Board of Health for
Peterborough Public Health
AGENDA
Board of Health Meeting
Wednesday, April 12, 2017 – 5:30 p.m.
Administration Building, 123 Paudash Street
Hiawatha First Nation

Opening Prayer: Tom Cowie

1. Call to Order
Mayor Mary Smith, Chair

1.1. **Opening Statement**
We acknowledge that where we meet is the land and territory of the Anishnaabeg [Ah-nish-naw-beg] people, and that we gather with gratitude to our Mississauga neighbours. We say "meegwetch" to thank them and other Aboriginal peoples for taking care of this land from time immemorial and for sharing this land with those of us who are newcomers. Out of that gratitude, we are called to treat the land, its plants, animals, stories, and its Peoples with honour and respect. We are all Treaty people.

1.2. **Moment of Silence: Art Vowles**

2. Confirmation of the Agenda

3. Declaration of Pecuniary Interest

4. Consent Items to be Considered Separately

Board Members: *Please identify which items you wish to consider separately for section 9, and advise the Chair when requested. For your convenience, circle the item(s) using the following list: 9.1.1 9.1.2 9.2.1 9.31*

5. Delegations and Presentations

5.1. **Presentation: Hiawatha First Nation – Water Treatment Update** (p. 5)
Chief Laurie Carr, Hiawatha First Nation
- Cover Report

5.2. **Presentation: Curve Lake First Nation – Moving Forward** (p. 6)
Chief Phyllis Williams, Curve Lake First Nation
- Cover Report
- Presentation

6. Confirmation of the Minutes of the Previous Meeting

6.1. **March 8, 2017** (p. 26)
- Cover Report
- Minutes, March 8, 2017

7. Business Arising From the Minutes

7.1. Peterborough Family Health Team – Update

7.2. March 2017 Meeting Evaluation – Education Request

8. Staff Reports

8.1. **Stewardship Committee Report: 2016 Draft Audited Financial Statements** (p. 33)
Councillor Henry Clarke, Chair, Stewardship Committee
- Cover Report

a. Staff Report - 2016 Audited Financial Statements
b. Auditor Letter of Engagement
c. 2016 Draft Audited Financial Statements *(to be provided separately)*

8.2. **Staff Presentation: Emergency Preparedness** (p. 43)
Gillian Pacey, Public Health Inspector
Edwina Dusome, Manager, Infectious Diseases and Emergency Preparedness
- Cover Report
- Presentation

8.3. **Staff Report: Feedback on the Modernization of the Public Health Standards (2017)** (p. 70)
Dr. Rosana Salvaterra, Medical Officer of Health
Larry Stinson, Director of Operations
- Staff Report

a. Feedback Document

9. Consent Items

9.1. **Correspondence**

9.1.1. **Correspondence for Direction**

a. Tobacco Endgame Approach - Simcoe Muskoka (p. 82)
   - SMDHU Briefing Note
   - A Tobacco Endgame for Canada ***(web hyperlink)***

b. Stop Marketing to Kids Coalition's Ottawa Principles and Sugary Drinks - Middlesex-London Health Unit (p. 97)

c. Low-Income Dental Program for Adults and Seniors - Porcupine (p. 102)

9.1.2. **Correspondence for Information**

- Cover Report (p. 104)

a. Opioid Addiction and Overdose – CPSO (p. 106)

b. Jordan's Principle – County of Peterborough (p. 108)

c. National Pharmacare Program – County of Prince Edward (p. 110)

d. Hepatitis C Treatment – Sylvia Jones, MPP (p. 115)

e. CMOH 2015 Annual Report (p. 116)

f. Smoke-Free Ontario Strategy – Minister Hoskins (p. 117)

g. alPHa - E-newsletter March 6/17 (p. 118)

h. alPHa – Standards for Public Health Services and Programs (p. 121)

i. Basic Income Guarantee – Wellington-Dufferin-Guelph (p. 124)

j. Children's Marketing Restrictions - Perth (p. 126)

9.2. **Staff Reports**

9.2.1. **alPHa Resolutions** (p. 127)

Dr. Rosana Salvaterra, Medical Officer of Health

- Cover Report

a. Accessible Contraception

b. Truth and Reconciliation Commission of Canada Calls to Action

9.3. **Committee Reports**

9.3.1. **Stewardship Committee – 2017 Budget Approval - Healthy Babies, Healthy Children Budget** (p. 135)

Councillor Henry Clarke, Chair, Stewardship Committee

- Cover Report

a. Staff Report - 2017 Budget Approval - Healthy Babies, Healthy Children Budget

10. New Business

11. <u>In Camera to Discuss Confidential Matters</u>

In accordance with the Municipal Act, 2001:

- Section 239(2)(c), A proposed or pending acquisition or disposition of land by the Board

12. <u>Motions for Open Session</u>

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

Date: May 10, 2017

Time: 5:30 p.m.

Location: Dr. J. K. Edwards Board Room, 3rd Floor, Peterborough Public Health, Jackson Square, 185 King Street

14. <u>Adjournment</u>

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

To: All Members
Board of Health

From: Dr. Rosana Salvaterra, Medical Officer of Health

Subject: Hiawatha First Nation – Water Treatment Update

Date: April 12, 2017

Proposed Recommendation:

That the Board of Health for Peterborough Public Health receive the following for information:
Presentation: Hiawatha First Nation – Water Treatment Update
Presenters: Chief Laurie Carr, Hiawatha Lake First Nation

To: All Members
Board of Health

From: Dr. Rosana Salvaterra, Medical Officer of Health

Subject: Curve Lake – Moving Forward

Date: April 12, 2017

Proposed Recommendation:

That the Board of Health for Peterborough Public Health receive the following for information:
Presentation: Curve Lake – Moving Forward
Presenters: Chief Phyllis Williams, Curve Lake First Nation

March 23, 2017

Curve Lake – Moving Forward

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 PPH Communications Manager or refer to the meeting summary issued shortly thereafter. Final motions are recorded in posted approved Minutes.

"Our Vision for the Mississauga's of Curve Lake First Nation is self sufficiency for the individuals and for the community, with a land base, an economy and infrastructure to meet the needs of the community"

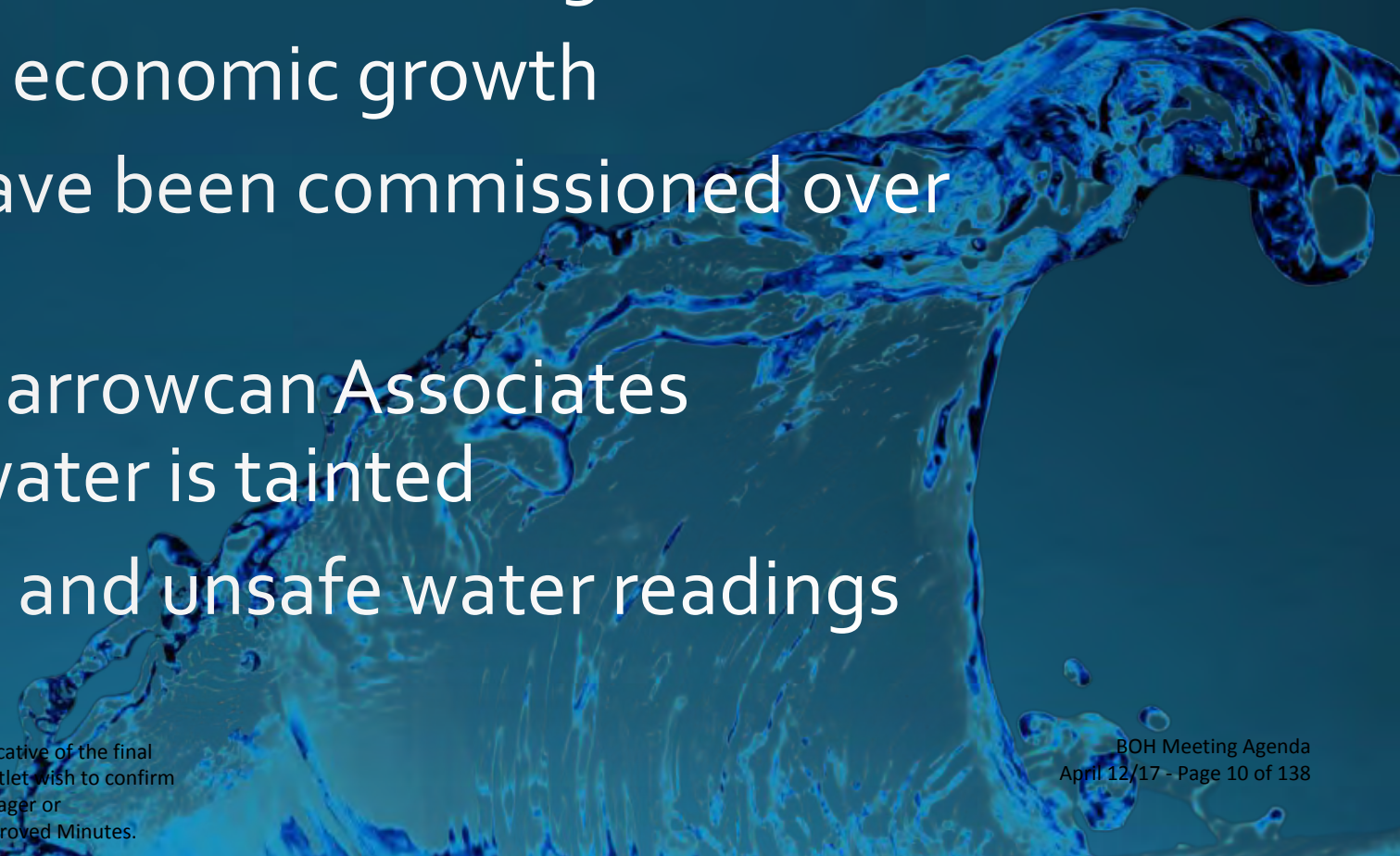
A Desire for Growth

Curve Lake is actively seeking new opportunities for our community in the areas of:

- Housing
- Economic Development
- Capital Improvements
- Recreation
- Education
- Overall quality of life

Water Quality Concerns are creating Growth Barriers

- Lack of safe, clean, consistent drinking water
- Hinders housing and economic growth
- Numerous studies have been commissioned over 20 years
- In 2002, a study by Narrowcan Associates confirmed that the water is tainted
- Boil water advisories and unsafe water readings are commonplace

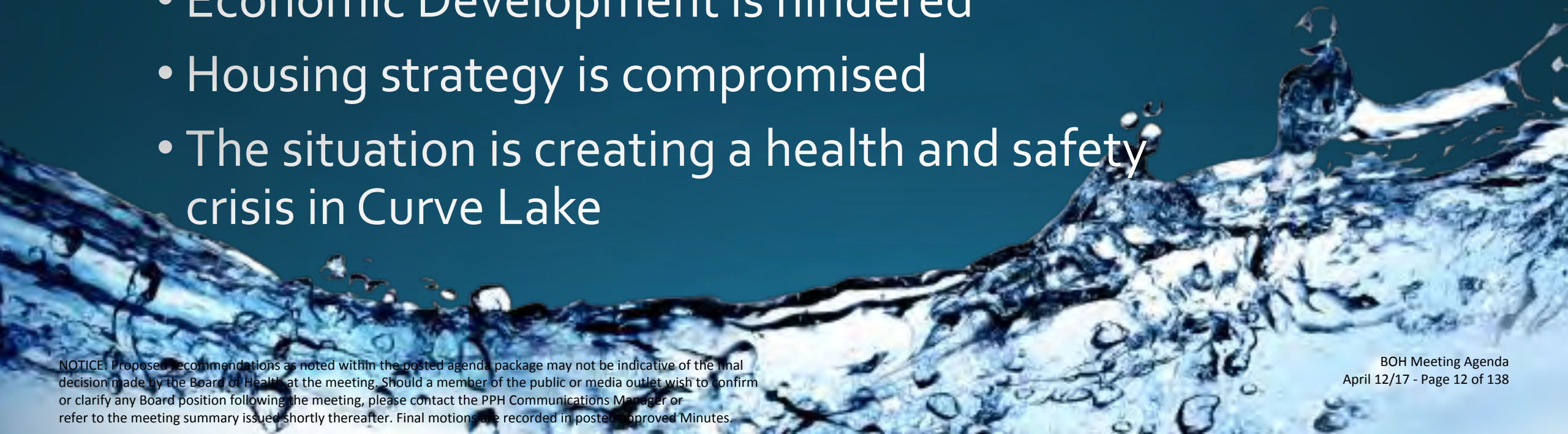


Water Quality Concerns are creating Growth Barriers

- Pumphouse is currently classed as high risk. New legislation puts the onus of this back on the First Nation but provides no new funding to offset and adhere to the new Bill
- We deal with boil water advisories, dry wells, eColi, coliform, iodine, magnese, aluminum

Water Quality Concerns are creating Growth Barriers

- We can not trust our water
- Can not safely swim at our beaches
- Economic Development is hindered
- Housing strategy is compromised
- The situation is creating a health and safety crisis in Curve Lake



Impacts from External Sources:

- Flooding of waterways, creation of Trent Severn Waterway
- Pollution
- Increased motorboat traffic
- Fertilizers
- Cottagers often had no septic's and used pipes into the lake
- Ground Under the Direct Influence of Surface Water wells
- Bill S-8 (Legislation about safe drinking water on FN lands)

Our Current Situation:

- We are currently experiencing draught conditions
- We currently have 6 locations with dry wells
- We have 16 Boil Water Advisories in place including our Health Centre and many private homes
- Beaches are commonly closed due to eColi contamination
- No trust of water sources
- Fish appear to be diseased/ Traditional food sources cannot be trusted

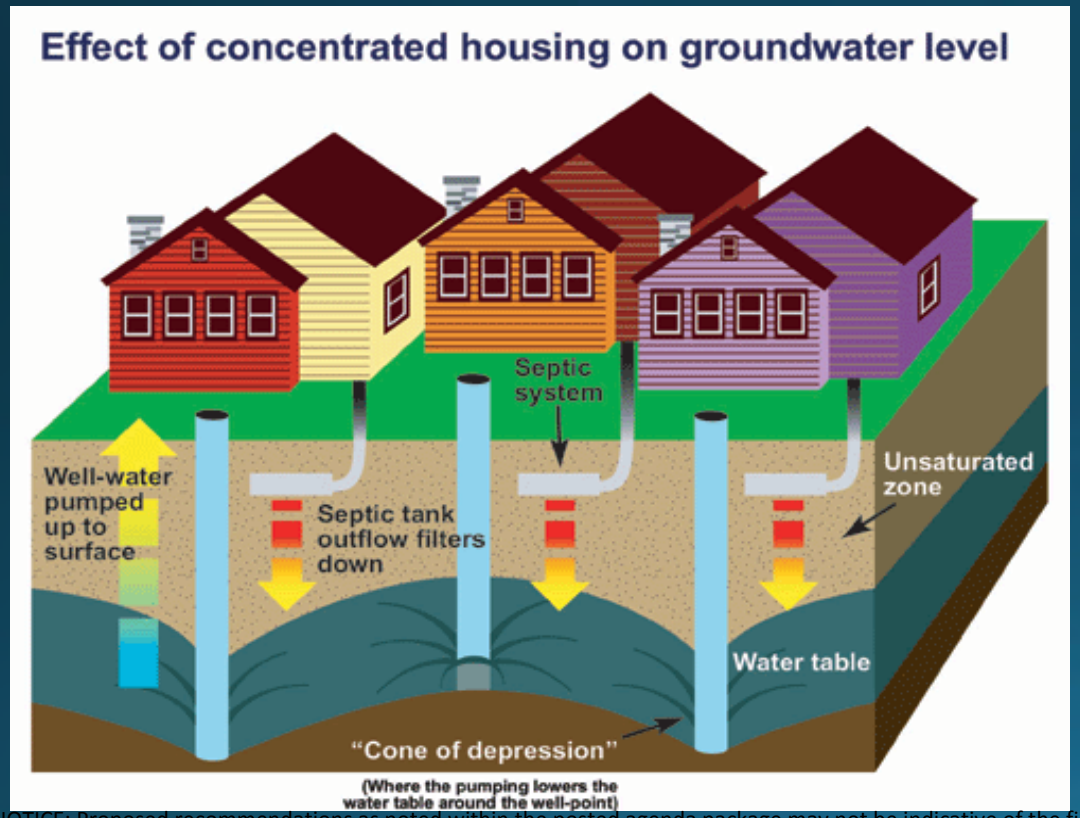
Our Current Situation:

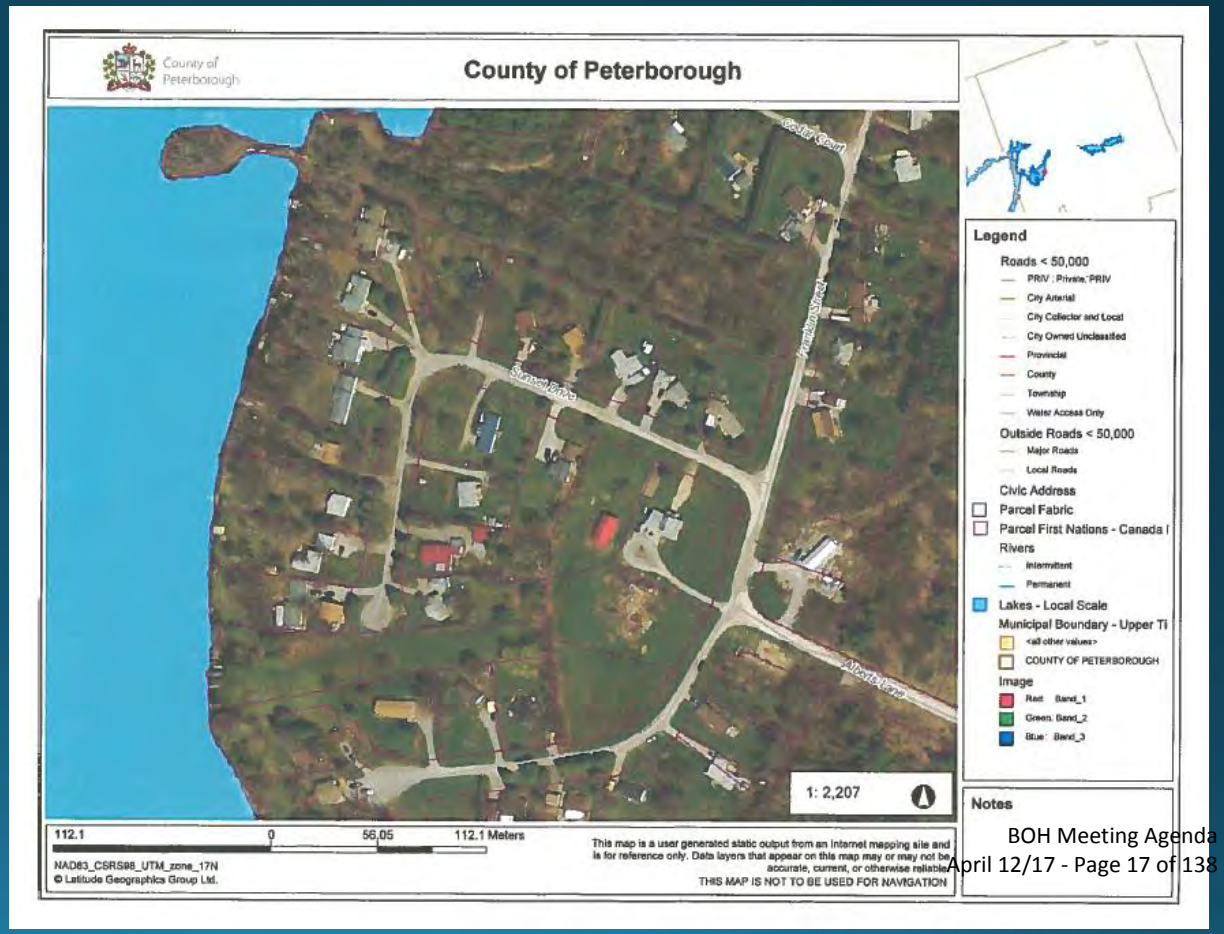
- Funders only look at government owned buildings in reports
- The threat is much greater then what is being reported
- We have had adverse readings of Aluminum and are unsure of the risks associated with this
- We are working with Health Canada to mitigate risks and educate ourselves and the community
- New threats to health are emerging
- Curve Lake has followed every protocol and requirement of the funder for over 20 years and still we wait and put our membership at risk

Our Current Situation:

- Small land base
- Growing population
- Concentrated housing
- Health issues among Elder population, dialysis, diabetes
- Septic system failure
- Dry wells

Curve Lakes drinking water comes from underground sources (aquifers). All of these sources of water are linked in a watershed through the water cycle. Drinking water sources can be easily contaminated, boat traffic, building on waterfront, spills, illegal dumping, farming, Trent Severn Waterway all contribute to contamination.





A Message from our Elders

In the early days of the settlement fish and game were abundant, we used the water for drinking, transportation, and washing taking care to live in balance with the water, the wildlife and the environment. We didn't live on the waters edge to protect it, understanding the importance and sacredness of the water. It provided everything to sustain us and we gave it respect and gratitude.

Completed to Date:

- PPA was submitted February 2010 requesting design dollars for this project to obtain specific approval to perform preliminary and final design at an estimated cost of $1,512,677
- PPA was updated and then denied due to new requirements as part of the National Assessment
- Curve Lake is in the process of completing a Value Engineering Study
- This is a priority and we would like to move this project forward

Curve Lake has a daily health and safety risk with regards to water, the vision statement of our community cannot be realized without access to clean, safe drinking water.

