construction developments or betterment of the asset. The Preschool Speech and Language Program has no significant capital assets.

Operating Grants

The Preschool Speech and Language Program claims each year from the Five Counties Children's Centre grants equivalent to its net allowable operating costs. While these claims for allowable operating costs are recorded as revenue in the current year, the reimbursement for these costs is dependent ultimately upon their acceptance by the Five Counties Children's Centre.

Budget Data

Budget data is compiled from the budget approved by the Board of Health, with subsequent adjustments. Budget data is not subject to audit.

Recognition of Revenue and Expenses

Revenue and expenses are reported on the accrual basis of accounting. The accrual basis of accounting recognizes revenue as they become available and measurable, expenses are recognized as they are incurred and measurable as a result of receipt of goods and services and the creation of a legal obligation to pay.

Use of Estimates

The preparation of financial statements in compliance with Canadian Public Sector Accounting Standards requires management to make estimates and assumptions for operating grants that affect the reported amounts of revenue and expenses during the year. Actual results could differ from the estimates, the impact of which would be recorded in future periods.

Staff Report

Guarding Minds at Work

Date:	June 10, 2015
To:	Board of Health
From:	Dr. Rosana Pellizzari, Medical Officer of Health

Original approved by	***Original approved by***
Rosana Pellizzari, M.D.	Kerri Tojcic, Co-Chair, Organizational Culture Committee

Recommendations

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

- receive the staff report, *Guarding Minds at Work,* for information;
- formally adopt the National Standard on Psychological Health and Safety for the organization; and
- endorse the creation of the Guarding Minds at Work Steering Committee which will oversee the implementation of the standard for the Peterborough County-City Health Unit.

Financial Implications and Impact

The work of the Guarding Minds at Work (GM@W) initiative will identify opportunities for organizational action and any new activities will be undertaken within existing budgets. Any requests for additional resources will be brought to the board for consideration and approval.

Decision History

The board had an oral presentation in June, 2014 advising that the Organizational Culture work at the Health Unit would be shifting over to incorporate the newly released national standards, facilitated by a website entitled "Guarding Minds at Work" which was commissioned by

the Great-West Life Centre for Mental Health in the Workplace, funded by The Great-West Life Assurance Company, and developed by experienced research-practitioners Dr. Joti Samra, Dr. Merv Gilbert, Dr. Martin Shain and Dr. Dan Bilsker from the Centre for Applied Research in Mental Health and Addiction (CARMHA) within the Faculty of Health Sciences at Simon Fraser University in Vancouver, Canada.

Background

As part of its 2013-17 strategic planning process, the board highlighted the work on organizational culture as a priority, including it within the *Quality and Performance* strategic direction. This work was initiated with an organization-wide survey in May, 2012 that identified positive workplace themes as well as several areas that required improvement and further attention. Addressing these areas has been done in the ensuing years, through ad hoc work groups aligned with the Organizational Culture Committee, which is co-chaired by Kerri Tojcic and Dr. Rosana Pellizzari.

When the National Standard of Canada on Psychological Health and Safety was released in January, 2013, staff reviewed the work and recommended that the board of health formally adopt the new standard as an organization. Given the commitment to moving to the new facility in 2015, it was felt that this work could commence but that it would not be endorsed until 2016 and then fully implemented in the following 2 - 3 years. Creating a Steering Committee to oversee the work is one step in achieving this proposed goal in this time frame.

The Steering Committee, as proposed, will report to the Executive Committee and provide the board with updates as required or requested. This initiative will be well linked to existing organizational structures such as the Joint Occupational Health and Safety Committee, the Management team, all three unions and the Organizational Culture Committee which will provide the forum for two way communications as we prepare to re-survey all employees in 2016. Currently in 2015, the organization is exploring each of the 13 psychosocial factors of the standard in preparation for the survey next year.

Rationale

In order for the board to endorse and adopt the National Standard on Psychological Health and Safety, a Steering Committee has been struck to oversee and guide the organizational activities required as part of this effort. Although this committee will report to senior management, this is also a priority for this board and requires both the support and buy-in from the board in order to communicate its importance both internally and externally to all stakeholders.

Strategic Direction

The board wishes to strengthen workplace culture and has embarked on a journey that will transition the previous work done by the Organizational Culture Committee over to work defined by Guarding Minds at Work in order to address all of the components required to

create a safe and supportive workplace as described by the new National Standard on Psychological Health and Safety, as well as fulfill objectives as set out in the Strategic Plan under the *Quality and Performance* strategic direction.

