The Board of Health for the Peterborough
County-City Health Unit
Agenda
Board of Health Meeting
4:45 p.m. Wednesday, January 11, 2012
(Boardroom, 10 Hospital Drive, Peterborough)

1. Call to Order
- 1.1 Welcome and Introductions
- 1.2 Proceedings at Meetings

2. Declaration of Pecuniary Interest

3. Elections
- 3.1 Chairperson
- 3.2 Vice-Chairperson

4. Appointments to Committees
- 4.1 Governance
- 4.2 Property

5. Establishment of Date and Time of Regular Meetings

6. Establishment of Honourarium for 2012

7. Confirmation of the Agenda

8. Delegations and Presentations

8.1 **A Day In The Life – Infant Toddler Development Worker**
Osk Jenkins

9. Confirmation of the Minutes of the Previous Meeting

9.1 **December 14, 2011**

10. Business Arising From the Minutes

11. Correspondence

12. Program Reports

13. New Business

13.1 **Staff Report: Infant Toddler Development Program**
Karen Chomniak, Program Manager

13.2 **Staff Report: Report on Summary of Selected Cancers: Peterborough County and City**
Andrew Kurc, Epidemiologist

13.3 **Performance Management Working Group, Ministry of Health and Long-Term Care: Public Health Accountability Agreement Indicators**
Presenter: Dr. Rosana Pellizzari, Medical Officer of Health

13.4 **2010 Annual Report of the Chief Medical Officer of Health**
Presenter: Dr. Rosana Pellizzari, Medical Officer of Health

13.5 Board/Management Planning Session

14. In Camera to discuss Confidential Personnel and Property Matters

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

February 8, 2011, Board Room, 10 Hospital Drive

16. Adjournment

c: All Members, Board of Health
Medical Officer of Health
Directors

2012 Board of Health
for the
Peterborough County-City Health Unit

Councillor Andrew Beamer, City of Peterborough

Councillor Henry Clarke, City of Peterborough

Mr. Jim Embrey, Provincial Representative

Mayor John Fallis, County of Peterborough

Mr. Paul Jobe, Provincial Representative

Chief Keith Knott, Curve Lake First Nation Representative

Councillor Lesley Parnell, City of Peterborough

Deputy Mayor Andy Sharpe, County of Peterborough

Councillor Jill Smith, Hiawatha First Nation Representative

Reeve Mary Smith, County of Peterborough

Mr. David Watton, Provincial Representative

Board of Health
for the
Peterborough County-City Health Unit
2011 Appointments to Committees

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

Governance:	Mr. Jim Embrey
	Chief Keith Knott
	Deputy Mayor Andy Sharpe
	Reeve Mary Smith
	Mr. David Watton (Chair)
Property:	Councillor Andrew Beamer
	Councillor Henry Clarke
	Deputy Mayor Andy Sharpe (Chair)

To: All Members
Board of Health

From: Dr. Rosana Pellizzari, Medical Officer of Health

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

Date: January 11, 2012

Recommendation:

That the regular meetings for the Board of Health be held on the second Wednesday of each month (excluding July and August) starting at 4:45 p.m. in the Board Room, 10 Hospital Drive, Peterborough, or at the call of the Chairperson.

A listing of the Board of Health meeting dates for 2012 is as follows:

January 11, 2012

February 8, 2012

March 14, 2012

April 11, 2012

May 9, 2012

June 13 2012

September 12, 2012

October 10, 2012

November 14, 2012

December 12, 2012

Original signed by

Rosana Pellizzari, M.D.

Staff Report

Board Honourarium and Allowances

Date:	January 11, 2012
To:	Board of Health
From:	Dr. Rosana Pellizzari, Medical Officer of Health
Original signed by _____ Rosana Pellizzari, M.D.	

Purpose

The Board of Health is required to establish the amount of honorarium paid to each member eligible for compensation in accordance with the Health Protection and Promotion Act at the first regular meeting of the Board of Health each year.

Decision History

Since 2007, the Board of Health has approved an honorarium of $145.61.

In 2011, because of the increased committee work undertaken by Board Members, the Board of Health referred this matter to the By-Law, Policies and Procedures Committee for a recommendation. The Board of Health policy, Number 2-240, was revised by the Committee and approved by the Board of Health on September 14, 2011. The policy established which activities were deemed eligible for compensation, and whether the honorarium was to be adjusted according to the nature and length of the activity.

To determine whether a change in the honorarium was necessary, the Governance Committee requested an updated environmental scan of board of health compensation and this was prepared by staff in October 2011. Due to a lack of time, the item has been deferred to the next meeting.

Financial Implications and Impact

The 2011 approved budget identified a total of $23,856 for Board of Health honoraria. The actual amount claimed and paid by December 31, 2011 was $22,933.

The 2012 approved budget did not include any changes to the Board of Health honoraria budget line. The Board has requested a quarterly report in order to monitor its utilization of these funds.

Recommendations

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

- Approve $145.61 as the honorarium for 2012;
- Request a report from the Governance Committee on whether any further adjustments to policy or rates are required based on their upcoming review and preliminary projections for 2012.

Background

The Board of Health honorarium, if approved, will have remained constant for 5 years. The Board has updated its policy to clarify when an honorarium is to be paid and when the rate requires an adjustment. Given changes in practices and the current fiscal constraints, additional review is necessary to ensure that rates are both fair and affordable.

All three collective agreements were negotiated in 2011 and the need to address compensation for non-union staff has been prioritized. The Governance Committee has entered into a dialogue with its non-union staff to identify a process that will hopefully lead to the establishment of a policy and procedure. It is anticipated that the Governance Committee will require additional meetings in 2012 to address this and make recommendation to the Board of Health for consideration.

According to Board of Health policy, 2012 will also see the completion of a 360° Performance Review for the Medical Officer of Health. There will be a number of additional meetings required to complete this work.

It will be challenging for the Board of Health to complete all of its required work in 2012 within its existing budget.

Comments

The Board of Health has taken steps to improve its oversight of its remuneration. This process is ongoing. The Board can expect to address this issue again later in the year and will have an opportunity to monitor its budget quarterly through-out 2012.

Strategic Direction

Board remuneration is an essential element of governance. This falls within the Board's strategic direction of "Continue to Meet Our Mandate".

Contact:

Rosana Pellizzari, Medical Officer of Health
(705) 743-1000, ext. 264
rpellizzari@pcchu.ca

Attachments:

Attachment A – Board of Health policy 2-240, Honoraria and Allowances
Attachment B – Health Protection and Promotion Act, 2004, part VI, Health Units and Board of Health (sec. s. 49 (1-11).

ATTACHMENT A

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

Board of Health Policy

Section:	Number:	Title:	Page:
Board of Health	**2-240**	**Honorarium and Allowances**	**1 of 2**

Approved by: Board of Health **Date: September 14, 2011** **Housekeeping Revision** **Approved by: _____** **On: _____**	**Original** **Approved by: Board of Health** **Date: December 10, 1986** **Revision** **Approved by: Board of Health** **On: September 14, 2011** **Reviewed** **By: By-Laws, Policies & Procedures Committee** **On: May 18, 2011**
Reference:	

An honorarium will be paid to each member of the Board of Health who is eligible for compensation in accordance with the Health Promotion and Protection Act.

The amount of the honorarium will be established by the Board of Health at the first regular meeting of the Board of Health each year.

The honorarium will be paid to each eligible Board member who attends:
(a) a regular meeting of the Board;
(b) a committee meeting;
(c) a conference or convention; or
(d) a business meeting on behalf of the Board.

A Board member who attends one meeting (or consecutive meetings) that extend over six hours, will receive one and one half times the regular honorarium.

A Board member will be paid one half of the regular honorarium when required to attend to Board business not covered in paragraph one. This will include cheque signing when not carried out a regular meetings.

Board members will not be compensated for attendance at community events unless representing the Chair of the Board of Health.

The quarterly financial report presented to the Board of Health will provide details of the Board of Health's section of the report.

Meeting attendance by County representatives on the Board of Health will be forwarded to the County Clerk’s office on a biannual basis.

Health Protection and Promotion Act
R.S.O. 1990, CHAPTER H.7

PART VI
HEALTH UNITS AND BOARDS OF HEALTH

Composition of board of health

49. (1) A board of health is composed of the members appointed to the board under this Act and the regulations. R.S.O. 1990, c. H.7, s. 49 (1).

Municipal members

(2) There shall be not fewer than three and not more than thirteen municipal members of each board of health. R.S.O. 1990, c. H.7, s. 49 (2).

Appointments by Lieutenant Governor in Council

(3) The Lieutenant Governor in Council may appoint one or more persons as members of a board of health, but the number of members so appointed shall be less than the number of municipal members of the board of health. R.S.O. 1990, c. H.7, s. 49 (3).

Remuneration

(4) A board of health shall pay remuneration to each member of the board of health on a daily basis and all members shall be paid at the same rate. R.S.O. 1990, c. H.7, s. 49 (4).

Expenses

(5) A board of health shall pay the reasonable and actual expenses of each member of the board of health. R.S.O. 1990, c. H.7, s. 49 (5).

Rate of remuneration

(6) The rate of the remuneration paid by a board of health to a member of the board of health shall not exceed the highest rate of remuneration of a member of a standing committee of a municipality within the health unit served by the board of health, but where no remuneration is paid to members of such standing committees the rate shall not exceed the rate fixed by the Minister and the Minister has power to fix the rate. R.S.O. 1990, c. H.7, s. 49 (6).

Term of office

(7) The term of office of a municipal member of a board of health continues during the pleasure of the council that appointed the municipal member but, unless ended sooner, ends with the ending of the term of office of the council. R.S.O. 1990, c. H.7, s. 49 (7).

Disqualification

(8) The seat of a municipal member of a board of health becomes vacant for the same reasons that the seat of a member of council becomes vacant under subsection 259 (1) of the *Municipal Act, 2001* or section 204 of the *City of Toronto Act, 2006*, as the case may be. R.S.O. 1990, c. H.7, s. 49 (8); 2002, c. 17, Sched. F, Table; 2006, c. 32, Sched. C, s. 23 (1).

Non-application

(9) Subsections (1) to (8) do not apply to,

(a) the regional municipalities of Durham, Halton, Niagara, Peel, Waterloo and York and the County of Oxford; or

(b) a single-tier municipality that, under the Act establishing or continuing it, has the powers, rights and duties of a local board of health or a board of health. 2001, c. 25, s. 477 (4).

Exception

(10) Subsections (4) to (6) apply despite section 283 of the *Municipal Act, 2001* and section 222 of the *City of Toronto Act, 2006*. 2002, c. 17, Sched. F, Table; 2006, c. 32, Sched. C, s. 23 (2).

Member of municipal council

(11) Subsections (4) and (5) do not authorize payment of remuneration or expenses to a member of a board of health, other than the chair, who is a member of the council of a municipality and is paid annual remuneration or expenses, as the case requires, by the municipality. R.S.O. 1990, c. H.7, s. 49 (11).

A Day In The Life Of Infant Development Workers

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

Our Infant Development Workers Wear Many Different Hats!

Julie Osk Cathy Marion

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

The Infant and Toddler ITDP Development Program

8:30 a.m.

8:30 a.m.

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

The Infant and Toddler Development Program

8:30 a.m.

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

The Infant and Toddler Development Program

8:30 a.m.

10:30 a.m.

10:30 a.m.

Five Counties Children's Centre
What we do for kids is amazing.

Peterborough Family Resource Centre

Kawartha-Haliburton Children's Aid Society

Kawartha Pine District School Board
(School for Young Moms)

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

The Infant and Toddler Development Program
ITDP

10:30 a.m.

10:30 a.m.

1:30 p.m.

1:30 p.m.

1:30 p.m.

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

The Infant and Toddler ITDP Development Program

1:30 p.m.

3:00 p.m.

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

The Infant and Toddler Development Program

3:00 p.m.

3:00 p.m.

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

The Infant and Toddler Development Program

Impact of the Program

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

The Infant and Toddler Development Program

Board of Health for the
Peterborough County-City Health Unit
Minutes
Wednesday, December 14, 2011
Board Room, 10 Hospital Drive

Present:

Board Members: Deputy Reeve Andy Sharpe, Chair
Councillor Andrew Beamer
Mr. Jim Embrey
Mayor John Fallis
Mr. Paul Jobe
Chief Keith Knott
Councillor Lesley Parnell
Reeve Mary Smith
Mr. David Watton

Regrets: Councillor Henry Clarke
Councillor Jill Smith

Staff: Mrs. Brittany Cadence, Supervisor, Communications Services
Mr. Andrew Kurc, Epidemiologist
Mrs. Barbara Matwey, Administrative Assistant
Dr. Rosana Pellizzari, Medical Officer of Health
Mrs. Alida Tanna, Administrative Assistant
Mr. Brent Woodford, Director, Corporate Services

1. Call to Order

Deputy Reeve Sharpe called the meeting to order at 4:50 p.m. and welcomed staff. Dr. Pellizzari introduced Mr. Brent Woodford, Director, Corporate Services and provided members with some brief background information on Mr. Woodford.

2. Confirmation of the Agenda

Moved by Reeve Smith — Seconded by Mayor Fallis

That the agenda be approved with the addition of correspondence from CUPE, ONA & OPSEU, and that agenda item 11, In-Camera be moved to immediately follow the approval of the agenda. - Carried - (M-11-135)

3. Declaration of Pecuniary Interest

There were no declarations of pecuniary interest.

In Camera

Moved by Mr. Jobe — Seconded by Mayor Fallis
That the Board of Health go In Camera to discuss confidential property and personnel matters.
- Carried - (M-11-136)

Moved by Councillor Parnell — Seconded by Mr. Watton
That the Board of Health rise from In Camera.
- Carried – (M-11-137)

Moved by Mr. Embrey — Seconded by Mr. Watton
That the Board of Health for the Peterborough County-City Health Unit approve the Memorandum of Settlement for Ontario Nurses Association (ONA);
- Carried - (M-11-138)

Moved by Chief Knott — Seconded by Councillor Parnell
That the Board of Health for the Peterborough County-City Health Unit approve the Health Unit's closure at twelve o'clock noon on Friday, December 23, 2011 and at twelve o'clock noon on Friday, December 30, 2011.
- Carried - (M-11-139)

Following the in camera session, Deputy Reeve Sharpe proposed that agenda item 9.2., Staff Report: 2012 Public Health Budgets be presented immediately before item 4, Delegations and Presentations.

Moved by Councillor Parnell — Seconded by Reeve Smith
That the agenda be further revised to allow for agenda item, 9.2., Staff Report: 2012 Public Health Budgets, to be presented immediately before item 4, Delegations and Presentations.
- Carried – (M-11-140)

Staff Report: 2012 Public Health Budgets
Presenter: Brent Woodford, Director, Corporate Services

Mr. Woodford and Dr. Pellizzari gave an overview of the budget and spoke about the impact of planned staff reductions for 2012.

Moved by Mr. Watton — Seconded by Reeve Smith

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

- the 2012 cost shared budget for public health programs and services in the total amount of $7,089,717;
- the 2012 cost shared budget for the vector-borne disease program in the total amount of $76,101; and,
- the 2012 program budgets funded 100% by the Ministry of Health and Long-Term Care as follows:

Infectious Disease Control	$222,233
Infection Prevention and Control Nurses	$84,872
Nurses Commitment	$170,040

- Carried - (M-11-139)

Moved by Councillor Parnell — Seconded by Reeve Smith

A recommendation that the Medical Officer of Health contact the CAO of the City and County to arrange a meeting with Minister Deb Matthews and members of the Board regarding public health funding.

- Carried - (M-11-140)

4. Delegations and Presentations

4.1 A Day in The Life - Epidemiologist
Presenter: Andrew Kurc

Mr. Kurc outlined the functions of an epidemiologist. He provided an overview of the different agencies that he collects such data of mortality rates, disease and injury rates, emergency room visits, school absenteeism rates, etc. and explained how he assists most programs throughout the health unit.

5. Confirmation of the Minutes of the Previous Meeting

Mr. Jobe noted a correction to item 9.5, Sub-Committee – Medical Officer of Health Performance Review.

Moved by Seconded by
Councillor Parnell Reeve Smith
That the minutes of the Board of Health meeting held on November 9, 2011 be approved as amended.

- Carried - (M-11-141)

6. Business Arising From the Minutes

Nil.

7. Correspondence

Moved by Seconded by
Councillor Parnell Councillor Beamer
That the following documents be received for information.

- Carried - (M-11-142)

1. Email correspondence received from delegations at the November 9, 2011 Board of Health meeting regarding wi-fi:
   - Sheena Symington, email dated November 15, 2011
   - Peter Stumpf, emails dated November 10 and December 2, 2011
2. Email dated December 2, 2011 from the Kawartha Safe Technology Initiative, to Chairman Sharpe and Board Members, regarding wi-fi.
3. Letter dated November 30, 2011 from the Honourable Leona Aglukkaq, Minister of Health, to Chairman Sharpe, in response to his letter dated October 3, 2011, regarding the reduction of artificial trans fat.
4. Letter dated November 24, 2011 from Dr. Rosana Pellizzari, to Lynn Fawn, Deputy Clerk/Office Supervisor, County of Peterborough, in response to her letter dated October 12, 2011, regarding the sale of beer and wine in convenience stores.
5. E-newsletter dated November 16, 2011 from Public Health Ontario.
6. Emails dated November 10, 2011, from Alida Tanna, Administrative Assistant, to Nancy Wright-Laking, City Clerk and Sally Saunders, County Clerk, forwarding a letter sent by Chairman Sharpe on November 2, 2011 to the Honourable Bob Chiarelli, Minister of Transportation, regarding cycling infrastructure.
7. Letter dated November 7, 2011 from Julie Spar Grand, Senior Vice President, Deputy General Counsel, National Hockey League, to Chairman Sharpe, in response to his letter dated May 30, 2011, regarding violence in hockey.
8. Letters/Resolutions from other Ontario Health Units:
   Grey Bruce Health Unit
   - Reducing Artificial Trans Fat

   Middlesex London Health Unit
   - Nutritious Food Basket

North Bay Parry Sound District Health Unit

- Contraband Tobacco

Thunder Bay District Health Unit

- Integration of Provincial Responsibilities for the Ontario Public Health Services

Toronto Public Health

- Submission to the Social Assistance Review Commission

Windsor-Essex County Health Unit

- Reducing Artificial Trans Fat

Moved by Mr. Embrey — Seconded by Mayor Fallis

To acknowledge receipt of delegation emails and update them on the Board of Health's progress.

- Carried - (M-11-143)

8. Program Reports

Nil.

9. New Business

9.1 2011/12 General Insurance Renewal

Presenter: Mr. David Warren, Canada Brokerlink

Moved by Councillor Smith — Seconded by Councillor Parnell

That the Board of Health for the Peterborough County-City Health Unit approve the 2011/12 General Insurance Program Renewal in the total amount of $49,119 (exclusive of HST).