Development - Quick Facts:

- Curve Lake estimates that $61 million is needed for necessary capital improvements
- The newest building is the Health Centre, constructed in 1996
- The oldest building is the Early Learning Centres, (baby and toddler area) built 1939
- The majority of buildings are well past their useful life span
- Renovation, remediation, maintenance and Curve Lake ingenuity has held them together

Development - Quick Facts:

- Curve Lake has expanded service delivery and the facilities have not grown with us
- Curve Lake is often used as an 'Success Story' example to other First Nations
- We are penalized by funders for doing well and keeping our facilities intact
- We are no longer able to expand with current assets
- When funding is made available it is generally to address worst case scenarios

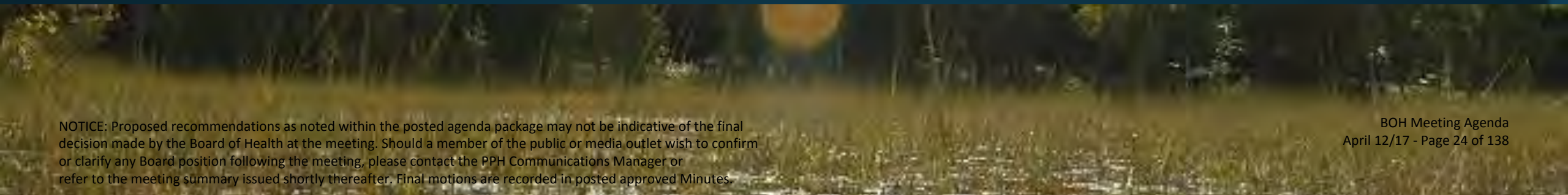
The Investment Plan:

- Water Treatment Facility $21,817,718
- Subdivision Development $3,453,200
- House Construction and Renovation (5 year) $6,950,000
- New Seniors Centre - $TBD
- Park Development $13,619,700
- Health Centre Expansion $2,015,000
- Early Learning Centre and School $7,200,000
- Road Repairs $825,460
- New Cultural Centre $TBD
- New Business Centre $TBD

(not in order of priority)

Growth Barriers

- Financial resources are not readily available
- INAC continues to fund programs but does not allocate money for these projects
- Policies and Procedures are met but, with new legislation and rules being introduced in many areas, we are surely going to fail in some areas as financially we cannot support it
- We struggle to maintain a safe, healthy community, without funding for growth we cannot ensure this



Miigwetch!

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To: All Members
Board of Health

From: Dr. Rosana Salvaterra, Medical Officer of Health

Subject: **Board of Health Minutes – March 8, 2017**

Date: April 12, 2017

Proposed Recommendation:

That the minutes of the meeting held on March 8, 2017, of the Board of Health for Peterborough Public Health, be approved as circulated.

Board of Health for
Peterborough Public Health
DRAFT MINUTES
Board of Health Meeting
Wednesday, March 8, 2017 – 5:30 p.m.
Dr. J.K. Edwards Board Room
Jackson Square, 185 King Street

In Attendance:

Board Members:	**Deputy Mayor John Fallis**
	Ms. Kerri Davies
	Councillor Henry Clarke
	Councillor Gary Baldwin
	Mr. Gregory Connolley
	Mayor Mary Smith, Chair
	Mr. Andy Sharpe
	Councillor Kathryn Wilson
Regrets:	**Mayor Rick Woodcock**
	Councillor Lesley Parnell
	Chief Phyllis Williams
Staff:	**Mr. Larry Stinson, Director of Operations**
	Ms. Natalie Garnett, Recorder
	Dr. Rosana Salvaterra, Medical Officer of Health
	Ms. Patti Fitzgerald, Assistant Director, Chief Nursing and Privacy Officer
	Ms. Brittany Cadence, Manager, Communication Services
	Ms. Alida Gorizzan, Executive Assistant

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1. Call to Order

Mayor Smith, Chair called the meeting to order at 5:35 p.m.

1.1 Welcome: Kathryn Wilson, Councillor, Hiawatha First Nation

Mayor Smith welcomed and introduced Councillor Kathryn Wilson from Hiawatha First Nation.

2. Confirmation of the Agenda

2.1 Confirm Agenda for March 8, 2017

MOTION:
That the agenda be approved as circulated.
Moved: Mayor Clarke
Seconded: Deputy Mayor Fallis
Motion carried. (M-2017-026)

3. Declaration of Pecuniary Interest

4. Consent Items to be Considered Separately

MOTION:
That the following items be passed as part of the Consent Agenda: 9.1.2, 9.2.1, 9.3.1, and 9.3.2.
Moved: Councillor Baldwin
Seconded: Mr. Connolley
Motion carried. (M-2017-027)

MOTION:
That the Board of Health for Peterborough Public Health receive the following for information:

- *Letter dated February 10, 2017 from Dr. Salvaterra to Deb Hammons, Central East Local Health Integration Network, regarding Jordan's Principle.*
- *Letter dated February 10, 2017 from Dr. Salvaterra to Peterborough County Council regarding Jordan's Principle. NOTE: A similar letter was also sent to Peterborough City Council.*
- *Letter dated February 13, 2017 from Chief Laurie Carr, Hiawatha First Nation to Dr. Salvaterra regarding the appointment of Councillor Kathryn Wilson to the Board.*
- *Email dated February 17, 2017 from Roselle Martino, Assistant Deputy Minister, Ministry of Health and Long-Term Care (MOHLTC) regarding the Ontario Public Health Standards (OPHS) Modernization.*
- *Email dated February 23, 2017 from Linda Stewart, Association of Local Public Health Agencies regarding the OPHS Modernization.*
- *Letter dated February 27, 2017 from the Board Chair to Minister Hoskins regarding the Expert Panel on Public Health.*
- *Infection Control in Personal Service Settings*
  Wellington Dufferin Guelph
- *Marijuana / Smoke-Free Ontario Act*
  Grey Bruce
  Windsor Essex
- *Opioid Addiction*
  Huron

Sudbury
Windsor Essex

Moved: Councillor Baldwin
Seconded: Mr. Connolley
Motion carried. (M-2017-027)

MOTION:
That the Board of Health for Peterborough Public Health:

- *Receive the staff report, 2017/2018 Budget Approval – Infant and Toddler Development Program (ITDP), for information; and,*
- *Approve the 2017/2018 budget for the ITDP in the total amount of $242,423.*

Moved: Councillor Baldwin
Seconded: Mr. Connolley
Motion carried. (M-2017-027)

MOTION:
That the Board of Health for Peterborough Public Health:

- *Receive for information, meeting minutes of the First Nations Committee for December 13, 2016; and,*
- *Approve Policy and Procedure 2-401 – Jordan's Principle.*

Moved: Councillor Baldwin
Seconded: Mr. Connolley
Motion carried. (M-2017-027)

MOTION:
That the Board of Health for Peterborough Public Health:

- *Receive for information, meeting minutes of the Governance Committee from November 1, 2016;*

And approve the following:

- *2-90 – Human Rights and Discrimination (revised);*
- *2-92 – Workplace Violence and Harassment Prevention (revised);*
- *2-185 By-law Number 10, Conduct of Open and In-Camera Meetings (revised);*
- *2-402, Immunization (new).*

Moved: Councillor Baldwin
Seconded: Mr. Connolley
Motion carried. (M-2017-027)

5. Delegations and Presentations

5.1. Presentation: Peterborough Family Health Team

MOTION:
That the presentation by Lori Richey, Executive Director, Peterborough Family Health Team, be received for information.
Moved: Councillor Clarke
Seconded: Mr. Connolley
Motion carried. (M-2017-028)

Councillor Clarke left the meeting at 6:03 p.m. and returned at 6:11 p.m.

5.2. Presentation: Nourish – It Takes a Village

MOTION:
That the presentation "Nourish – It Takes a Village" by Joëlle Favreau, Community Development Supervisor, YWCA Peterborough and Carolyn Doris, Registered Dietitian, Peterborough Public Health, be received for information.
Moved: Deputy Mayor Fallis
Seconded: Mr. Sharpe
Motion carried. (M-2017-029)

6. Confirmation of the Minutes of the Previous Meeting

6.1. February 11, 2017

MOTION:
That the minutes of the Board of Health for the Peterborough Public Health meeting held on February 11, 2017 be approved as circulated.
Moved: Councillor Clarke
Seconded: Mr. Connolley
Motion carried. (M-2017-030)

7. Business Arising From the Minutes

8. Staff Reports

8.1 Staff Presentation: A Day in the Life of a Communications Manager

MOTION:
That the presentation "A Day in the Life of a Communications Manager" by Brittany Cadence, Communications Manager, be received for information.
Moved: Mr. Connolley
Seconded: Ms. Davies
Motion carried. (M-2017-031)

8.2 Staff Presentation: Ontario Public Health Standards Modernization

MOTION:
That the presentation "Ontario Public Health Standards Modernization" by Dr. Salvaterra, Medical Officer of Health, be received for information.
Moved: Mr. Connolley
Seconded: Deputy Mayor Fallis
Motion carried. (M-2017-032)

9. Consent Items

9.1 Correspondence

9.1.1 Correspondence for Direction

10. New Business

10.1 Appointment: Councillor Kathryn Wilson, First Nations Committee

MOTION:
That the Board of Health for Peterborough Public Health appoint Councillor Kathryn Wilson to its First Nations Committee.
Moved: Councillor Clarke
Seconded: Mr. Connolley
Motion carried. (M-2017-033)

11. In Camera to Discuss Confidential Matters

MOTION:
That the Board of Health for Peterborough Public Health go In Camera to discuss one item under Section 239(2)(b) Personal matters about an identifiable individual, including municipal or local board employees; and, one item under Section 239(2)(d) Labour relations or employee negotiations, at 7:19 p.m.
Moved: Deputy Mayor Fallis
Seconded: Councillor Clarke
Motion carried. (M-2017-034)

MOTION:
That the Board of Health for Peterborough Public Health rise from In Camera at 7:38 p.m.
Moved: Councillor Baldwin
Seconded: Deputy Mayor Fallis
Motion carried. (M-2017-035)

12. Motions from In Camera for Open Session

MOTION:
That the Board of Health for Peterborough Public Health ratify the tentative agreement with OPSEU.
Moved: Councillor Baldwin
Seconded: Councillor Wilson
Motion carried. (M-2017-036)

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

The next meeting will be held April 12, 2017 in the Administrative Building, 123 Paudash Street, Hiawatha First Nation at 5:30 p.m.

14. Adjournment

MOTION:
That the meeting be adjourned.
Moved by: Councillor Clarke
Seconded by: Deputy Mayor Fallis
Motion carried. (M-2017-037)

The meeting was adjourned at 7:40 p.m.

Chairperson

Medical Officer of Health

To: All Members
Board of Health

From: Councillor Henry Clarke, Chair, Stewardship Committee

Subject: **Stewardship Committee Report: 2016 Draft Audited Financial Statements**

Date: April 12, 2017

Proposed Recommendation:

That the Board of Health for Peterborough Public Health:

- *receive the staff report, 2016 Draft Audited Financial Statements, for information;*
- *receive the engagement letter from the Auditors and recommend the Chair of the Board of Health and Chair of the Stewardship Committee sign it; and*
- *receive and approve the 2016 Draft Audited Financial Statements for Peterborough Public Health.*

Background:

The Stewardship Committee met last on April 6, 2017. At that meeting, the Committee requested that these items come forward to the Board at their next meeting.

Please be advised that Richard Steiginga, Partner, Collins Barrow Chartered Accountants, will be on hand should you have any questions regarding the statements.

The draft statements will be circulated separately, and not publicly posted until after the Board has officially approved them. Approved statements are posted here:
http://www.peterboroughpublichealth.ca/about-us/about-us-2/plans-reports/

Attachments:

Attachment A – Staff Report - 2016 Draft Audited Financial Statements
Attachment B – Auditor Letter of Engagement
Attachment C – 2016 Draft Audited Financial Statements *(to be provided separately)*

Staff Report

2016 Draft Audited Financial Statements

Date:	March 29, 2017
To:	Stewardship Committee
From:	Dr. Rosana Salvaterra, Medical Officer of Health

Original approved by	***Original approved by***
Rosana Salvaterra, M.D.	Larry Stinson, Director of Operations

Proposed Recommendations

That the Stewardship Committee for the Board of Health for Peterborough Public Health:

- receive the staff report, *2016 Draft Audited Financial Statements,* for information;
- accept the engagement letter from the Auditors and recommend the Chair of the Board of Health and Chair of the Stewardship Committee sign it; and
- recommend to the Board of Health the acceptance of the 2016 Audited Financial Statements for Peterborough Public Health.

Financial Implications and Impact

Agreement with the recommendations will result in costs attached to the annual audit fees. An effective audit process will contribute to effective management of financial management and compliance with legislative requirements and GAAP principles.

Decision History

Board approval of the Letter of Engagement and Audited Financial Statements is required annually.

Background

The responsibilities and requirements of auditors include reporting to the Board any relationships they may have with the Board.

These relationships include:

- Holding a financial interest, directly or indirectly, in the Board;
- Holding a position, directly or indirectly, that gives the right or responsibility to exert significant influence over the financial or accounting policies of the Board;
- A personal or business relationship with immediate family, close relatives, partners or retired partners of the Board;
- Having an economic dependence on the work of the Board;
- Providing services to the Board other than auditing (for example: consulting services).

The auditors have not identified any relationship.

The auditors have committed to expressing an opinion on whether our Financial Statements fairly represent, in a material way, the financial position of the Board.

The auditors note that their obligation is to obtain reasonable, but not absolute assurance that the financial statements are free of material misstatement. That is: the auditor will examine our records but will not guarantee they will find a misstatement, if one is present. This also means that there may be small misstatements but the misstatement will not have a significant bearing on our Financial Statements.

The auditors will:

- Assess the risk that the financial statements contain misstatement(s) that are material to the Financial Statements;
- Examine on a test basis the evidence supporting amounts and disclosures to the financial statements (for example: compare invoices to cheque amounts, lease commitments, etc.);
- Assess the accounting principles used and their application;
- Assess the estimates made;
- Examine internal controls in place.

The Board is required to:

- Meet with the auditors prior to the release and approval of the financial statements to review audit, disclosure and compliance issues;
- If necessary, review matters raised by the auditors with management, and if necessary report back to the auditors on the Board's findings;

- Make known to the auditors any issues of fraud or illegal acts or non-compliance with any laws or regulatory requirements known to the Board that may affect the financial statements;
- Provide direction to the auditor on any additional work the auditor feels should be undertaken in response to issued raised or concerns expressed;
- Make enquiries into the findings of the auditor with respect to corporate governance, management conduct, management cooperation, information flow and systems of internal control;
- Review the draft financial statements; and
- Pre-approve all professional and consulting services to be provided by the auditors. In our case, there are none.

Strategic Direction

Support for the recommendations will support achievement of our strategic directions related to:

- Capacity and Infrastructure
- Quality and Performance

Contact:

Larry Stinson, Director of Operations
(705) 743-1000, ext. 255
lstinson@peterboroughpublichealth.ca

Attachments:

Attachment B – Letter of Engagement
Attachment C – Draft Audited Statements (to follow)

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272 Charlotte Street
Peterborough, Ontario K9J 2V4
Canada
T: 705.742.3418
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www.collinsbarrowkawarthas.com

December 2, 2016

Members of the Board of Health
Peterborough Public Health
Jackson Square
185 King Street
Peterborough, Ontario
K9J 2R8

Re: Audit of the consolidated Financial Statements of Peterborough Public Health

Dear Sirs:

This report is intended solely for the use of the Board of Health and should not be distributed without our prior consent. We accept no responsibility to a third party who uses this communication.

We have been engaged to express an audit opinion on the consolidated financial statements of Peterborough Public Health ("the health unit") for the year ended December 31, 2016. Canadian Auditing Standards ("CAS") require that we communicate the following information with you in relation to your audit.

Management is responsible for establishing and maintaining an adequate internal control structure and procedures for financial reporting. This includes the design and maintenance of accounting records, recording transactions, selecting and applying accounting policies, safeguarding of assets and preventing and detecting fraud and error.

Auditor Independence

CAS require communications with audit committees, or other appropriate parties responsible for governance, at least annually, regarding all relationships between the health unit and our Firm that, in our professional judgement, may reasonably be thought to bear on our independence.

We will, through our planning process, identify any potential independence threats and will communicate any concerns we identify. The health unit, management and the Board of Health have a proactive role in this process, and are responsible for understanding the independence requirements applicable to the health unit and its auditor. You must also bring to our attention any concerns you may have, or any knowledge of situations or relationships between the health unit, management, personnel (acting in an oversight or financial reporting role) and our Firm, its partners/principals and audit team personnel that may reasonably be thought to bear on our independence.

In determining which relationships to report, these standards require us to consider relevant rules and related interpretations prescribed by the Chartered Professional Accountants of Ontario (registered name of The Institute of Chartered Accountants of Ontario) and applicable legislation, covering such matters as:

(a) holding a financial interest, either directly or indirectly, in a client;

(b) holding a position, either directly or indirectly, that gives the right or responsibility to exert significant influence over the financial or accounting policies of a client;

(c) personal or business relationships of immediate family, close relatives, partners or retired partners, either directly or indirectly, with a client;

(d) economic dependence on a client; and

(e) provision of services in addition to the audit engagement.

In accordance with our professional requirements, we advise you that we are not aware of any relationships between the health unit and our Firm that, in our professional judgement, may reasonably be thought to bear on our independence.

Accordingly, we hereby confirm that our audit engagement team, our Firm and the other Collins Barrow offices are independent with respect to the health unit within the meaning of the Rules of Professional Conduct Rule 204 of the Chartered Professional Accountants of Ontario (registered name of The Institute of Chartered Accountants of Ontario).

Our Responsibilities as Auditor

As stated in the engagement letter, our responsibility as auditor of your health unit is to express an opinion on whether the consolidated financial statements present fairly, in all material respects, the financial position, results of operations and cash flows of the health unit in accordance with Canadian Public Sector Accounting Standards.

An audit is performed to obtain reasonable but not absolute assurance as to whether the financial statements are free of material misstatement. Due to the inherent limitations of an audit, there is an unavoidable risk that some misstatements of the financial statements will not be detected (particularly intentional misstatements concealed through collusion), even though the audit is properly planned and performed.

Our audit includes:

- Assessing the risk that the financial statements may contain material misstatements that, individually or in the aggregate, are material to the financial statements taken as a whole;
- Examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements;
- Assessing the accounting principles used, and their application; and
- Assessing the significant estimates made by management.

As part of our audit, we will obtain a sufficient understanding of the business and internal control structure of the health unit to plan the audit. This will include management's assessment of:

- The risk that the financial statements may be materially misstated as a result of fraud and error; and

- The internal controls put in place by management to address such risks.

The engagement team must undertake a documented planning process prior to commencement of the audit to identify concerns, address independence considerations, assess the engagement team requirements, and plan the audit work and timing. It may be necessary to contact members of the Board of Health if significant matters arise from planning procedures.

An audit does not relieve management or those responsible for governance of their responsibilities for the preparation of the health unit's financial statements.

Board of Health Members' Responsibilities

The Board of Health's role is to act in an objective, independent capacity as a liaison between the auditor and management to ensure the auditors have a facility to consider and discuss governance and audit issues with parties not directly responsible for operations.

The Board of Health's responsibilities include:

- Being available to assist and provide direction in the audit planning process when and where appropriate;
- Meeting with the auditors as necessary and prior to release and approval of financial statements to review audit, disclosure and compliance issues;
- Where necessary, reviewing matters raised by the auditor with appropriate levels of management, and reporting back to the auditors their findings;
- Making known to the auditor any issues of disclosure, corporate governance, fraud or illegal acts, non-compliance with laws or regulatory requirements that are known to them, where such matters may impact the financial statements or the Independent Auditors' Report;
- Providing guidance and direction to the auditor on any additional work the auditor feels should be undertaken in response to issues raised or concerns expressed;
- Making such enquiries as appropriate into the findings of the auditor with respect to corporate governance, management conduct, cooperation, information flow and systems of internal controls; and
- Reviewing the draft financial statements prepared by management, including the presentation, disclosures and supporting notes and schedules, for accuracy, completeness and appropriateness, and then approve the draft financial statements.

Audit Approach

Outlined below are certain aspects of our audit approach which are intended to help you in discharging your oversight responsibilities. Our general approach to the audit of Peterborough Public Health is to assess the risks of material misstatement in the financial statements and then respond by designing audit procedures.

Illegal Acts, Fraud, Intentional Misstatements and Errors

Our auditing procedures, including tests of your accounting records, will be limited to those considered necessary in the circumstances and will not necessarily disclose all illegal acts, fraud, intentional misstatements or errors should any exist. We will conduct the audit under CAS, which include procedures to consider (based on the control environment, governance structure and circumstances encountered during the audit), the potential likelihood of fraud and illegal acts occurring.

These procedures are not designed to test for fraudulent or illegal acts, nor will they necessarily detect such acts or recognize them as such, even if the effect of its consequences on the financial statements is material. However, should we become aware that an illegal or possible illegal act or an act of fraud may have occurred, other than one considered clearly inconsequential, we will communicate this information directly to the Board of Health.

It is management's responsibility to detect and prevent illegal actions. If such acts are discovered or the Board of Health becomes aware of circumstances under which the health unit may have been involved in fraudulent, illegal or regulatory non-compliance situations, such circumstances must be disclosed to us.

Related Party Transactions

During our audit, we conduct various tests and procedures to identify transactions considered to involve related parties. Related parties exist when one party has the ability to exercise, directly or indirectly, control, joint control or significant influence over the other. Two or more parties are related when they are subject to common control, joint control or common significant influence. Related parties also include management, directors and their immediate family members and companies with which these individuals have an economic interest.

We will ensure that any related party transactions that are identified during the audit have been represented by management to have been disclosed in the notes to financial statements, recorded in accordance with Canadian Public Sector Accounting Standards, and have been reviewed with you. Management is required to advise us if any related party transactions have occurred that have not been disclosed to us. The Board of Health is required to advise us if they are aware of or suspect any other related party transactions have occurred which have not been disclosed in the financial statements.

Significant Accounting Principles and Policies

The health unit's financial statements will be prepared by management using various accounting principles, which have been incorporated into the health unit's accounting policies and disclosed in the notes to the financial statements. Where accounting policies have changed from one period to the next, such changes will be noted and the effect of these changes will be disclosed.