Contact:

Rosana Pellizzari, MD, CCFP, MSC, FRCPC
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Kerri Tojcic
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Co-Chair, Organizational Culture Committee
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Attachments:
Attachment A – Guarding Minds at Work Steering Committee Terms of Reference

Organizational
POLICY AND PROCEDURE

Section: Organization	**Number:** 4-38	**Title:** Guarding Minds at Work Steering Committee, Terms of Reference
Approved by: Medical Officer of Health		**Original Approved by Executive Committee On** (YYYY-MM-DD)**: 2015-05-19**
Signature:		**Author:** Medical Officer of Health
Date (YYYY-MM-DD)**:** 2015-05-19		
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.

Goal

To operationalize the Board of Health's commitment to providing a safe, secure and health promoting work environment for all its employees.

Purpose

The Board of Health considers the mental health and psychological safety of its employees to be as important as other aspects of health and safety. The organization is committed to supporting a mentally healthy workplace through appropriate policies, programs and services. A psychologically healthy and safe workplace has been defined in a national standard on Psychological Health and Safety in the Workplace as a "*workplace that promotes workers' psychological well-being and actively works to prevent harm to worker psychological health, including in negligent, reckless or intentional ways".* The implementation of a system to support this is not about assessing individual's mental health. It is about considering the impact of workplace processes, policies and interactions on the psychological health and safety of all employees.

Membership

The Guarding Minds at Work Steering Committee will be comprised of health unit employees representing the following organizational perspectives:

- Medical Officer of Health
- Management (Executive and/or Management Committee)
- Co-Chairs of the Organizational Culture Working Group

- Human Resource Advisor
- Representative from Joint Occupational Health and Safety Committee
- Union Representation
- Health Promoter assigned to Workplace Health

Expected membership term is two years.

Chairperson

The Chair will be chosen from and by the members, annually

Reporting

The Committee will report to the Executive, Joint Occupational Health and Safety and Organizational Culture Committees via the general circulation of minutes, or through direct updates provided by a Committee representative as needed. The Board of Health will be kept informed.

Minutes

1. An assigned support staffperson will be responsible for recording the minutes of each meeting.
2. The minutes will be circulated in draft to Committee members for review and/or correction via email within two weeks of the meeting.
3. Once approved by the Committee, the Secretary or Chair must ensure that the minutes are saved electronically to a designated drive accessible to all staff, and issue a notice to staff of their availability.
4. Approved minutes will be added to the agendas of affiliated committees.

Frequency of Meetings

Meetings will be held monthly at a minimum.

Decision Making

The opinion of a majority of members in attendance.

Terms of Reference

Terms of Reference will be reviewed by the Committee every two years, or more frequently as required.

Evaluation

The Committee will conduct a self-evaluation bi-annually, or more often as needed.

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: Mr. Scott McDonald

Subject: **Committee Report: Governance**

Date: June 10, 2015

The Governance Committee met last on May 19, 2015. At that meeting, the Committee requested that the following items come forward to the Board of Health for consideration. Supporting documentation has been included (and linked) where available.

1. **Governance Committee Meeting Minutes:**

   Recommendation:

   That the Board of Health for the Peterborough County-City Health Unit receive for information, meeting minutes of the Governance Committee for February 12, 2015.

   Please refer to the following documents:

   a. Governance Committee Minutes, February 12, 2015

2. **By-Laws, Policies and Procedures**

   Recommendation:

   That the Board of Health for the Peterborough County-City Health Unit approve the following:
   - *2-342 Medical Officer of Health Selection; and*
   - *2-152, Board Leadership and Committee Member Selection.*

   Please refer to the following documents:

   a. 2-342 Medical Officer of Health Selection (revised)
   b. 2-152, Board Leadership and Committee Member Selection (new)

   Item a has been revised to reflect the addition of new materials issued by the Ministry on Medical Officer of Health appointments.

   With respect to item b, at the previous Governance meeting, the Committee directed staff to create a new procedure to address the Committee's new task (as per the revised Terms of Reference) to provide oversight and advise on the annual selection of Board members for its

standing committees. Staff felt that the addition of identifying volunteers for Board leadership positions was also pertinent and could be added to this process.

For the Board's information, the following policies were also reviewed by the Committee at the May meeting and no further changes were suggested:

- 2-170 By-Law Number 8, Building Code Act - Sewage Systems
- 2-374 Contractor Performance and Litigation

Lastly, Committee members were working on revising By-Law 3, Calling of and Proceedings at Meetings, to reflect the adoption of a consent agenda to bring forward to this meeting. It was felt that further work was needed and this will go back to the Governance Committee for additional consultation in August.

3. Work Plan

Recommendation:

That the Board of Health of the Peterborough County-City Health Unit receive the Governance Committee work plan for information.