- Carried - (M-11-144)

Moved by Mr. Embrey — Seconded by Mr. Watton

That the Director, Corporate Services, Mr. Brent Woodford undertake a comparison of Councillors' Accident, Legal and Liability insurance for adequacy of coverage and report back to the Board at the next meeting.

- Carried - (M-11-145)

9.2 Staff Report: 2012 Public Health Budgets

This item was moved up in the agenda, please refer to item 3 for details.

9.3 Staff Report: Implementation of the Chief Nursing Officer Initiative
Bob Dubay, Accounting Supervisor

Moved by: Chief Knott
Seconded by: Mr. Jobe

That the Board of Health for the Peterborough County-City Health Unit approve the addition of the Chief Nursing Officer position and the provincial funding, for 2011, in the amount of $29,175 and, for 2012, in the amount of $116,699.

- Carried - (M-11-146)

9.4 2010 Annual Report of the Chief Medical Officer of Health:
Health, Not Health Care – Changing the Conversation
Presenter: Dr. Rosana Pellizzari, Medical Officer of Health

Deferred.

10. Committee Reports

10.1 Governance Committee

Moved by: Mr. Embrey
Seconded by: Councillor Beamer

That the Board of Health for the Peterborough County-City Health Unit receive for information, meeting minutes of the Governance Committee for June 9, 2011, approved by the Committee on October 14, 2011.

- Carried - (M-11-147)

11. In Camera to Discuss Confidential Personnel and Property Matters

This item was moved up in the agenda, please refer to item 3 for details.

12. Date, Time, and Place of the Next Regular Meeting

The next meeting of the Board of Health will take place on January 11, 2012 or at the call of the Chair.

13. Adjournment

Moved by
Mr. Jobe

Seconded by
Mr. Embrey

That the meeting be adjourned.

- Carried – (M-11-148)

The meeting adjourned at 8:20 p.m.

_____
Chairperson

_____
Medical Officer of Health

To: All Members
Board of Health

From: Dr. Rosana Pellizzari, Medical Officer of Health

Subject: **Correspondence**

Date: January 11, 2012

Recommendation:

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

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1. Letters dated December 19, 2011 from Dr. Rosana Pellizzari, to local Members of Provincial Parliament regarding water pipes.

2. Email dated December 23, 2011 from Laura Pisko-Bezruchko (Director, Standards, Programs & Community Development, Ministry of Health Promotion and Sport) and Sylvia Shedden (Director, Public Health Standards, Practice and Accountability Brand, Public Health Division, Ministry of Health and Long-Term Care), to Chairman Sharpe, regarding performance targets for indicators included in the 2011-13 Public Health Accountability Agreement.

3. Email dated January 5, 2012 from the Association of Local Public Health Agencies (alPHa) regarding the 2012 Winter Symposium.

Original signed by

Rosana Pellizzari, M.D.

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

December 19, 2011

Mr. Jeff Leal, M.P.P. Peterborough
236 King Street
Peterborough, ON K9J 7L8

Dear Mr. Leal,

At its November 9, 2011 meeting, the Board of Health for the Peterborough County-City Health Unit considered the attached staff report titled *"Tobacco, Second-hand Smoke and Water-pipes (Hookah, Shisha)"*. The report reviewed the emerging use of water pipes and their potential impact on public health and the Health Unit's tobacco enforcement program.

The Board approved Motion No. M-11-127, moved by Councillor Smith, seconded by Mayor Fallis:

THAT the Board of Health for the Peterborough County-City Health Unit request:

- *Local municipalities with smoking by-laws to amend their bylaw to create a new definition of smoke and include prohibition of the burning of substances in all indoor public spaces, workplaces and outdoor public spaces; and*
- *That the Ministry of Health and Long-Term Care monitor and assess the public health effects of exposure to smoke from water-pipe usage in public indoor spaces.*

The Board later moved that this motion be forwarded to local Members of Provincial Parliament.

Sincerely,

Original signed by

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

Encl.

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

December 19, 2011

Ms. Laurie Scott, M.P.P. Haliburton-Kawartha Lakes-Brock
14 Lindsay St. N.
Lindsay, ON K9V 1T4

Dear Ms. Scott,

At its November 9, 2011 meeting, the Board of Health for the Peterborough County-City Health Unit considered the attached staff report titled *"Tobacco, Second-hand Smoke and Water-pipes (Hookah, Shisha)"*. The report reviewed the emerging use of water pipes and their potential impact on public health and the Health Unit's tobacco enforcement program.

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- *That the Ministry of Health and Long-Term Care monitor and assess the public health effects of exposure to smoke from water-pipe usage in public indoor spaces.*

The Board later moved that this motion be forwarded to local Members of Provincial Parliament.

Sincerely,

Original signed by

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

Encl.

From: Shedden, Sylvia (MOH) [mailto:Sylvia.Shedden@ontario.ca]
Sent: Friday, December 23, 2011 2:55 PM
To: 2andysharpe@gmail.com
Cc: Alida Tanna; Rosana Pellizzari; Harlow, Steve (MHP); Martino, Roselle (MOH); Pisko, Laura (MHP); Belfie, Laura (MHP); Sweetnam, Jacky (MOH)
Subject: Peterborough County - Performance Targets for the 2011-13 Accountability Agreement Indicators

Sent on behalf of Laura Pisko-Bezruchko and Sylvia Shedden

Dear Mr. Sharpe,

We are pleased to provide you with a joint communication from Steve Harlow, Assistant Deputy Minister, Sport, Public Health and Community Programs, Ministry of Health Promotion and Sport, and Roselle Martino, Executive Director (A), Public Health Division, Ministry of Health and Long-Term Care that provides performance targets for the indicators included in the 2011-2013 Public Health Accountability Agreement, and explains the process for negotiation of the targets. Please also find attached four additional documents: 1) two spreadsheets (one for health protection indicators and one for health promotion indicators) that include your individualized baselines and proposed targets for 2012 and 2013; 2) a document that includes supplementary provincial data and a summary of proposed targets in relation to baseline data for all indicators; and 3) the Webinar Participant Guide referred to in the communication.

Please feel free to contact either of us if you have any questions.

Sincerely,

Laura Pisko-Bezruchko
Director
Standards, Programs & Community Development
Ministry of Health Promotion and Sport
416-327-7445 (office)
416-451-3185 (cell)

Sylvia Shedden
Director
Public Health Standards, Practice and Accountability Branch
Public Health Division
Ministry of Health and Long-Term Care
416-327-7423

Ministry of Health and Long-Term Care

Executive Director's Office

Public Health Division
11th Floor, Hepburn Block
Queen's Park
Toronto ON M7A 1R3

Telephone: (416) 212-3831
Facsimile: (416) 325-8412

Ministère de la Santé et des Soins de longue durée

Bureau du directeur général

Division de la santé publique
Édifice Hepburn, 11e étage
Queen's Park
Toronto ON M7A 1R3

Téléphone: (416) 212-3831
Télécopieur: (416) 325-8412

Ministry of Health Promotion and Sport

Office of the
Assistant Deputy Minister
Sport, Public Health and
Community Programs

777 Bay Street, 18th Floor
Toronto ON M7A 1S5
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www.mhp.gov.on.ca

Ministère de la Promotion de la santé et du Sport

Bureau du
sous-ministre adjoint
Sports, santé publique et
programmes communautaires

777, rue Bay, 18e étage
Toronto ON M7A 1S5
Tél. : 416 326-4371
Téléc. : 416 326-4864
ATS : 416 212-5723
ATS sans frais : 1 866 263-1410
www.mhp.gov.on.ca

December 23, 2011

MEMORANDUM TO: Board of Health Chairs and Medical Officers of Health/CEOs

RE: Performance Targets for the Accountability Agreement Indicators

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The Ministries of Health and Long-Term Care and Health Promotion and Sport are very pleased to have this opportunity to provide performance targets for the indicators included in the 2011-2013 Public Health Accountability Agreements to all boards of health. The ministries have reviewed baseline data for all Public Health Units and have established proposed targets for improvement for Ontario's public health system. We welcome the opportunity to initiate performance target negotiations with all boards of health and we look forward to a continued productive relationship as we work together to improve accountability and performance for all boards and public health units in Ontario, and the public health system as a whole.

The initiation of performance target negotiations for Ontario's public health system represents a significant milestone in the continued implementation of the government's public health renewal agenda, and the performance framework for public health. The government has made significant strides in public health renewal including: the release of the Initial Report on Public Health, the Ontario Public Health Standards (OPHS), the Public Health Organizational Standards and the Accountability Agreements including performance indicators.

The indicator targets are intended to move all boards toward improved performance in key areas of health protection and health promotion, and reflect achievable increments of change. For indicators that are directly linked to required activities under the OPHS, the goal will be to move individual boards toward full achievement of the requirements set out in the Standards. For other indicators, directional/incremental targets will also be set to improve board performance, resulting in system level improvement.

Along with this memo you will find two target negotiation spreadsheets, one for the health protection

…/2

indicators and one for the health promotion indicators. Each spreadsheet includes your board's individualized indicator baseline data, proposed targets for performance improvement for the remaining term of the Accountability Agreement; 2012 and 2013, and rationale for the proposed targets. Please review the attached spreadsheets and respond to the Ministries via PHUIndicators@ontario.ca with your acceptance of the proposed targets or any proposals for revised targets.

As communicated previously, baseline and target setting for the Low-Risk Drinking Guidelines indicator is underway as new syntax is being developed that is compatible with the new, national Low-Risk Drinking Guidelines that were released on November 25, 2012. The health promotion target negotiation spreadsheet enclosed is for your information only. It will be updated with individualized baseline and target information for the Low-Risk Drinking Guidelines indicator and will be sent to each board in mid-January for completion.

We recognize that boards of health may want to discuss their targets and/or negotiate alternate targets with the ministries prior to completing the enclosed table. Between January 16-20, 2012 meetings can be arranged with Sylvia Shedden and/or Laura Pisko-Bezruchko. If you are interested in scheduling a meeting please contact Melisa Arias-Montes at 416-212-7817 for health protection or Sid Banerji for health promotion at 416-326-2044.

We are also planning to offer an informational webinar on January 16, 2012 from 12:00 to 1:00pm to review the performance targets and negotiations process and to answer any questions. The dial-in information is the following:

Teleconference dial-in: 416-212-8014 or 1-866-500-5845
Participant code: 9783274#
Webinar URL: https://elearning.moh.gov.on.ca/phu_indicators/
The participant guide for the webinar is attached.

Please contact Sylvia Shedden for health protection indicators at 416-327-7423 or Laura Pisko-Bezruchko for health promotion indicators at 416-327-7445 if you have any questions about this package or about the negotiations process. Please also see Appendix A of this document which includes instructions for completing and responding to the enclosed spreadsheets.

In closing we would like to express our gratitude to our colleagues from the field who have contributed their time, effort, and expertise to this important work. This work would not have been possible without their commitment.

Yours sincerely,

Original Signed By

Steve Harlow
Assistant Deputy Minister

Original Signed By

Roselle Martino
Executive Director (A)

Enclosure: Appendix A

c: Sylvia Shedden, Director, Public Health Standards, Practice and Accountability, MOHLTC
Laura Pisko-Bezruchko, Director, Standards, Programs & Community Development, MHPS

Appendix A

Completing and Responding to Target Negotiation Spreadsheet: Instructions for Boards

Step 1	√ Please review the target negotiation spreadsheets. √ Note that an updated version of the health promotion target negotiation spreadsheet which will include the Low-Risk Drinking Guidelines indicator will be sent to you in mid-January for completion.
Step 2	√ For each indicator, please complete column 1 for both 2012 and 2013 by entering "Y" if you accept the proposed performance target and enter "N" if you do not accept the proposed target.
Step 3	√ If you have entered "N" in column 1 for any performance indicator, please identify your proposed alternate target for 2012 and/or 2013 in columns 2 and/or 4.
Step 4	√ Please provide your rationale for any proposed alternate performance target in columns 3 and/or 5.
Step 5	√ Please enter the current date in the "Board of Health Proposed Targets" Section and submit the completed table to PHUIndicators@ontario.ca by January 31st, 2012 or as soon as possible thereafter. As noted in the attached memo, if you wish to schedule a meeting to discuss your board's baseline and/or performance targets please contact Melisa Arias-Montes at 416-212-7817 or Sid Banerji at 416-326-2044.

PETERBOROUGH COUNTY - CITY BOARD OF HEALTH Accountability Agreement Performance Indicator Targets		Ontario Median	Ontario Range	Your Baseline	MOHLTC Identified Targets				Board of Health Proposed Targets					
					Date: 12/23/2011				Date:					
					2012 Target	Rationale for 2012 Target	2013 Target	Rationale for 2013 Target	1 Board of Health Accepts (Y/N)		2	3	4	5
Indicator									###	2013	2012 Target	Board of Health Rationale for 2012 Target	2013 Target	Board of Health Rationale for 2013 Target
1	% of high risk food premises inspected once every 4 months while in operation Baseline Year: 2010	82%	15% - 100%	86%	100%	It is anticipated that with improvements to business practices and data quality, the board of health will be able to make signficant improvements in 2012.	100%	All boards of health are expected to meet the requirements as stated in the Ontario Public Health Standards.						
2	% of pools and public spas by class inspected while in operation Baseline Year: 2010	73%	0% - 100%	57%	≥ 75%	It is acknowledged that baseline results may be reflective of issues with data retrieval. It is anticipated that with improvements to business practices and data quality, the board of health will be able to make signficant improvements in 2012.	100%	All boards of health are expected to meet the requirements as stated in the Ontario Public Health Standards.						
3	% of high-risk Small Drinking Water Systems (SDWS) inspections completed for those that are due for re-inspection Baseline Year: unavailable	cannot be established	cannot be established	cannot be established	100%	The target for this indicator is not negotiable. Baseline data is not available for this indicator. All boards of health are expected to complete the required inspections of high-risk SDWS as stated in the Ontario Public Health Standards.	100%	The target for this indicator is not negotiable. All boards of health are expected to complete the required inspections of high-risk SDWS as stated in the Ontario Public Health Standards.						
4	Time between health unit notification of a case of gonorrhoea and initiation of follow-up *This indicator measures the percentage of confirmed gonorrhoea cases where initiation of follow-up occurred within 0-2 business days* Baseline Year: 2010	80%	0% - 100%	93%	100%	Trend data has shown significant improvements in performance every year since 2008 for a number of boards of health, indicating that a 100% target is likely achievable.	100%	All boards of health are expected to meet the requirements as stated in the Ontario Public Health Standards.						

PETERBOROUGH COUNTY - CITY BOARD OF HEALTH Accountability Agreement Performance Indicator Targets		Ontario Median	Ontario Range	Your Baseline	MOHLTC Identified Targets				Board of Health Proposed Targets					
					Date: 12/23/2011				Date:					
					2012 Target	Rationale for 2012 Target	2013 Target	Rationale for 2013 Target	1 Board of Health Accepts (Y/N)		2	3	4	5
	Indicator								###	2013	2012 Target	Board of Health Rationale for 2012 Target	2013 Target	Board of Health Rationale for 2013 Target
5	Time between health unit notification of an Invasive Group A Streptococcal Disease (iGAS) case and initiation of follow-up *This indicator measures the percentage of confirmed iGAS cases where initiation of follow-up occurred on the same day as receipt of lab confirmation of a positive case* Baseline Year: 2010	94%	3% - 100%	87%	100%	iGAS is a serious disease that requires immediate follow-up. Historical data has also shown relatively low case counts for all boards of health. With improvements in business practices, it is anticipated that all boards of health will be able to initiate follow-up of all cases on the same day.	100%	iGAS is a serious disease that requires immediate follow-up. Historical data has also shown relatively low case counts for all boards of health. With improvements in business practices, it is anticipated that all boards of health will be able to initiate follow-up of all cases on the same day.						
6	DEFERRED: % of known high risk personal services settings inspected annually	n/a	n/a	n/a										
7a	% of vaccine wasted by vaccine type that is stored/administered by the public health unit (HPV) Baseline Year: 2010	0.1%	0.0% - 16.6%	0.0%	Maintain or improve current wastage rates	Boards of health that are successful in meeting the requirements as stated in the Ontario Public Health Standards are required to maintain their results or improve.	Maintain or improve current wastage rates	Boards of health that are successful in meeting the requirements as stated in the Ontario Public Health Standards are required to maintain their results or improve.						
7b	% of vaccine wasted by vaccine type that is stored/administered by the public health unit (influenza) Baseline Year: 2010	2.7%	0.0% - 33.3%	2.6%	Maintain or improve current wastage rates	Boards of health that are successful in meeting the requirements as stated in the Ontario Public Health Standards are required to maintain their results or improve.	Maintain or improve current wastage rates	Boards of health that are successful in meeting the requirements as stated in the Ontario Public Health Standards are required to maintain their results or improve.						
8	DEFERRED: % completion of reports related to vaccine wastage by vaccine type that is stored/ administered by other health care providers	n/a	n/a	n/a										
9a	% of school-aged children who have completed immunizations for Hepatitis B Baseline Year: 2009/10	80.3%	29.0% - 89.8%	77.9%	Maintain or improve current coverage rates	Due to the timing of the target negotiation process, it is acknowledged that significant performance improvement of school-based immunization programs in the 2011/2012 school year may not be achievable. As such, boards of health are required to maintain coverage rates or improve where possible.	95.0%	Boards of health are required to improve immunization coverage and work towards achievement of National immunization coverage targets.						

PETERBOROUGH COUNTY - CITY BOARD OF HEALTH Accountability Agreement Performance Indicator Targets		Ontario Median	Ontario Range	Your Baseline	MOHLTC Identified Targets				Board of Health Proposed Targets					
					Date: 12/23/2011				Date:					
					2012 Target	Rationale for 2012 Target	2013 Target	Rationale for 2013 Target	1 Board of Health Accepts (Y/N)		2	3	4	5
Indicator									###	2013	2012 Target	Board of Health Rationale for 2012 Target	2013 Target	Board of Health Rationale for 2013 Target
9b	% of school-aged children who have completed immunizations for HPV Baseline Year: 2009/10	52.0%	1.7% - 65.0%	46.0%	Maintain or improve current coverage rates	Due to the timing of the target negotiation process, it is acknowledged that significant performance improvement of school-based immunization programs in the 2011/2012 school year may not be achievable. As such, boards of health are required to maintain coverage rates or improve where possible.	90.0%	The target has been established to move all boards of health towards achievement of National coverage targets.						
9c	% of school-aged children who have completed immunizations for meningococcus Baseline Year: 2009/10	86.7%	52.5% - 93.8%	79.6%	Maintain or improve current coverage rates	Due to the timing of the target negotiation process, it is acknowledged that significant performance improvement of school-based immunization programs in the 2011/2012 school year may not be achievable. As such, boards of health are required to maintain coverage rates or improve where possible.	90.0%	Boards of health are required to improve immunization coverage and work towards achievement of National immunization coverage targets.						