The accounting policies adopted may be acceptable policies under Canadian Public Sector Accounting Standards; however, alternative policies may also be acceptable under Canadian Public Sector Accounting Standards. The health unit and the Board of Health have a responsibility to not adopt extreme or inappropriate interpretations of Canadian Public Sector Accounting Standards that may have inappropriate or misleading results. Alternative policies, if adopted, may produce significant changes in the reported results of the operations, financial position and disclosures of the health unit.

The Board of Health has a responsibility to review the accounting policies adopted by the health unit, and where alternative policies are available, make determinations as to the most appropriate policies to be adopted in the circumstances. If members of the Board of Health are concerned that the adoption or change of an accounting policy may produce an inappropriate or misleading result in financial reporting or disclosure, this concern must be discussed with management and the auditors. If the Board of Health believes that a policy or policies adopted are inappropriate or produce a misleading result in the circumstances, these concerns should be discussed with us directly, either privately or in Board of Health meetings.

Risk-based

Our risk-based approach focuses on obtaining sufficient appropriate audit evidence to reduce the risk of material misstatement in the financial statements to an appropriately low level. This means that we focus our audit work on higher risk areas that have a higher risk of being materially misstated.

Based on our knowledge of the health unit's business and our past experience, we have identified the following areas that have a potentially higher risk of a material misstatement.

- Revenue recognition.

Materiality

Materiality is defined as:

Materiality is the term used to describe the significance of financial statement information to decision makers. An item of information, or an aggregate of items, is material if it is probable that its omission or misstatement would influence or change a decision. Materiality is a matter of professional judgement in the particular circumstances.

We plan to use an overall materiality of $370,000 and a performance materiality of $314,500. The overall materiality for last year's audit was $370,000 and the performance materiality was $314,500.

Materiality is used throughout the audit and in particular when:

a) Identifying and assessing risk of material misstatement;

b) Determining the nature, timing and extent of further audit procedures; and

c) Evaluating the effect of uncorrected misstatements, if any, on the financial statements and in forming an opinion on the auditors' report.

Audit Procedures

In responding to our risk assessment, we will use a combination of tests of controls, tests of details and substantive analytical procedures. The objective of the tests of controls is to evaluate whether certain controls operated effectively. The objective of the tests of details is to detect material misstatements in the account balances and transaction streams. Substantive analytical procedures are used to identify differences between recorded amounts and predictable expectations in larger volumes of transactions over time.

Should any member of the Board of Health wish to discuss or review any matter addressed in this letter or any other matters related to financial reporting, please do not hesitate to contact us at any time.

To ensure there is a clear understanding and record of the matters discussed, we ask that members of the Board of Health sign their acknowledgement in the spaces provided below.

Yours very truly,

Collins Barrow Kawarthas LLP

Richard Steiginga, CPA, CA

Acknowledgement of Board of Health:

We have read and reviewed the above disclosures and understand and agree with the comments therein:

Peterborough Public Health

Are you aware of any frauds, illegal acts or management override of internal controls at the health unit?

Yes / No (please circle one)

If yes, please contact our office immediately

_____	_____
Name	Position
_____	_____
Name	Position

To: All Members
Board of Health

From: Dr. Rosana Salvaterra, Medical Officer of Health

Subject: **Emergency Preparedness**

Date: April 12, 2017

Proposed Recommendation:

That the Board of Health for Peterborough Public Health receive the following for information:
Presentation: Emergency Preparedness
Presenters: Gillian Pacey, Public Health Inspector; Edwina Dusome, Manager, Infectious Diseases and Emergency Preparedness

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Emergency Preparedness

Peterborough Public Health

Board of Health Meeting

April 12, 2017

Gillian Pacey, Public Health Inspector

Edwina Dusome, Manager

Objective

Orient the Board of Health on our emergency response plan

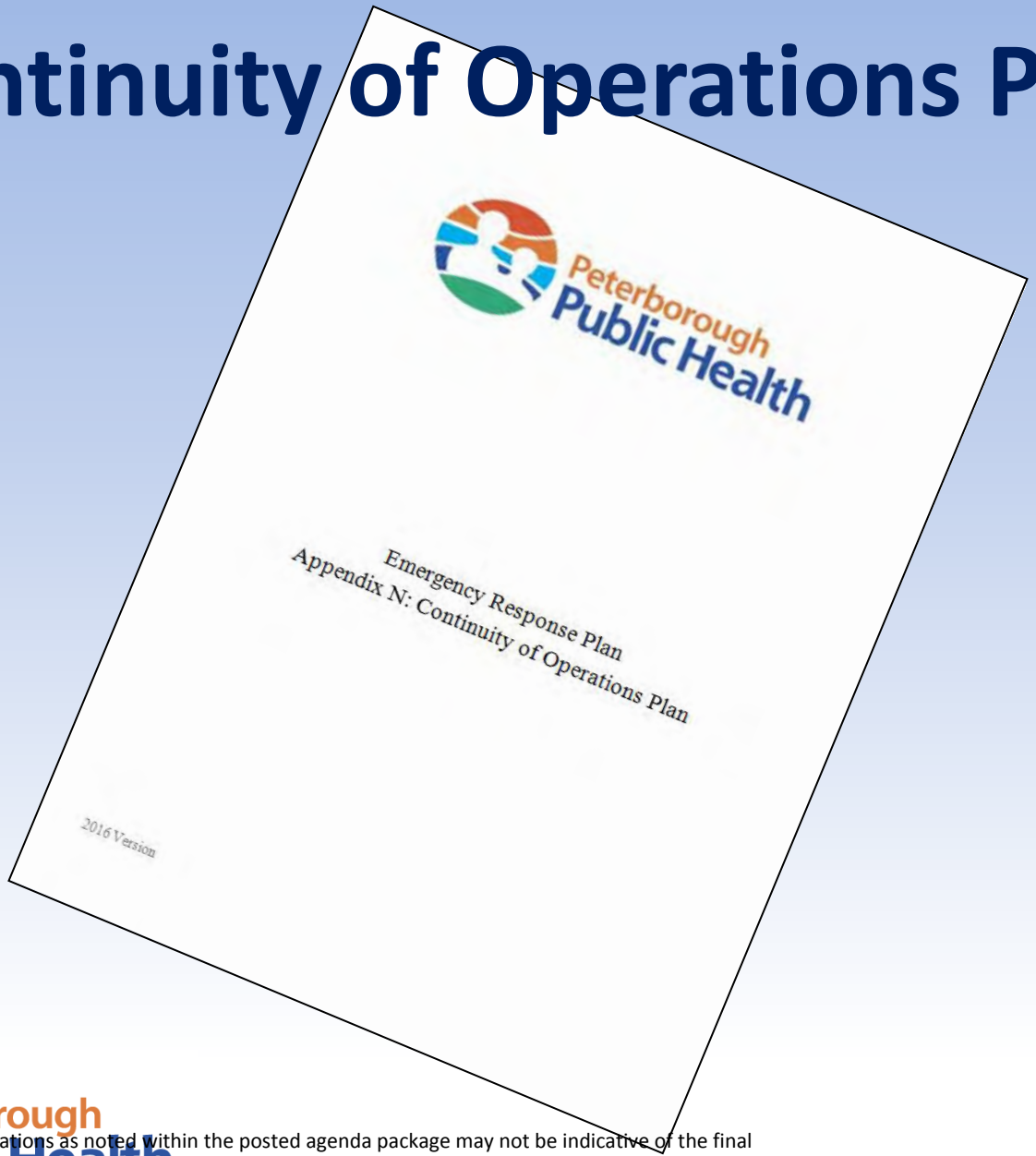
- Pandemic Plan
- Emergency Response Plan
- Continuity of Operations Plan

Emergency Response Plan

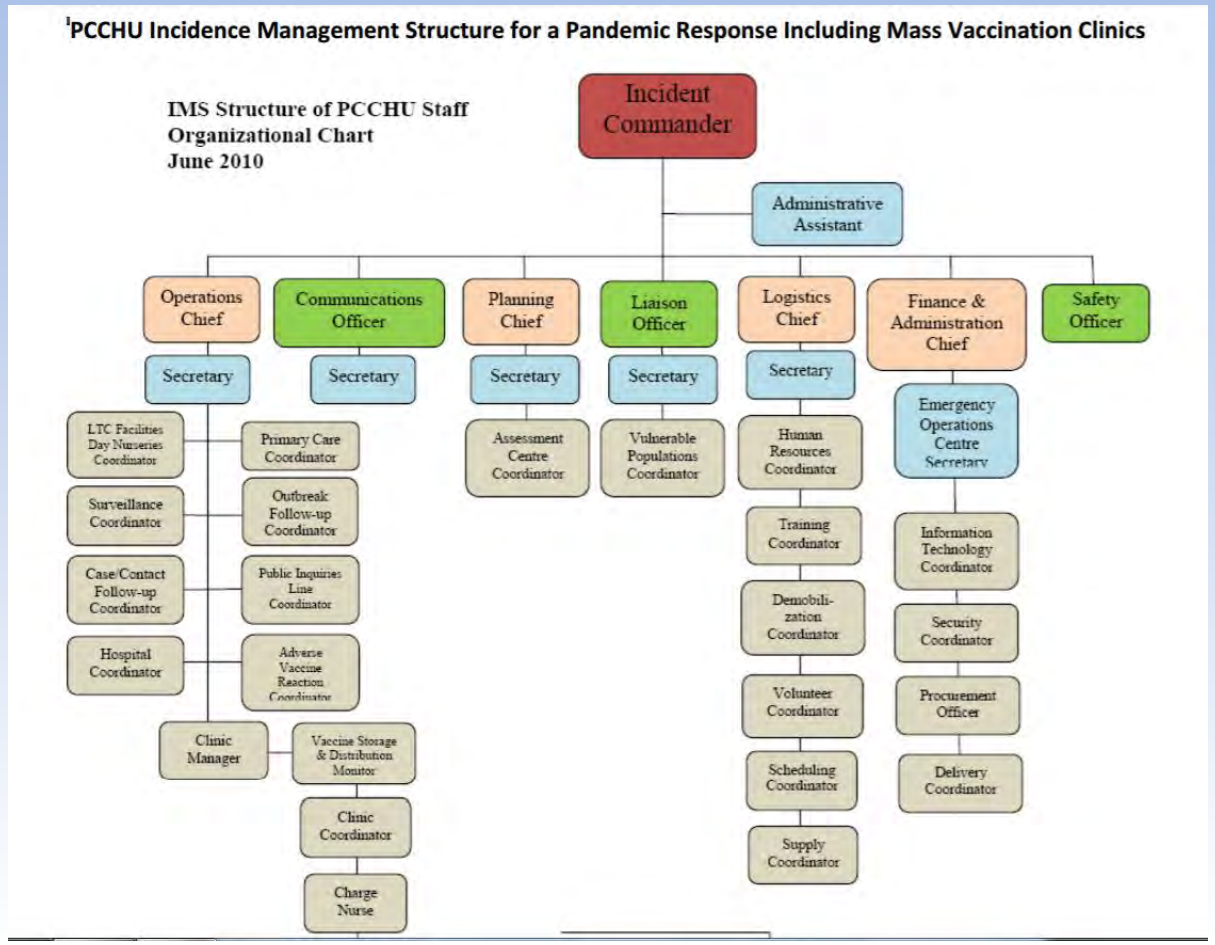
PPH Emergency Responsibilities Include….

- Inspect evacuation and reception centres
- Ensure drinking water safety
- Inspect temporary mortuary sites
- Provide public information
- Ensure infection control

Continuity of Operations Plan



Incident Management System



Emergency Operations Centre

Communication

- ✓ communication plan
- ✓ emergency notification plan

Communication Channels for disseminating information

- Press Conferences for Media (TV, radio,news- paper)
- Websites and Electronic Mail
- Fact Sheets and Posters
- Advertisements and Bulletins
- Telehealth and Health Canada Info Line
- **Public Inquiry Line**

Internal Emergency Exercises

Is Peterborough prepared for a pandemic?

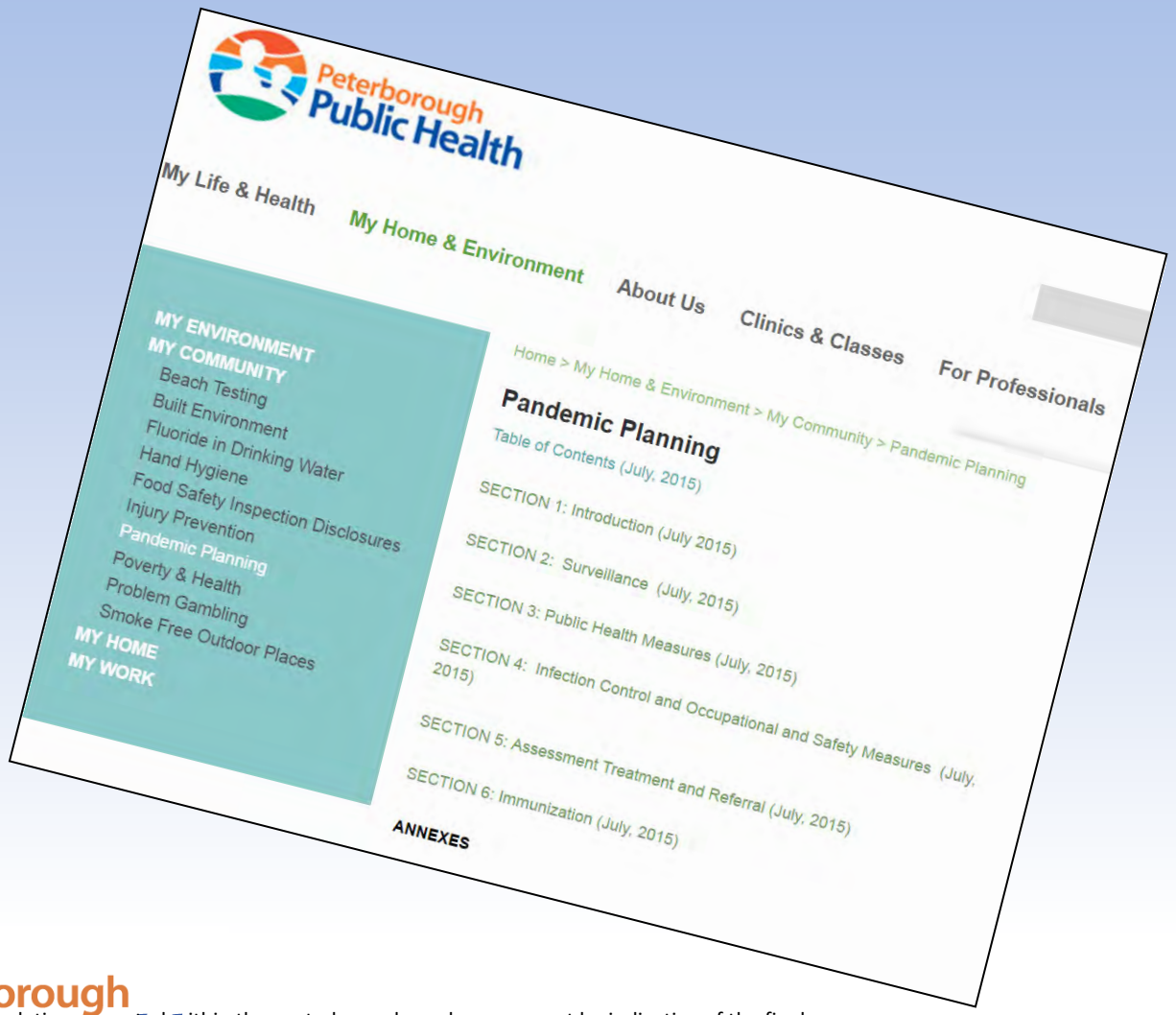
Uncertainty and Unpredictability of an Influenza Pandemic

- Where will it occur?
- When it will occur?
- What the impact will be?
- Will interventions be effective?

Public Health will play a lead role!!

Peterborough Public Health

Pandemic Plan



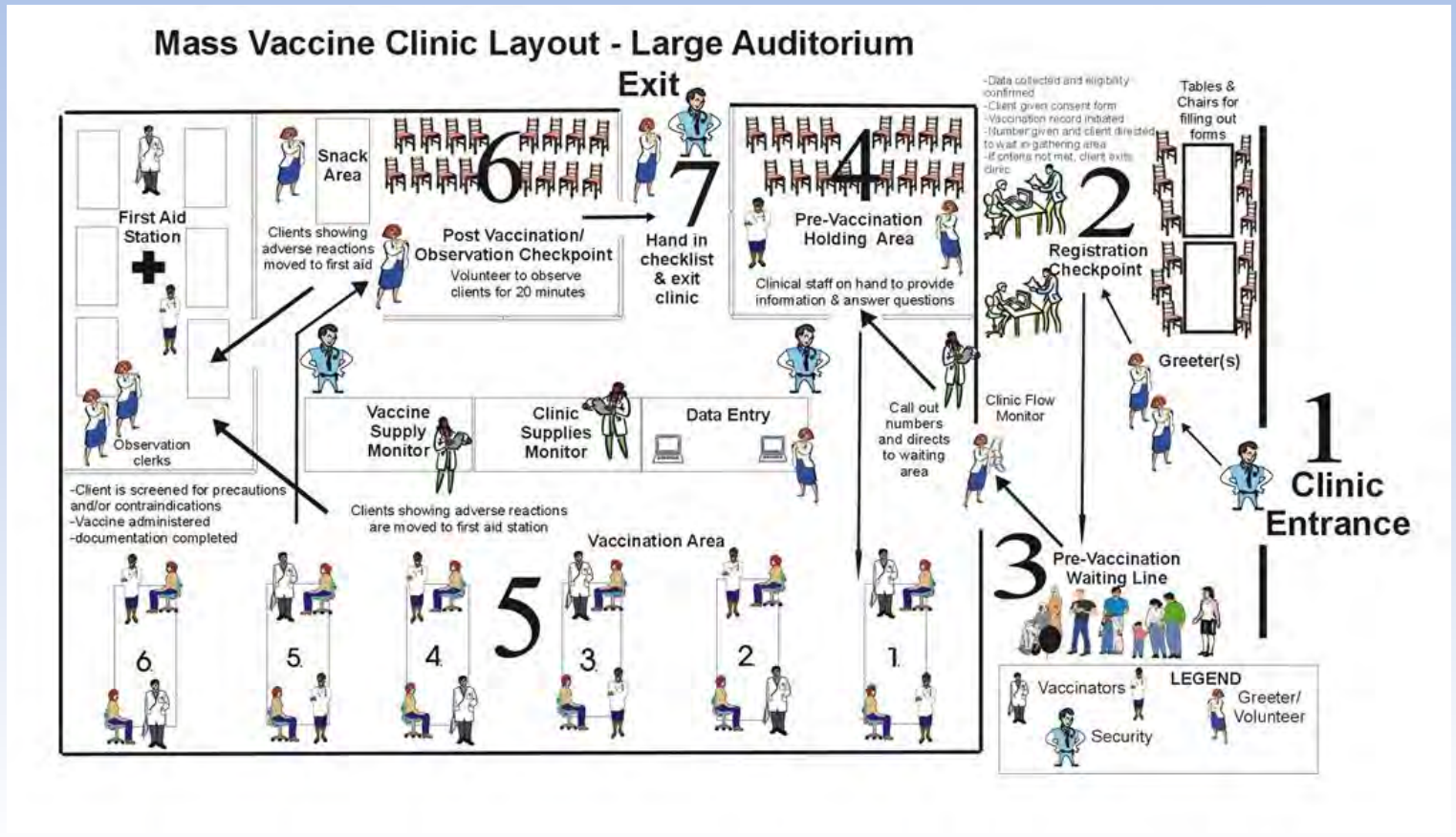
Surveillance

- ✓ reportable diseases
- ✓ outbreaks
- ✓ school absenteeism
- ✓ emergency room data
- ✓ infection control meetings
- ✓ Ontario Influenza Bulletins

Our staff

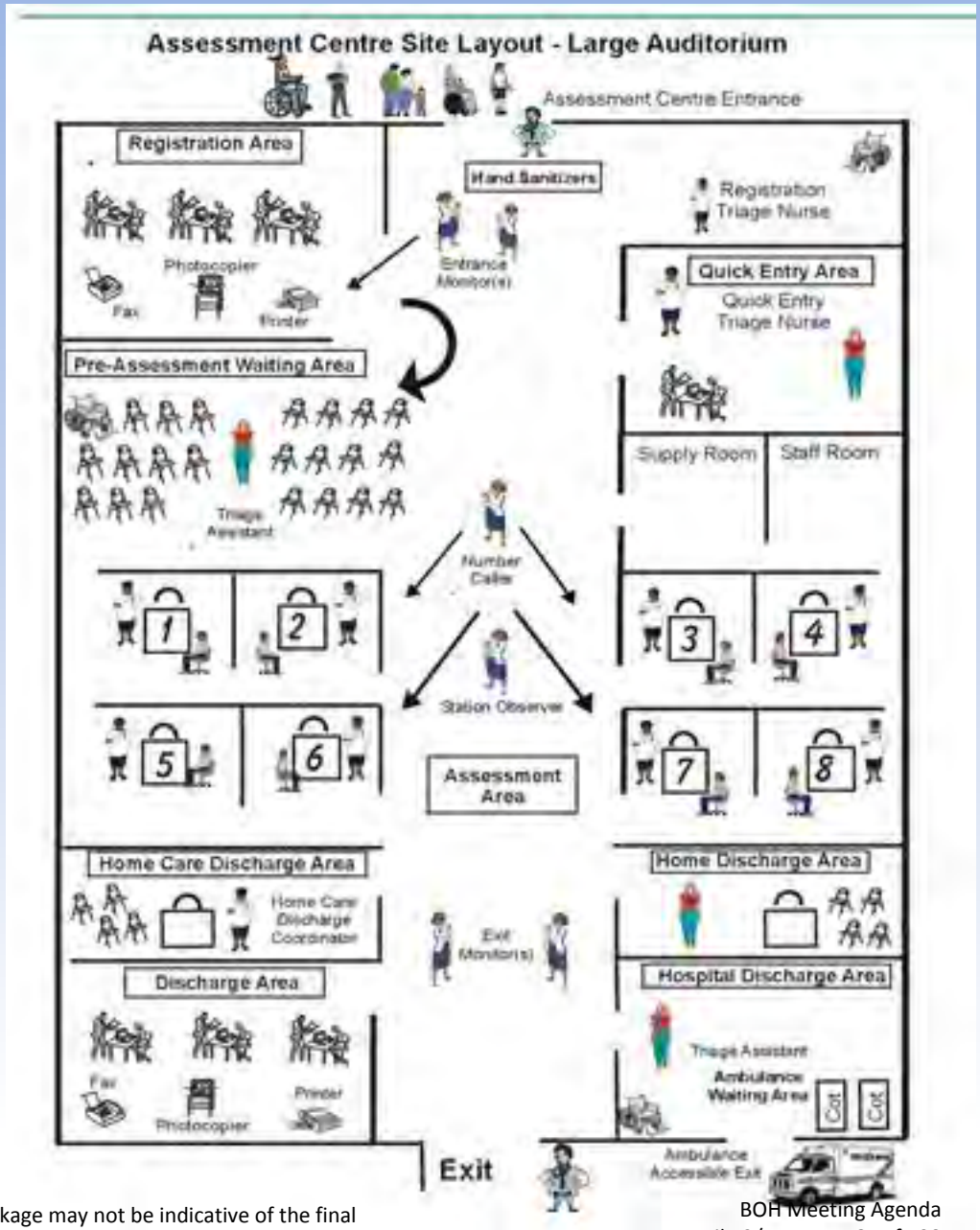
- immunizers
- investigators
- audits
- signage
- databases
- fit testing
- IPAC team
- vaccine distribution, storage area and evacuation process

Mass Vaccination Plan



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 PPH Communications Manager or refer to the meeting summary issued shortly thereafter. Final motions are recorded in posted approved Minutes.