Please refer to the following documents:

a. 2015 Governance Work Plan

Board of Health for the
Peterborough County-City Health Unit
MINUTES
Governance Committee Meeting
Thursday, February 12, 2015 – 5:00 – 7:30 p.m.
City and County Rooms, 150 O'Carroll Avenue, Peterborough

In Attendance:

Members:	**Mr. Gregory Connolley**
	Deputy Mayor John Fallis
	Mr. Scott McDonald, Chair
	Mayor Mary Smith
Staff:	**Dr. Rosana Pellizzari, Medical Officer of Health**
	Ms. Alida Tanna, Administrative Assistant, Recorder
	Mr. Brent Woodford, Director, Corporate Services
Regrets:	**Councillor Lesley Parnell**
	Ms. Natalie Garnett

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1. Call To Order

Dr. Pellizzari called the meeting to order at 5:12 p.m.

2. Elections

2.1 Chairperson

Dr. Pellizzari, Medical Officer of Health, called for nominations for the position of Chairperson.

MOTION:
That Mr. Scott McDonald be appointed as Chairperson of the Governance Committee for the Peterborough County-City Health Unit for 2015.
Moved: Mayor Smith
Seconded: Deputy Mayor Fallis
Motion carried. (M-2015-001-GV)

Mr. McDonald assumed the Chair.

2.2 Vice Chairperson

Mr. McDonald, Chair, called for nominations for the position of Vice-Chairperson.

MOTION:
That Mayor Mary Smith be appointed as Vice-Chairperson of the Governance Committee for the Peterborough County-City Health Unit for 2015.
Moved: Deputy Mayor Fallis
Seconded: Mr. Connolley
Motion carried. (M-2015-002-GV)

3. Confirmation of the Agenda

Mayor Smith requested the addition of item 9.4, Compliments Tracking.

MOTION:
That the Agenda be approved as circulated.
Moved: Deputy Mayor Fallis
Seconded: Mr. Connolley
Motion carried. (M-2015-003-GV)

4. Declaration of Pecuniary Interest

5. Delegations and Presentations

6. Confirmation of the Minutes of the Previous Meeting

6.1 **November 3, 2014**

It was noted that the action arising out of item 8.7 pertaining to a consent agenda should have indicated that this would be referred to staff for further development.

MOTION:
That the minutes of the Governance Committee meeting held on November 3, 2014, be approved as amended, and provided to the Board for information at their next meeting.
Moved: Deputy Mayor Fallis
Seconded: Mayor Smith
Motion carried. (M-2015-004-GV)

6.2 **December 18, 2014**

MOTION:
That the minutes of the Governance Committee meeting held on December 18, 2014, be approved as circulated, and provided to the Board for information at their next meeting.

Moved:	Mayor Smith
Seconded:	Deputy Mayor Fallis
Motion carried.	(M-2015-005-GV)

7. Business Arising from the Minutes

7.1 Provincial Appointments

Dr. Pellizzari advised that the Health Unit was contacted by the Agency Liaison and Public Appointments Branch of the Ministry of Health and Long-Term Care regarding Mr. Andy Sharpe's application, and was advised that it was currently under review.

MOTION:
That the Governance Committee receive the oral report, Provincial Appointments, for information.

Moved:	Deputy Mayor Fallis
Seconded:	Mayor Smith
Motion carried.	(M-2015-006-GV)

7.2 Consent Agenda

The Committee was provided with the following items for reference:

a. Article: The Consent Agenda - A Tool For Improving Governance
b. Current Board of Health Meeting Procedural By-Law
c. Selwyn Township Council Meeting Procedural By-Law

It was noted that several items on the current agenda could fall under a consent section (e.g., Committee minutes, staff reports and presentations for information). It was also requested that correspondence which require Board action should include proposed recommendations in the Board package.

MOTION:
That the Governance Committee request that staff propose changes to By-Law Number 3 - Calling of and Proceedings at Meetings, based on moving to a consent agenda, and that this item be brought forward to the next meeting for further discussion.

Moved: Mayor Smith
Seconded: Deputy Mayor Fallis
Motion carried. (M-2015-007-GV)

8. Correspondence

9. New Business

9.1 Board / Management Planning Session

Given other pressing matters, it was determined that this session should be deferred.

MOTION:
That the Board / Management Planning Session be deferred and rescheduled at a date to be determined by staff.
Moved: Mayor Smith
Seconded: Mr. Connolley
Motion carried. (M-2015-008-GV)

9.2 Policies and Procedures for Review

a. Governance Terms of Reference

The Committee reviewed the Terms of Reference and proposed the following amendments:

a. the addition of establishing an annual work plan for the Committee;
b. that the Committee provide oversight and advise on the annual selection of Board members for its standing Committees; and,
c. be the point of contact between the non-union staff group and the Board.

With respect to follow-up required on these items:

a. ACTION: Mary Smith and Alida Tanna to draft a work plan to be brought forward to the next meeting of the Governance Committee.
b. ACTION: Staff to draft a procedure on Committee appointments to be brought forward to the next meeting.