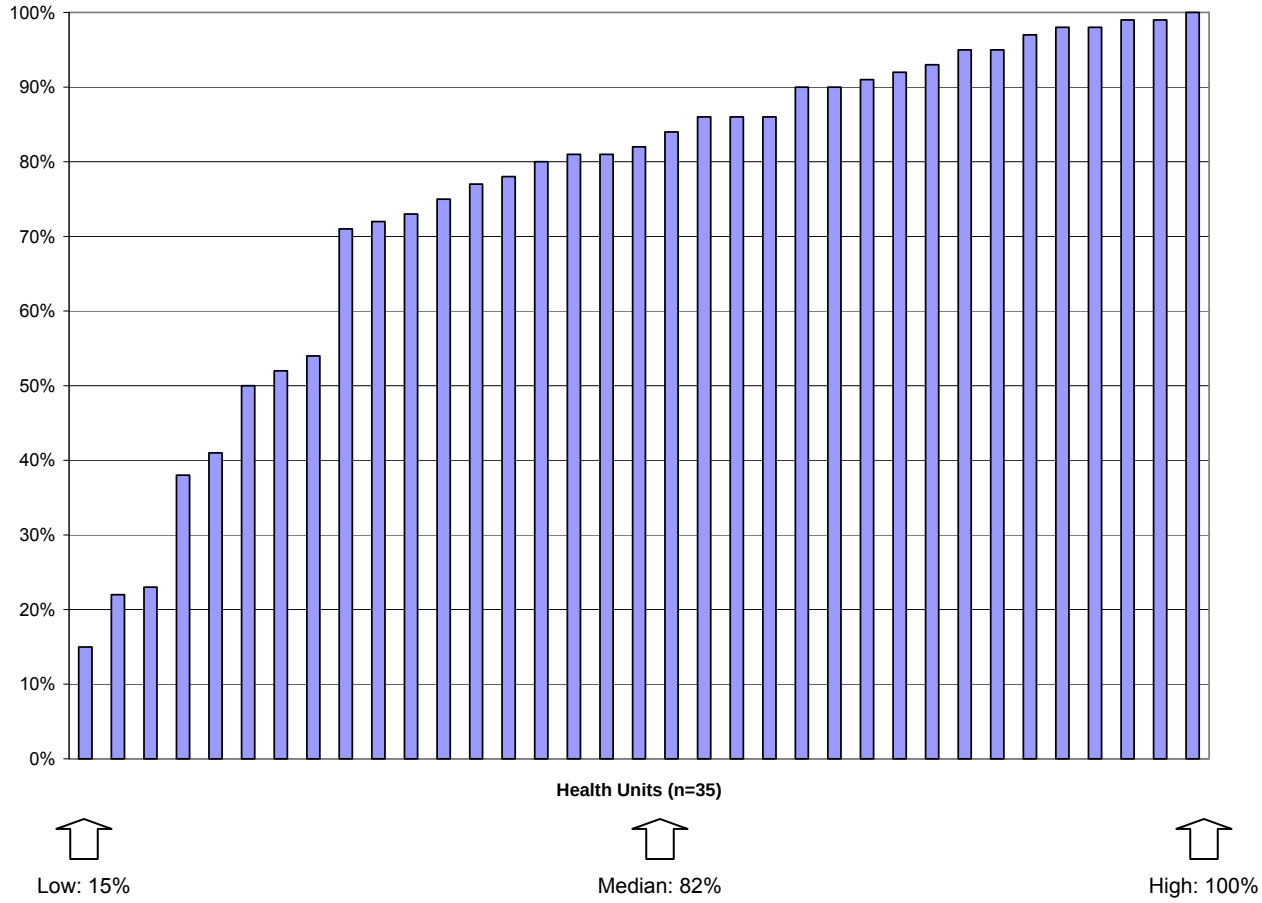
This spreadsheet is for information purposes only. *An updated version of this spreadsheet with information for the Low-Risk Drinking Guidelines Indicator will be sent to you in early January 2012 for completion.*

	PETERBOROUGH Accountability Agreement Performance Indicator Targets	Baseline Period	Ontario Median	Ontario Range	Your Baseline	MHPS Identified Targets December 2011				Board of Health Proposed Targets Date:					
										1 Board of Health Accepts (Y/N)		2	3	4	5
	Indicator					2012 Target	Rationale for 2012 Target	2013 Target	Rationale for 2013 Target	2012	2013	2012 Target	Board of Health Rationale for 2012 Target	2013 Target	Board of Health Rationale for 2013 Target
10	% of youth (ages 12-18) who have never smoked a whole cigarette	2009+2010	84.2%	67.3%-92.5%	87.6%	N/A	MHPS will monitor 2012 results but due to data quality, will only set a 2013 target using combined 2012-2013 data.	89.4%	Achievement of targets will result in continued improvement at the provincial level. Your health unit is in quartile 2 which has been assigned a target of +2% relative to your baseline based on current performance and room for further improvement.						
11	% of tobacco vendors in compliance with youth access legislation at the time of last inspection	2011	94%	79%-100%	86%	≥90%	Achievement of targets will result in maintaining the current provincial tobacco vendor compliance rates. Your health unit has been assigned a tobacco vendor compliance rate target of ≥90% based on current performance and room for further improvement. A minimum of a 90% tobacco vendor compliance rate has been documented as the level that effectively limits youth access to tobacco products and takes into consideration other confounding factors.	≥90%	Achievement of targets will result in maintaining the current provincial tobacco vendor compliance rates. Your health unit has been assigned a tobacco vendor compliance rate target of ≥90% based on current performance and room for further improvement. A minimum of a 90% tobacco vendor compliance rate has been documented as the level that effectively limits youth access to tobacco products and takes into consideration other confounding factors.						
12	Fall-related emergency visits in older adults aged 65+ (rate per 100,000 per year)	2009	6,020	3817-8365	5,863	N/A	MHPS will continue to monitor 2012 results but due to data lag, will only set a 2013 target.	5,687	Achievement of targets will result in a reversal of the current provincial trend of increasing falls rates among those aged 65 years+. Note that 2013 target reflects 2012 achievements. Your health unit is in quartile 2 which has been assigned a target of -3% relative to your baseline, based on current performance and room for further improvement.						
13	**Pending calculation based on new low-risk drinking guidelines** % of population (19+) that exceeds the Low-Risk Drinking Guidelines	TBD	TBD	TBD	TBD										
14	Baby Friendly Initiative Status (category)	2011	N/A	Preliminary - Designated	Designated	Designated	MHPS' goal is to have all public health units BFI Designated to support breastfeeding in Ontario. Currently your health unit is in the Designated category, with the assigned target of maintaining BFI Designation.	Designated	MHPS' goal is to have all public health units BFI Designated to support breastfeeding in Ontario. Your health unit will be in the Designated category, with the assigned target of maintaining BFI Designation.						

Supplementary Provincial Summary Data and Proposed Targets
Public Health Accountability Agreement Indicators
Ministry of Health and Long-Term Care (MOHLTC) and Ministry of Health Promotion and Sport (MHPS)

Indicator 1: % of high-risk food premises inspected once every 4 months in operation

Description: Monitors rates of completed food safety inspections to monitor risks, and to ensure that boards of health are meeting the prescribed inspection frequency for permanent high risk food premises.



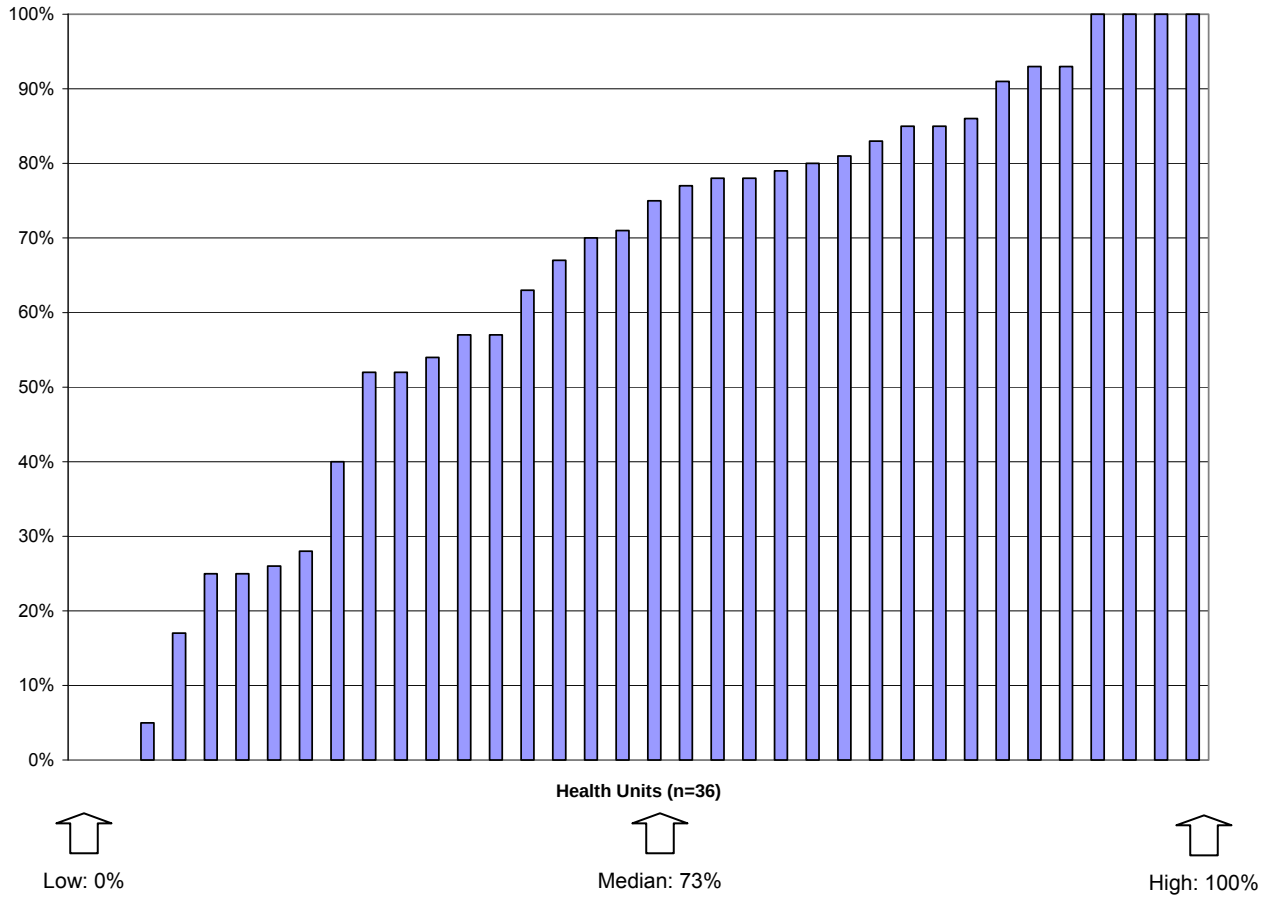
Proposed Performance Targets:

Baseline Result (2010)	2012 Target	2013 Target
≥70% - 100% or Unknown	100%	100%
<70%	≥85%	100%

Background document for Board of Health information only - not for broader circulation

Indicator 2: % of pools and public spas by class inspected while in operation

Description: In the early stages of implementation, this indicator will track the proportion of Class A pools (including municipal pools) inspected once every 3 months and at least twice a year while in operation.



Proposed Performance Targets:

Baseline Result (2010)	2012 Target	2013 Target
≥80% - 100%	100%	100%
≥60% - 79%	≥85%	100%
<60%	≥75%	100%

Indicator 3: % of high-risk Small Drinking Water Systems (SDWS) inspections completed for those that are due for re-inspection

Description: Proportion of inspections completed every 2 years of SDWS that have been identified as high risk and that are due for re-inspection.

Provincial Data:

As program implementation began in 2009, comprehensive baseline data is not currently available.

Performance Targets:

Baseline Result	2012 Target*	2013 Target*
Not available	100% (includes inspections that are due in 2012 and those that are overdue)	100% (includes inspections that are due in 2013 and those that are overdue)

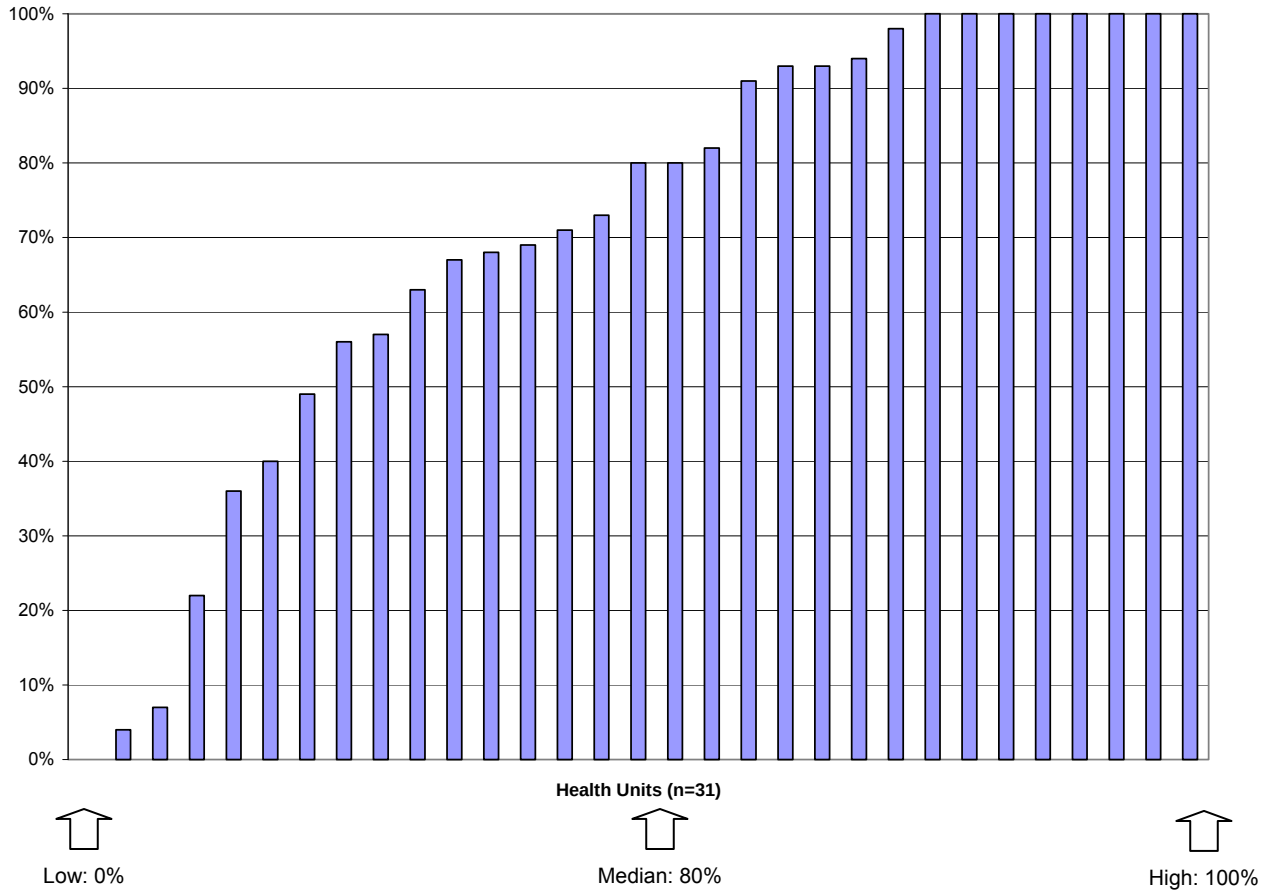
*Targets for this indicator will be non-negotiable.

Indicator 4: Time between health unit notification of a case of gonorrhoea and initiation of follow-up

Description:

- Proportion of confirmed gonorrhoea cases where initiation of follow-up occurred within 0-2 business days.

% of Gonorrhoea Cases Followed-Up within 0-2 Work Days by Board of Health, 2010.



Proposed Performance Targets:

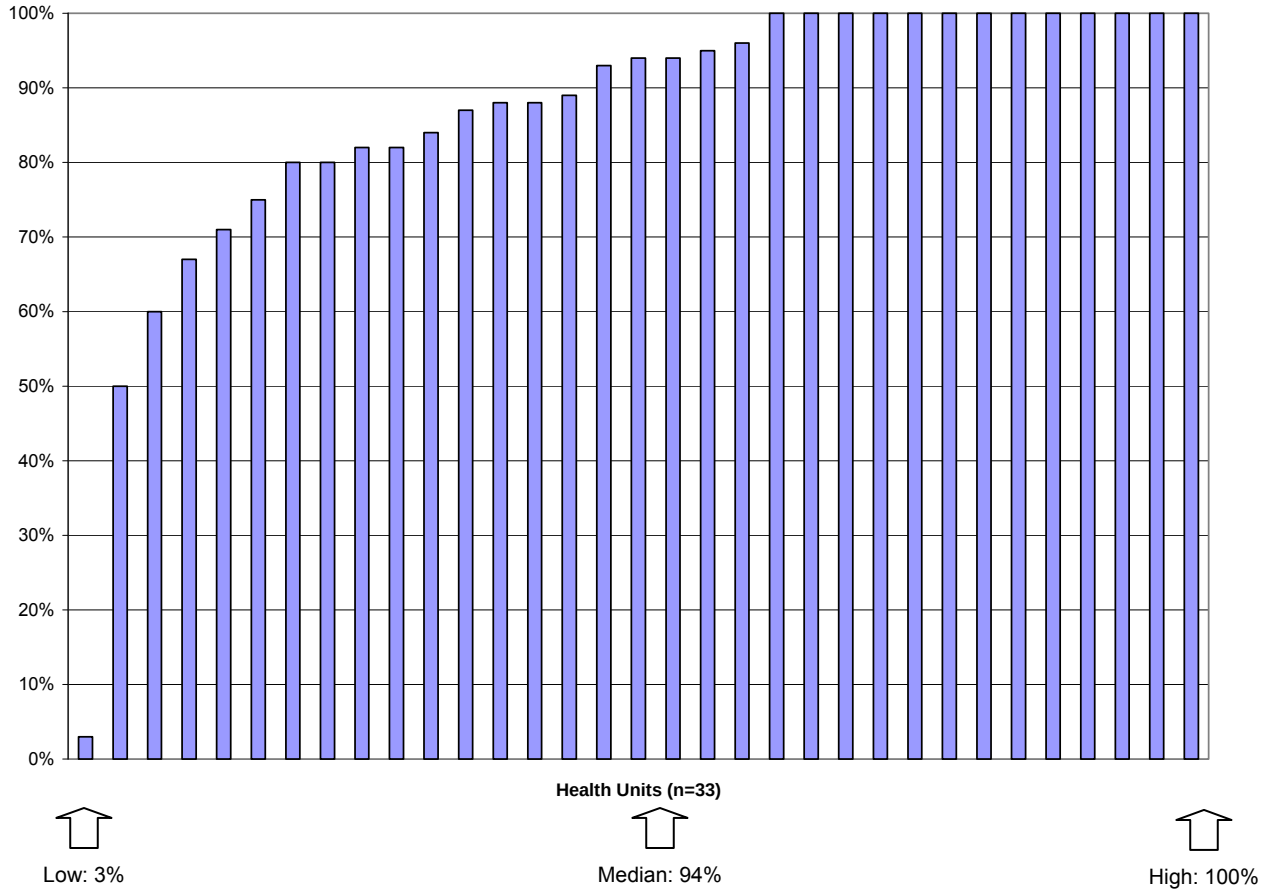
Baseline Result (2010)	2012 Target	2013 Target
≥70% - 100% or Unknown	100%	100%
<70%	≥ 70%	100%

Indicator 5: Time between health unit notification of a case of an invasive Group A Streptococcal Disease (iGAS) case and initiation of follow-up

Description:

- Proportion of confirmed iGAS cases where initiation of follow-up occurred on the same day as receipt of lab confirmation of a positive case.