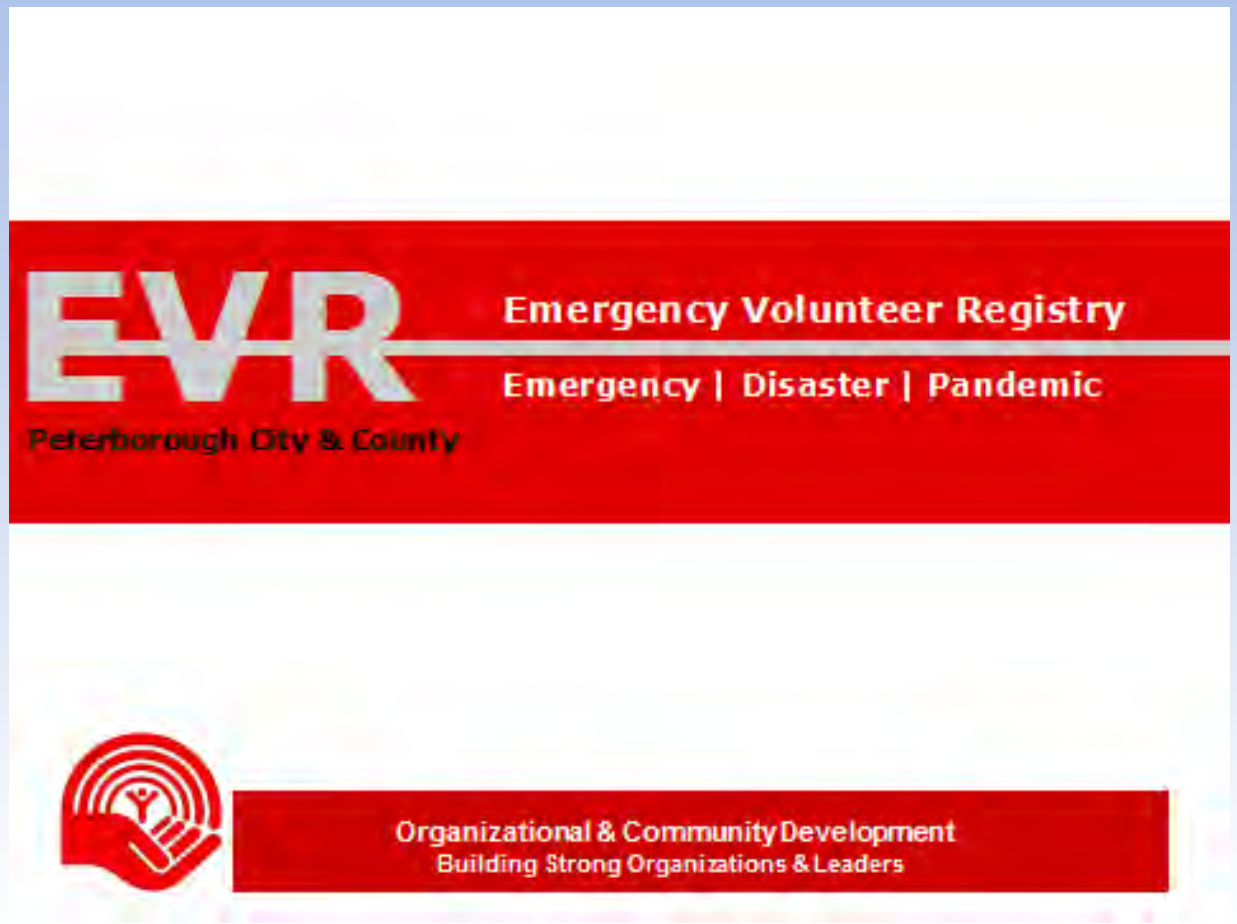
Assessment Centre Plan



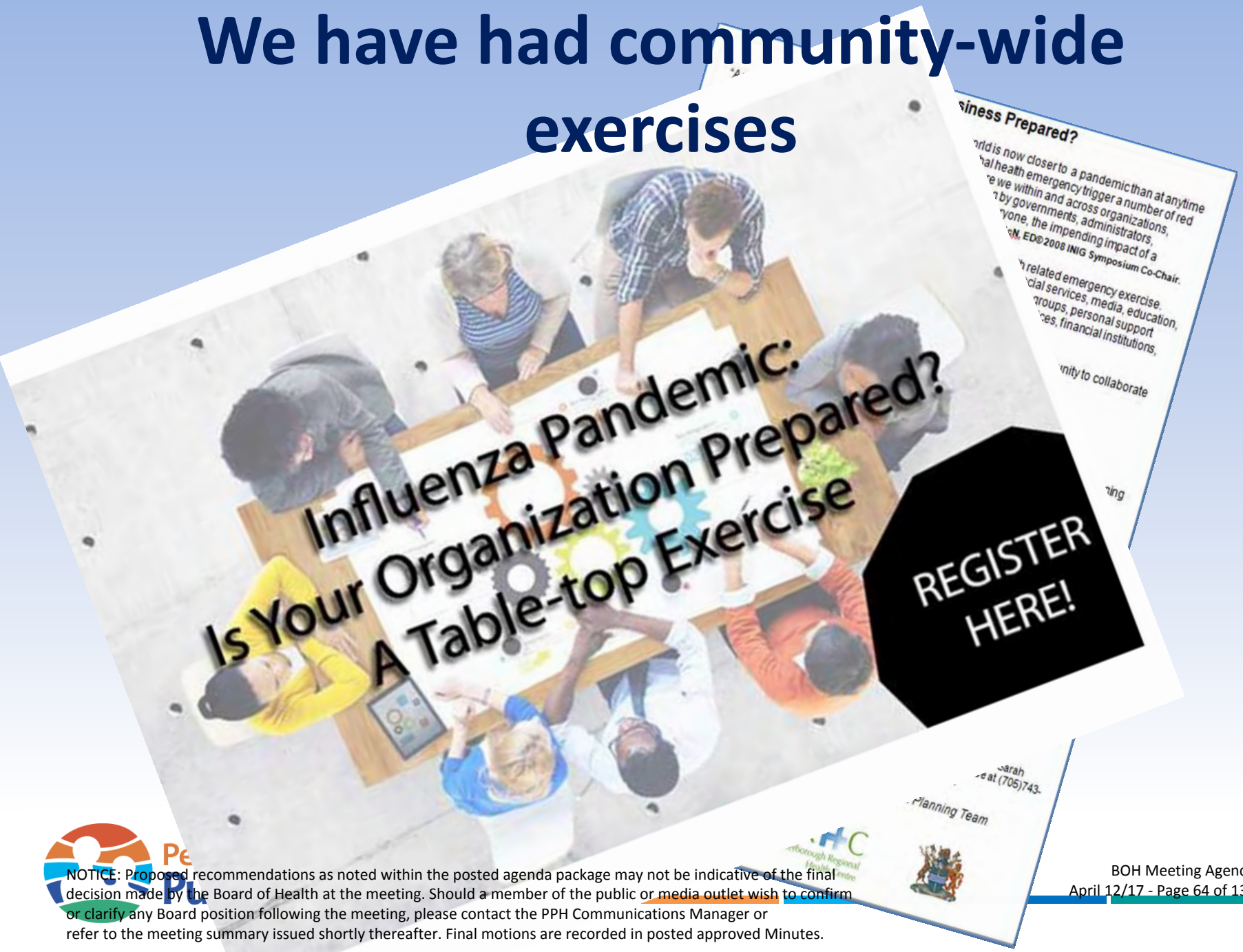
Peterborough Interagency Outbreak Planning Team Objectives:

1. strengthen collaboration
2. encourage development of plans
3. ensure plans are consistent
4. ensure clarity of roles and responsibilities
5. help with testing of local plans

Volunteer Management System



We have had community-wide exercises



How did we do after the 2016 pandemic exercise?

- worth attending
- well run
- informative
- able to use info to improve their plans
- community plan is necessary
- good networking
- identified gaps

Apr 19, 2016 | Vote 0 0

Planning for a Peterborough pandemic

More than 200 community members gather for mock pandemic response exercise

Peterborough This Week
By Lance Anderson

PETERBOROUGH — More than 200 members from various organizations tested their response to a mock influenza pandemic on Tuesday (April 19).

Packed into the Evinrude Centre, the employees practiced how best to protect the community during a large-scale influenza outbreak.

The mock emergency event was orchestrated by the Peterborough City-County Health Unit.

Dr. Rosana Salvaterra, medical officer health, started the session with an overview of what public health agencies learned during the last pandemic when the H1N1 virus started spreading around the world in 2009.

"In Canada, there was considerable variation in the timing and intensity of pandemic waves, especially the first wave, across the country," says Salvaterra. "Greater impact was seen in pregnant women and Aboriginal peoples and persons with morbid obesity were newly recognized as being at high risk for complications."

Pandemic Planning Exercise
Lance Anderson/This Week
Community members gather for a mock pandemic planning exercise at the Evinrude Centre on Tuesday (April 19).Lance Anderson/This Week

2/4

How did our community respond to the 2009 pandemic?

- highly successful undertaking
- high rates of immunization
- vulnerable groups were protected early
- public education and awareness was strong
- community collaboration was very effective
- information from 2009 exercise was helpful
- primary care practitioners able to respond effectively

We have a community

Aware of the Need to Prepare	Recognizes the Need for a Community Wide Response	Participates in Exercises	Willing to invest in Preparedness	Has Organizations with Written Plans	Able to Identify Issues and Mobilize to Respond

Effectively responded to 2009 pandemic

EMERGENCY PREPAREDNESS WEEK

Free Event – Open to the Public

Your Worst Nightmare

What to do when crisis hits... are you prepared?

Tuesday, May 9, 2017

7:00 p.m. - **8:30** p.m.

Evinrude Centre

911 Monaghan Road, Peterborough

Emergency and Pandemic Preparedness Event

Join this interactive presentation that simulates a realistic emergency as it unfolds. Learn how community agencies respond during a crisis. Test your own readiness so you're prepared when the next emergency strikes!

Light refreshments available.

To register, visit **Eventbrite.ca** and search **Your Worst Nightmare** or for more information, call 705-743-1000, ext. 224.

Organized by: **Peterborough Interagency Outbreak Planning Team**

Thank you!

Peterborough Public Health

Staff Report

Feedback on the Modernization of the Public Health Standards (2017)

Date:	April 12, 2017
To:	Board of Health
From:	Dr. Rosana Salvaterra, Medical Officer of Health

Original approved by	
Rosana Salvaterra, M.D.	

Proposed Recommendations

That the Board of Health for Peterborough Public Health:

- receive the staff report, *Feedback on the Modernization of the Public Health Standards (2017)*;
- approve the draft submission, *Modernization of the Public Health Standards (2017) – Feedback from Peterborough Public Health;* and (if applicable),
- direct staff to submit the feedback to Assistant Deputy Minister Roselle Martino, Population and Public Health Division.

Financial Implications and Impact

It is still unclear whether the modernized standards will be revenue-neutral, as intended. The board will be made aware of financial implications and impact as they are identified by staff.

Decision History

On February 17th, 2017, the Standards for Public Health Programs and Services were released as a consultation document by the Population and Public Health Division of the Ministry of Health and Long Term Care (MOHLTC). The content of the revisions to the Ontario Public Health Standards (OPHS) was presented to the board at its March 8th, 2017 meeting. Since then, staff has been engaged in internal consultations to understand the proposed changes and their implications.

Background

Internally, managers have held discussions with their teams and all feedback has been captured in one document for reference. This was reviewed in the preparation of the board's submission. On March 28th, two members of the board and two staff attended a regional consultation held in Oshawa for boards of health in the Central East LHIN and their staff.

The board has an opportunity to provide additional feedback at its April meeting. Pending approval by the board, this document will be provided as feedback to the Population and Public Health Division.

Strategic Direction

The modernization of the standards and the organizational response apply to all four strategic directions of the board's current plan:

- Community-Centred Focus
- Determinants of Health and Health Equity
- Capacity and Infrastructure
- Quality and Performance

Contact:

Dr. Rosana Salvaterra
Medical Officer of Health
(705) 743-1000, ext. 264
agorizzan@peterboroughpublichealth.ca

Attachments:

Attachment A – Modernization of the Public Health Standards (2017) – Feedback from Peterborough Public Health

Modernization of the Public Health Standards (2017)

Feedback from Peterborough Public Health

April 2017

Table of Contents

INTRODUCTION

The board of health for Peterborough Public Health (legal name, Peterborough County-City Health Unit) is encouraged that the scope and mandate for public health has been reviewed in the light of the Ministry's transformation agenda. We see ourselves as critical partners in the overall goal of improving and protecting the health and well-being of our population. The consultation period has been a time rich with thought and conversation for all of our organization. We appreciate this opportunity to provide the Population and Public Health Division with this written feedback. This represents a mere fraction of the discussions to date, with the anticipation that there will be more opportunities to fully appreciate and understand the changes inherent in this newly articulated vision as it becomes a reality. We look forward to making this journey with you.

This document has been organized into three parts: Opportunities, Concerns, and Recommendations for Implementation.

We hope that you will find our comments are helpful.

SECTION 1: OPPORTUNITIES

1.1 Engagement with Indigenous communities

The board is happy to see that **respectful engagement with Indigenous communities** is now acknowledged as a vital part of partnership and collaboration. This was noticeably absent in the preceding Ontario Public Health Standards (OPHS). Peterborough has a long legacy of respectful engagement with Curve Lake First Nation and Hiawatha First Nation, and we support that this expectation has been now made explicit for our peers. Looking to the future, we have prioritized work with Indigenous populations, both on and off reserve, and we are committed to becoming stronger allies in efforts to address health inequities and improve health outcomes. Given the geographic challenges that some of our more northern boards of health face, we hope that there will be a commitment from the Province to provide the financial supports required for this engagement to occur.

1.2 Health equity

The board appreciates that a new Foundational Standard on Equity has been added. The articulation of a clear mandate and expectations for local boards of health will lead to a deeper understanding of priority populations in our communities, both through direct engagement and through an analysis of local data and program outcomes. We believe that more of our staff will need to develop new skills and increase focus on evidence-informed public health interventions to decrease health inequities. This should result in more effective programming, not only at public health but with all of our local partners, including the Central East LHIN (CE-LHIN) and boards of education. We look forward to setting common goals to reduce health inequities, and to an increased awareness among the public, including our elected officials, of the importance of addressing the social determinants of health (SDOH).

At the provincial level, we now have a clear rationale to transform mandates and agendas and mobilize resources and supports to ensure this work evolves and grows. We envision a larger role for Public Health Ontario (PHO) to support the disaggregation of data, community engagement, cultural competency, cultural safety, addressing barriers to accessibility for priority populations). We will benefit from the participation of more provincial agencies in providing centralized data support to better identify and understand the priority populations by various SDOH indicators. We will look for strengthened and coordinated policy support for health equity work across all of the public health units.

Some of the changes that we anticipate include:

- Increased impetus to develop common messages and media campaigns for SDOH and health equity.
- Raising the awareness of the public about local health inequities and their causes with sufficient reach, and then measuring and evaluating that awareness (this will require additional resources).

- Opportunities for various stakeholders at the provincial level to work together and to support stronger local partnerships focused on improving equity (i.e., Ministry of Education, LHINs, municipal organizations, etc.)

Further to comments already made, the expectation for all boards of health to meaningful engage with Indigenous populations will only be possible if boards and staff acquire the cultural competencies to make this work safe and effective for partners. We expect that this too will be work that can be done in collaboration with our LHIN and we have already embarked on this common agenda with our LHIN partner.

1.3 Increased opportunity for local flexibility

The wording of the modernized standards allows for local decisions on priorities for health promotion. The board's experience with the OPHS was a persistent inability to meet all of the requirements in all of the areas where prevention of illness or injury is possible. The new standards will allow us to focus our efforts where they are most needed and most effective. This is a positive change for us.

1.4 Increased expectation for collaboration

Peterborough is a community with strong connections and partnerships. With one regional hospital and one networked family health team operating throughout our public health unit, collaboration across the health care sector, and with our LHIN, will not be a new activity for our staff. We expect the need for provincial communications to assist with messaging this new expectation to partners, although we have already begun to do this ourselves as well.

SECTION 2: CONCERNS

Although we support most of the changes that have been made to the standards, we would like to take this opportunity to highlight five separate concerns where we are hoping reconsideration may lead to minor but critical changes to support our board's efforts in improving local health outcomes.

2.1 The role of public health in reproductive health

Although it makes sense to incorporate many aspects of reproductive health into the new Healthy Growth and Development standard, **improved access and uptake of contraception and the prevention of unintended pregnancies, as a program goal, is not explicitly stated.** It would be our recommendation that this be addressed.

A current program outcome for Healthy Growth and Development states "*Individuals and families have increased knowledge, skills and access to local resources related to healthy growth and development to effectively manage the different life stages and their transitions (e.g., maternal, newborn, child, and youth)"*. Although one might argue that addressing the contraception needs of a population may be implied, we would recommend that, given the ongoing need to protect women's rights in 2017 and beyond, as well as the fact that Ontario continues to experience net migration from countries where women do not enjoy equal status or access, there should be an explicitly stated outcome that requires public health to collaborate with other partners, to ensure that contraception is accessible. For example, the addition of a new program outcome: "*Individuals and families of childbearing age are accessing and using contraception effectively to plan and space their births*" would provide public health with the mandate to work with other partners across the health care system to ensure better access to contraception.

Requirement 2 in the Healthy Growth and Development standard currently mandates boards to implement a program of public health interventions based on a number of inputs. If a program outcome that addresses access and use of contraception can be added, as recommended above, then this requirement could be used to design the interventions that will ultimately lead to this outcome.

2.2 Pregnancy is not an infectious disease

Many would take offence to see contraception and pregnancy counselling included in a public health program that addresses infection. It would be our recommendation that these required activities be moved from Infectious and Communicable Diseases Prevention and Control, over to the new Growth and Development standard, where the contraception awareness outcome currently appears and where work to improve access is currently not explicitly stated but implied.

2.3 The right to confidential testing and treatment of STIs is not protected

Ontario provides a legislated foundation for the protection of patient confidentiality but existing legislation does not address the additional confidentiality needs and privacy concerns of persons who are at risk of contracting and transmitting a sexually transmitted infection (STI). Given the sensitive nature of how these infections are acquired, sometimes an individual may not approach his or her own health care provider for testing. They may not feel safe accessing testing or treatment in their own small community, where providers or persons employed in labs are known to them. They may not wish to have other providers engaged in their circle of care automatically attain access to any testing results. They may not wish to have testing performed in a nominal or even non-nominal way – anonymous testing may be the only acceptable procedure.

A quick review of the English literature published between 2010 and 2017 reveals at least four relevant citations that attest to the importance of confidentiality for persons infected with HIV. This may be heightened in persons living in rural areas and in youth. As one article aptly stated, "consent and confidentiality underpin good practice" (Galvin, J 2014).

Currently in Ontario, residents can expect reasonable access to confidential STI testing. A website (https://www.ontario.ca/page/sexual-health-clinics#section-1, accessed on March 29, 2017) provides the viewer with both a quick link to a "Sexual Health Clinic" near them, as well as the following statement: "Service is free and confidential. A health card is not required."

The new programs and standards as written threaten this access as the provision of confidentiality is not explicitly required in the standards.

The Infectious and Communicable Diseases Prevention and Control standard includes language in the program outcomes that includes *"timely and effective detection", "effective case management", "priority populations have access …"* and *"reduced transmission"*. In addition, Requirement 13 states *"The board of health shall collaborate with health care providers and other relevant partners to ensure access to, or provide, based on local assessment, clinical services for priority populations to promote and support healthy sexual practices, contraception, pregnancy counselling, and the prevention and/or management of sexually transmitted infections and blood-borne infections"*.

The words "confidential and free" do not appear – and both those concepts, the principle that the service should be provided in a confidential manner, and the principle that services will be provided to individuals without health cards, are not explicitly stated. This is a serious concern to our board of health as we believe them to be pillars of effective STI prevention and control.

Our recommendation to the Population and Public Health Division is that our provincial and local mandates explicitly articulate the commitment to vigorously protect confidential and free access to STI diagnosis and treatment as both a program outcome and a board of health requirement. Otherwise, it will be in danger of being eroded or overlooked as boards of health seek to collaborate across the sector with other providers.