MOTION:
That the Governance Committee recommend to the Board of Health at its next meeting:
- *That staff provide the revised Governance Committee Terms of Reference to the Board of Health for approval.*

Moved:	Mayor Smith
Seconded:	Mr. Connolley
Motion carried.	(M-2015-009-GV)

b. 2-153, Board Remuneration

MOTION:
That the Governance Committee recommend to the Board of Health at its next meeting:

- *That staff provide the revised policy 2-153, Board Remuneration, to the Board of Health for approval.*

Moved:	Deputy Mayor Fallis
Seconded:	Mayor Smith
Motion carried.	(M-2015-010-GV)

c. Hiring Policies

Mr. McDonald noted that policy 12-800 appeared to be a duplication of policy 12-211 included in the agenda package. The Committee agreed to the retirement in principle and requested that the correct policy be circulated via e-mail to the members after the meeting.

MOTION:
That the Governance Committee recommend to the Board of Health at its next meeting:

- *That the Board approve the retirement of the following policies:*
    - *12-210, Employment, Changes*
    - *12-211, Employment, Changes in Status*
    - *12-220, Employment, Classifications*
    - *12-800, Staffing*

Moved:	Mayor Smith
Seconded:	Mr. Connolley
Motion carried.	(M-2015-011-GV)

9.3 alPHa Governance Toolkit

The Committee felt this item should be deferred for further discussion at the next meeting, and given that the proposed work plan will be drafted based on activities in the tool kit.

MOTION:
That the item, alPHa Governance Toolkit, be deferred to the next Governance Committee meeting for further discussion.

Moved: Mayor Smith
Seconded: Deputy Mayor Fallis
Motion carried. (M-2015-012-GV)

9.4 Compliments Tracking

Mayor Smith referred to correspondence that was emailed to Alida Tanna and Dr. Pellizzari previously on this item which provided detail on how the Peterborough Lakefield Police Service tracks compliments.

It was noted that currently, the Health Unit shares compliments received in writing with the staff person, Manager, Director and Medical Officer of Health.

MOTION:
That the item, Compliments Tracking, be referred to staff for further consideration and implementation should they deem it appropriate.
Moved: Mayor Smith
Seconded: Mr. Connolley
Motion carried. (M-2015-013-GV)

10. In Camera to Discuss Confidential Personal Matters

MOTION:
That the Governance Committee go In Camera to discuss confidential personal matters at 6:07 p.m.
Moved: Mayor Smith
Seconded: Deputy Mayor Fallis
Motion carried. (M-2015-014-GV)

MOTION:
That the Board of Health for the Peterborough County-City Health Unit rise from In Camera at 7:40 p.m.
Moved: Mayor Smith
Seconded: Deputy Mayor Fallis
Motion carried. (M-2015-015-GV)

11. Motions for Open Session

12. Date, Time and Place of Next Meeting

ACTION: Alida Tanna to schedule meetings for the remainder of the year (May, August, November).

13. <u>Adjournment</u>

MOTION:
That the meeting be adjourned.

Moved by:	Mr. Connolley
Seconded by:	Mayor Smith
Motion carried.	(M-2015-016-GV)

The meeting was adjourned at 7:41 p.m.

Chairperson

Recorder

Board of Health

POLICY AND PROCEDURE

Section: Board of Health	**Number:** 2-342	**Title:** Medical Officer of Health Selection
Approved by: Board of Health		**Original Approved by Board of Health On** (YYYY-MM-DD)**: 2013-04-13**
Signature:		**Author:** Medical Officer of Health
Date (YYYY-MM-DD)**:** 2013-04-13		
Reference: Guide to Medical Officers of Health (MOH), Associate MOH and Acting MOH Appointments (Ministry of Health and Long-Term Care, May 2015) *attached*		

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.

POLICY:

Objective:

To establish a formal system for the recruitment and selection a Medical Officer of Health.

Policy Statement:

The Peterborough County-City Health Unit recognizes the basic principles inherent in the Human Rights Code that illustrate the inherent dignity and worth of every person, and to provide for equal rights and opportunities without discrimination. All employment decisions will be based on the applicant's ability to do the job and not on factors that are unrelated to the job.

1.0 The hiring process for a Medical Officer of Health will be the responsibility of the Board of Health with assistance from the Director of Corporate Services and Human Resources Advisor.

2.0 The Board is responsible for assuring that the employee possesses all the qualifications, knowledge, skills, and abilities required to perform the duties of the position.