% of iGAS Cases Followed-Up on the Same Day by Health Unit, 2010.



Proposed Performance Targets:

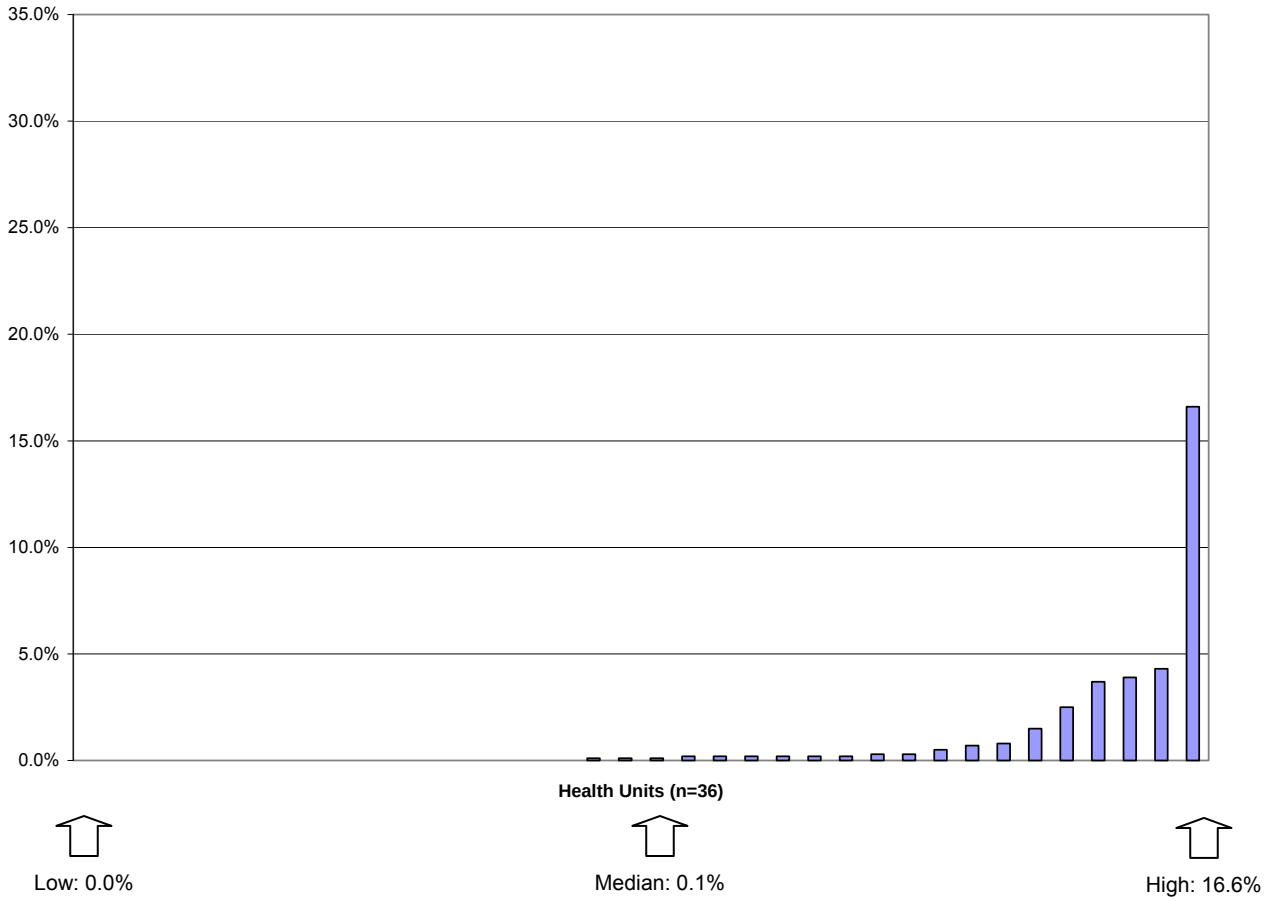
Baseline Result (2010)	2012 Target	2013 Target
All boards of health (3% - 100%)	100%	100%

Indicator 7a: % of vaccine wasted by vaccine type that is stored/administered by the public health unit (HPV)

Description:

- Monitors the percentage of wastage of publicly funded vaccines that are stored, transported or administered by public health units for the HPV (Gardasil) vaccine.

Percent wastage of HPV vaccine by health unit, 2010



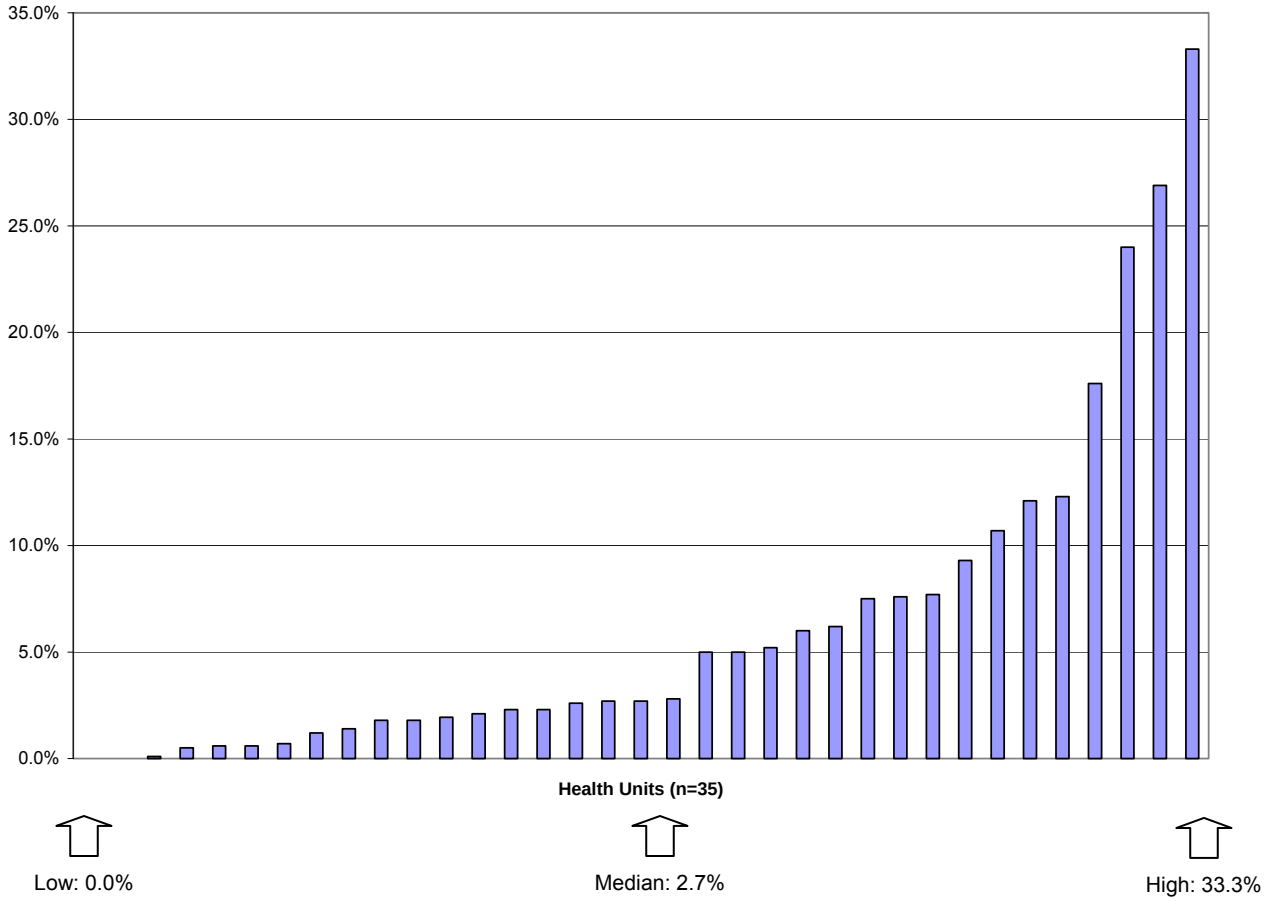
Proposed Performance Targets:

Baseline Result (2010)	2012 Target	2013 Target
≤5% wastage	Maintain or improve current wastage rates	Maintain or improve current wastage rates
>5% wastage	≤5%	≤5%

Indicator 7b: % of vaccine wasted by vaccine type that is stored/administered by the public health unit (Influenza)

Description: Monitors the percentage of wastage of publicly funded vaccines that are stored, transported, or administered by public health units; in this case, Influenza vaccines: Vaxigrip and Fluviral

Percent Wastage of Influenza vaccine by Health Unit, 2010



Proposed Performance Targets:

Baseline Result (2010)	2012 Target	2013 Target
≤5% wastage	Maintain or improve current wastage rates	Maintain or improve current wastage rates
>5% - 15% wastage	≤5% wastage	≤5% wastage
>15% wastage	<10% wastage	≤5% wastage

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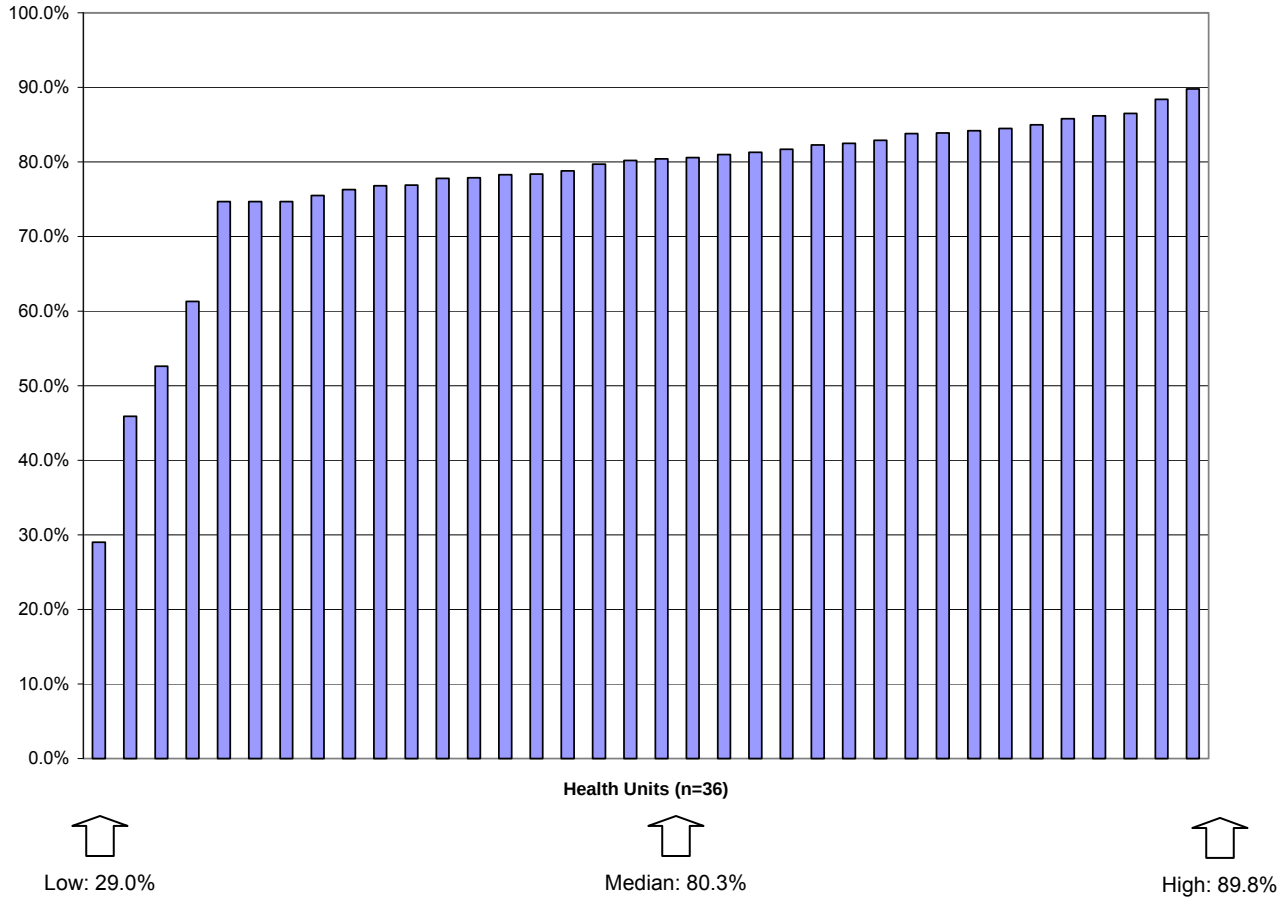
Indicator 9a: % of school-aged children who have completed immunizations for Hepatitis B

Description: Percentage of 12 year old students who have completed their immunization series with the hepatitis B vaccine by the end of the school year.

Hepatitis B Immunization coverage of Grade 7 students by health unit, 2009/10 school year.



Proposed Performance Targets:

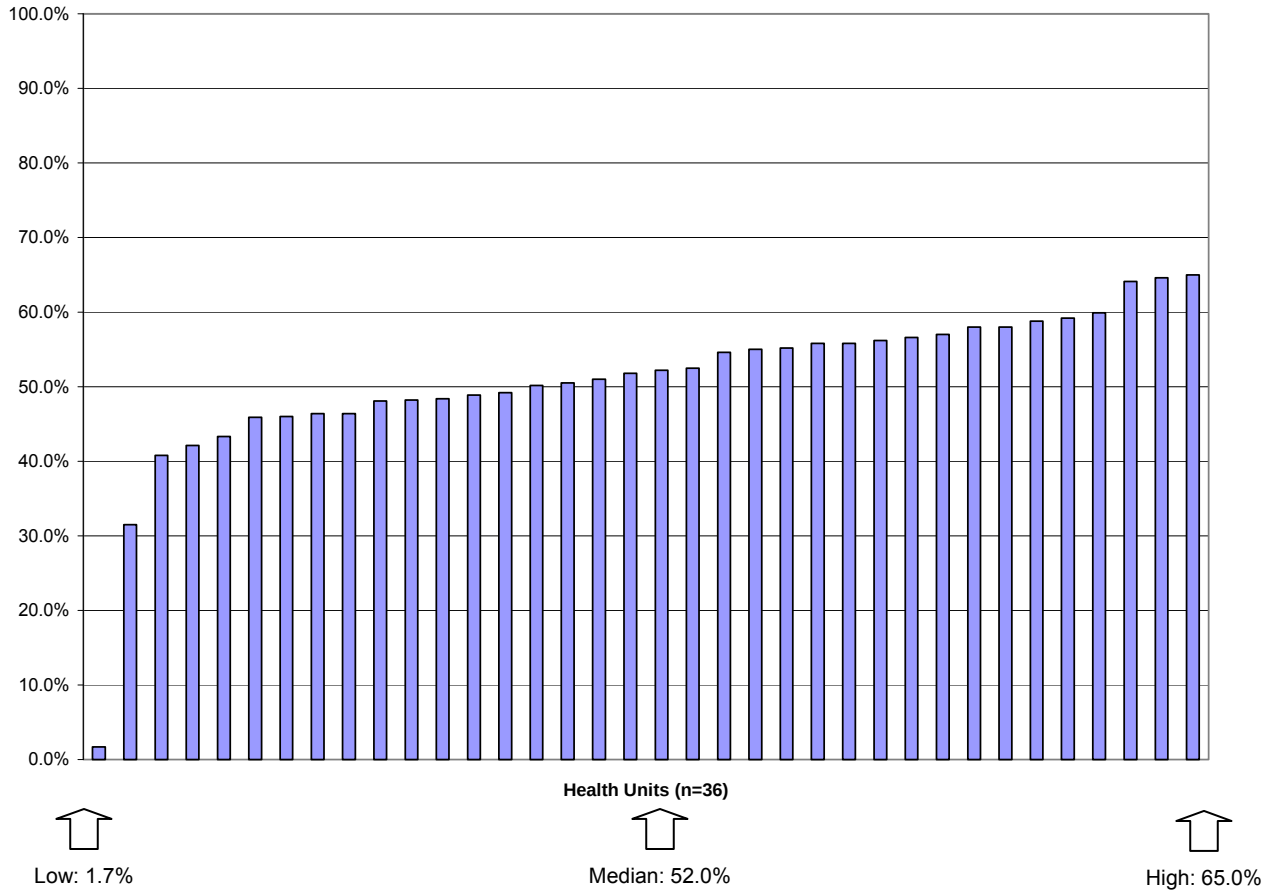
Baseline Result (2009/10)	2012 Target (2011/12 School Year)	2013 Target (2012/13 School Year)
All boards of health (29.0% - 89.8%)	Maintain or improve current coverage rates	95%

Indicator 9b: % of school-aged children who have completed immunizations for HPV

Description:

- Percentage of 13 year old female students who have completed their immunization series with the Human Papillomavirus (HPV) vaccine by the end of the school year.

HPV Immunization coverage of Grade 7 students by health unit, 2009/10 school year.