2.4 Rationale and evidence for vision screening in schools is lacking

We would like to understand the rationale for including a new requirement for boards of health to *"provide, in collaboration with community partners, visual health supports and vision screening"* in schools. Without additional information, we are unable to form an opinion, or even anticipate what this new requirement will mean for us in Peterborough. We did not find that this issue was satisfactorily addressed in our regional consultation and we respectfully request further information and disclosure.

2.5 Lack of emphasis on healthy public policy

Of particular concern to our board is the absence of healthy public policy work in the outcome statements and requirement descriptions. Although the Healthy Communities Domain of the Policy Framework does include an increase in both "*policies and practices that create safe, supportive and healthy environments*" in its objective, the majority of program outcomes highlight changes in awareness, attitudes and beliefs and not in the partnership and policy development outcomes that will be needed to support the overlying goal of improving and protecting the health and well-being of our populations. Although policy is captured as a requirement under the new Health Equity Standard, there are other areas, unrelated to health equity, were policy work is vital. We would like to see the need to develop policy strengthened in the final version of the standards.

SECTION 3: RECOMMENDATIONS REGARDING IMPLEMENTATION

3.1 The importance of articulating the provincial perspective as well

The modernized standards and associated requirements indicate the role of boards of health in delivering public health programs and services but they would be strengthened by the articulation of the provincial role in ensuring outcomes are met. This is particularly important now that the modernized standards are allowing for greater flexibility in the determination of local priorities. With local public health agencies expected to use criteria like their local epidemiology of diseases and health problems, their unique partnerships, and their local needs, it becomes more incumbent on the public health system to define what will be done regionally and provincially. Provincial communication strategies, health education and promotion campaigns, programs of public health interventions that will support and supplement the work done in local communities will be required in order to have a complete picture of the work that lies ahead.

There is a clear effort to integrate public health into the broader health system, which has value, but how do we ensure the public health system across the province is integrated? We appreciate that you have been consulting with us on what training or other supports we will require in order to comply with the changes in our mandate. An important part of that will be a clear articulation of what boards can expect from the Division, the Ministry of Health and Long-Term Care, other Ministries, and PHO. With no enhancement of funding for local public health, gains in achieving program goals and outcomes will be achieved by: increasing ability to direct activities/resources where they will have the greatest impact; decreasing inefficiencies (duplication of effort where it is not warranted); and enhancing capacity (through increased efforts towards public health goals by other sectors/partners). However, this will only be accomplished if we have foundational support from the province to ensure that by focusing our limited capacity, we are not creating holes and gaps that will lead to unintended consequences.

3.2 Ensure adequate support to achieve the desired transition

Whether that is provincially supported training on planning and evaluation, effective use of provincial funds for provincial resource centres, or support for regional and discipline (or practice-based networks) for better information sharing and coordination of efforts, our organization will require provincial investments in order to ensure successful transition to new expectations and requirements from the province. We appreciate the opportunity that has been given to us at regional consultations to provide you with some early indications of what supports are anticipated to be needed. We expect that these preliminary thoughts and suggestions will need to be revisited and enhanced as we progress through this period of transition.

3.3 Acknowledgement of the capacity issue

Although the modernization has been assumed to be a "no net increase" set of standards, because it is unclear what can be safely reduced or eliminated and what the potential demand of new areas of work will require (especially population health assessment), it is impossible to know for certain if this will be the case. There is still a significant portion of our new mandate that is ambiguous and will only emerge as terms are defined, new protocols, guidance documents and resources are developed – and it is bound to have a significant impact on capacity, potential gaps and intended areas of focus. There are a number of examples of new work or populations in the new standards (e.g., emerging adults, mental health promotion). From the information available, it would appear that the increased demands will outweigh any reductions. It should also be acknowledged that the impact of these changes will vary with each board of health, with particular concern for smaller boards that have limited central support systems. This is also coming at a time when the vast majority (at least 28 out of 36) boards of health are facing layoffs due to 0% increase in funding for the past 3 years (a 0% increase is a effectively a budget cut). We are very concerned that once the dust has settled, the net result of this modernization may be a loss of public health provision in those programs with less prescriptive requirements. How can this be prevented? If we are to turn to our LHIN-funded partners and the LHIN itself, for collaboration and potentially even some sharing of resources, how might that happen? What tools will the Population and Public Health Division utilize to ensure that local public health will be able to access resources currently located in other parts of the health care system?

3.4 Program outcomes require more attention

Concerns persist with regard to whether proposed program outcomes fall within board of health scope and whether they are the right outcomes to achieve. Since the outcomes will lead to the accountability measures, the outcomes will influence largely what activities get done (i.e., what gets measured gets done) and we are not convinced that the right work has been identified. For example, many of the outcomes are focused on awareness and education and not on actual environmental or behavioural change. Outcomes should **not** be selected based on what is easy to measure or is currently available. If there are better outcomes without currently available data, systems should be developed to find ways to measure consistently over time and across regions. As part of the preparation for implementation, it would be our request that program outcomes be validated with the field and where appropriate, changes be made. Once a new set of accountability indicators have been identified for these standards, we will require systems in place to collect. Many of these should be collected provincially, with disaggregation to the public health unit level.

To: **All Members**
Board of Health

From: **Dr. Rosana Salvaterra, Medical Officer of Health**

Subject: **Correspondence for Direction – Tobacco Endgame Approach, Simcoe Muskoka District Health Unit**

Date: **April 12, 2017**

Proposed Recommendation:

That the Board of Health for Peterborough Public Health:

- *receive for information, letters dated March 15, 2017 from Scott Warnock, Chair, Board of Health for Simcoe Muskoka District Health Unit to Ministers Philpott and Hoskins, copied to Ontario Boards of Health, regarding a tobacco endgame approach; and,*
- *endorse their motion and communicate this support to Minister Philpott and Minister Hoskins, with copies local MPs, local MPPs, Dr. Theresa Tam, Interim Chief Public Health Officer, Dr. David Williams, Chief Medical Officer of Health, Roselle Martino, Assistant Deputy Minister, Population and Public Health (MOHLTC), the Association of Local Public Health Agencies, and Ontario Boards of Health; and,*
- *forward the report, A Tobacco Endgame for Canada, to local municipalities, with a copy to the Association of Municipalities of Ontario, highlighting strategies that are relevant (e.g., zoning by-laws to limit supply).*

Background:

In March, the board chair for the SMDHU wrote to the provincial and federal Ministers of Health, expressing support for the federal tobacco strategy that aims at reducing the prevalence of tobacco use in Canada to 5% by the year 2035. The board has shared copies of these letters, as well as a copy of A Tobacco Endgame for Canada, which is a report from a summit that took place in 2016.

The SMDHU board commended the federal government for setting the target of 5% by 2035. It also recommended that the federal government consider adding actions from the Tobacco Endgame report. The board made similar recommendations to the provincial government, asking that any new provincial strategy align with the federal plans.

It is recommended that Peterborough's board of health familiarize itself with the content of the forwarded summit report and also send letters of support and recommendation to both federal and provincial Ministers of Health.

Attachments:

- SMDHU Letters to Ministers Philpott and Hoskins
- SMDHU Briefing Note ***(included to provide a summary of the full report below)***
- A Tobacco Endgame for Canada ***(web hyperlink)***

simcoe muskoka
DISTRICT HEALTH UNIT

Sent by Email at: Jane.Philpott@parl.gc.ca

March 15, 2017

Dr. Jane Philpott
Minister of Health
Government of Canada
House of Commons
Ottawa, Ontario
K1A 0A6

Dear Minister Philpott,

On March 15th the Board of Health for the Simcoe Muskoka District Health Unit passed the following motion:

> THAT the Board of Health write to the federal Minister of Health supporting the federal government's proposal to commit to a target of less than 5% tobacco use by 2035;
>
> AND FURTHER THAT the Board of Health recommend that the federal government's approaches include those identified at the 2016 summit, A Tobacco Endgame for Canada;
>
> AND FURTHER THAT the Board of Health write to the Ontario Minister of Health to recommend that the Smoke Free Ontario Strategy be aligned with the proposed tobacco endgame in Canada.

This motion is in recognition of the fact that despite a substantial reduction of tobacco use in the Canadian population in recent decades, smoking remains the most important cause of death. It is also in recognition that without fundamentally new approaches to tobacco control there will be an inadequate continued reduction in use, and an increase in tobacco-related mortality in the decades to come. Background on this motion, including a definition of the endgame concept can be found in the attached briefing note.

The federal government is to be commended for its stated commitment to the renewal of its Federal Tobacco Control Strategy, and to this end for its consultation paper, Seizing the Opportunity: the Future of Tobacco Control in Canada proposing a target of less than 5% tobacco use by 2035. This is a commendable goal, in keeping with a tobacco endgame approach. The federal consultation paper also proposes six key elements that would help to

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❑ **Cookstown:** 2-25 King Street S, Cookstown, ON, L0L 1L0, 705-458-1103, FAX: 705-458-0105
❑ **Gravenhurst:** 2-5 Pineridge Gate, Gravenhurst, ON, P1P 1Z3, 705-684-9090, FAX: 705-684-9887
❑ **Huntsville:** 34 Chaffey St, Huntsville, ON, P1H 1K1, 705-789-8813, FAX: 705-789-7245
❑ **Midland:** B-865 Hugel Ave, Midland, ON, L4R 1X8, 705-526-9324, FAX: 705-526-1513
❑ **Orillia:** 120-169 Front St. S, Orillia, ON, L3V 4S8, 705-325-9565, FAX: 705-325-2091

address population health inequities and to support tobacco control in priority populations, such as indigenous populations, tobacco users and youth. It also speaks to the importance of capacity building in the pursuit of enhanced tobacco control.

This is commendable content, however the Board of Health supports a further strengthening of the Federal Tobacco Control Strategy with the inclusion of the approaches within the 2016 summit paper, A Tobacco Endgame for Canada (attached).

The tobacco endgame approach proposed in this document includes some of the concepts within the federal consultation paper; however its content goes beyond this, and includes a number of recommendations that are either very well supported by research or are promising new possibilities for action. These include the strong endorsement for increased tobacco taxation (and other price-enhancing strategies) as the most important means of smoking reduction, very well supported by research, with data provided in the endgame report on both the anticipated impact on tobacco use and on government revenues. Others include increasing restrictions on marketing, including instituting plain packaging (which the federal government has already proposed) and implementing a 18A classification (adult accompaniment) for movies that depict smoking.

Both the federal consultation paper and the endgame document speak to the importance of enhancing smoking cessation. The endgame document provides a range actions that are consistent with this goal and would augment those provided within the federal consultation paper. It also proposes strategies to reduce the production, supply and distribution of tobacco, including possible new structures to these ends.

Both documents speak of holding the tobacco industry accountable for its impact on health. The endgame strategies include the importance of litigation and the resulting substantial financial impact on the industry. In addition it should be noted that the release of internal industry documentation would serve to enhance surveillance on tobacco industry strategies and actions.

The endgame paper also cites the importance of new funding streams for tobacco control, and also proposes the creation of an endgame steering committee or “cabinet”. These recommendations would serve as important enhancements to building capacity, in keeping with one of the key elements in the federal consultation paper. In order to develop and maintain a sustained and successful tobacco endgame strategy over time, a clear model of leadership and accountability will be required.

In order to achieve a tobacco endgame, the tobacco control strategies of the provinces would need to align with the Federal Tobacco Control Strategy. To this end the Federal Tobacco Control Strategy should specifically site such provincial alignment, and the policy instruments to achieve this. Consistent with this, attached you will find my letter on behalf of the Board of

Health to Ontario Minister of Health Dr. Eric Hoskins recommending that the Smoke Free Ontario Strategy be aligned with the proposed tobacco endgame in Canada.

The federal government is to be commended for considering a bold but very necessary goal of less than 5% tobacco use by 2035. The Board of Health is entirely in support of this goal, and recommends the inclusion of the endgame strategies that will be necessary to achieve it for the health of Canadians.

Sincerely,

ORIGINAL SIGNED BY

Scott Warnock,
Chair, Board of Health

Att. (3) Briefing Note and attachments
A Tobacco Endgame for Canada 2016 Summit Paper
Letter to Minister Dr. Eric Hoskins

c. Ontario Minister of Health
Chief Public Health Officer of Canada
Chief Medical Officer of Health of Ontario
Association of Local Public Health Agencies
Ontario Public Health Association
Ontario Boards of Health
Simcoe Muskoka local Members of Parliament
Local Members of Provincial Parliament
North Simcoe and Centre Health Integration Networks
Association of Municipalities of Ontario
Simcoe Muskoka Municipalities

simcoe muskoka
DISTRICT HEALTH UNIT

Sent by Email at: ehoskins.mpp@liberal.ola.org

March 15, 2017

Dr. Eric Hoskins
Minister of Health
Government of Ontario
Hepburn Block, 10th Flr.
80 Grosvenor St.
Toronto ON M7A 2C4

Dear Minister Hoskins:

On March 15th the Board of Health for the Simcoe Muskoka District Health Unit passed the following motion:

> THAT the Board of Health write to the federal Minister of Health supporting the federal government's proposal to commit to a target of less than 5% tobacco use by 2035;
>
> AND FURTHER THAT the Board of Health recommend that the federal government's approaches include those identified at the 2016 summit, A Tobacco Endgame for Canada;
>
> AND FURTHER THAT the Board of Health write to the Ontario Minister of Health to recommend that the Smoke Free Ontario Strategy be aligned with the proposed tobacco endgame in Canada.

This motion is in part in recognition of the fact that despite a substantial reduction of tobacco use in the Ontario population with the successes of the Smoke Free Ontario Strategy, smoking remains the most important cause of death. It is also in recognition that without fundamentally new approaches to tobacco control there will be an inadequate continued reduction in use, and an increase in tobacco-related mortality in the decades to come. Background on this motion, including a definition of the endgame concept can be found in the attached briefing note.

In the attached letter to federal Minister of Health Dr. Jane Philpott, I have communicated the Board of Health's commendation of the federal government for its stated commitment to the renewal of its Federal Tobacco Control Strategy, and to this end for its consultation paper, Seizing the Opportunity: the Future of Tobacco Control in Canada (attached) proposing a target of less than 5% tobacco use by 2035. This is a commendable goal, in keeping with a tobacco

endgame approach. My letter to Minister Philpott also cites the Board of Health's support for a further strengthening of the Federal Tobacco Control Strategy with the inclusion of the approaches within the 2016 summit paper, A Tobacco Endgame for Canada (attached), and provides examples of the benefits of this.

The tobacco endgame approach proposed in this document includes some of the concepts within the federal consultation paper; however its content goes beyond this, and includes a number of recommendations that are either very well supported by research or are promising new possibilities for action.

Building capacity is one of the key elements in the federal consultation paper. Continued financial support for tobacco resource centres such as the Ontario Tobacco Research Unit and the Smoking and Health Action Foundation is crucial as their work has been essential over the decades, and will be needed to help inform and guide in a tobacco control endgame in Ontario.

In order to achieve a tobacco endgame, the tobacco control strategies of the provinces would need to align with the Federal Tobacco Control Strategy. Given that the Smoke Free Ontario Strategy is presently under review, its alignment with a tobacco endgame approach presently emerging within the Federal Tobacco Control Strategy would be very timely. Such an approach would be consistent with the provincial government's stated commitment to achieve the lowest smoking rate in the country.

The federal government is to be commended for considering a bold but very necessary goal of less than 5% tobacco use by 2035. The Board of Health is entirely in support of this goal, and recommends the inclusion of the endgame strategies necessary to achieve it. Consistent with this, the Board of Health also recommends that the Smoke Free Ontario Strategy be aligned with the proposed tobacco endgame to achieve better health for Ontarians.

Sincerely,

ORIGINAL SIGNED BY

Scott Warnock,
Chair, Board of Health

Att. (4) Briefing Note and attachments
Seizing the Opportunity: the Future of Tobacco Control in Canada Paper
A Tobacco Endgame for Canada 2016 Summit Paper
Letter to Minister Dr. Jane Philpott

c. Minister of Health of Canada
Chief Public Health Officer of Canada
Chief Medical Officer of Health of Ontario

Association of Local Public Health Agencies
Ontario Public Health Association
Ontario Boards of Health
Simcoe Muskoka local Members of Parliament
Local Members of Provincial Parliament
North Simcoe and Centre Health Integration Networks
Association of Municipalities of Ontario
Simcoe Muskoka Municipalities

Tobacco Endgame

Update: New **Date: March 15, 2017**

Issue

The health and financial burdens of tobacco-related disease in Canada remain unacceptably high, and will continue to increase, even if all MPOWER measures of the Framework Convention on Tobacco Control are implemented. At a recent summit in 2016, a wide array of experts identified key new recommendations to implement toward a tobacco endgame in Canada.

Recommendations

THAT the Board of Health receive this briefing note for information;

AND FURTHER THAT the Board of Health write to the federal Minister of Health supporting the federal government's proposal to commit to a target of less than 5% tobacco use by 2035;

AND FURTHER THAT the Board of Health recommend that the federal government's approaches include those identified at the 2016 summit, A Tobacco Endgame for Canada;

AND FURTHER THAT the Board of Health write to the Ontario Minister of Health to recommend that the Smoke Free Ontario Strategy be aligned with the proposed tobacco endgame in Canada;

AND FURTHER THAT copies be sent to the Chief Public Health Officer of Canada, the Chief Medical Officer of Health of Ontario, the Association of Local Public Health Agencies, the Ontario Public Health Association, all Ontario Boards of Health, and within Simcoe Muskoka the local Members of Parliament, the local Members of Provincial Parliament and the Local Health Integration Networks;

AND FURTHER THAT the Board of Health sponsor the accompanying resolution in Appendix A at the 2017 Annual General Meeting of the Association of Local Public Health Agencies.

Current Facts

Smoking is still a big problem

- A very high number of Canadians are still addicted to tobacco smoking. In 2014, 18.1%, or 5.4 million Canadians aged 12 years and over were smokers[1].
- As a risk factor, smoking is responsible for the most death and disability in Canada[2]. In 2002, 17% of deaths in Canada were due to smoking[3].
- The direct and indirect financial costs of tobacco smoking was estimated to be $18.7 billion in Canada in 2013[4].

The status quo is not enough

- Under the status quo, and even if all the existing technical and policy-based "MPOWER" measures in the World Health Organization's Framework Convention on Tobacco Control were implemented, the health and financial burden of tobacco will continue to grow. For example, smoking-related deaths in Ontario would continue to increase beyond 2030, while smoking rates would fall by less than half over the same time period[5].

Canada is ready for a tobacco endgame

- The concept of a "tobacco endgame" has gained public health support globally[6] and within Canada[5]. The endgame envisions a future that is free of commercial tobacco; it is a strategic process in which measures are implemented that gradually decrease smoking prevalence, demand and supply to extremely low levels. Importantly, it is distinct from an outright ban on tobacco products while demand remains high[5].
- A tobacco endgame defines a desired target for the rate of smoking prevalence and a date by which it is to be met. In 2015, experts convened to form a Steering Committee for Canada's Tobacco Endgame, and the committee subsequently defined an endgame goal of less than 5% tobacco prevalence by 2035 ("less than 5 by 35")[5].
- In 2016, Queen's University hosted a summit on A Tobacco Endgame for Canada (report provided in Appendix B). This process collated the work of experts from broad sectors, including cancer control, health policy, law, tobacco control, academia, medicine, economics, social activism, non-governmental organizations, mental health and addiction, and professional organizations. Importantly, the summit background paper synthesizes recommendations for potential endgame measures in the Canadian context[5].
- The Federal Tobacco Control Strategy is scheduled for renewal at the end of March, 2017[5,7]. This represents a unique opportunity to bring forward a tobacco endgame initiative. To this end, on February 22, 2017 the Federal Government posted a consultation paper entitled Seizing the Opportunity: the Future of Tobacco Control in Canada. This paper proposes a number of endgame strategies (without using this term), including being "committed to a target of less than 5% tobacco use by 2035". Public response to this document is being sought by April 13th, 2017. This paper can be accessed at the following linked location.

Background

The **World Health Organization Framework Convention on Tobacco Control** is a legally binding international health treaty on tobacco control, which 180 countries have ratified, including Canada[8]. To support the country-level implementation of effective tobacco demand reduction policies, the World Health Organization developed an "MPOWER" package of technical measures and resources. The six components of the **"MPOWER" measures** are as follows: **m**onitor tobacco use and prevention policies; **p**rotect people from tobacco smoke; **o**ffer help to quit tobacco use; **w**arn about the dangers of tobacco; **e**nforce bans on tobacco advertising, promotion and sponsorship; and **r**aise taxes on tobacco[9].

The **Federal Tobacco Control Strategy** is a horizontal initiative with a governance structure that spans multiple federal partner organizations, including Health Canada (lead department), Public Health Agency of Canada, Public Safety Canada, Royal Canadian Mounted Police, Canada Border Services Agency, Canada Revenue Agency, and Public Prosecutions Canada. It was initiated in 2001 and renewed for five years in 2012, with an end date on March 31, 2017. The objective of the strategy is to reduce the use of tobacco and tobacco-related death and disease in Canada. The renewed strategy has focused on prioritizing populations with higher smoking rates, and monitoring and assessing the illicit and licit tobacco markets[7].

The background paper**,** A Tobacco Endgame for Canada, is provided in Appendix B. The paper offers a broad suite of innovative measures which could be implemented as part of Canada's tobacco endgame. These strategies are not only novel, and potentially radical, but they are supported by evidence[10]. For example, mandating plain and standardized packaging of cigarettes is an evolutionary intervention that eliminates product promotion[10]. Restructuring the tobacco retail environment and reducing tobacco outlet density may curtail youth smoking; this can be achieved by establishing tobacco retail-free zones around youth facilities or further restricting the types of outlets that can sell tobacco[10].