3.0 Qualifications for Boards of Health staff can be found in *Regulation 566, of the Health Protection and Promotion Act, R.R.O 1990.*

4.0 Selection of the successful candidate(s) will be responsibility of the Board of Health.

The Board of Health will be bound by the *Health Protection and Promotion Act, R.S.O. 1990,* with respect to the hiring of Board of Health staff as follows:

Medical Officer of Health

Section 62**:**

1.0 Every Board of Health,
   a) shall appoint a full-time Medical Officer of Health; and
   b) may appoint one or more Associate Medical Officers of Health of the Board of Health, R.S.O. 1990, c.H.U, s.62

Vacancy

2.0 If the position of Medical Officer of Health of a Board of Health becomes vacant, the Board of Health and the Minister, acting in concert, shall work expeditiously towards filling the position with a full-time Medical Officer of Health, 2002, c.32, s. 171.

Eligibility for Appointment

Section 64:

No person is eligible for appointment as a Medical Officer of Health or an Associate Medical Officer of Health unless,
   a) he or she is a physician;
   b) he or she possesses the qualifications and requirements prescribed by the regulations for the position, and
   c) the Minister approves the proposed appointment, R.S.O. 1990, c. H.7, s. 64.

Chief Medical Officer of Health May Act Where Risk to Health

Section 77.1:

3.0 For the purpose of section 77,1, subsection 1, the Chief Medical Officer of Health,
   a) may exercise anywhere in Ontario
      i. any of the powers of a Board of Health, including the power to appoint a Medical Officer of Health or Associate Medical Officer of Health *(acting)* and
      ii. any of the powers of a Medical Officer of Health.

PROCEDURE

1.0 Posting of the position:
- 1.1 When a vacancy arises, the Board will determine the nature and placement of advertisement (i.e., internal/external, local, out-of-town, professional journals/ newsletters, etc.).
- 1.2 The Director Corporate Services will draft the advertisement and send to the Board for approval.
- 1.3 The Director Corporate Services and Board to finalize dates for posting, closing, and reviewing applications.

2.0 Selection of Applicants:
- 2.1 An interview committee will be established by the Board consisting of no fewer than 2 interviewers.
- 2.2 The committee will screen applications.
- 2.3 The Director of Corporate Services will contact candidates to arrange interviews.

3.0 The interview process:
- 3.1 The committee formulates questions and format of interviews.
- 3.2 Interviews may include the following:
  - 3.2.1 Rating system
  - 3.2.2 Position specific testing

4.0 Interview follow-up and selection of successful applicant:
- 4.1 References may be asked for at any time during the selection process.
- 4.2 References will be checked by the Director of Corporate Services.
- 4.3 The Director of Corporate Services will summarize candidate`s scores from the rating sheet or testing (if applicable) and present to the committee.
- 4.4 The committee will discuss and a decision will be reached and referred to the Board for ratification.
- 4.5 The Director of Corporate Services for follow-up and offer of employment.

5.0 Expenses
- 5.1 Expenses will be considered on a case-by-case basis and must be approved by the Board.

Review/Revisions

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

Guide to Medical Officers of Health, Associate Medical Officers of Health and Acting Medical Officers of Health Appointments

May, 2015

Public Health Division

Ontario

1. Recruitment and Appointment of MOH/AMOH

Section 62(1)(a) of the *Health Protection and Promotion Act* (HPPA) requires every board of health (BOH) to appoint a full-time medical officer of health (MOH). Boards may also appoint one or more associate medical officer of health (AMOH) (s. 62(1)(b)). While the HPPA does not define the full-time MOH requirement specified in section 62(1)(a), please be advised that the ministry's expectation of a full-time MOH is a minimum of 0.8 full-time equivalents, i.e. 35 to 40 hours or four (4) business days per week, excluding after hours availability. The ministry may request verification of full-time MOH status including copies of signed offer letters, employment contracts and/or other relevant documents.

Section 62(2) stipulates that if the position of the MOH becomes vacant, the BOH and the Minister of Health and Long-Term Care, acting in concert, shall work expeditiously towards filling the position with a full-time MOH.

Boards of health are responsible for the recruitment process that should result in the expeditious appointment of a qualified MOH (and AMOHs as applicable). Such a process includes appointing a candidate as MOH by a BOH motion and applying to the Minister of Health and Long-Term Care for approval of this proposed appointment.

Consistent with section 69(1) of the HPPA, boards of health must ensure that there is an Acting MOH appointed pending ministerial approval of the MOH appointment.

2. Powers and Use of MOH/AMOH Title

A permanent MOH or AMOH appointment is not legally valid unless and until it is approved in writing by the Minister of Health and Long-Term Care as stated in section 64(c) of the HPPA. This means the physician will not be able to perform any of the duties or exercise any of the statutory powers of a MOH or AMOH as set out in the HPPA, unless appointed by the BOH as the Acting MOH. Note that appointment of an Acting MOH also requires the approval of the Chief Medical Officer of Health (CMOH) and the Minister of Health and Long-Term Care where the appointment is for more than six months (see sections 69(3) and (4) of the HPPA; see section 5 below).