Proposed Performance Targets:

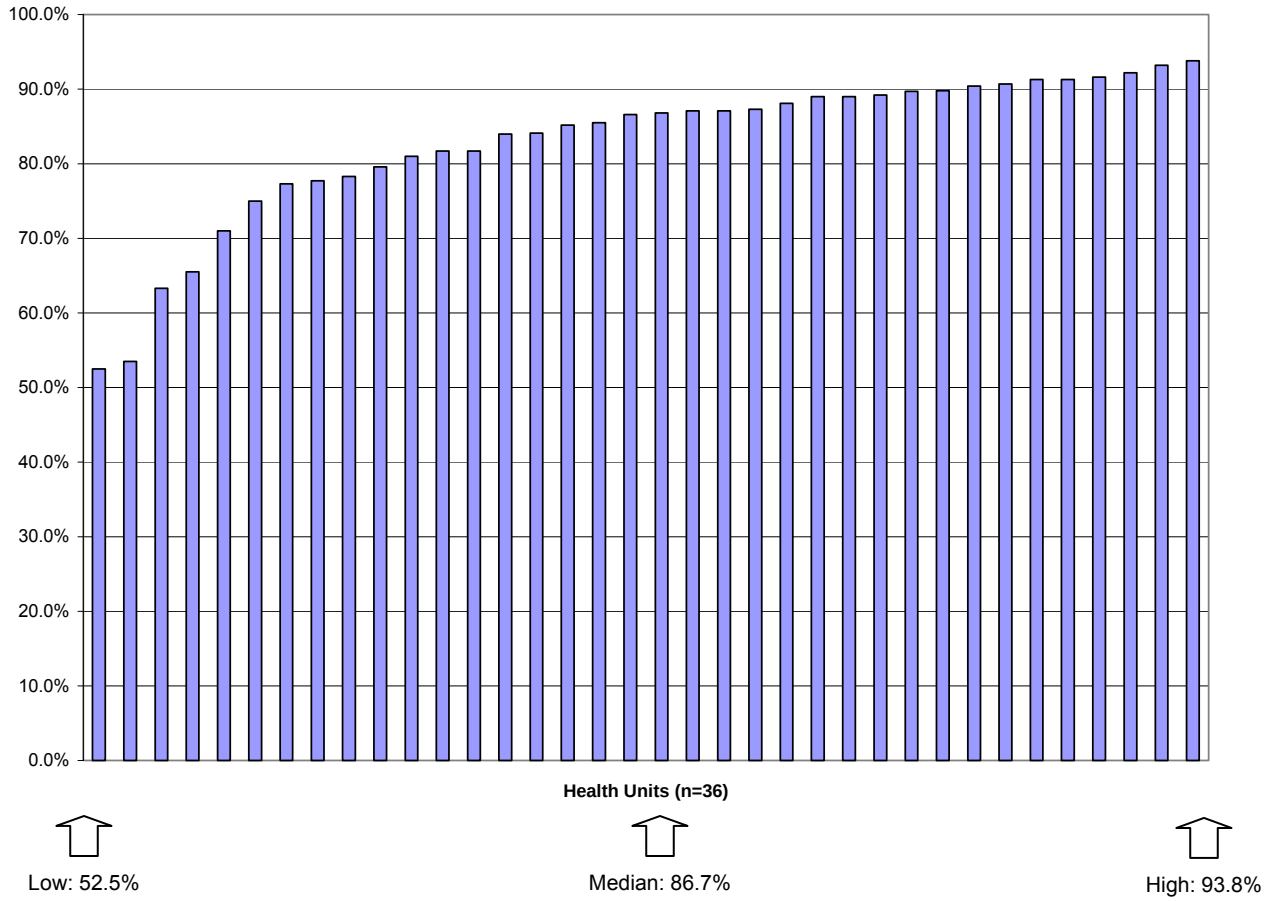
Baseline Result (2009/10)	2012 Target (2011/12 School Year)	2013 Target (2012/13 School Year)
All boards of health (1.7% - 65.0%)	Maintain or improve current coverage rates	90%

Indicator 9c: % of school-aged children who have completed immunizations for Meningococcus

Description:

- Percentage of 12 year old students who have completed their immunization series with the meningococcal conjugate C or ACYW vaccine by the end of the school year.

Meningococcal Immunization coverage of Grade 7 students by health unit, 2009/10 school year.



Proposed Performance Targets:

Baseline Result (2009/10)	2012 Target (2011/12 School Year)	2013 Target (2012/13 School Year)
≥90%	Maintain or improve current coverage rates	Maintain or improve current coverage rates
<90%	Maintain or improve current coverage rates	90%

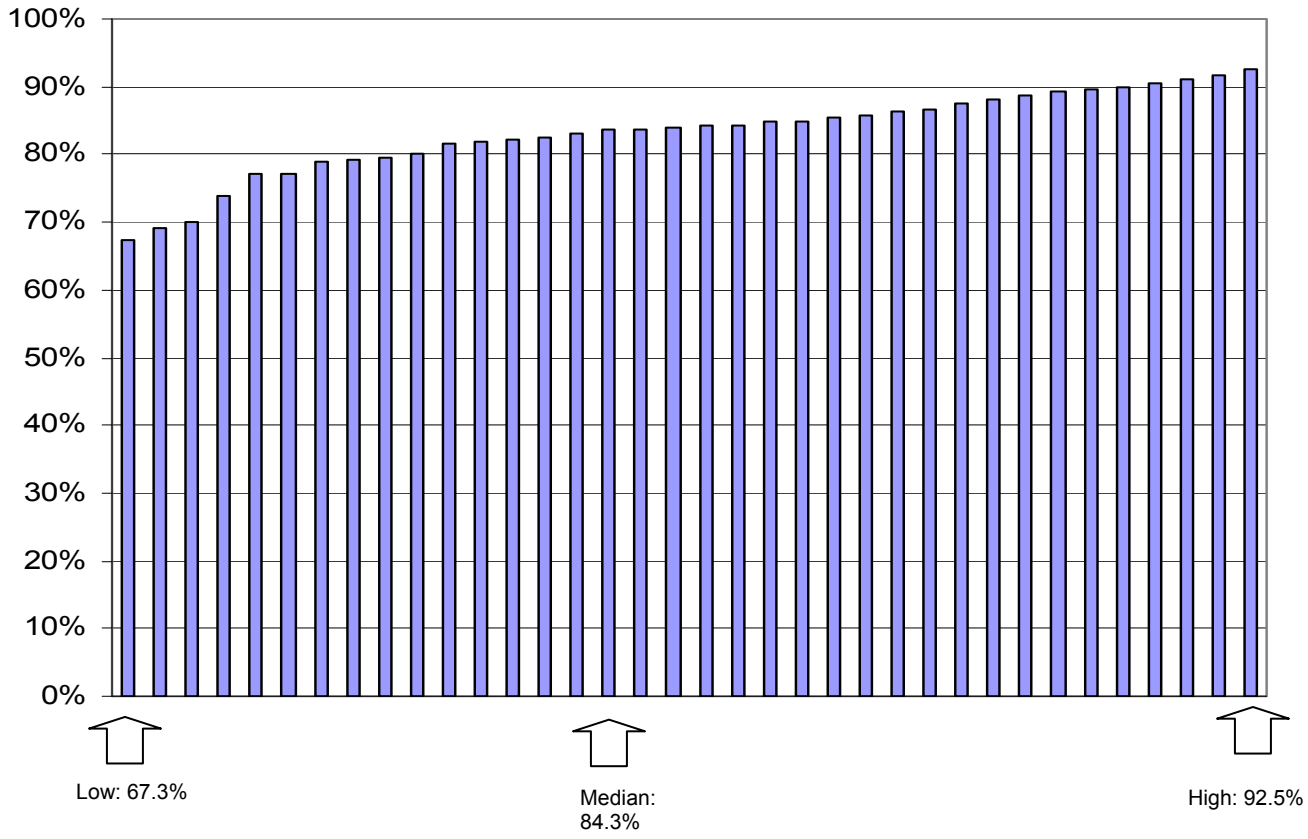
Background document for Board of Health information only - not for broader circulation

Indicator 10: % of youth (ages 12 - 18) who have never smoked a whole cigarette

Description:

- This indicator measures the percent of youth ages 12- 18 who report they have never smoked a whole cigarette.

Percentage of youth (ages 12-18) who have never smoked a whole cigarette by health unit, 2009 and 2010.



Proposed Performance Targets:

Performance Quartile at Baseline	2012 Target*	2013 Target
1	N/A	+1% relative to baseline
2	N/A	+2% relative to baseline
3	N/A	+2% relative to baseline
4	N/A	+3% relative to baseline

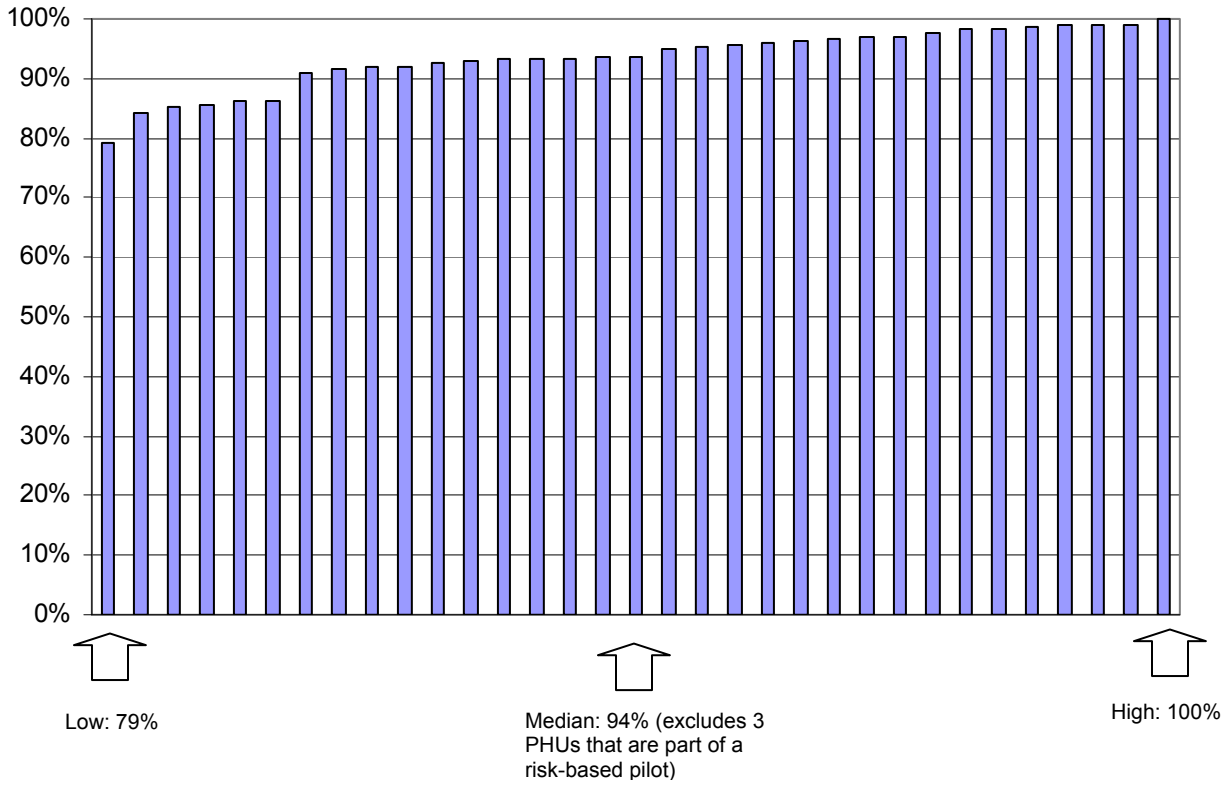
***** MHPS will monitor 2012 results but will only set a 2013 target using combined 2012-2013 data.

Indicator 11: % of tobacco vendors in compliance with youth access legislation at the time of last inspection

Description:

- Measures enforcement of, and compliance with, provisions of the Smoke-Free Ontario Act (SFOA) that relate to vendor compliance with requirements to restrict youth access to tobacco.

Percent of tobacco vendors in compliance with youth access legislation at time of last inspection by health unit, 2011.



Proposed Performance Targets:

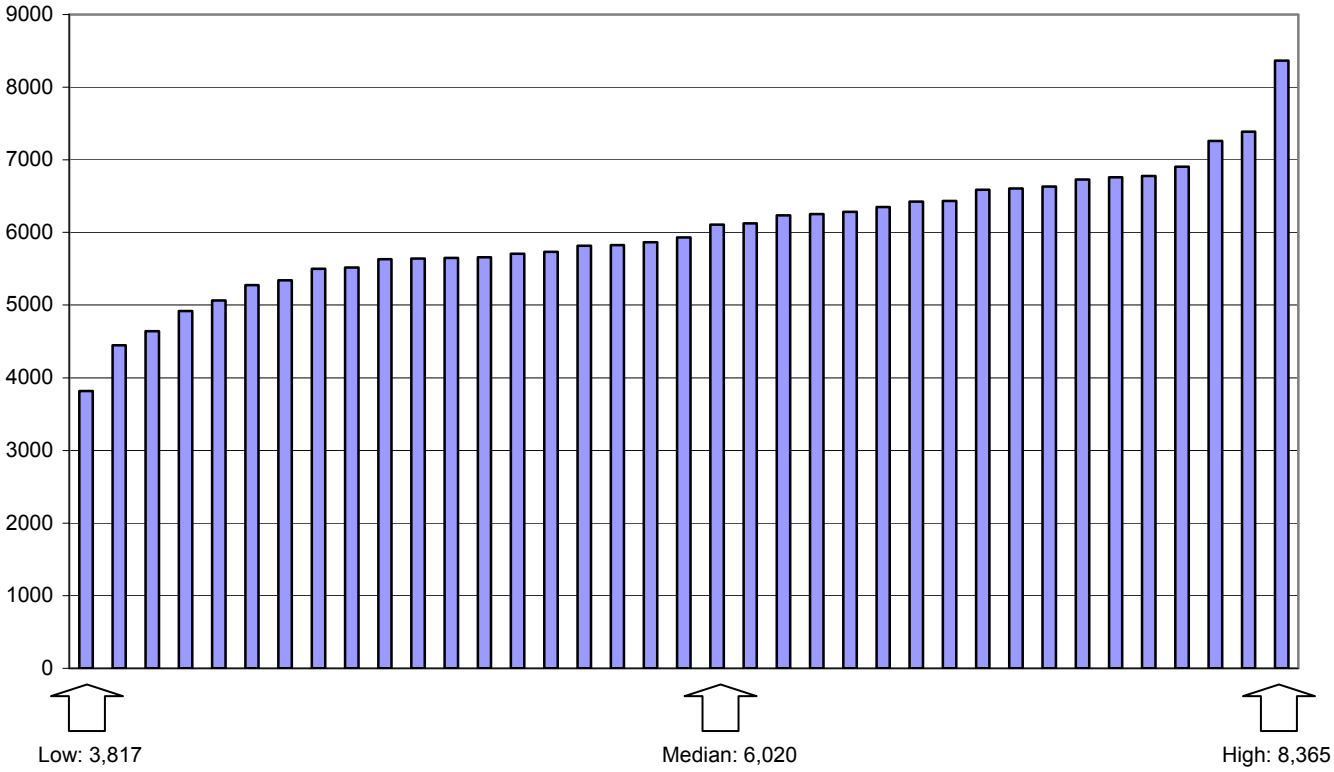
Performance Quartile at Baseline	2012 Target	2013 Target
1	≥90%	≥90%
2	≥90%	≥90%
3	≥90%	≥90%
4	≥90%	≥90%

Indicator 12: Fall-related emergency visits in older adults aged 65+

Description:

- Monitors the rate of injuries related to falls that result in visits to hospital emergency departments, in adults aged 65 years and older.

Rate per 100,000 of older adults aged 65+ with fall-related emergency visits by health unit, 2009.



Proposed Performance Targets:

Performance Quartile at Baseline	2012 Target*	2013 Target
1	N/A	-2% relative to baseline
2	N/A	-3% relative to baseline
3	N/A	-4% relative to baseline
4	N/A	-5% relative to baseline

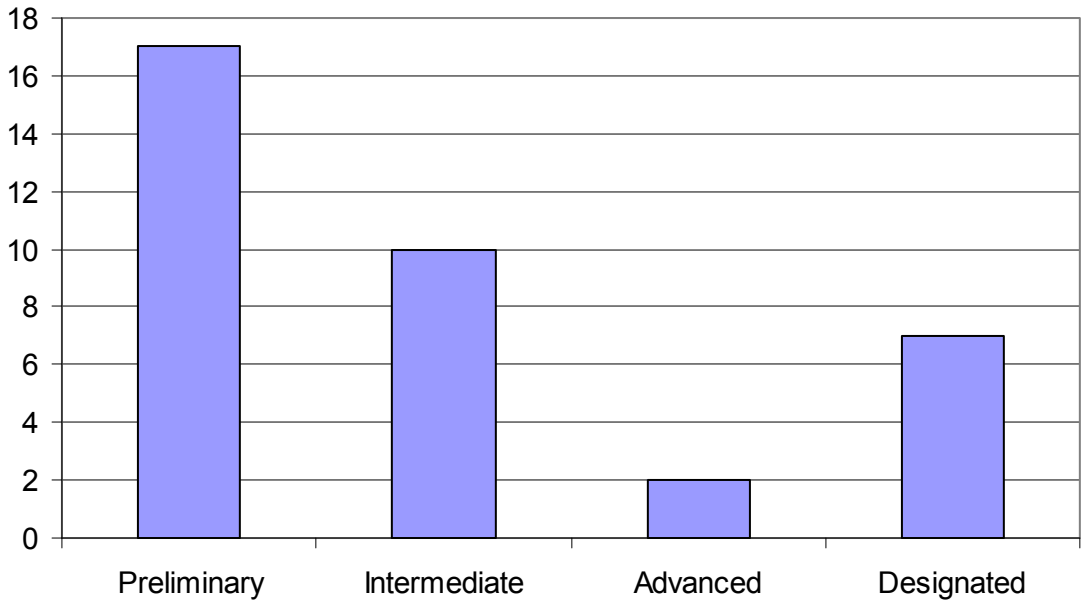
* MHPS will continue to monitor results but due to data lag, will only set a 2013 target.

Indicator 14: Baby Friendly Initiative (BFI) Status

Description:

- This indicator monitors the BFI status of all Ontario public health units using the MHPS Public Health Unit BFI Status Report 2011.

Baby Friendly Initiative Status by health unit, 2011.



Proposed Performance Targets:

Performance Quartile at Baseline	2012 Target	2013 Target
Designated	Designated	Designated
Advanced	Designated	Designated
Intermediate	Advanced	Designated
Preliminary	Intermediate	Advanced

2011-2013 Accountability Agreement Performance Indicators Webinar

Adobe Connect Pro Meeting Participant Guide

1. Session Details

Date: **Monday, January 16, 2012**

Time: **12:00pm – 1:00pm (*please sign-in 5 - 10 minutes before start time)***

Topic: **Accountability Agreement Performance Indicators, Targets, and Negotiations**

Software: **Adobe Connect Pro using "Flash" software**
(see below for more information)

2. Session Access

You link into the session through a telephone conference call and via a web site. In order to hear the presentation:

- Call from a speaker phone, if available
- From Toronto call: 416-212-8014; all others call toll-free: 1-866-500-5845
- Wait for the prompt and enter the Conference ID: 9783274#

In order to see the presentation you will need to:

- Click on the link: **https://elearning.moh.gov.on.ca/phu_indicators/**
- You will see the option to Login, or the option to enter as a "Guest".
- Select Enter as a Guest. You will be prompted to enter your name.
- Enter your name (as you would like other participants to see it, for example, "Dr. John Smith").
- Click "Enter Room" - you should be in!