The expert recommendations from A Tobacco Endgame for Canada are grouped by key approaches:

- dispel myths regarding the economics of an endgame, especially the implications of raising tobacco taxes;
- scale up successful interventions (such as tobacco taxation);
- establish road maps and accountability frameworks in tobacco cessation;
- align supply-side tobacco measures with public health goals;
- further regulate tobacco products to reduce their addictiveness and attractiveness;
- approach vaporized nicotine products (e.g. electronic cigarettes) with the dual aims of promoting cessation in smokers while discouraging use by non-smokers;
- use age-based measures to prevent a new generation of smokers; and
- maximize the health benefits of tobacco litigation[5].

Contacts

Jennifer Loo, Public Health and Preventive Medicine Resident, University of Toronto
Lee Zinkan-McKee, Manager Tobacco Free Living Ext. 7483
Martin Kuhn, Supervisor Tobacco Free Living Ext. 7248
Steve Rebellato, Director Environmental Health Ext. 7487
Charles Gardner, Medical Officer of Health and CEO Ext. 7219

References

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DRAFT RESOLUTION FOR alPHa RESOLUTIONS SESSION (YEAR: 2017)

TITLE: **Committing to a Tobacco Endgame in Canada**

SPONSOR: **Simcoe Muskoka District Health Unit**

WHEREAS tobacco use remains the leading cause of preventable death and disease in Canada; and

WHEREAS the direct and indirect financial costs of tobacco smoking are substantial and were estimated as $18.7 billion in 2013; and

WHEREAS 18.1% of adolescents and adults, or 5.4 million Canadians, were still smokers in 2014; and

WHEREAS under the status quo, and even with the implementation of all MPOWER measures under the World Health Organization Framework Convention on Tobacco Control, Ontario research has estimated that smoking-related deaths will continue to increase beyond 2030, while smoking rates will decline by less than half in the same period; and

WHEREAS a tobacco endgame shifts the focus from tobacco "control" to envision a future that is free from commercial tobacco, and is a strategic process to implement measures that gradually decrease smoking prevalence, demand and supply to extremely low levels; and

WHEREAS there is growing support in Canada and globally for a tobacco endgame, with the adoption of Endgame targets by Ireland, Scotland, Finland, and New Zealand; and

WHEREAS a Steering Committee for Canada's Tobacco Endgame was convened in 2015 and identified an endgame goal of less than 5% tobacco prevalence by 2035; and

WHEREAS a summit on A Tobacco Endgame for Canada in 2016 brought together experts from broad sectors and published a Background Paper with evidence-based and innovative recommendations for tobacco endgame measures in Canada; and

WHEREAS the Federal Tobacco Control Strategy is scheduled for renewal after March 31, 2017;

WHEREAS the federal government's consultation paper Seizing the Opportunity: the Future of Tobacco Control in Canada proposed a number of endgame strategies including being committed to a target of less than 5% tobacco use by 2035;

WHEREAS the provincial Smoke Free Ontario Strategy is also presently under review; and

WHEREAS it is the position of alPHa that Governments of Canada, Ontario and Canadian municipalities must act immediately to minimize the use of tobacco products and their related health impacts;

NOW THEREFORE BE IT RESOLVED that the Association of Local Public Health Agencies write to the federal Minister of Health supporting the federal government's proposal to commit to a target of less than 5% tobacco use by 2035;

AND FURTHER THAT the Association of Local Public Health Agencies recommend that the federal government's approaches include those identified at the 2016 summit, A Tobacco Endgame for Canada;

AND FURTHER THAT the Association of Local Public Health Agencies write to the Ontario Minister of Health to recommend that the Smoke Free Ontario Strategy be aligned with the proposed tobacco endgame in Canada;

AND FURTHER THAT copies be sent to the Chief Public Health Officer of Canada, and the Chief Medical Officer of Health of Ontario.

To: **All Members**
Board of Health

From: **Dr. Rosana Salvaterra, Medical Officer of Health**

Subject: **Correspondence for Direction –Stop Marketing to Kids Coalition's Ottawa Principles and Sugary Drinks, Middlesex-London Health Unit**

Date: **April 12, 2017**

Proposed Recommendation:

That the Board of Health for Peterborough Public Health:

- *receive for information, the letter dated March 28, 2017 from Jesse Helmer, Chair, Middlesex-London Board of Health to Ontario Boards of Health, regarding support for Stop Marketing to Kids Coalition's Ottawa Principles and further action on sugary drinks; and,*
- *endorse their letter and communicate this support to Minister Philpott, with copies local MPs, Dr. Theresa Tam, Interim Chief Public Health Officer, the Association of Local Public Health Agencies, and Ontario Boards of Health.*

Background:

The Board of Health should consider advocating to the Hon. Jane Philpott, Minister of Health, urging that The Ottawa Principles be incorporated into Health Canada's Healthy Eating Strategy and specifically in work related to restricting marketing to children that is currently under development. The Board should also advocate that restrictions on commercial marketing to children should not apply to advertisement or promotion by a public health authority or person acting in collaboration with a public health authority for educational purposes.

Considerations include the following:

- Health Canada's Healthy Eating Strategy (October 2016) is currently in the process of being developed, and both public and professional consultation has been initiated and will be occurring in the near future. So far, Health Canada communication has indicated that restrictions will focus on the marketing of unhealthy food and beverages only.
- The Ottawa Principles and Bill S-228 restrict all marketing to children (including healthier choices). Restricting marketing of all food and beverages addresses industry use of loopholes for the purpose of profit generation. Both of these documents make exceptions for public health activities.
- Restrictions on commercial marketing of all foods and beverages impact commercial activities that promote local food and healthy eating. For example, promotion of local apples at a family festival, or at point of purchase in a grocery store could be classified as marketing to children. Restriction of marketing of all foods and beverages will impact

activities such as vegetable and fruit promotion by the Canada Produce Marketing Association.

- The Ottawa Principles are more comprehensive than Bill S-228, and include important components such as restrictions on cross-border media marketing and in child-focused settings. The Ottawa Principles also encompass a wider age range (0-16) than Bill S-228 (0-13).
- Organizations such as alPHa, Dietitians of Canada and the Ontario Society of Nutrition Professionals in Public Health have endorsed the Ottawa Principles. The Middlesex London Board of Health, Toronto Public Health and the Windsor-Essex County Health Unit are listed as having endorsed The Ottawa Principles.
- Presently, staff are working with multiple sectors to improve eating environments and reduce the impact of marketing to children. Work being done with recreation settings is similar to that outlined in the London-Middlesex report.

Attachments:

- MLHU Letter to Minister Philpott

BUREAU DE SANTÉ DE MIDDLESEX-LONDON HEALTH UNIT

Tuesday March 28, 2017

RE: Support for Stop Marketing to Kids Coalition's Ottawa Principles and Further Action on Sugary Drinks

Dear Ontario Boards of Health,

Sugar consumption has progressively become a major public health concern. Excessive intake of sugar has been linked to obesity, type 2 diabetes, cardiovascular disease, dental caries, metabolic syndrome and a lower intake of nutrient-dense beverages. Two priority areas for reducing sugar consumption and supporting healthy eating behaviours among children, youth and families, include restricting food and beverage marketing to children and improving the food environment in municipal and family-focused centres.

At its February 16th, 2017 meeting, the Middlesex-London Board of Health received Report No. 006-17, "***City of London Beverage Vending Review and Opportunity for Further Action on Sugary Drinks"***, where it was recommended that the Board of Health:

- Direct staff to complete the online endorsement of the Stop Marketing to Kids Coalition's (Stop M2K) Ottawa Principles to communicate its support to restrict food and beverage marketing to children and youth 16 years of age and younger; and,
- Communicate support for STOP M2K's Ottawa Principles by sending Report No. 006-17 re: City of London Beverage Vending Review and Opportunity for Further Action on Sugary Drinks, and its appendices to other Boards of Health in Ontario.

There is greater understanding today about how commercial food and beverage marketing negatively impacts the development of healthy habits, particularly for children and youth. According to the World Health Organization 2016 report, ***Report of the Commission to End Childhood Obesity*****,** "the evidence base shows that unhealthy food marketing is an important and independent causal factor in the childhood obesity epidemic". Children and youth are targeted by companies and highly exposed to the marketing of less healthy food and beverage through many channels including online, on television and through social media. Stop M2K's Ottawa Principles outline definitions, scope and principles to guide policy-making in Canada to help protect children and youth from the influence of commercial food and beverage marketing.

Restricting marketing to children and youth is one part of a comprehensive strategy to improve children's nutrition and long-term health outcomes. Changes to the food environment are also needed. Public health units are in a unique position to work with their local municipalities to implement healthy changes within the local food environment, as well as to communicate support for restricting food and beverage marketing to children at a federal level by endorsing Stop M2K's Ottawa Principles.

Sincerely,

Jesse Helmer, Chair
Middlesex-London Board of Health

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MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 006-17

TO: Chair and Members of the Board of Health

FROM: Dr. Gayane Hovhannisyan, Acting Medical Officer of Health
Laura Di Cesare, Acting Chief Executive Officer

DATE: 2017 February 16

CITY OF LONDON BEVERAGE VENDING REVIEW AND OPPORTUNITY FOR FURTHER ACTION ON SUGARY DRINKS

Recommendation

It is recommended that the Board of Health:

1. ***Receive Report No. 006-17 re: City of London Beverage Vending Review and Opportunity for Further Action on Sugary Drinks;***
2. ***Support the receipt of $15,000 from the Healthy Kids Community Challenge fund from the City of London's Child and Youth Network to implement a community education campaign on the health risks associated with sugary drinks and the benefits of water;***
3. ***Direct staff to complete the online endorsement of the Stop Marketing to Kids Coalition's (Stop M2K) Ottawa Principles to communicate its support to restrict food and beverage marketing to children and youth 16 years of age and younger; and***
4. ***Communicate support for STOP M2K's Ottawa Principles by sending Report No. 006-17 re: City of London Beverage Vending Review and Opportunity for Further Action on Sugary Drinks, and its appendices to other Boards of Health in Ontario.***

Key Points

- Sugary drinks are the single-largest source of sugar in our diets.
- Public education about the health risks associated with sugary drinks is required, as are policies at the municipal, provincial and federal levels that help to restrict access to unhealthy choices.
- A comprehensive strategy that includes federal legislation to restrict commercial food and beverage marketing to children and youth 16 years and under is necessary.

Update on the City of London Beverage Vending Review

In September 2016, staff from both the City of London and the Health Unit began working together to: assess current beverage vending machine offerings; conduct a survey to seek input from facility users and City of London residents on what changes could be made to the beverage vending machine environment in city-run facilities; review the literature and conduct an environmental scan to inform proposed changes; and propose five policy options for consideration. The survey methodology, research findings and policy options can be found in the Health Unit's report (Appendix A).

The Health Unit's recommendation to remove beverage vending machines was not adopted by the City of London; however, the Health Unit remains committed to working with city staff to determine how best to improve vending machine offerings. The Health Unit's survey results and the community dialogue around sugary drinks have highlighted the need for greater public awareness regarding the public health concerns associated with consumption and marketing of sugary drinks. The Health Unit has the opportunity to receive $15,000 from the Healthy Kids Community Challenge fund, from the City of London's Child and Youth Network, to implement a public education campaign to reinforce the fact that sugary drinks should only be consumed sparingly and that water is the best choice for hydration and health. The Health Unit will also

continue to work closely with Middlesex County's Healthy Kids Community Challenge partners to improve the food and beverage environments in community centres, schools and childcare settings.

Reducing the Availability of Sugary Drinks

Municipal and family-focused centres are priority settings for supporting healthy eating behaviours among children, youth and families. The removal of beverage vending machines makes the healthy choice (plain tap water) the easy choice, and reduces consumer confusion around sugary drinks, which are marketed by the beverage industry as "healthier" ("health-washed"), because such drinks would no longer be available for sale. From a health perspective, sports drinks, vitamin waters and juices also contribute to the negative health effects of too much sugar in the diet. Appendix B provides considerations for consumers when selecting drinks often found for sale in vending machines.

Rationale for a Ban on Marketing and Advertising

Brand logos and product advertisements are positively associated with consumers' purchasing decisions, specifically of unhealthy foods (e.g., salty snacks, candy and sugar-sweetened beverages). Vending machines not only act as mini-billboards, but provide quick, easy access to energy-dense, nutrient-poor sugary drinks. The Heart and Stroke Foundation of Canada's 2017 Report on the Health of Canadians takes aim at the food and beverage industry for marketing directly to children and youth, and shows how industry marketing reaches them in the home, at school, on the street and in recreational centres. The most accessible and heavily marketed choices are often energy-dense, nutrient-poor processed foods and sugary drinks, like those found in vending machines. According to the report, "parents are doing the best job they can but our environment makes it hard." The report recommends legislation restricting food and beverage marketing aimed at children and youth, and calls for a comprehensive strategy that includes public awareness and policies that support reduced sugar consumption and access, especially in "liquid form." Policies at the municipal, provincial and federal levels, which increase access to healthy food and beverage choices and restrict access to unhealthy choices, are required.

Opportunity to Take Action on Food and Beverage Marketing

There is greater understanding today about how commercial food and beverage marketing prevents children and youth from developing healthy habits that would extend into adulthood. The Stop Marketing to Kids Coalition (Stop M2K), founded by the Heart and Stroke Foundation in collaboration with the Childhood Obesity Foundation, is working to restrict all food and beverage marketing to children and youth 16 years and under. The Coalition has developed the Ottawa Principles, which provide definitions, scope and requirements that should be used to guide development of federal legislation to restrict commercial marketing to children and youth. There is an opportunity for all Ontario Boards of Health to continue to work with local municipal governments to implement healthy changes within the food environment at the local level, while at the same time communicating Board of Health support for the Stop M2K Coalition's recommendations, by signing the online endorsement. It is recommended that the Middlesex-London Board of Health direct Health Unit staff to complete the online endorsement and communicate its support by sending this report and its appendices to the other Boards of Health.

This report was prepared by Ellen Lakusiak, Kim Loupos and Heather Thomas, Health Unit Registered Dietitians, and Linda Stobo, Program Manager, Chronic Disease Prevention and Tobacco Control.

Dr. Gayane Hovhannisyan, MD, MHSc, CCFP, FRCPC
Acting Medical Officer of Health

Laura Di Cesare, CHRE
Acting Chief Executive Office

This report addresses the following requirements of the Ontario Public Health Standards (revised May 2018): Foundational Standard 1, 3, 4, 5, & Chronic Disease Prevention 1, 2, 4, 5, 6 | Child Health 1, 4.

To: **All Members**
Board of Health

From: **Dr. Rosana Salvaterra, Medical Officer of Health**

Subject: **Correspondence for Direction – Low-Income Dental Program for Adults and Seniors, Porcupine Health Unit**

Date: **April 12, 2017**

Proposed Recommendation:

That the Board of Health for Peterborough Public Health:

- *receive for information, the letter dated March 28, 2017 from Donald W. West, Chief Administrative Officer for Porcupine Health Unit, to Minister Hoskins, copied to Ontario Boards of Health, regarding the implementation of a low-income dental program for adults and seniors; and,*
- *endorse their resolution and communicate this support to Minister Hoskins, with copies local local MPPs, Dr. David Williams, Chief Medical Officer of Health, Roselle Martino, Assistant Deputy Minister, Population and Public Health (MOHLTC), the Association of Local Public Health Agencies, and Ontario Boards of Health.*

Attachments:

- Porcupine Letter to Minister Hoskins

March 28, 2017

Porcupine
Health Unit • Bureau de santé

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

Head Office:
169 Pine Street South
Postal Bag 2012
Timmins, ON P4N 8B7

Phone: 705 267 1181
Fax: 705 264 3980
Toll Free: 800 461 1818

email: info4you@porcupinehu.on.ca
Website: www.porcupinehu.on.ca

Dear Minister Hoskins,

RE: LOW-INCOME DENTAL PROGRAM FOR ADULTS AND SENIORS

On March 17, 2017, the Porcupine Health Unit Board of Health passed the following resolution:

WHEREAS, the Board of Health for the Porcupine Health Unit recognizes the importance of dental health in the overall health and well-being in our population; and

WHEREAS, the Porcupine Health Unit has identified that oral health concerns lead to greater emergency department and day surgery visit rates in our area, than the Provincial average; and

WHEREAS, a 2015 Porcupine Health Unit Study demonstrated that more than a third of emergency department visits for dental concerns are repeat visits, and the highest proportion of repeat visits are in the 19-44 year age group; and

WHEREAS, there is a great cost to both acute health care services and the individual patient from a lack of dental care. Pain, low self-esteem, complications from antibiotic treatment, and infections which may be serious and progress rapidly are all common complications of a lack of dental services; and

WHEREAS, the majority of these acute dental complications are avoidable with proper dental treatment, and the lack of treatment is largely due to an inability to pay for dental services;

NOW THEREFORE BE IT RESOLVED THAT, the Board of Health for the Porcupine Health Unit appreciates the Ministry of Health and Long-Term Care's plan to address this important public health issue, but encourages consideration for more urgent implementation of expanded public dental programs for those living on low incomes; and

FURTHERMORE BE IT RESOLVED THAT, a copy of this resolution be forwarded to the Honourable Dr. Eric Hoskins, Minister of Health and Long-Term Care, Dr. David Williams, Chief Medical Officer of Health for the Ministry of Health and Long-Term Care, the Association of Local Public Health Agencies, Ontario Boards of Health, and Gilles Bisson, MPP, Timmins - James Bay.

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

Yours very truly,

Donald W West BMath, CPA, CA
Chief Administrative Officer

DW:mc

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

To: All Members
Board of Health

From: Dr. Rosana Salvaterra, Medical Officer of Health

Subject: **Correspondence for Information**

Date: April 12, 2017

Proposed Recommendation:

That the Board of Health for Peterborough Public Health receive the following for information:

a. Letter dated March 7, 2017 from Dr. Gerace, College of Physicians and Surgeons to the Board Chair, in response to her initial letter dated February 2, 2017, regarding opioid addiction and overdose.

b. Letter dated March 9, 2017 from the County of Peterborough, to Prime Minister Trudeau and Premier Wynne, copying Peterborough Public Health, regarding their support of Jordan's Principle.

c. Letter dated March 14, 2017 from the County of Prince Edward, to Prime Minister Trudeau and Premier Wynne, copying Peterborough Public Health, regarding the development of a National Pharmacare Program.

d. Letter dated March 22, 2017 from Sylvia Jones, MPP, Dufferin-Caledon, to the former Board Chair, regarding Hepatitis C treatment.

e. Letter dated March 29, 2017 from Dr. David Williams, Chief Medical Officer of Health, regarding the CMOH 2015 Annual Report, Mapping Wellness: Ontario's Route to Healthier Communities. NOTE: The full report can be viewed here - http://www.health.gov.on.ca/en/common/ministry/publications/reports/cmoh_15/docs/cmoh_15.pdf ***(web hyperlink)***

f. Letter dated March 31, 2017 from Minister Hoskins regarding the modernization of the Smoke-Free Ontario Strategy.

Correspondence from the Association of Local Public Health Agencies (alPHa):

g. alPHa e-newsletter dated March 6, 2017

h. alPHa letter dated March 17, 2017 to Roselle Martino, Assistant Deputy Minister, MOHLTC, regarding the Public Health Programs and Services Consultation.

Letters/Resolutions from other Health Units:

Basic Income Guarantee

i. Huron

Children's Marketing Restrictions…

j. Perth

Ref. #12308

March 7, 2017

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Rocco Gerace MD
Registrar
Telephone: (416) 967-2600 x400
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80 College Street,
Toronto, Ontario.
Canada
M5G 2E2
Toll free: (800) 268-7096

Mayor Mary Smith
Chair, Board of Health
Peterborough Public Health
Jackson Square, 185 King Street
Peterborough, ON K9J 2R8

Dear Madam Mayor Smith:

Re: Opioid Addiction and Overdose

Thank you for your letter of February 2 regarding the challenges that Peterborough is having with opioid use, emergency department visits and hospital admissions.

The College would agree with your assertion that actions to address overdose should include better informing Canadians about the risks of opioids, supporting better prescription practices, reducing easy access to unnecessary opioids, supporting better treatment options and improving the national evidence base.

Currently, the College is supporting better prescription practices by doing the following:

- Investigating 80+ physicians who have prescribed 650 OME/day to 8 or more patients and dispensed 20,000 OME in a single dispense.
- The goal of these investigations will be to work with physicians to support continued safe prescribing and to avoid sudden cessation where possible.
- Highlighting key issues in *Dialogue*, including tapering and other strategies to manage challenging chronic pain issues. There will be further articles in our next issue in March.
- Working with the Ministry of Health, eHealth Ontario, Health Quality Ontario and others to establish practices to promote appropriate prescribing. The CPSO is of the view that physician opioid prescribing will be improved when physicians have access to comprehensive medication profiles for their patients prior to prescribing, and to reports about how their prescribing practices compare to other physicians.

In addition, the College will be communicating the revised Canadian guidelines for chronic non-cancer pain and revising the existing policy, Prescribing Drugs, to include this new information.

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

You have asked whether the College would issue guidance to physicians who prescribe opioids as follows:

- To discuss the risk of addiction and overdose for themselves and their families and
- To prescribe naloxone.

The College's existing Consent to Treatment already sets out the requirements for obtaining consent. The College would expect physicians to discuss risks prior to prescribing any medication. With respect to naloxone, the recent Dialogue article provides information to the profession about the value of discussing the risks of overdose specifically and prescribing naloxone for appropriate patients.

Naloxone may not be required for every patient that is prescribed an opioid, depending on the patient and their circumstances. As well, while we understand that access to naloxone has been improved, this access may be compromised if it is prescribed for patients who may not require it. Given the potential system implications of this suggestion, it may be worthwhile to discuss this matter with the Chief Medical Officer of Health. We would be pleased to participate in these discussions.

I trust this information is helpful to you.