In addition, section 63 of the HPPA states that: A board of health shall not describe the position of a person whose services are employed by the board by a title that incorporates the title "medical officer of health" or "médecin-hygiéniste", or the designation "M.O.H." or "m.-h." or other designation representing the title, unless the person is the medical officer of health, associate medical officer of health or acting medical officer of health of the board.

3. Required Physician Qualifications for a MOH/AMOH Position

As per section 64 of the HPPA, a physician must have the following qualifications in order to be eligible for appointment as a MOH or AMOH:

- must be a physician (i.e. hold a current *Certificate of Registration for Independent Practice* with the College of Physicians and Surgeons of Ontario (CPSO));
- must possess the qualifications and requirements stated under O. Reg. 566** (Qualifications of Boards of Health Staff) of the HPPA; and
- his/her appointment has been approved by the Minister of Health and Long-Term Care.

**Regulation 566 of the HPPA provides as follows:

1.(1) The requirements for employment as a medical officer of health or an associate medical officer of health in addition to those set out in section 64 of the Act are that the person be the holder of:

(a) a fellowship in community medicine from The Royal College of Physicians and Surgeons of Canada (RCPSC); [or]

(b) a certificate, diploma or degree from a university in Canada that is granted after not less than one academic year of full time post graduate studies or its equivalent in public health comprising,

(i) epidemiology,

(ii) quantitative methods,

(iii) management and administration, and

(iv) disease prevention and health promotion; [or]

(c) a qualification from a university outside Canada that is considered by the Minister to be equivalent to the qualifications set out in clause (b).

To obtain a current license or certificate from the CPSO please visit http://www.cpso.on.ca/ or call 1-800-268-7096.

To view the HPPA and associated regulations visit http://www.ontario.ca/laws.

4. Required Documentation to be Sent to the Minister to Apply for Approval of MOH or AMOH Appointment

The following documentation must be provided to the Minister of Health and Long-Term Care to consider the approval of a proposed MOH/AMOH appointment:

- ✔ Physician's permission/consent that the BOH may share his/her documents with the ministry;
- ✔ A letter to the Minister of Health and Long-Term Care from the Chair of the BOH requesting that the Minister approve the proposed appointment;
- ✔ A copy of the resolution from the BOH appointing the physician as MOH/AMOH on condition of approval by the Minister of Health and Long-Term Care;
- ✔ A current curriculum vitae (CV) for the MOH/AMOH candidate;
- ✔ A copy of the candidate's specialty certificate and/or master degree certificate(s) in public health or equivalent, or other verification from the program director indicating he/she has successfully completed the requirements for a Master of Public Health (MPH) degree or specialty certification in Public Health and Preventive Medicine (formerly Community Medicine) from the RCPSC. Please note that a copy of the candidate's MPH transcript may also be required;
- ✔ A copy of the candidate's current Certificate of Registration for Independent Practice with the CPSO;
- ✔ A current Certificate of Professional Conduct from the CPSO;
- ✔ If the physician possesses MPH or equivalent qualifications from a university outside of Canada, a copy of the MPH transcript, official course descriptions, etc. may also be required;
- ✔ Upon request, other documents may be required by the ministry, to determine whether the physician meets the statutory and regulatory requirements for the position.

The package of required documentation listed above, for approval of the MOH/AMOH appointment, must be submitted to the ministry at the following address:

Send package to:	Please also copy:	Please also copy:
Hon. Dr. Eric Hoskins Minister of Health and Long-Term Care 10th Floor Hepburn Block 80 Grosvenor Street Toronto ON M7A 2C4	**Dr. David L. Mowat, MBChB, MPH, FRCPC** Interim Chief Medical Officer of Health Ministry of Health and Long-Term Care Public Health Division 21st Floor, 393 University Avenue Toronto ON M7A 2S1	**Sheila Rennie** Public Health Practice Advisor Ministry of Health and Long-Term Care Public Health Division Public Health Standards, Practice & Accountability Branch 21st Floor, 393 University Ave Toronto ON M7A 2S1

The candidate becomes the MOH or AMOH for the BOH once the Minister of Health and Long-Term Care is satisfied that they have met the statutory and regulatory requirements for the position and approves the appointment in writing.

5. Appointment of an Acting MOH

There are several scenarios whereby a BOH may be without a MOH due to resignation, retirement, secondment, illness, leave, vacation, conferences where the MOH is out of province/country, etc.

In such a situation an appointed and approved AMOH for the given BOH may act as the MOH, without approval from the CMOH or the Minister of Health and Long-Term Care.

Where there is no AMOH, or the AMOH is unable or unwilling to act as the MOH, then section 69(1) of the HPPA would apply and "the board of health shall appoint forthwith a physician as acting medical officer of health".

Please note that a "physician" (while not defined in the HPPA) is considered to be a person with a current *Certificate of Registration for Independent Practice* with the CPSO that enables the person to practice in Ontario.