3. Troubleshooting and Support

If this is your first time using Adobe Connect Pro you must:

- Test that "Flash" is installed on your computer. "Flash" is the software that Adobe Connect uses to run the webinar session. "Flash" can be downloaded free from the link below. The site will tell you if you have the most current version of the software which will allow you to view the presentation.

Ontario

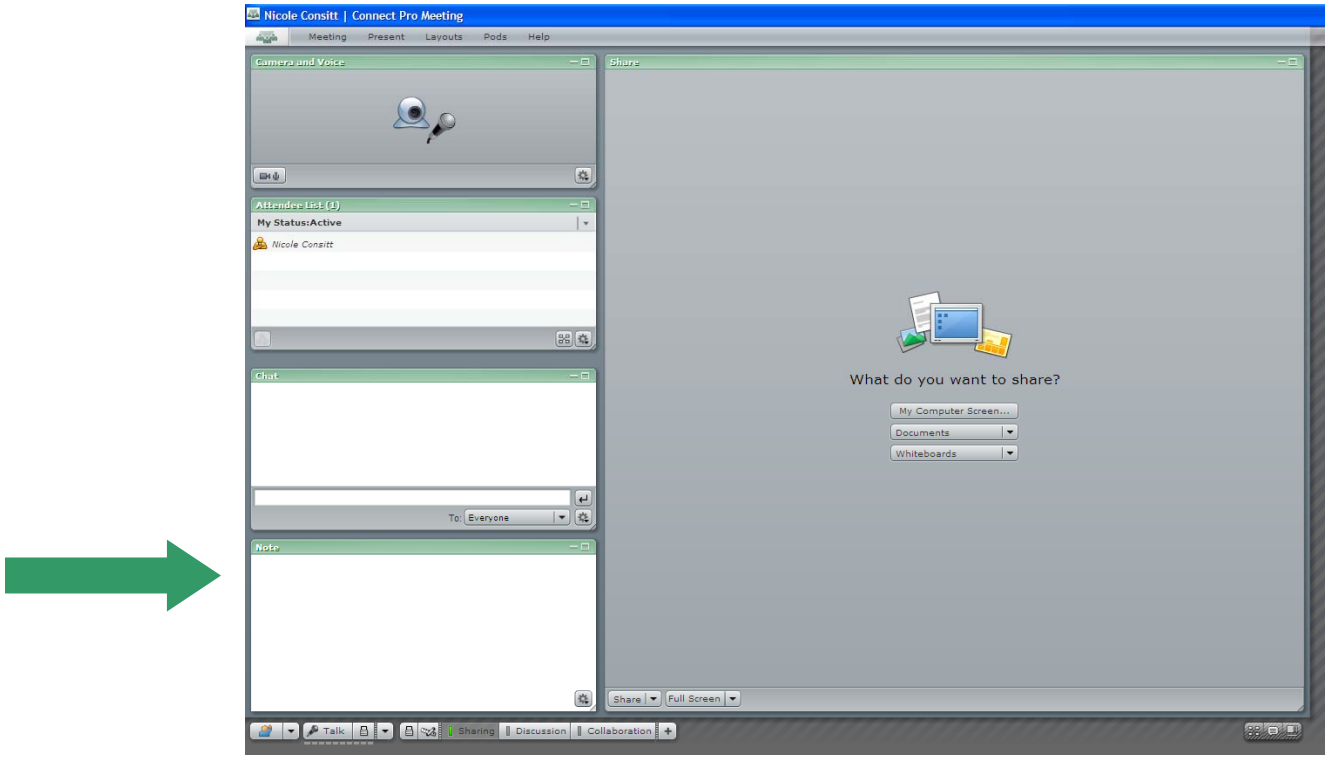
To install “Flash”:

- Go to: http://www.adobe.com/shockwave/download/download.cgi?P1_Prod_Version=ShockwaveFlash
- Click the Install button (note: you do not have to download the Yahoo! Toolbar in order to download flash; uncheck the “Yahoo! Toolbar” option box).
- If the install fails, it could be that you are not allowed to install new software on your computer and you will need to speak to your system administrator.

Throughout the webinar, instructions and troubleshooting tips will be posted as needed by the webinar presenters in the “notes pod” (see Figure 1) to assist you. Please note that the “notes pod” is for the presenters’ use, and although the pod will be visible to participants, participants will not be able to enter information into the pod.

In addition, Jacky Sweetnam and Michele Weidinger will be available via e-mail at: **Jacky.Sweetnam@ontario.ca** and **Michele.Weidinger@ontario.ca** during the webinar to assist participants with any technical difficulties related to Adobe Connect Pro. Participants can also use the “Help” menu for assistance.

Figure 1: Note Pod



4. Questions and Answers during the Webinar

In order to pose questions using the “chat pod” throughout the presentation you will need to:

- Assign someone to collect questions from all of those in attendance, if you are participating in the webinar as part of a larger group. Also, assign one person to type these questions into the “chat pod”.
- Type your question into the “chat pod” that will appear on your computer screen (see Figure 2); and determine whether you would like to direct your question to everyone, or privately to the presenters, or to another participant (see Figure 3).
- When you have typed your question into the “chat pod” and have determined your intended audience, press “enter” key within the “chat pod”.

Figure 2: Chat Pod

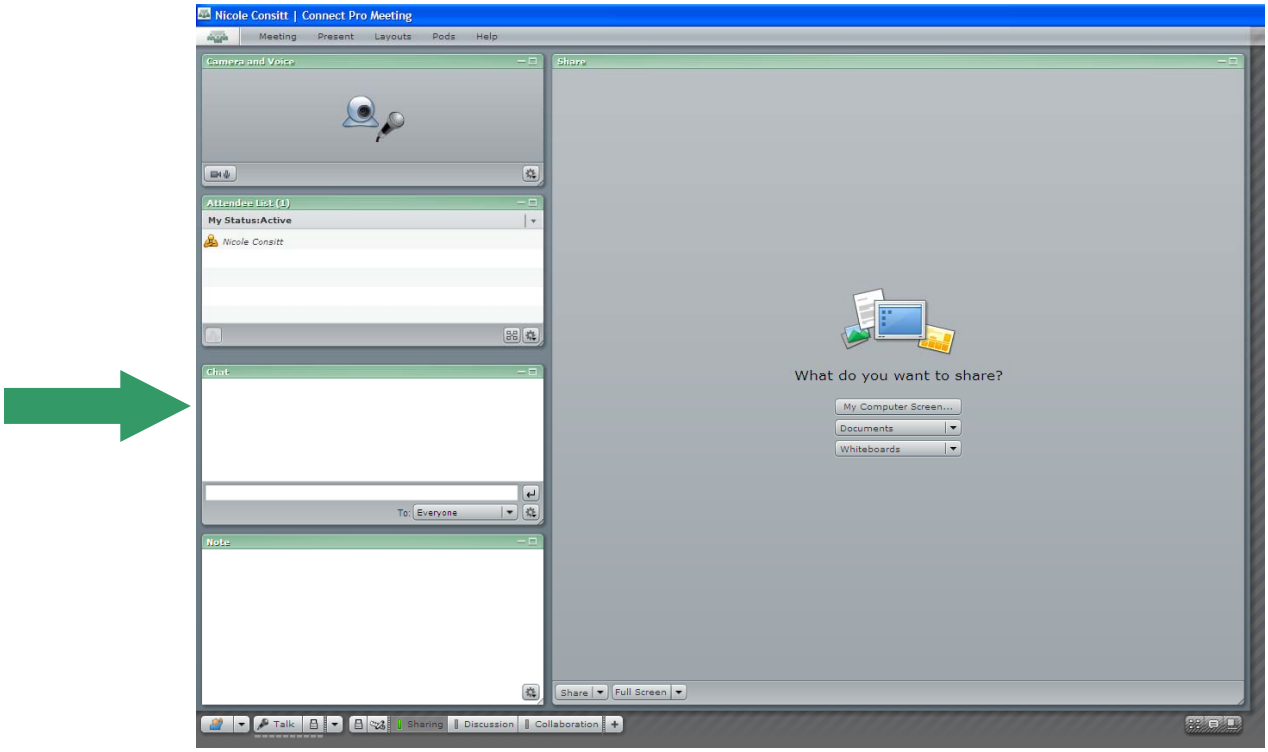
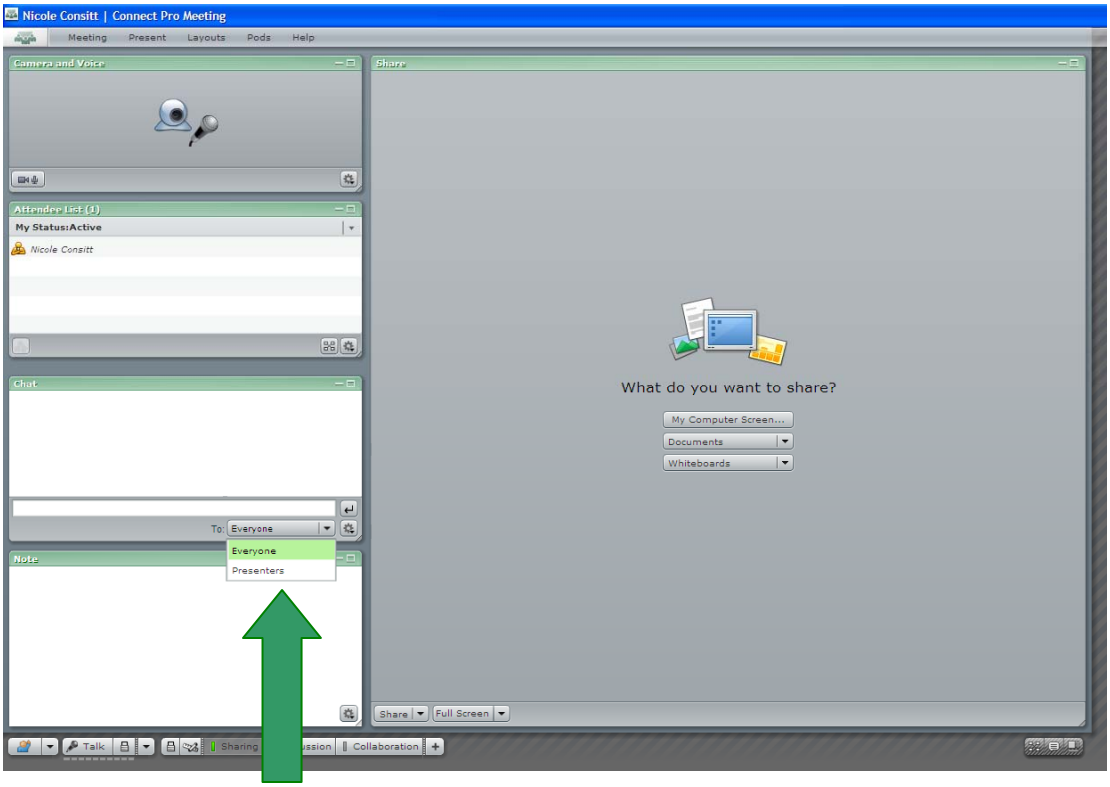


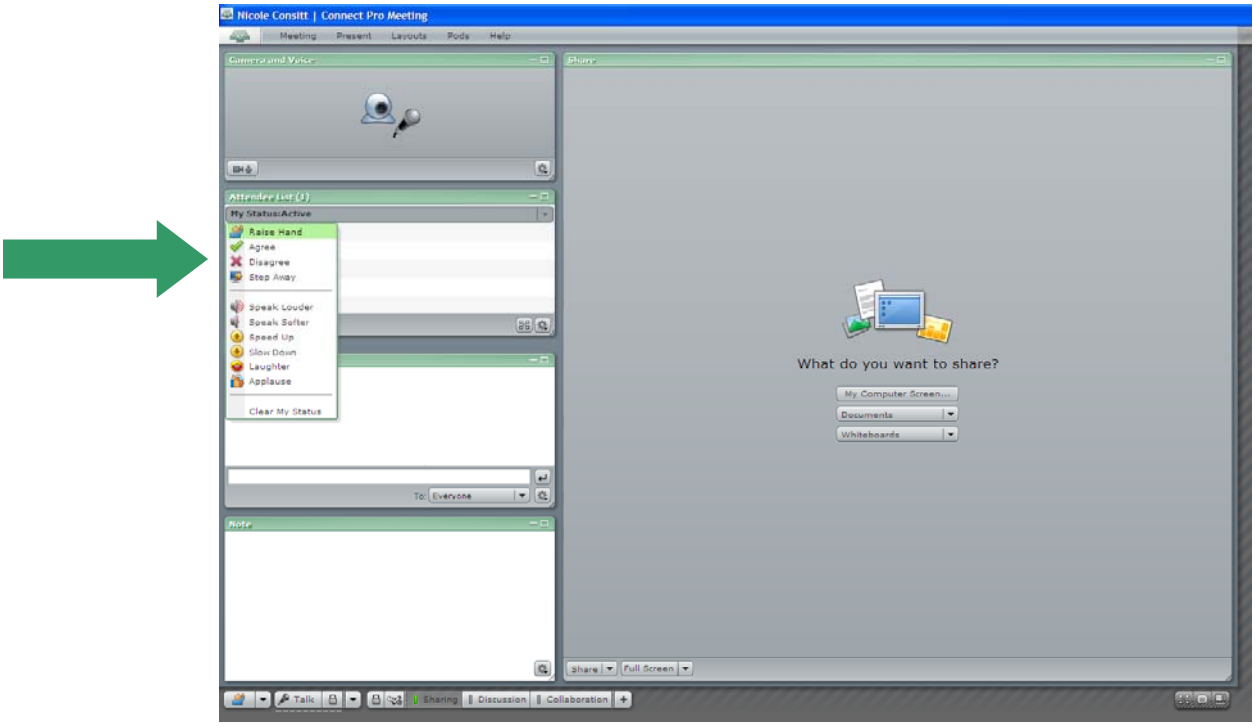
Figure 3: Chat Pod Options



Questions will also be accepted via teleconference any time during the presentation. The webinar presenters will mute all participant lines at the beginning of the presentation, and the lines will remain muted throughout the presentation. The webinar presenters will un-mute all participant lines following the completion of the presentation and will allow time for questions and answers via teleconference.

Throughout the webinar, you can also provide feedback to the presenters by indicating your "status". Simply highlight your name and use the drop-down menu provided (see Figure 4) to indicate if you would like the presenter to speak more loudly, more slowly, etc.

Figure 4: Attendee Feedback and Status Drop-Down Menu



5. Conference Call Etiquette - A Few Simple Requests

a. Please be prompt in joining the meeting, as joining in late may be disruptive for the presenters and participants.
b. The teleconference line will be muted throughout the presentation to minimize any excessive background noise that may occur during the teleconference.
c. During the question and answer period, when the teleconference line is un-muted, please use the “mute” function on your telephone until you have a question to ask.
d. If you do not have a “mute” function on your telephone – please press *6 which will mute your teleconference line, and press *6 again to un-mute when you want to ask a question.

THANK YOU AND WE LOOK FORWARD TO YOUR PARTICIPATION!

I ♥ PH

2012 alPHa Winter Symposium

Promoting Public Health in Ontario

February 9 & 10, 2012
Novotel Toronto Centre
45 The Esplanade
Downtown Toronto

A conference on ideas to increase the profile of public health and its work in the province

Open to all Ontario Board of Health members, Medical and Associate Medical Officers of Health, senior public health managers, and Communications Managers.

Day 1 is a full day that will feature presentations by communications and health promotion experts on promoting public health in Ontario.

Day 2 will feature business meetings for both the Boards of Health Section and COMOH, and a plenary session with Ministry officials.

A limited block of guestroom accommodations have been reserved at the Novotel Toronto Centre hotel. Please book with the hotel directly by ***January 18, 2012*** *to reserve a room; call* ***416-367-8900****, fax 416-360-8285, or email:* ***h0931@accor.com***

Registration details are attached.

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ABOUT THE NOVOTEL TORONTO CENTRE HOTEL

alPHa encourages attendees to think about their impact on the environment and consider carpooling, VIA Rail or GO Train where possible.

Hotel Web Site

http://www.novotel.com/gb/hotel-0931-novotel-toronto-centre/index.shtml

Directions

From Pearson International Airport or Highway 401 Eastbound, exit onto Highway 427 South. Exit Highway 427 onto the Gardiner Expressway (after about 20 minutes). Exit the Gardiner Expressway onto Yonge Street North. Immediately after turning onto Yonge Street, there will be an overpass. Immediately after the overpass turn right onto The Esplanade. The hotel is after the stop sign on the right hand side.

Please note the hotel does not provide shuttle service to/from airports.

Rail station: Union Station
Subway station: Union Station (University Line)
Hotel is an 8-minute walk east of Union Station. Walk east along Front Street and go south on Yonge Street for one block. Turn left onto The Esplanade.

Parking

For overnight guests, self-parking in the hotel's underground garage is available at $25 per car per day (includes taxes). Overnight guests wishing to park must provide a license plate number to the front desk; payment will be made at check-out. For self-parking day guests, there are two payment options:

A. If paying with the hotel, the cost for same-day parking is $16.95 including taxes. Please provide the hotel with the license plate number.
B. If paying at the meter, daily maximum rate is $11. Tickets must be purchased at the machine.

There is no valet parking at the hotel.

Hotel Reservations

As the designated venue for the 2012 Winter Symposium, the Novotel Toronto Centre at 45 The Esplanade has reserved a block of rooms at the group rate of $145 plus 13% HST per night, single or double occupancy. Please reserve accommodations by **January 18, 2012** by calling **(416) 367-8900** or emailing h0931@accor.com, and by quoting the alPHa conference. After this date, the hotel cannot guarantee the same rate. Reservations will be guaranteed with a major credit card. Late arrival is considered to be after 6:00 PM; please notify the hotel if arriving late. Guaranteed reservations are held until 12:00 AM midnight at which point it will be cancelled. A no show or a cancelled room on the date of arrival will be billed in its entirety for the whole stay as confirmed. Cancellation of individual reservation must be received **21 days prior to arrival**. Check-in time is 3:00 PM, check-out time is 12:00 PM.

continued

ABOUT THE NOVOTEL TORONTO CENTRE HOTEL continued

Early Departure Fee

At the time of check-in, the departure date will be rechecked. If departing prior to the date agreed upon there will be a 50% early departure fee of the daily room rate.