Yours truly,

Rocco Gerace MD
Registrar

cc: Dr. David Williams, Chief Medical Officer of Health, MoHLTC

Peterborough County
Our History - Your Future

March 9, 2017

The Right Honourable Justin Trudeau, Prime Minister
House of Commons
Ottawa, Ontario
Canada
K1A 0A6

The Honourable Kathleen Wynne, Premier
Queen's Park
Room 281, Main Legislative Building
Toronto, Ontario
M7A 1A1

Dear Prime Minister Trudeau and Premier Wynne:

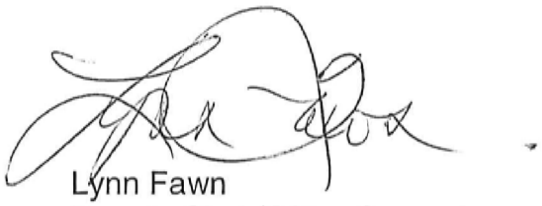
Re: Jordan's Principle and access to services by First Nation Children in Peterborough

At its meeting held the 1st day of March, 2017, Peterborough County Council passed the following resolution:

> "Be it resolved that County Council supports Peterborough Public Health's letter dated February 10, 2017 relating to the Board's January 11, 2017 adoption of a policy related to Jordan's Principle, as recommended for all levels of government by the Truth and Reconciliation Commission."

Thank you for your consideration on this matter.

Yours truly,



Lynn Fawn
Deputy Clerk/Office Supervisor
Telephone Ext. 2102
Fax: 705-876-1730
Email: lfawn@ptbocounty.ca

c: The Honourable J. Philpott, Minister of Health
The Honourable E. Hoskins, Minister of Health and Long-Term Care
M. Monsef, MP, Peterborough-Kawartha
K. Rudd, MP, Northumberland-Peterborough South
J. Schmale, MP, Haliburton-Kawartha Lakes-Brock
J. Leal, MPP, Peterborough
L. Scott, MPP, Haliburton-Kawartha Lakes-Brock
G. King, CAO County of Peterborough
A. Seabrooke, CAO, City of Peterborough
Dr. Salvaterra, Medical Officer of Health, Peterborough Public Health
L. O'Brien, Chair, Central East LHIN
P. Williams, Chief, Curve Lake First Nation
G. Cowie, Chief, Hiawatha First Nation

TheCounty
PRINCE EDWARD COUNTY • ONTARIO

From the Office of the Clerk
The Corporation of the County of Prince Edward
332 Picton Main Street, Picton, ON K0K 2T0
T: 613.476.2148 x 1022 | F: 613.476.5727
clerks@pecounty.on.ca | www.thecounty.ca

March 14, 2017

The Right Honourable Justin Trudeau, Prime Minister
Office of the Prime Minister
80 Wellington Street
Ottawa, ON K1A 0A2

The Honourable Kathleen Wynne, Premier
Room 281-111 Wellesley Street West
Toronto, ON M7A 1A1

Dear Sir and Madam:

Re: Request to Federal Government to Move Forward with a National Pharmacare Program

Please be advised that, at the regular meeting of Council for The Corporation of the County of Prince Edward held March 14, 2017, the following Committee of the Whole motion was adopted:

Motion CW-64-2017
Moved by Councillor Roberts
Seconded by Councillor Graham

THAT Council support the resolution adopted by the County of Peterborough on January 18, 2017 as it relates to a request to the Federal Government to move forward with the development of a National Pharmacare Program.

CARRIED

A copy of the January 18, 2017 County of Peterborough resolution is attached hereto.

Yours truly,

Laura McMahon,
Deputy Clerk

cc. The Honourable J. Philpott, Minister of Health
The Honourable E. Hoskins, Minister of Health and Long-Term Care M. Monsef, MP, Peterborough-Kawartha K. Rudd, MP, Northumberland-Peterborough South
J. Schmale, MP, Haliburton-Kawartha Lakes-Brock
J. Leal, MPP, Peterborough
L. Scott, MPP, Haliburton-Kawartha Lakes-Brock G. King, CAO County of Peterborough R. Quaiff, Chair, Eastern Ontario Wardens'Caucus Association of Municipalities Ontario
Dr. Salvaterra, Medical Officer of Health, Peterborough Public Health
Association of Municipalities of Ontario

Peterborough County
Our History - Your Future

January 20, 2017

The Right Honourable Justin Trudeau, Prime Minister
Office of the Prime Minister
80 Wellington Street
Ottawa, Ontario
K1A 0A2

The Honourable Kathleen Wynne, Premier
111 Wellesley Street West, Room 281
Toronto, Ontario
M7A 1A1

Dear Prime Minister Trudeau and Premier Wynne:

Re: Pharmacare

At its meeting held the 18th day of January, 2017, Peterborough County Council passed the following resolution:

> "Whereas Evidence has been provided to the Federal Government's Standing Committee on Health regarding the potential benefits of the development of a National Pharmacare Program;
>
> And Whereas the Citizens' Reference Panel on Pharmacare in Canada has recently recommended "immediate action to address flaws in the current patchwork of public and private drug coverage";
>
> And Whereas the article from the Canadian Medical Association Journal, http://www.cmaj.ca/content/187/7/491 Estimated cost of universal public coverage of prescription drugs in Canada, indicates there would be a net benefit to developing a National Pharmacare Program;
>
> And Whereas a National Pharmacare Program would provide savings to municipalities while at the same time providing medication to residents who currently have no medical benefits program;

Include also AMO

Now, Therefore Be It Resolved that Peterborough County calls on the Federal government to move forward with the development of a National Pharmacare Program;

Be It Also Resolved that Peterborough County calls on the Provincial government to work with the Federal government to accomplish the development of a National Pharmacare Program; and

Be It Also Resolved that the Warden and CAO of Peterborough County ask the EOWC to make it a priority to encourage the senior levels of government to move forward with the development of a National Pharmacare Program;

Further, Be It Resolved that this motion be circulated to Peterborough Public Health and through AMO to other municipalities for support and to our MPs and MPPs for their information and support."

Thank you for your consideration on this matter.

Yours truly,

Lynn Fawn
Deputy Clerk/Office Supervisor
Telephone Ext. 397
Fax: 705-876-1730
Email: lfawn@county.peterborough.on.ca

Encl. Canadian Medical Association Journal

c: The Honourable J. Philpott, Minister of Health
The Honourable E. Hoskins, Minister of Health and Long-Term Care
M. Monsef, MP, Peterborough-Kawartha
K. Rudd, MP, Northumberland-Peterborough South
J. Schmale, MP, Haliburton-Kawartha Lakes-Brock
J. Leal, MPP, Peterborough
L. Scott, MPP, Haliburton-Kawartha Lakes-Brock
G. King, CAO County of Peterborough
R. Quaiff, Chair, Eastern Ontario Wardens' Caucus
Association of Municipalities Ontario
Dr. Salvaterra, Medical Officer of Health, Peterborough Public Health

Early release, published at www.cmaj.ca on March 16, 2015. Subject to revision.

CMAJ RESEARCH

Estimated cost of universal public coverage of prescription drugs in Canada

Steven G. Morgan PhD, Michael Law PhD, Jamie R. Daw BHSc MSc, Liza Abraham BSc, Danielle Martin MD MPubPol

CMAJ Podcasts: author interview at soundcloud.com/cmajpodcasts/drug-coverage

Abstract

Background: With the exception of Canada, all countries with universal health insurance systems provide universal coverage of prescription drugs. Progress toward universal public drug coverage in Canada has been slow, in part because of concerns about the potential costs. We sought to estimate the cost of implementing universal public coverage of prescription drugs in Canada.

Methods: We used published data on prescribing patterns and costs by drug type, as well as source of funding (i.e., private drug plans, public drug plans and out-of-pocket expenses), in each province to estimate the cost of universal public coverage of prescription drugs from the perspectives of government, private payers and society as a whole. We estimated the cost of universal public drug coverage based on its anticipated effects on the volume of prescriptions filled, products selected and prices paid. We selected these parameters based on current policies and practices seen either in a Canadian province or in an international comparator.

Results: Universal public drug coverage would reduce total spending on prescription drugs in Canada by $7.3 billion (worst-case scenario $4.2 billion, best-case scenario $9.4 billion). The private sector would save $8.2 billion (worst-case scenario $6.6 billion, best-case scenario $9.6 billion), whereas costs to government would increase by about $1.0 billion (worst-case scenario $5.4 billion net increase, best-case scenario $2.9 billion net savings). Most of the projected increase in government costs would arise from a small number of drug classes.

Interpretation: The long-term barrier to the implementation of universal pharmacare owing to its perceived costs appears to be unjustified. Universal public drug coverage would likely yield substantial savings to the private sector with comparatively little increase in costs to government.

Competing interests: Michael Law reports receiving personal fees from Health Canada outside of the submitted work. Danielle Martin is a volunteer member of the board of Canadian Doctors for Medicare. No other competing interests were declared.

This article has been peer reviewed.

Correspondence to: Steven Morgan, steve.morgan@ubc.ca

CMAJ 2015. DOI:10.1503/cmaj.141564

Universal health care coverage encourages access to necessary care and protects patients from financial hardship, and the World Health Organization has declared that governments are obligated to promote universal coverage of necessary health care services, including prescription drugs.[1] All developed countries with universal health insurance systems provide universal coverage of prescription drugs — with the exception of Canada.

Federal cost-sharing of provincially run programs established Canada's national system of universal, comprehensive public insurance for hospital care in the 1950s and medical care in the 1960s.[2] Canada has a single-payer public insurance system for these services in each province and territory. Such coverage for prescription drugs was recommended by the 1964 Royal Commission on Health Services, the 1997 National Forum on Health, and the 2002 Royal Commission on the Future of Health Care in Canada.[3–5] Despite these recommendations, prescription drugs in Canada are currently funded by a fragmented patchwork of public and private drug plans that varies by province and leaves many Canadians with little or no drug coverage at all.[6]

Federal drug plans cover First Nations and other targeted populations that account for 2% of prescription costs in Canada; provincial drug plans cover various populations, accounting for a total of 36% of prescription costs in Canada (ranging from 28% in New Brunswick to 41% in Alberta).[7] A total of 36% of drug costs Canada-wide are funded through private insurance plans,

Ontario
LEGISLATIVE
ASSEMBLY

Sylvia Jones, MPP
Dufferin-Caledon

Room 443, Legislative Building
Toronto, Ontario M7A1A8

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Fax: 416-325-1936
E-Mail: sylvia.jonesla@pc.ola.org

March 22nd, 2017

Chair Scott McDonald
Peterborough Public Health
Jackson Square, 185 King St.
Peterborough, ON
K9J 2R8

Dear Chair McDonald,

I wanted to inform you of an exciting development regarding my private member's bill, *The Greater Access to Hepatitis C Treatment Act, 2016*. Bill 5 sought to ensure that every individual in Ontario with hepatitis C would receive treatment upon the recommendation from their physician, no matter the stage of their disease.

On February 21, 2017, the Ontario government announced the conclusion of negotiation through the pan-Canadian Pharmaceutical Alliance (pCPA). As a result of the pCPA agreement, Ontario expanded access to three already-funded hepatitis C treatments (Harvoni, Sovadi, Ibavyr) and added four new drugs (Epclusa, Zepatier, Daklinza and Sunverpra) to the ODB formulary. In addition, coverage will be extended to all patients regardless of severity of disease or genotype within the next 12 months.

I am pleased that the government has listened to the recommendation of the Canadian Agency for Drugs and Technologies (CADTH) and experts like you and adopted my proposal by announcing this important and overdue change. Thank you for your support in advocating for patients with hepatitis C.

Sincerely,

Sylvia Jones, MPP
Dufferin-Caledon
Deputy Leader of the PC Caucus
Progressive Conservative Critic for Infrastructure

From: MacDonald, Gillian (MOHLTC) **On Behalf Of** Williams, Dr. David (MOHLTC)
Sent: March-29-17 3:59 PM
To: Ontario MOHs
Subject: CMOH 2015 Annual Report

Dear Colleagues,

I am pleased to provide you with a copy of my 2015 Annual Report, *Mapping Wellness: Ontario's Route to Healthier Communities*.

Mapping Wellness makes the case for how good local data can be used to improve wellness for whole communities and certain groups and individuals within a community. It explains that if we know where the problems are and what the problems are, programs and services can be developed to suit a specific community's needs, and can be made more cost effective.

Stakeholders across Ontario have acknowledged the need for and value of local data, which can contribute to healthier individuals and healthier communities. Building on these sentiments, my report recommends investing in local data by implementing a provincial population health survey that collects data at the community and neighborhood levels. It further recommends increasing access to public health information, and using the information to address health disparities.

I would like to take this opportunity to thank Peel, Niagara, Toronto, Halton, Durham and Sudbury health units for their contributions to this report. The stories that appear in this report are compelling examples of how local level data can make a real difference – something I know all health units understand and appreciate.

I am hopeful that this report will contribute to improving community health and wellness, and, with your support, achieve the stated goal of implementing a local-level population health survey in Ontario.

Please note that the report will be publicly released tomorrow and further discussed at TOPHC on Friday.

Thank you for your ongoing support.

David

David C. Williams, MD, MHSc, FRCPC
Chief Medical Officer of Health

Ministry of Health
and Long-Term Care

Office of the Minister

10th Floor, Hepburn Block
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Ministère de la Santé
et des Soins de longue durée

Bureau du ministre

Édifice Hepburn, 10e étage
80, rue Grosvenor
Toronto ON M7A 2C4
Tél 416-327-4300
Téléc 416-326-1571
www.ontario.ca/sante

Ontario

MAR 3 1 2017

Dear Colleagues,

Over the past ten years, Ontario has seen a remarkable drop in the number of people who smoke. Yet 2,000,000 Ontarians – almost one in five (17.4%) – still smoke. While significant progress has been achieved smoking rates have plateaued in recent years. Although our province has the third lowest rate of smoking in the country, there is still more work to be done.

Promoting a smoke-free Ontario is part of the government's plan to build a better Ontario. When I released the Patients First: Action Plan for Health Care, I committed to transforming our health care system to make it more transparent, accountable, and sustainable. Ontarians will have better and faster access to quality health services. They will have better information so they can make decisions that will help them live healthy and stay healthy. And their health services will be protected for generations to come.

Our government continues to work towards this commitment, and I am pleased to formally announce the modernization of the Smoke-Free Ontario Strategy. Ontario has an opportunity to identify priorities which build on lessons learned over the last ten years since the Smoke-Free Ontario Act (SFOA) came into effect, address the current landscape of emerging issues and products, and incorporate new evidence.

The modernization of the Smoke-Free Ontario Strategy will be responsive to emerging evidence and aligned with the ministry's strategic vision and priorities. An Executive Steering Committee as well as a separate Committee with Indigenous partners, will be established focusing on the following main themes: Prevention, Protection, Cessation and Emerging Products with Research, Surveillance and Evaluation cutting across all themes. Membership details and Terms of Reference will be shared shortly.

Throughout the modernization exercise, we will engage with all our sector partners and citizens of Ontario. I look forward to continuing to work collaboratively with you to ensure Ontario continues to be a national and international leader in tobacco control.

Yours sincerely,

Dr. Eric Hoskins
Minister

c: Dr. Robert Bell, Deputy Minister
Roselle Martino, Assistant Deputy Minister, Population and Public Health Division
Laura Pisko, Director, Health Protection Policy and Programs Branch

alPHa
Association of Local PUBLIC HEALTH Agencies

Information Break

March 6, 2017

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

alPHa Winter 2017 Symposium - Feb. 23

alPHa has wrapped up another successful Symposium last week in Toronto which focused on the updated Ontario Public Health Standards. Sincere thanks to the guest presenters, Dr. Brent Moloughney and attendees who contributed to the productive, engaging discussion on the new Standards. alPHa is currently preparing a summary of the event proceedings and will share these with the membership in the coming weeks. In the meantime, slide presentations from the Symposium may be viewed on alPHa's website (see below; username and password required).
Download Winter 2017 Symposium PowerPoints here

Patients First Update

Health system integration bulletins from the Province are available online to keep the public abreast of work supported by the *Patients First Act, 2016.*
Read the latest (Feb. 24) Health System Integration bulletin
Go to Health System Integration updates

Updated Public Health Standards -- On February 17, the Ministry of Health and Long-Term released its Standards for Public Health Programs and Standards Consultation Document. Ministry officials are in the process of organizing regional consultations which will allow boards of health to seek clarification and context on the standards and to provide input on anticipated operational considerations, implementation requirements and supports. Written submissions to the ministry on the draft standards are due April 3.
Download the OPHS Consultation Document

At the February 23rd Winter Symposium, assistant deputy minister Roselle Martino gave an overview of the updated Standards, and Dr. Brent Moloughney followed up with a preliminary assessment of the changes. Immediately at the end of the event, alPHa emailed their slide presentations to the membership and outlined the association's next steps.

alPHa has requested that the province extend the April 3rd deadline, but encourages all boards

of health to submit their input by this date in the event an extension is not granted. On behalf of the Association, Dr. Moloughney has prepared a report on Symposium participants' comments on the standards provided during the group discussion on February 23rd (click link below; login required). In the next several weeks, alPHa will share its position statement(s) on the new standards with boards of health so that they can endorse and/or include them in their own board's response to the ministry.
Read alPHa's request to extend the OPHS consultation deadline
View Dr. Moloughney's report on initial analysis & summary of alPHa members' input on new Standards

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Boards of Health Section Meeting Wrap-Up

On February 24, board of health representatives from across the province attended the alPHa BOH Section meeting during the Winter Symposium. Guest presenters included Ontario's Chief Medical Officer of Health, Dr. David Williams, in his inaugural address to Section members. He spoke to the updated Standards for Public Health Programs and Services, as well as the Province's strategy on opioid addiction and overdose. Public health nurse Elena Hasheminejad (York Region) and health promoter Allison Imrie (Peel Region) from the Ontario Public Health Unit Collaboration on Cannabis (OPHUCC) gave an overview of the federal framework on cannabis legalization and regulation, including Task Force recommendations. Michael Perley, Director of the Ontario Campaign for Action on Tobacco, concluded the meeting with his update on Smoke-Free Ontario and the current landscape of tobacco and vaping.
Download the Feb. 24 BOH slide presentations (scroll down list)

TOPHC 2017: Global challenges. Local solutions.

More than 700 public health professionals from across the province are expected to gather in Toronto from March 29 to 31 to attend TOPHC 2017. The Ontario Public Health Convention this year, located at the Beanfield Centre (formerly Allstream Centre), will explore global public health challenges and showcase local solutions while examining opportunities to collaborate locally, provincially and nationally on challenges. Keynote speakers will share insights on climate change and public health emergencies, urban renewal, and immigrant and refugee health. Attendees can choose from a variety educational pathways in chronic disease and injury prevention, environmental health, family health, infectious diseases and control, among others.
View TOPHC 2017 program
Register here for TOPHC 2017

Upcoming Events - Mark your calendars!

March 29-31, 2017 - **TOPHC 2017**: Global challenges. Local Solutions. The Beanfield Centre (formerly Allstream Centre), Toronto. Register now!

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

Click here for the Notice of Annual General Meeting and calls for resolutions, Distinguished Service Award Nominations, and Board of Health Nominations to alPHa Board.

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

March 17, 2017 UPDATED

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

Dear Roselle,

Re: Public Health Programs and Services Consultation

On behalf of member Medical Officers of Health, Boards of Health and Affiliate organizations of the Association of Local Public Health Agencies (alPHa), I am writing today to provide our initial feedback on the *Standards for Public Health Programs and Services Consultation Document* that was released for comment on February 17.

We recognize that a great deal of work went into this review, and appreciate the fact that many of our members were directly involved in the development of the revised Standards for Public Health. We are also pleased with the decision to hold regional consultations and hope that the feedback that you receive from our members as part of these will be carefully considered, as our members will be more likely to provide more detailed operational feedback not covered here. Finally, we are most appreciative of the extension to the original April 3 deadline to accommodate a more thorough consideration of the document.

Our response as an Association is based primarily on what we heard at the 2017 alPHa Winter Symposium and follow-up discussions during meetings of our Council of Ontario Medical Officers of Health (COMOH) and Boards of Health Sections as well as the alPHa Executive Committee and Board of Directors since that time.

We understand that the intent of the present consultation is to gather feedback on operational considerations and implementation requirements and supports. We expect that the most useful feedback on these will be heard as part of the regional consultations that will take place later this month, as staff and managers who are most familiar with the various programs and services are in the best position to provide the required analysis and advice.

Indeed, a recurring theme that we have heard from our members during and following our February symposium is that it will be difficult to fully assess the operational implications of the revised standards before more clarity on the more specific expectations are available. We are given to understand that these will emerge with the development of protocols, guidance documents and annual service plan template, and we would appreciate assurances that the field will be fully involved in this process so that we can answer the operational and implementation questions as they arise.

Similarly, the importance of examining the existing and potential capacity, resource and funding issues cannot be overstated. These have been at the forefront of our discussions of the revised standards so far, and the expectations will need to be more clearly understood before an assessment of the capacity to meet them can be properly carried out.

The above uncertainties notwithstanding, we already have significant concerns about capacity in light of our escalating struggles to meet our existing mandate and respond to local needs with constrained budgets. These struggles will only intensify with the new program and process obligations that are laid out in the revised standards and the continued implementation of the public health funding formula.

We have, for example, communicated on several occasions as part of our feedback on the Patients First initiative that increasing engagement with the health care sector carries with it significant resource implications. Assisting with the planning of health care delivery services is a new application of public health's expertise in population health assessment, which requires different analytical approaches and is in addition to the applications that we will be expected to continue.

Even if this and the various other added requirements are offset by the subtraction or consolidation of others, there will be resource implications related to adapting our service delivery processes to the shifts in expectations, including retraining staff for new obligations, re-allocating resources and developing outreach and negotiation strategies for programs that we are no longer expected to provide directly but are still expected to ensure are available. New administrative requirements such as developing annual public health service plans and individualized programs of public health interventions will also entail significant additional consideration.

We also have some concerns about the much less prescriptive approach to the health promotion standards. Although we are very receptive to the greater latitude to tailor health promotion / chronic disease prevention programs via local public health "intervention plans", we see a potential risk to their effectiveness and sustainability in the current fiscal climate. If available resources remain static (as they have now for two years in most cases), meeting the more explicit health protection requirements on an ongoing basis will almost certainly erode the resources left over for the delivery of effective tailored health promotion programs and services over time. We recommend that there be mechanisms developed to mitigate this risk and protect our critical work in the more flexible areas of the standards.