A BOH appointment of a physician to serve as the Acting MOH is effective immediately. No further approval is required for an appointment of less than six (6) months duration; however, if the Acting MOH appointment extends 6 months or longer, it must be approved in writing by the Minister of Health and Long-Term Care and the CMOH to be legally valid. (See sections 69(3) and (4) of the HPPA).

Should an Acting MOH appointment expire prior to obtaining approval by the Minister and CMOH of an extension to the appointment, the physician would not legally be able to exercise any of the statutory powers of a MOH set out in the HPPA, including the ability to make orders in response to any communicable disease event. If such a circumstance should occur, the BOH must appoint forthwith another physician to serve as the Acting MOH while the Minister of Health and Long-Term Care and CMOH approval to extend the original acting appointment is pending.

Furthermore, an approval of an appointment or a continuation of an appointment under section 69(6) of the HPPA may be made subject to any conditions that the Minister of Health and Long-Term Care and the CMOH consider appropriate, and the approval may be withdrawn if those conditions are not met.

Please note that in health units where the MOH position is vacant and there is an AMOH that has been appointed by the BOH and approved by the Minister of Health and Long-Term Care and is able to act in the MOH position, approval by the Minister of Health and the CMOH is not required should the position extend beyond 6 months while the board undertakes a search for a full-time MOH.

6. Required Documentation to be Sent to the Minister and CMOH to Apply for Approval of an Acting MOH Appointment

The aforementioned documentation must also be provided to the CMOH and the Minister to consider for the approval of a proposed Acting MOH appointment of 6 months or more. If the Acting MOH appointee does not possess all the MOH qualifications required under the HPPA and/or is a qualified physician enrolled in an MPH program or equivalent, or is a physician with US qualifications; the following documents are also required:

✔ Confirmation of enrolment and transcripts of MPH courses taken, if required.

✔ Confirmation of CPSO approved education plan and arrangements for a supervisor/mentor.

Please note: If the approval of the Acting MOH appointment is subject to conditions other documents may be required.

Questions?

For any questions regarding required documentation or the process for submission please contact Sheila Rennie at 416-314-1739 or via email at Sheila.Rennie@ontario.ca

Table 1: Summary of Requirements

	APPOINTMENT				
Requirements	MOH	Associate MOH	Acting MOH < 6 mo	Acting MOH > 6 mo	Acting MOH in training >6 mo
Full-time (minimum 0.8 FTE)	√				
Physician consents to share documents	√	√		√	√
Letter to Minister requesting approval	√	√		√	
Letter to Minister and CMOH requesting approval				√	√
Board of Health resolution to appoint	√	√	√	√	√
Physician's current CV	√	√		√	√
Physician's current CPSO registration	√	√	√	√	√
Physician's RCPSC certification if applicable	√	√			
Physician's MPH degree if applicable	√	√			
CPSO Certificate of Professional Conduct	√	√		√	√
Copies of undergraduate and post graduate degrees confirming CV	√	√		√	√
Confirmation of enrolment and transcripts of MPH courses taken	√	√			√
CPSO approved education plan and arrangements for a supervisor/mentor					√
Other documents as requested	√			√	√

Board of Health

POLICY AND PROCEDURE

Section: Board of Health	**Number:** 2-152	**Title:** Board Leadership and Committee Membership Selection
Approved by: Medical Officer of Health		**Original Approved by Board of Health On** (YYYY-MM-DD)**:**
Signature:		**Author:** Governance Committee
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.

PROCEDURE

Objective(s)

1. To receive and review expressions of interest from Board of Health Members for Board leadership positions (Chair and Vice-Chair) as well as Committee appointments to ensure that the needs and composition of the Board leadership and its Committees are met.

2. To identify members of the community who may wish to volunteer on Board Committees.

Procedure

1. A call for expressions of interest will be issued by the Chair of the Governance Committee via e-mail on October 1st of each calendar year (or the closest Monday).

2. Board of Health Members will be sent an Expression of Interest Form (Appendix A) to complete and submit no later than fourteen (14) days after the initial call.

3. In non-municipal election years, forms will be reviewed by Governance Committee members in closed session at their November meeting.

4. In the event that some Committees are not fully subscribed, the Chair of the Governance Committee will follow up personally with Board Members to request their participation prior to the November meeting.

5. Board Members may also recommend appointments for community volunteer positions on a Board Committee using the Expression of Interest Form.

6. Based on the information gathered and the predetermined needs of the Board, the Committee will make a recommendation to the Board for leadership positions and Committee membership for the coming year at their January meeting.

Review/Revisions

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

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

EXPRESSION OF INTEREST FORM
Board of Health Leadership and Committee Membership

Name: _____

Date: _____

I am interested in the position of: [please tick desired position]

LEADERSHIP

☐ Board of Health Chair
☐ Board of Health Vice-Chair

COMMITTEES

☐ Fundraising Committee Member
☐ Governance Committee Member
☐ Property Committee Member
☐ I am unable to participate in a Committee at this time.