Nearby Recreational Activities

- Hotel fitness centre, indoor heated pool, sauna and jacuzzi
- Sony Centre for the Performing Arts
- Air Canada Centre
- Hockey Hall of Fame
- Toronto Harbourfront Centre (public skating available)
- Theatre District (Mirvish Theatres)

Nearby Restaurants

Finn MacCool's Irish Pub
Irish Pub & Restaurant
70 The Esplanade
Casual, $$
416-362-2495

Bier Markt
Belgian Restaurant
58 The Esplanade
Trendy, $$$
416-862-7575

Scotland Yard English Pub
English Pub
56 The Esplanade
Casual, $$
416-364-6572

The Keg
Steakhouse
26 The Esplanade
Casual, $$$
416-367-0685

C'est What?
Pub / Restaurant & Music Bar
67 Front Street East
Casual, $$
416-867-9499

Hot House Cafe
Italian Restaurant
35 Church Street
Casual, $$88
416-366-7800

The Old Spaghetti Factory
Italian Restaurant
54 The Esplanade
Casual, $$
416-864-9761

Spring Rolls
Asian Restaurant
85 Front Street East
Casual, $$
416-365-7655

Chaska
Indian Take-Out & Bakery
125 Lower Jarvis St.
Takeout, $
416-551-1177

Starbucks
Coffee House
81 Front Street East
Casual, $

Second Cup
Coffee House
65 Front Street East
Casual, $

Tim Horton's
Donuts & Coffee
73A Front Street East
Casual, $

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REGISTRATION INFORMATION

Conference Registration Fees

Full Conference:	$265 + HST
Includes 2 breakfasts, 4 breaks, 2 lunches, 1 reception, Thursday & Friday program sessions	
Daily Rate:	
Thursday - includes breakfast, breaks, lunch, reception and full day programs	$215 + HST
Friday - includes breakfast, breaks, lunch and scheduled meetings	$140 + HST
Emeritus:	
Full Conference	$133 + HST
Thursday - includes breakfast, breaks, lunch, reception and full day programs	$108 + HST
Friday - includes breakfast, breaks, lunch and scheduled meetings	$70 + HST
Public Health & Preventive Medicine Residents:	
Includes 2 breakfasts, 4 breaks, 2 lunches, 1 reception, all program sessions	Fees Waived

Registration & Payment

Online Registration / Credit Card Payment:
Register and pay online using Visa or Master Card by accessing our secure system. **Click here and register online today**.

Register By Mail:
If you wish to pay by cheque, complete the attached registration form and mail or fax to:

Association of Local Public Health Agencies
2 Carlton Street, Suite 1306
Toronto, ON M5B 1J3
Fax: 416-595-0030

Cancellation Policy:
Cancellations must be received at alPHa by **Thursday, February 2, 2012** for a full refund of your registration fee. Cancellations received February 3, 2012 are subject to a 20% administrative fee. There are no refunds for cancellations received February 6 and after; however, substitutions are allowed.

Important: Hotel room cancellations must be confirmed directly with the Novotel Toronto Centre at least 21 days prior to arrival (i.e. January 19, 2012) and *not* through alPHa.

Contact: For questions about registration and payment contact Karen Reece, at 416-595-0006 ext 24, by email at karen@alphaweb.org or fax 416-595-0030.

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REGISTRATION FORM

Delegate's Name: _____

Title: _____

Health Unit/Org. _____

Address: _____

Contact Person: _____ Tel: _____ ext._____

E-mail: _____

Delegate's position: ❑ BOH Member ❑ A/MOH ❑ Affiliate ❑ PHPMR ❑ Speaker ❑ Other

Food requirements (if severe allergy, please indicate): _____

_____

Emergency Contact: _____ Home Tel._____

Cell: _____ Email: _____

REGISTRATION FEES:

alPHa Members

❑ Full Conference	$ 265	$_____
❑ Thursday	$ 215	$_____
❑ Friday	$ 140	$_____

Emeritus

❑ Full Conference	$ 133	$_____
❑ Thursday	$ 108	$_____
❑ Friday	$ 70	$_____

Public Health & Preventive Medicine Residents Waived $ 0

❑ Full Conference ❑Thursday ❑ Friday

(Please indicate your affiliated university: _____; program year: _____)

Plus 13 % HST	$ _____
TOTAL	**$ _____**

Please return completed registration form along with your payment to:

ASSOCIATION OF LOCAL PUBLIC HEALTH AGENCIES
2 Carlton Street, Suite 1306, Toronto, ON M5B 1J3
Tel: 416-595-0006 ext 24 Fax: 416-595-0030 E-mail: karen@alphaweb.org

Staff Report

Infant Toddler Development Program

Date:	January 11, 2012
To:	Board of Health
From:	Dr. Rosana Pellizzari, Medical Officer of Health

Original signed by	**Original signed by**
_____	_____
Rosana Pellizzari, M.D.	Larry Stinson, Director, Public Health Programs

Purpose

To review the Board of Health's commitment to host the Infant and Toddler Development Program (ITDP).

Decision History

The Health Unit has a 30 year history of hosting the ITDP. Dr. Enid Dutton, Medical Officer of Health at the time, was responsible for obtaining Board of Health approval to establish the program on December 1, 1980.

The program is 100% provincially funded by the Ministry of Children and Youth Services (MCYS) through the Ministry of Community and Social Services (MCSS). The approved budget is $242,423 and has not increased since 2002/03. The program is run on a fiscal budget year (April 1 to March 31).

Senior management and Chairs of the Board of Health have communicated with MCSS and MCYS officials many times over the past ten years to resolve the funding issue. Roughly 90% of the program costs are related to salaries and benefits. Since 2002/03, wages, benefits, mileage, and other costs have increased by 28%.

At the May 13, 2009 Board of Health meeting, the following motion (M-09-68) was approved:

That:

1. the Board of Health continue to administer the Infant and Toddler Development Program to March 31, 2010 on the condition that the program receives adequate funding; and
2. if in the opinion of the Board of Health the program is not adequately funded, the Board of Health give notice to the Ministry of Community, Family and Children's Services of its intention to terminate its Agreement with the Ministry dealing with the Infant and Toddler Development Program.

At the February 9, 2011, Board of Health meeting, motion (M-11-21) was approved:

That the Board of Health for the Peterborough County-City Health Unit:
1. Continue to administer the Infant and Toddler Development Program for 2011/12; and
2. Review the funding status and program direction for the 2012/13 fiscal year in consultation with representatives from the Ministry of Children and Youth Services (MCYS) and the Ministry of Community and Social Services (MCSS).

Financial Implications and Impact

Currently, the Board of Health receives an allocation for administrative ($14,259) and occupancy costs ($2,500) of $16,759 annually. These costs have remained consistently low for the last 21 years and do not accurately reflect the public health resources being expended to deliver this service.

Throughout the 1980's, the program consisted of 3.0 FTE (full-time equivalent) Infant Development Workers (IDWs), 1.0 FTE Secretary, and 0.1 FTE Manager. The complement of IDWs has eroded significantly over the past ten years as the costs of wages and benefits have increased without any increase in funding. The 2009/10 staffing complement was 2.5 FTE IDWs, 1.0 FTE Secretary, and 0.1 FTE Manager. In mid-2010, a 0.8 FTE IDW position was gapped due to a parenting leave of absence as a way to address the budget shortfall. For the 2012/13 budget year, the program can afford 1.9 FTE IDWs, 0.5 FTE Secretary, and 0.1 FTE Manager.

Recommendations

In light of the efficiencies that the ITDP has achieved over the past two years, that the Board of Health for the Peterborough County-City Health Unit:

1. continue to administer the Infant and Toddler Development Program for 2012/13; and
2. review the funding status and program direction for the 2013/14 fiscal year in consultation with MCSS/MCYS representatives.

Background

The Infant Toddler Development Program offers a number of services to families with infants and young children (birth to 36 months old) in Peterborough County and City

who are considered to be “at risk” or vulnerable to developmental delays because of prematurity, or social or economic concerns; are diagnosed with special needs such as Down syndrome, cerebral palsy or spinal bifida; or are otherwise delayed in development. IDWs offer home visits, telephone follow-up, consultations to individuals and groups, developmental assessments and corresponding activities to promote learning and development, and service coordination with other community agencies. The program is staffed by two child development specialists and two pediatric occupational therapists.

The number of children being referred to and served by the ITDP has not decreased. Staff and management have been creative in adjusting programming in light of funding shortfalls while still meeting best practices and program mandates. For example, modifications have been made in the follow-up of those infants born at 36 weeks gestation or later: if there are no other risk factors, families receive a telephone call and encouragement to monitor their child’s development on their own, and call the ITDP if they have questions or concerns. The Ontario Early Years Centre (OEYC) is continuing to partner with the ITDP on a monthly drop-in program for parents of multiple births - “Peterborough Multiples Network”. IDWs also provide consultation to parents and caregivers attending other groups at the OEYC and School for Young Moms, and to foster parents, thus extending their reach.

Results of the recent client satisfaction survey indicate that parent and caregiver respondents were pleased with the services their children were receiving from the ITDP program. Respondents identified that the information, reassurance, and support that they received regarding their child’s development was invaluable.

Comments

The IDWs are highly motivated and experienced, requiring minimal supervision. Program staff have built a strong, professional reputation in the community and continue to collaborate effectively with community partners (e.g., Five Counties Children’s Centre, Children’s Aid Society, Child and Family Youth Clinic, Ontario Early Years Centre, Family Health Teams and Pediatricians, and School for Young Moms). The program is well integrated with Ontario Public Health Standards in that IDWs share clients with Healthy Babies, Healthy Children; provide consultation and child development expertise for Reproductive Health and Child Health program staff; and consult regularly with Nutrition Promotion and Injury Prevention program staff.

The MCSS/MCYS has conducted numerous studies including site visits over the years. The Ontario Association of Infant and Child Development continues its extensive lobbying efforts regarding the precarious situation that all Infant Development programs face across the province, to no avail. Local annual meetings with the Ministry Consultant include line-by-line reviews of the budget, best practices, Ministry guidelines, and policies and procedures whereby staff are commended for their efforts and their fiscal responsibility.

Priority Populations

The following priority populations* are relevant with respect to this staff report:

✓	Priority Population		
	Adults	✓	People with Disabilities, Chronic Conditions
✓	Children	✓	People with Lower Education and Literacy Levels, English as A Second Language
✓	First Nation		People with Mental Health Issues and Addictions
	General Public		Pregnant Women
	Older Adults/Seniors	✓	Rural Residents
✓	Parents		Youth

*The Priority Populations are based on a list originally developed in April 2010 as part of the Foundational Standards Requirements under the Ontario Public Health Standards.

Strategic Direction

Important linkages have been established and by keeping the ITDP the Health Unit continues the strategic direction of "building on our leadership role" and maintaining a valuable service in our community.

Contact:

Karen Chomniak, Manager, Family Health
(705) 743-1000, ext. 242
kchomniak@pcchu.ca

Staff Report

Report on Summary of Selected Cancers: Peterborough County and City

Date:	January 11, 2012
To:	Board of Health
From:	Dr. Rosana Pellizzari, Medical Officer of Health

Original signed by	**Original signed by Andrew Kurc *for***
_____	_____
Rosana Pellizzari, M.D.	Donna Churipuy, Manager, Environmental Health

Purpose

The purpose of the Summary of Selected Cancers in Peterborough County-City (2012) report is to provide members of the Board of Health with an overview of the burden of cancer in Peterborough County and City including the incidence, mortality and trends of selected common cancers among Peterborough County and City residents between 1986 and 2007. In addition to highlighting trends, the report intends to identify those cancers whose patterns of incidence or mortality differ significantly from the province of Ontario.

The report will also make recommendations that the Peterborough County-City Health Unit can implement to reduce the burden of cancer both locally and provincially.

Decision History

Historically, the Peterborough County-City Board of Health has sought to reduce the incidence of cancer by implementing programs and services which reduce tobacco use; reduce exposure to ultraviolet radiation; reduce alcohol use and high risk drinking; increase healthy eating; reduce exposure to environmental toxins; improve access to approved cancer screening programs; and improve access of vulnerable populations to resources and services.

In the past, the Board of Health has advocated for strategies such as increased federal and provincial investment in comprehensive tobacco control; retention of government control of liquor retailing; improved access to nutritious foods; a ban on indoor tanning for those less than 18 years of age; and a reduction of poverty.

Financial Implications and Impact

Addressing the burden of cancer on local residents will require improved surveillance and monitoring at the provincial and local levels, and increased comprehensive health promotion activities; both of which require ongoing investment in epidemiology, and cancer prevention programs.

Recommendations

That the Board of Health for the Peterborough County-City Health Unit receive this staff report for information, and, endorse the recommendations outlined in the technical report, Summary of Selected Cancers in Peterborough County-City 2012.

Background

In Canada, cancer is the leading cause of premature death and the reason for almost 30% of all potential life years lost. Cancer is not a single disease, rather is a class of more than 100 diseases characterized by uncontrolled growth and spread of abnormal cells in some part of the body.

According to recent statistics from the Canadian Cancer Society (2011), 40% of women and 45% of men in Canada will develop cancer during their lifetimes. The number of new cancer cases has been increasing in Ontario each year: from estimates of 64,000 cases in 2008 to about 65,100 new cases of cancer in 2010. This may reflect improvements in screening and early diagnosis, population growth, and the changing demographics in the province. Four types of cancer – male prostate, colorectal, female breast, and lung – account for over half of cancer cases diagnosed in Ontario men and women. Between 1986 and 2007, male prostate, female breast, and lung and colorectal cancer among both sexes were the most commonly diagnosed cancers in Peterborough.

There are many known risk factors for cancer including age, family history, tobacco use, a diet with a high proportion of fat, alcohol use, sunlight, and other occupational and environmental exposures.

Whereas, age and family history are non-modifiable risk factors several other risk factors are modifiable. For example, the single most important risk factor associated with lung cancer is smoking which also contributes to numerous other cancers including breast, bladder, and cervical cancers. Exposure to environmental tobacco smoke (ETS) also plays a role in the development of lung and other cancers. The most easily modifiable risk factor for melanoma is

excessive exposure to the sun; the incidence of skin cancer can be reduced by decreasing sun exposure and increasing the use of sun protection. Alcohol use is associated with increased risk of oral, colorectal and breast cancers. Cancers associated with alcohol use showed evidence of a dose–response relationship, indicating that increased consumption is associated with increased risk of developing one or more alcohol-related cancers. Therefore reduced consumption of alcohol will reduce the risk of developing cancer. Eating habits can also play a role in reducing the risk of developing cancer. A diet high in fruits and vegetables can decrease the risk of developing oral and colorectal cancers. There is also evidence to suggest that physical activity can reduce the risk of cancers including colorectal and post-menopausal breast cancer.

In 1998, cancer accounted for $11.8 billion (16 percent) of the total indirect costs of illness in Canada ($75 billion) ranking second overall (Canadian Cancer Society). Indirect costs include estimates of the value of life lost due to premature death and the value of activity days lost due to disability. Unless more is done to prevent cancer, the estimated direct costs of cancer care by the year 2020 will increase to $2 billion in Ontario, compared with $1.22 billion in 2001/02. Historically, less than 1% of all government spending on cancer has been devoted to preventing cancer.

The Peterborough County-City Health Unit is mandated to collaborate with community partners to promote provincially approved screening programs related to the early detection of cancer. The Cancer Prevention program works in partnership with local and regional networks of stakeholders committed to preventing cancer and detecting cancer early. The Peterborough County-City Health Unit is also collaborating with the University of Toronto on a research study to determine why some Ontarians do not avail themselves of screening programs for cancer, e.g. pap testing, mammography, or screening for occult fecal blood. . The study team will be conducting focus groups in Peterborough and other communities to determine who are the "never" or "under screened"; what are their barriers to screening; and what might enable them to get screened.

Comments

As reported in Summary of Selected Cancers in Peterborough County-City (2012) compared to Ontario, Peterborough males experienced higher incidence rates of lung cancer (6.5%) and melanoma (24.4%) however had significantly lower incidence rates of prostate cancer (5.4%). Relative to the province, Peterborough women had significantly higher rates of lung cancer (21.9%), melanoma (21.5%), and uterine cancers (14.7%). Overall, lung cancer mortality rates were significantly higher for both Peterborough men (6.6%) and women (14.9%) compared to Ontario. Between 1986 and 2007, incidence and mortality rates for all of the selected cancers were significantly higher in Peterborough men relative to Peterborough women. This report provides us with a summary and a baseline for further exploration.

Conclusion

Cancer prevention starts with healthy living by addressing the aforementioned modifiable factors, and reducing exposure to toxins in the workplace, home and the environment. Integration of comprehensive health promotion strategies into many health unit, community, and provincial programs needs to continue in order to: raise awareness; increase knowledge and, skills; and, provide the supportive environments needed for successful behavior change and reduced exposure to toxins. Enhancement of provincial and local risk factor surveillance data is needed to better understand and address melanoma, lung and uterine cancer rates in Peterborough. The Ontario Health Study provides an excellent opportunity for Peterborough residents to participate in a longitudinal cohort examining the link between risk factors and the onset of chronic diseases like cancer. It is anticipated that the study will assist both individuals and populations in identifying and possibly avoiding or mitigating risks for developing chronic diseases.

Early detection of cancer has proven effective and improves a person's chance of survival. Early screening measures exist for a number of cancers including breast, cervical, and colorectal cancers. Genetic screening and counselling are also available for people with a family history of cancer. Aggressive promotion of cancer screening, actions to reduce barriers to screening, and further exploration of cancer screening trends among sub-populations need to continue.

Continued investment in cancer prevention strategies throughout the life span will not only reduce the costs of cancer care but will also improve the quality of life for many people, their families and friends.

Priority Populations

The following priority populations* are relevant with respect to this staff report:

✓	**Priority Population**		
✓	Adults		People with Disabilities, Chronic Conditions
✓	Children		People with Lower Education and Literacy Levels, English as A Second Language
✓	First Nation	✓	People with Mental Health Issues and Addictions
✓	General Public		Pregnant Women
✓	Older Adults/Seniors		Rural Residents
	Parents	✓	Youth

*The Priority Populations are based on a list originally developed in April 2010 as part of the Foundational Standards Requirements under the Ontario Public Health Standards.

Strategic Direction

By implementing the recommendations in the accompanying report, the Peterborough County-City Health Unit Board of Health will: continue to meet its public health mandate; build on our leadership role; and expand existing and build new strategic partnerships.

Contact:

Andrew Kurc, Epidemiologist
(705) 743-1000, ext. 358
akurc@pcchu.ca

Attachments:

Attachment A – Summary of Selected Cancers in Peterborough County-City 2012. January 2012.