As we observed above, there is still much that has not yet been defined within the new standards, and there are additional uncertainties about the outcomes of the correlated health system transformation processes. We do see this as an important opportunity to answer questions and address concerns, and it will be exceedingly important that these processes (including but not limited to the Expert Panel on Public Health, the Public Health-Local Health Integration Network Work Stream, the new Accountability Framework) are appropriately bridged to ensure that we have the information we need to guide us through the transformation process. We would appreciate assurances that we will be full participants in ensuring that these processes and their products serve the best interests for effective health protection and promotion throughout the province.

It is important to note that the above points are reflective of the collective discussions that our members have had in the short time since the release of the consultation document. The emergence of other questions and concerns as the revised Standards are more closely examined are a near-certainty, and we hope that you will remain open to discussing them – including feedback on content - in the months leading to the January 2018 implementation.

In closing, we recognize that having such explicit and comprehensive public health standards is unusual in Canada and we are grateful to have a strong foundation for the practice of public health in Ontario. We thank you for the opportunity to assist in further strengthening Ontario's public health system to most effectively protect and promote the health of all Ontarians.

Yours sincerely,

Carmen McGregor
alPHa Vice-President

COPY: Dr. David Williams, Chief Medical Officer of Health
Sharon Lee Smith, Associate Deputy Minister, Policy and Transformation, Ministry of Health and Long-Term Care
Dr. Bob Bell, Deputy Minister of Health and Long-Term Care, Ministry of Health and Long-Term Care

HURON
COUNTY

March 9, 2017

The Hon. Dr. Helena Jaczek
Minister of Community and Social Services

The Hon. Chris Ballard
Minister Responsible for the Poverty Reduction Strategy

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

Dear Ministers;

We are writing to convey our support for Basic Income in Ontario and the recommendations made in the Honourable Hugh Segal's discussion paper, "Finding a Better Way: A Basic Income Pilot Project for Ontario".

The Huron County Board of Health feels strongly that ensuring everyone has an income sufficient to meet basic needs and live with dignity is one of the most important initiatives the provincial government could pursue to promote health, well-being and equity amongst Ontarians. Our support for basic income is informed by overwhelming evidence of the powerful link between income and health. People living with a lower income are at far greater risk of preventable medical conditions across the lifespan, including cancer, diabetes, heart disease, mental illness, and their associated health care costs, compared with those living with higher income. Children are particularly vulnerable to the impacts of growing up with low income, due to its deleterious effect on early childhood development.

This letter also serves to support our views on the important principles and elements of Basic Income:

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

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- replacing Ontario Works (OW) and Ontario Disability Support Program (ODSP) with basic income at rates that reflect the cost of living,
- the stipulation that no one is worse off than before the basic income program.

As has been conveyed by The Ontario Public Health Association and other Boards of Health in Ontario, we would emphasize that while basic income is an important form of income security for those on OW and ODSP, it is also crucial for those who are employed yet still living in poverty, including the precariously employed. While we see a great deal of promise in Basic Income, we also believe that basic income can only have a strong impact on the health-damaging conditions of poverty and precarious employment if it is part of, and not a replacement for, a comprehensive approach that includes progress on other key policies and programs. This includes affordable high quality child care, affordable housing, expanded health benefits, and labour law reform, among others.

Yours Sincerely,

Tyler Hessel
Chair, Huron County Board of Health

Maarten Bokhout
Acting Medical Officer of Health

cc:
Ontario Public Health Association – Mary Wales, Communications Coordinator
Association of Local Public Health Agencies
All Health Units

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March 15, 2017

The Honourable Dr. Jane Philpott
Health Canada
70 Colombine Driveway
Tunney's Pasture
Ottawa, ON I1A 0K9

Jane .Philpott@parl.gc.ca

Dear Minister Philpott:

Re: Children's Marketing Restrictions, Federal Healthy Eating Strategy & Support for Bill S-228 & Bill C-313

The Perth District Health Unit Board of Health received correspondence from Huron County regarding children's marketing restrictions, the federal Healthy Eating Strategy and support for Bill S-228 and Bill C-313 (attached). Our Board of Health passed a resolution endorsing Huron County's position and is writing this letter to indicate support for the federal government's Healthy Eating Strategy and, in particular, the strategy initiatives that would protect children through restricting the commercial marketing of foods and beverages. In addition, the Board of Health also supports two current private members bills seeking to address this issue: Senator's Green-Raine's Private Member's Bill S-228, which if passed, would prohibit advertisement of food and beverages to children under the age of 13 years; and Peter Julian's Private Members Bill C-313 which focuses on developing a national strategy on advertising to children and amending the *Broadcasting Act*.

The time for action on this issue is now. Food and beverage advertising influences food choices. The majority of food and beverages marketed to children and youth are high in sugar, fat, and sodium. Children are exposed to this marketing repeatedly each day through television, websites, video games, apps and social media. In Canada, the average child watches about two hours of television each day and sees 4-5 food and beverage ads per hour. In Perth County, NutriSTEP surveillance data shows that 40% of children 3-5 years old watch TV while eating and about 65% of children have two or more hours of screen time each day.

Given the screen time of children and youth, their exposure to food and beverage advertising is higher than it has ever been. They are especially vulnerable to advertising because they lack an understanding of the persuasive intent of marketing. The research is clear that the marketing of food and beverages high in sugar, fat and salt to children contributes to the unhealthy eating habits of Canadian youth and the rising risk of nutrition related diseases presenting in this generation. Legislation that restricts food and beverage marketing to this susceptible population is a crucial and proven strategy for improving the eating habits and overall health of children and youth.

The Perth District Health Unit is committed to protecting the health and well-being of our residents. We strongly believe that the implementation of federal marketing restrictions along with the other initiatives outlined in the recently announced Healthy Eating Strategy will help to do this.

Sincerely,

T J Barresi

Teresa Barresi
Board Chair

c. alPha
John Nater, MP
Randy Pettapiece, MPP
Huron County Health Unit

To: All Members
Board of Health

From: Dr. Rosana Salvaterra, Medical Officer of Health

Subject: **alPHa Resolutions for Submission**

Date: April 12, 2017

Proposed Recommendation:

That the Board of Health for Peterborough Public Health approve the submission of the following draft resolutions for the Association for Local Public Health Agencies (alPHa) Resolution Session (2017):

- *Accessible Contraception*
- *Truth and Reconciliation Commission of Canada Calls to Action*

Attachment A – Accessible Contraception
Attachment B – Truth and Reconciliation Commission of Canada Calls to Action

DRAFT RESOLUTION FOR alPHa RESOLUTIONS SESSION (YEAR: 2017)

TITLE: **Accessible Contraception**

SPONSOR: **Peterborough Public Health**

WHEREAS individuals have a right to sexual and reproductive health services and the freedom to make informed decisions in regards to their sexual health;

WHEREAS the cost of birth control is the most significant barrier, among others, that prevents women from obtaining, initiating and continuing their contraceptive method of choice[1];

WHEREAS 40% of Ontarians have financial difficulty paying for their prescription medicines (i.e., have to borrow money or go without other things) and the cost of the method of contraception is almost exclusively borne by the user or their private insurer[2,3];

WHEREAS in Canada, there are more than 180,700 unintended pregnancies annually with an associated direct cost over $320 million[4] and in 2014 in Ontario there were 23,746 induced abortions[5];

WHEREAS there is increasing evidence that a universal contraception subsidy in developed nations is cost-effective for the health system due to savings incurred through avoidance of indirect and direct costs related to the management of unintended pregnancy; and

WHEREAS priority populations such as youth, immigrants, and those living with a low income experience inequitable access to contraceptives;

NOW THEREFORE BE IT RESOLVED that the Association of Local Public Health Agencies (alPHa) request that the Ministry of Health and Long-Term Care:

- regularly collect data on pregnancy intention and the use of modern contraceptive methods among people throughout the reproductive age range; and,
- ensure that birth control is available at little or no cost for all Ontario women and their partners.

[1] Black, A., and Guilbert, E. Canadian Contraception Consensus. SOGC No. 329, October 2015. https://sogc.org/wp-content/uploads/2015/11/gui329Pt1CPG1510.pdf

[2] Morgan, S.G., D. Martin, MA Gagnon, B Mintzes, J.R. Daw, and J. Lexchin. (2015) Pharmacare 2020: The future of drug coverage in Canada. Vancouver, Pharmaceutical Policy Research Collaboration, University of British Columbia.

[3] Angus Reid Institute. Prescription drug access and affordability an issue for nearly a quarter of all Canadian households. http://angusreid.org/wp-content/uploads/2015/07/2015.07.09-Pharma.pdf

[4] Black, A.Y., Guilbert, E., Hassan, F., Chatziheofilou, I., Lowin, J., Jeddi, M., Filonenko, A., Trussell, J. The Cost of Unintended Pregnancies in Canada: Estimating Direct Cost, Role of Imperfect Adherence, and the Potential Impact of Increased Use of Long-Acting Reversible Contraceptives. J Obstet Gynaecol Can 2015; 37(12):1086–1097. http://www.jogc.com/article/S1701-2163(16)30074-3/pdf

[5] Canadian Institute for Health Information. Induced Abortions Report in Canada in 2014. https://www.cihi.ca/sites/default/files/document/induced_abortion_can_2014_en_web.xlsx

DRAFT RESOLUTION FOR alPHa RESOLUTIONS SESSION (YEAR: 2017)

TITLE: **Truth and Reconciliation Commission of Canada (TRC) Calls to Action**

SPONSOR: **Peterborough Public Health**

WHEREAS the modernized Standards for Public Health Programs and Services recognize the requirement for boards of health to engage with Indigenous communities in ways that are meaningful for them; and

WHEREAS the Truth and Reconciliation Commission of Canada (TRC) Calls to Action are extremely well aligned with public health practice as they address the roots of Indigenous health and social inequities; and

WHEREAS understanding and addressing attitudinal and systemic racism is a critical area for public health action;

NOW THEREFORE BE IT RESOLVED that the Association of Local Public Health Agencies (alPHa) publicly acknowledge the harm that of colonization and the residential school system caused and continue to cause to Indigenous people living in Ontario;

AND FURTHER that the board and staff of alPHa commit to work towards Indigenous cultural competency that is reflected in alPHa's planning, implementation, and evaluation of all program(s), activities, and policies, and engage with Indigenous partners in a way that is meaningful for them;

AND FURTHER that alPHa assist member boards of health in:

- committing to reading and understanding the Calls to Action and the role that boards of health can play as part of reconciliation;
- ensuring that all staff and board members are competent to act as better allies and provide culturally safe care to the Indigenous people within the areas of their geographic responsibility;
- assessing the unique health needs and health inequities experienced by Indigenous peoples;
- modifying and reorienting public health interventions to be culturally safe for Indigenous peoples;
- engaging with Indigenous communities in a way that is meaningful for them; and,
- supporting policy development and health equity analysis to decrease health inequities experienced by Indigenous peoples;

AND FURTHER that alPHa request that Public Health Ontario and the Association of Public Health Epidemiologists of Ontario engage with Indigenous population health expertise, including staff at the National Collaborating Centre for Aboriginal Health (NCCAH), to advise and assist the field on how Ontario's public health sector can best participate in TRC Call to Action #19 which calls on the federal government, in consultation with Aboriginal[i] peoples, to establish measurable goals to redress health inequities and to report annually on the progress being made here in Ontario.

AND FURTHER that alPHa advocate to the Ministry of Health and Long-Term Care, and other relevant government bodies, to ensure that Ontario's Indigenous peoples have more equitable access to the social determinants of health as well as access to culturally safe health care and Aboriginal healing practices.

Background:

On December 15, 2015, the Truth and Reconciliation Commission of Canada (TRC) released its final report on Canada's Indian Residential Schools (IRS).[1] The TRC was constituted and created by the Indian Residential Schools Settlement Agreement. The TRC spent six years travelling to all parts of Canada and heard from more than 6,000 witnesses, most of whom survived the experience of living in the schools as students. Indigenous peoples were taken from their families as children, forcibly if necessary, and placed for much of their childhoods in residential schools. The federal government has estimated that at least 150,000 First Nations, Métis and Inuit students passed through the system over more than 100 years ago.[2]

The Final Report discusses what the Commission did and how it went about its work, as well as what it heard, read, and concluded about the schools and afterwards, based on all the evidence available. The TRC's mandate included truth telling of experiences of survivors, as well as a focus on reconciliation.[2]

Reconciliation was an overall objective of the TRC.[3] As Canadians and as Treaty Peoples, we all have on-going individual and collective responsibilities to come to terms with events of the past, and begin establishing respectful and healthy relationships with Indigenous communities.

To quote the TRC:
"*Reconciliation is going to take hard work. People of all walks of life and at all levels of society will need to be willingly engaged. Reconciliation calls for personal action. People need to get to know each other. They need to learn how to speak to, and about, each other respectfully. They need to learn how to speak knowledgeably about the history of this country. And they need to ensure that their children learn how to do so as well…*
Reconciliation calls for federal, provincial, and territorial government action.
Reconciliation calls for national action.
The way we govern ourselves must change. Laws must change.
Policies and programs must change.
The way we educate our children and ourselves must change.
The way we do business must change.
Thinking must change.
The way we talk to, and about, each other must change.
All Canadians must make a firm and lasting commitment to reconciliation to ensure that Canada is a country where our children and grandchildren can thrive."

Ninety-four Calls to Action for Canadians were released to begin redressing the legacy of Indian Residential Schools and advancing the process of reconciliation. Table 1 is a summary of the health-related Calls, although there are others that might be relevant to public health as they address social determinants of health. The TRC also released a set of guiding principles to move forward on truth and reconciliation.

Table 1: Health related Calls to Action

Call to Action #	Summary of the direction
18	Make the links between current Indigenous health disparities and Canadian governmental policies
19	Establish measureable goals and close the gap in health outcomes
20	Recognize and address distinct health needs of Inuit, Métis and off-reserve Aboriginal people
21	Fund Aboriginal healing centres to address the physical, mental, emotional and spiritual harms caused by residential schools
22	Recognize and use Aboriginal healing practices
23	Increase and retain Aboriginal health professionals; ensure all health professionals are culturally competent
24	Coursework and training in all medical and nursing schools

The alPHa-OPHA Health Equity Workgroup spent a portion of its monthly meetings from February 2016 to February 2017 reading the 94 Calls to Action and discussing each Call and the role of public health. At the same time, the Ontario Ministry of Health and Long-Term Care has released a draft of the Modernized Standards for Public Health Programs and Services: Consultation Document which states:

"*The Indigenous population in Ontario is comprised of First Nations, Métis, and Inuit people. There are many different First Nations and urban Indigenous communities across the province, each with their own histories, cultures, governance and organizational approaches.*

Relationships between boards of health and Indigenous communities and organizations need to come from a place of trust, mutual respect, understanding, and reciprocity. It is important to acknowledge that as part of this relationship building, First Nations in Ontario believe that Canada, as a Treaty partner, also has an obligation to continue to contribute to the improvement of health care and health outcomes for their communities.

One important first step for boards of health in beginning to build and/or further develop their relationships with Indigenous communities is to ensure it is done in a culturally safe way."[4]

This Resolution is one step for alPHa and its members to begin their process towards reconciliation. It will not be the last.

References:

1. Truth and Reconciliation Commission of Canada. *Truth and Reconciliation Commission of Canada Website Homepage.* Retrieved March 33, 2017: http://www.trc.ca/websites/trcinstitution/index.php?p=3

2. Truth and Reconciliation Commission of Canada. *Honouring the Truth, Reconciling the Future: Summary Report of the Truth and Reconciliation Commission of Canada.* McGill-Queen's University Press. Retrieved March 13, 2017: http://www.trc.ca/websites/trcinstitution/File/2015/Honouring_the_Truth_Reconciling_for_the_Future_July_23_2015.pdf

3. Truth and Reconciliation Commission of Canada. *Canada's Residential Schools: Reconciliation, The Final Report of the Truth and Reconciliation Commission of Canada Volume 6.* McGill-Queen's University Press. Retrieved March 13, 2017: http://www.myrobust.com/websites/trcinstitution/File/Reports/Volume_6_Reconciliation_English_Web.pdf

4. Ministry of Health and Long-Term Care. *Standards for Public Health Programs and Services: Consultation Document*. Planning and Performance Branch, Population and Public Health Division. February 17, 2017. Retrieved March 13, 2017: https://c.ymcdn.com/sites/alphaweb.site-ym.com/resource/collection/86D31666-E7EA-42F1-BDA1-A03ECA0B4E3D/OPHS_Consultation_170217.pdf

[i] Where "Aboriginal" is used in this resolution, it is as a direct reference to the language of the TRC Calls to Action.

To: All Members
Board of Health

From: Councillor Henry Clarke, Chair, Stewardship Committee

Subject: **Stewardship Committee Report: 2017 Budget Approval - Healthy Babies, Healthy Children Program**

Date: April 12, 2017

Proposed Recommendation:

That the Board of Health for Peterborough Public Health:

- *receive the staff report, 2017 Budget Approval - Healthy Babies, Healthy Children Program, for information; and*
- *approve the 2017 budget for the Healthy Babies, Healthy Children (HBHC) program in the total amount of $928,413.*

Background:

The Stewardship Committee met last on April 6, 2017. At that meeting, the Committee requested that this item come forward to the Board at their next meeting.

Attachments:

Attachment A – Staff Report - 2017 Budget Approval - Healthy Babies, Healthy Children Program

Peterborough Public Health

Staff Report

2017 Budget Approval - Healthy Babies, Healthy Children Program

Date:	March 29, 2017
To:	Stewardship Committee
From:	Dr. Rosana Salvaterra, Medical Officer of Health

Original approved by	***Original approved by***
Rosana Salvaterra, M.D.	Dale Bolton, Manager, Finance and Property Karen Chomniak, Manager, Family Health

Proposed Recommendations

That the Stewardship Committee for the Board of Health for Peterborough Public Health:

- receive the staff report, *2017 Budget Approval - Healthy Babies, Healthy Children Program,* for information; and
- recommend to the Board of Health approval of the 2017 budget for the Healthy Babies, Healthy Children (HBHC) program in the total amount of $928,413.

Financial Implications and Impact

The HBHC budget is 100% funded by the Ontario Ministry of Children and Youth Services (MCYS).

The 2017 budget has been completed based on the provincial funding allocation of $928,413. The provincial allocation has not been increased since 2013 when additional funding was received for a 1.0 FTE Public Health Nurse (PHN) position. However, the funding received in 2013 was associated with a new client screening tool and did not help with existing programs requirements. Funding for the base operations of the program has not increased since 2007.

Lack of funding increases to cover the cost of increasing wage and benefit costs, has resulted in a steady declined in staffing levels over the past number of years. In 2017, the overall program staff complement will decrease by .10 FTE PHN staff from the prior year. With no additional funding anticipated, the program will manage with 4.8 PHN FTEs, 1.8 FTEs Family Home Visitors

(FHVs) and 1.1 FTE Administrative Assistant (AA). The program continues to struggle to maintain program services and targets without additional funding.

The proposed budget for January – December 2017 is a balanced budget within the funding allocation of $928,413.

Healthy Babies Healthy Children Program Budget – 2017

Expenditures

Salaries	$680,469
Benefits	197,839
Universal screening – Early ID	25,575
Staff development	1,000
Travel	9,900
Audit and legal fees	1,800
Communications	5,100
Program resources	6,730
Total Program Expenditures	**$928,413**

Funding

Ministry of Children Youth Services	**$928,413**

Decision History

The Board of Health has hosted and supported the HBHC program since its inception in 1998. Letters have been sent by this Board and other provincial public health agencies (such as the Association of Local Public Health Agencies (alPHa)) to the provincial government, government ministers, and opposition party critics. These letters have advocated that HBHC be maintained as a 100 percent provincially-funded program; and that sufficient increases to the annual budget be granted to keep pace with demands from client families, partner agencies, and the community, and on Public Health agencies themselves as employers.

Background and Rationale

Introduced in 1998 by the Government of Ontario, the HBHC program is mandated as a component of both Child Health and Reproductive Health programs of the Ontario Public Health Standards of the Ministry of Health and Long-Term Care.

HBHC is a prevention and early intervention program designed to help pregnant women and families with children from birth to six years of age. It is delivered by PHNs and FHVs (who provide peer support) through telephone consultation and home visiting. The program gives

families in Ontario the information and support they need to give their children a healthy start in life; and also to provide more intensive services and supports for families with children who may not reach their full potential due to identified risk factors. These interventions result in long-term health, education, and economic benefits.

MCYS implemented a number of significant changes during the latter part of 2012 and first part of 2013, including:

- a revised HBHC Protocol and the Guidance Document;
- an HBHC Screen to identify vulnerable pregnant women and children and families so they can access services and supports more quickly;
- the HBHC Liaison Nurse role to provide training and support to staff of hospital maternal-child units, prenatal clinics, and midwifery practices, to effectively administer the HBHC Screen; and
- enhanced HBHC home visiting to more effectively support at-risk families through the use of standardized assessment tools and best practice parenting education curriculum to help ensure the effectiveness of home visiting.

Commencing in 2015, MCYS required all HBHC programs to implement a Continuous Quality Improvement (CQI) program to assist with identifying and reviewing performance indicators compared to aspirational service targets.

In an attempt to increase the accurate completion of our HBHC Screens, in 2016 our local program together with Peterborough Regional Health Centre participated in a pilot project for the electronic completion and transmission of HBHC Screens through the Better Outcomes Registry Network (BORN). Unfortunately, an advancement such as this is overshadowed by inadequate funding and staffing resources. The capacity of Peterborough Public Health to achieve targets and provide necessary services will continue to be compromised without adequate resources.

Strategic Direction

The HBHC program is identified as a requirement under both the Reproductive Health and Child Health Standards in the Ontario Public Health Standards 2008. Approval of the budget will contribute to the program and Peterborough Public Health's ability to continue to meet its mandates of:

- Community-Centred Focus; and
- Determinants of Health and Health Equity

Contact:

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