BOARD-APPOINTED COMMUNITY VOLUNTEERS (optional)

I recommend the following community member for an appointment to the _____ Committee.

Name: _____

Phone: _____ E-mail: _____

Please describe why this individual would be a candidate for this appointment:

_____

_____

_____

Governance Committee Work Plan (2015)

TASK	ACTION	COMMENTS
MAY 20, 2015		
Non Union Relations		Ongoing
2-120, By-Law Number 3, Calling of and Proceedings at Meetings	Review/Decision	Changes to incorporate consent agenda.
2-152, Board Leadership and Committee Membership Selection	Review/Decision	Creation of new procedure.
2-170, By-Law 8 - By-law Number 8: Building Code Act – Sewage Systems	Review	No changes proposed.
2-342/43, Medical Officer of Health, Selection	Review	Addition of Guide to Medical Officers of Health/Associate Medical Officers of Health and Acting Medical Officers of Health Appointments (MOHLTC, May 2015).
2-374, Contractor Performance and Litigation	Review	No changes
AUGUST 18, 2015		
Non Union Relations		Ongoing
2-280/81, Complaints	Review/Decision	Staff to propose changes.
2-185, Conduct of Open and In-Camera Meetings	Review/Decision	Mayor Woodcock and Natalie Garnett reviewing document.
2-340/41, Medical Officer of Health Performance Review	Review/Decision	Staff to propose changes.
2-345, Medical Officer of Health (Absence)	Review	No changes
Plan timing for Medical Officer of Health Performance Review	Decision	Seek BOH Volunteers for Review Committee. Can occur over Q4 2015.
Feedback from BOH/Management Planning Session	Review	Identify learning opportunities for the Board in 2015/16

TASK	ACTION	COMMENTS
NOVEMBER 17, 2015		
Non Union Relations		Ongoing
Board Remuneration Review	Decision	Staff to recommend changes (if any) for 2016 Board remuneration
Board Leadership and Committee Selection	Decision	Committee to determine recommendations for Board leadership and Committee representation. Callout to occur on October 1.
Orientation/Education Needs for 2016	Decision	
2-140, By-Law, By-Law Number 5: Powers, Duties and Term of Office of the Chairperson and Vice-Chairperson of the Board of Health	Review	
2-190/92, Sponsorship	Review	
2-251, Orientation	Review	

Board of Health Work Plan
June 2015 – March 2016

Month	Governance Committee	Property Committee	Fundraising Committee	Board of Health Meetings
June 2015		• Finalize agreements to purchase 185 King Street and Sell HD • Participate in staff and public communications	• Determine its TOR and proposed membership • Launch its fundraising campaign for NOURISH kitchen	• Strike a working group to propose strategies to strengthen FN/BOH relationships • Community Engagement Strategy Launch • Guaranteed Annual Income and Poverty reduction to be addressed
Summer 2015	• Complete by-law revision to adopt a consent agenda • Regular review of other Board by-laws and policies (Complaints; Conduct of Open and In-Camera Meetings; MOH Performance Review; MOH Absence) • Plan timing for MOH Performance Review • Feedback from BOH/Management Planning Session • Non–Union Compensation		• Enlist BOH assistance in fundraising	• No meetings scheduled at present
September 2015				• Adopt by-law to include a consent agenda • FN/BOH Working Group

Month	Governance Committee	Property Committee	Fundraising Committee	Board of Health Meetings
				active • Non-Union Compensation • Constitute the MOH Performance Appraisal working group • Day in the Life Re-instituted (quarterly)
October 2015	• Board poll for committee and executive positions (2016)		• World Food Day possible fundraising event	• World Food Day celebrations
November 2015	• Board Remuneration Review • Board Leadership and Committee Selection • Orientation/ Education Needs for 2016 • Regular review of other Board by-laws and policies (Powers, Duties and Term of Office of the Chairperson and Vice-Chairperson of the Board of Health; Sponsorship; Orientation)			
December 2015				
January 2016				• Elect new executive and appoint committee members;
February 2016				• BOH/Mgmt Planning Session to review Mission, Vision and Values
March 2016				

Educational Event requested by BOH members:

- **What policy and advocacy are the CPHA/OPHA and alPHa engaged in and what could be our role in that?**

Agenda items requested by BOH members:

- **Update on Vector Borne Diseases (including Powassan)**
- **Link between housing and health and recommendations for Peterborough or advocacy to other levels of government and LHIN**
- **Alcohol updates**
- **Suicide Prevention and the role of Public Health (Kerri Davies to inform BOH members of scheduled events such as 'safety talks')**
- **Updates on Tobacco prevention and control**