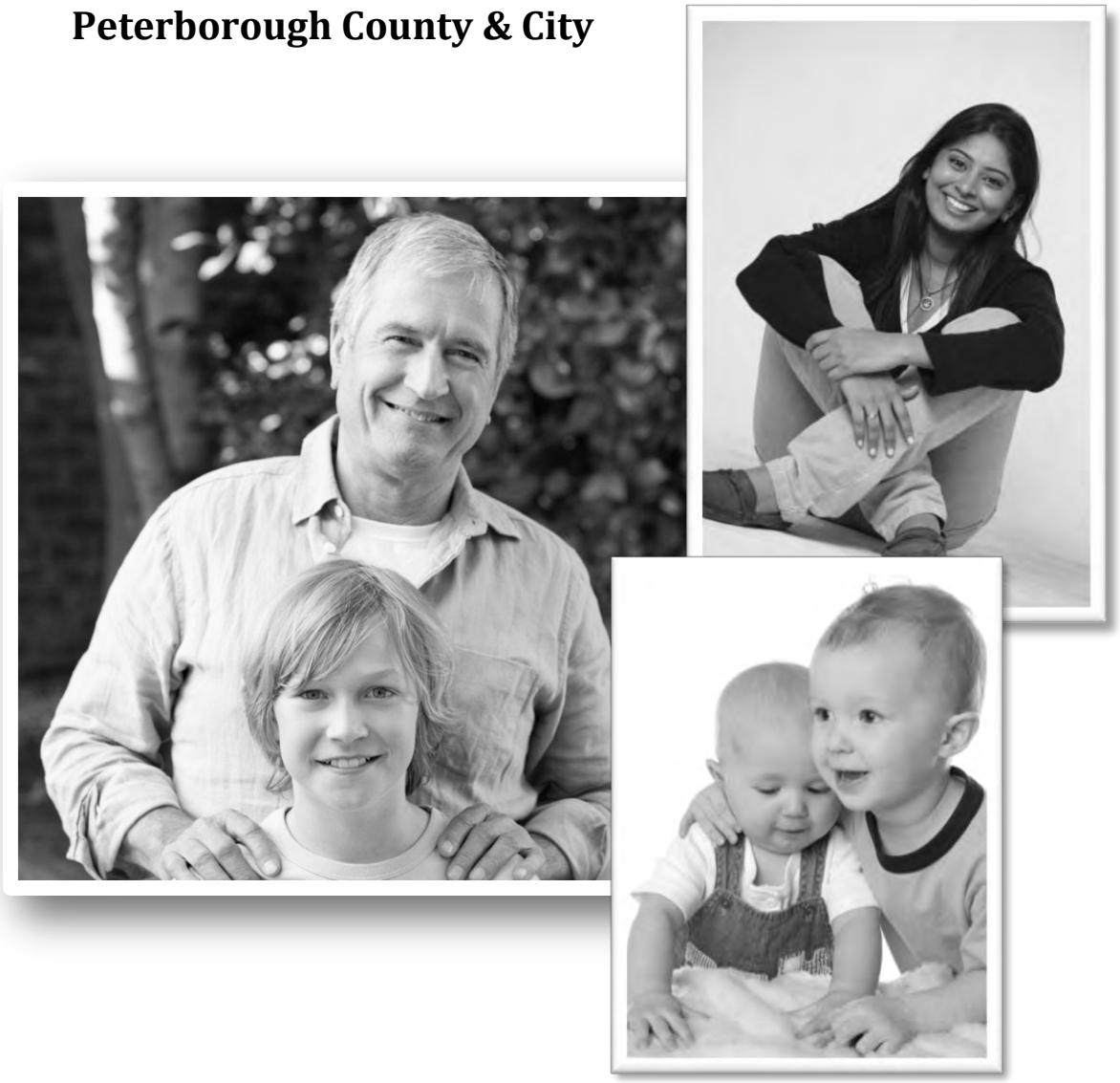
References

Canadian Cancer Society (2011). Canadian Cancer Statistics. Retrieved from http://www.cancer.ca/Canada-wide/About%20cancer/Cancer%20statistics/Past%20statistics.aspx?sc_lang=en

January 2012

Summary of Selected Cancers

Peterborough County & City



Author: Andrew R. Kurc

Reference

Peterborough County-City Health Unit. Summary of Selected Cancers in Peterborough County-City 2012. January 2012.

Lead Author

Summary of Selected Cancers in Peterborough County-City 2012 was written in principle by Andrew R. Kurc, Epidemiologist, Peterborough County-City Health Unit.

Reviewers

Hallie Atter; Manager, Community Health, Peterborough County-City Health Unit (PCCHU)
Donna Churipuy; Manager, Environmental Health Programs, PCCHU
Mary Daly; Public Health Nutritionist, Nutrition Promotion, PCCHU
Suzanne Galloway; Health Promoter, Substance Misuse Prevention Program, PCCHU
Jane Hoffmeyer; Health Promoter, Tobacco Use Prevention, PCCHU
Dr. Rosana Pellizzari; Medical Officer of Health, PCCHU

Acknowledgements

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Brittany Cadence; Supervisor, Communications Services, PCCHU
Clifford Ekwempe; Research Assistant, Epidemiology Department, WEC
Jane Naylor; Secretary, Communications and Foundational Standards, PCCHU

Distribution

Copies of this document can be downloaded at: http://www.pcchu.ca/Plans/Plans-home.html

Comments, corrections and queries can be directed to:
Andrew R. Kurc, Epidemiologist
Peterborough County-City Health Unit
10 Hospital Drive
Peterborough, ON K9J 8M1
tel. 705.743.1000, Ext. 358
email. akurc@pcchu.ca

Table of Contents

Report Overview

The purpose of the *Summary of Selected Cancers in Peterborough County-City 2012* report is to present information to the public and specialists on the incidence, mortality and trends of selected common cancers among Peterborough County and City residents during the years 1986 to 2007. For the purposes of this document, "common" refers to those cancers whose frequency was greatest during the reporting period. In addition to highlighting trends, the report intends to identify those cancers whose patterns of incidence or mortality differ significantly from the province of Ontario.

Data Sources

The data presented in this report was obtained from several sources:

Ontario Cancer Registry
Cancer data are provided by Cancer Care Ontario (CCO) who manages the Ontario Cancer Registry. Cancer Care Ontario monitors cancer incidence, mortality, survival patterns and trends over time. The Ontario Cancer Registry includes data on all newly diagnosed cases of cancer in Ontario since 1964 and includes approximately 97% of all cancer cases in Ontario. Records of new cancer diagnoses and deaths in Ontario are based on hospital discharge summaries, pathology reports, records from regional cancer centres and death records. This data is disseminated using SEERStat software.

Canadian Community Health Survey
Risk factor data were obtained from the Canadian Community Health Survey (CCHS) conducted by Statistics Canada. The CCHS collects health determinants, health status and health system utilization data from people aged 12 years or older living in households across Canada. People living in First Nations communities are not included in the sample for the CCHS; therefore, data presented for Peterborough do not include residents of Curve Lake or Hiawatha First Nations. Sample sizes for Peterborough are small and as a result there is large degree of variability associated with some of the estimates provided. Estimates from the CCHS have been presented with a 95% confidence interval (that is, 19 times out of 20 the *true* value will fall in this range) to provide an indication of the reliability of the estimate.

More detailed content on a number of risk factors can be found in the Peterborough County-City Health Unit's *Community Assessment Report 2010*, available:
http://www.pcchu.ca/Plans/Community%20Assessment%20Report%202010%20-November%2011.pdf

Glossary

Incidence and Mortality Rates
The number of new events that occur in a defined period. For incidence rates, the event is a new case of cancer; in mortality rates, the event is a death attributable to cancer. The denominator is the population at risk of experiencing the event during this period. Rates are calculated from the formula:

$$number\ of\ new\ events\ in\ defined\ period \div average\ population\ during\ defined\ period$$

Often these figures are quite small and are therefore expressed as multiples of 1,000 (e.g.: 5 cases per 100,000)

p-value
The letter *p* stands for this probability value. Usually found in an expression such as p<.05, which means the probability that this result could have been produced by chance is less than five percent.

Rate Ratio (RR)
The rate occurring in Population A divided by the rate occurring in Population B, which indicates their relative size. These populations may be an exposed and unexposed group, different geographies, or different genders.

Standardization
Age and sex standardization removes the effects of differences in the age and gender structure of populations among areas and over time. These rates show the number of events per 100,000 population that would have occurred in a given area if the age structure of the population of that area was the same as the age structure of a specified standard population. For the purposes of this document, the 1991 Canadian population distribution has been used as standard.

Notes

- Unless otherwise stated, rates presented have been age-standardized.
- "Peterborough" refers to the City of Peterborough and Peterborough County combined.
- In order to evaluate independent samples, Ontario counts and rates do not include Peterborough data.
- Due to the small population size of Peterborough City and County, many cancers occur infrequently. Due to confidentiality issues, statistics fewer than five cases will be suppressed and denoted with "^" in tables, and missing in figures.

Highlights

- Incidence rates of all cancers combined has been increasing since 1986 in Peterborough in both males and females
- Male prostate, female breast, and lung and colorectal cancer among both sexes were the most commonly diagnosed cancers in Peterborough between 1986 and 2007
- Prostate, lung and colorectal cancers accounted for 56% of male cancers in Peterborough; these cancers accounted for 55% of male cancer deaths
- Breast, lung and colorectal cancers accounted for 55% of all cancer diagnoses among Peterborough women and accounted for 52% of all female cancer deaths
- Relative to Ontario, Peterborough males had significantly higher incidence rates of lung cancer (6.5%) and melanoma (24.4%)
- Relative to Ontario, Peterborough males had significantly lower incidence rates of prostate cancer (5.4%)
- Compared to the province, Peterborough women experienced significantly higher rates of lung cancer (21.9%), melanoma (21.5%), and uterine cancers (14.7%)
- Lung cancer mortality rates were significantly in Peterborough men (6.6%) and women (14.9%) relative to Ontario
- Between 1986 and 2007, incidence and mortality rates of all selected cancers were significantly higher in Peterborough men relative to Peterborough women
- Mortality rates from all cancers combined among males has been decreasing whereas rates have not changed a great deal among females

Introduction

Cancer is not a single disease; there are more than 100 different types of cancer. Cancers are a class of diseases in which cells show uncontrolled growth or division, invade other tissues, and spread to other locations in the body. These characteristics distinguish them from benign tumours

The number of new cancer cases has been increasing in Ontario each year: an estimated 65,100 new cases of cancer occurred in Ontario in 2010, an increase from estimates of 64,000 cases in 2008. Four types of cancer – male prostate, colorectal, female breast, and lung – account for over half of cancer cases diagnosed in Ontario men and women. The overall prevalence of cancers is also increasing due to the increased number of cancers diagnosed as well as improved survival of cancer patients. Breast, prostate and colorectal cancers were the most prevalent cancers as of January 1, 2005.

Approximately 28,200 cancer deaths occurred in 2010 in Ontario. Male prostate, colorectal, female breast and lung cancers accounted for nearly half of all deaths due to cancer. Lung cancer remains the leading cause of cancer deaths accounting for 28% of cancer deaths in men and 26% of cancer deaths in women.

Cancer affects Canadians 50 years of age or older more than other age groups, representing 88% of new cases and 95% of deaths due to cancer. More men than women will be diagnosed with a new cancer, 51.7% and 48.3%, respectively, and more men will die from cancer, accounting for 52.5% and 47.5% of cancer deaths, respectively. The median age of cancer diagnoses among both sexes is 65 to 69 years old and the median age at death is 70 to 74 years old.

Cancer in Peterborough

Most Common Cancers

In Peterborough 888 new cases of cancer were diagnosed in 2007. The incidence of all cancers combined was significantly higher among males than females (475.5 cases per 100,000 persons compared to 382.2 cases per 100,000, respectively). Incidence of all cancers among both genders has been increasing since 1986, where rates were 388.8 per 100,000 among males and 372.2 per 100,000 among females – Figure 1.

In males, prostate cancer was the most commonly diagnosed cancer with 124 cases in 2007 (126.9 cases per 100,000). The most frequently diagnosed cancer among females was breast cancer with 108 cases in 2007 (98.6 cases per 100,000). Lung cancer also occurs at high rates among both sexes (52.7 cases per 100,000 and 56.2 cases per 100,000) – Table 1. In 2007 males had significantly greater incidence rates of all cancers combined, colorectal, and bladder cancers.

Between 1986 and 2007, the most common cancers diagnosed among Peterborough residents were: lung, colorectal, prostate, breast, non-Hodgkin lymphoma (NHL), bladder, melanoma, leukemia, corpus uteri (uterine), and oral cavity (oral) cancers – Table 2. During this time frame, males had significantly higher incidence of all the aforementioned cancers common to both sexes with the exception of breast cancer.

Cancer Mortality

There were 385 deaths due to cancer in 2007, or 181.2 deaths per 100,000 persons. Males had significantly higher rates of cancer mortality than females between 1986 and 2007. Slightly more females (195, or 50.6%) died from cancer in 2007 than males (n=190). Since 1986, there have only been two other occasions where more females died from cancer than males: 1987 (52.4%), and 1999 (51.7%). While incidence rates of cancers have been increasing since 1986 among both sexes, mortality rates among males have been decreasing whereas mortality rates among females have not varied to a great extent. Lung cancer accounts for the greatest proportion of deaths due to cancer, with 25.3% of deaths in 2007 among men and 31.3% of deaths in women. Lung, colorectal, female breast, and male prostate cancers combined accounted for just over half (205, or 53.0%) the deaths among Peterborough cancer patients in 2007. While some cancers occur with relative frequency, for example melanoma, deaths from these cancers are uncommon.

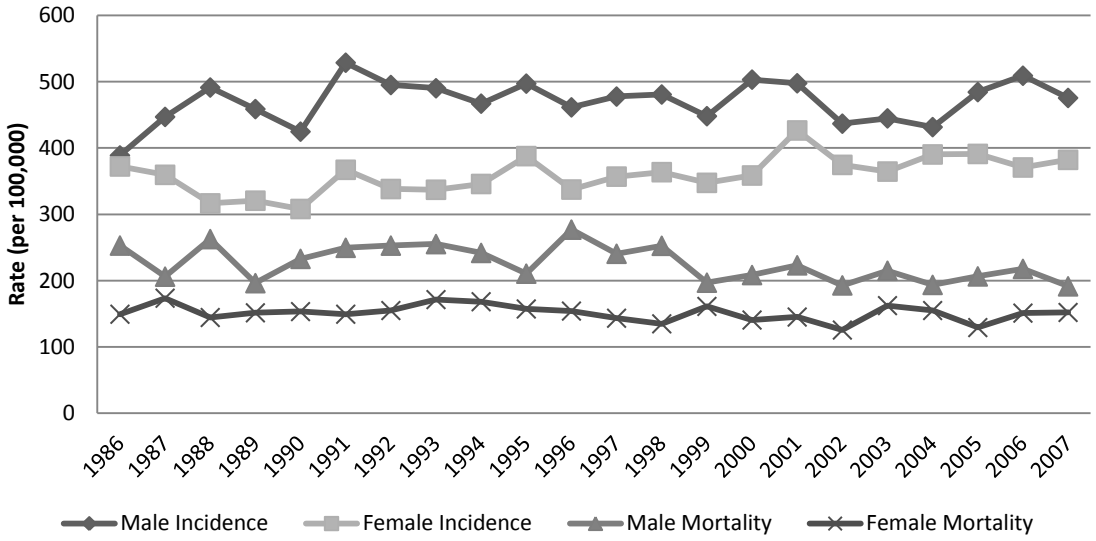


Figure 1. Incidence and mortality rates of all cancers combined in Peterborough by sex; 1986-2007

Table 1. New cancer cases, deaths, and incidence and mortality rates in Peterborough by sex; 2007

Cancer Type	Males		Females	
	Cases	Deaths	New Cases	Deaths
All Cancers Combined	461 (475.5)*	190 (191.5)	427 (382.2†)	195 (152.1†)
Lung	52 (52.7)	48 (48.0)	64 (56.2)	61 (48.4)
Colorectal	65 (68.3)	25 (24.7)	46 (34.7†)	20 (14.4)
Breast	^	0	108 (98.6)	26 (21.7)
Prostate	124 (126.9)	24 (23.7)	-	-
NHL	15 (15.5)	7 (6.9)	28 (25.2)	11 (7.5)
Leukemia	20 (20.6)	13 (12.7)	18 (15.6)	^
Bladder	26 (25.3)	10 (10.1)	8 (6.1†)	^
Melanoma	24 (27.4)	^	23 (22.7)	^
Uterine	-	-	26 (22.7)	^
Oral	18 (18.8)	7 (7.4)	^	^

* count (rate per 100,000)

† significantly different ($p<0.05$)

Table 2. New cancer cases, deaths, and incidence and mortality rates in Peterborough by sex; 1986-2007

Cancer Type	Males		Females	
	Cases	Deaths	New Cases	Deaths
All Cancers Combined	7,984 (470.8)*	3,846 (225.2)	7,203 (361.6†)	3,309 (150.9†)
Lung	1,381 (79.1)	1,166 (66.8)	1,025 (49.6†)	752 (35.2†)
Colorectal	1,054 (61.3)	514 (30.2)	999 (44.0†)	443(18.6†)
Breast	21 (1.2)	8 (0.5)	1,905 (98.5†)	547 (26.4†)
Prostate	1,977 (113.8)	433 (25.5)	-	-
NHL	348 (21.5)	142 (8.5)	283 (13.9†)	122 (5.3†)
Leukemia	292 (17.9)	158 (9.6)	201 (10.0†)	121 (5.4†)
Bladder	387 (22.1)	108 (6.3)	151 (6.9†)	43 (1.8†)
Melanoma	381 (17.6)	53 (3.2)	239 (13.6†)	37 (2.0†)
Uterine	-	-	407 (21.2)	37 (1.7)
Oral	265 (15.9)	98 (5.8)	130 (6.4†)	42 (2.0†)

* count (rate per 100,000)
† significantly different ($p<0.05$)

Key Points

- *The incidence of all cancers combined has been increasing since 1986 in Peterborough and Ontario in both males and females*
- *Male prostate, female breast, and lung and colorectal cancer among both sexes were the most commonly diagnosed cancers*
- *Mortality rates from all cancers combined among males has been decreasing whereas rates have not changed a great deal among females*
  Males had significantly higher incidence and mortality rates of all cancers

Types of Cancer in Peterborough and Ontario

The proportion of cancer cases and deaths among Peterborough men and women for the period of 1986 to 2007 is highlighted in Figures 2 through 5. The figures also indicate provincial distributions of cancer cases and deaths for comparison. Among men, prostate (24.8%), lung (17.3%), and colorectal (13.2%) were the most frequently diagnosed cancers during this period; the same three cancers account for most of the cancer-related deaths among Peterborough men (11.3%, 30.3%, and 13.4%, respectively). Breast (26.4%), lung (14.2%), and colorectal (13.9%) cancers were the most frequently diagnosed cancers in Peterborough women as well and also accounting for the largest proportion of deaths (16.5%, 22.7%, and 13.4%, respectively). These distributions are generally similar to the province.

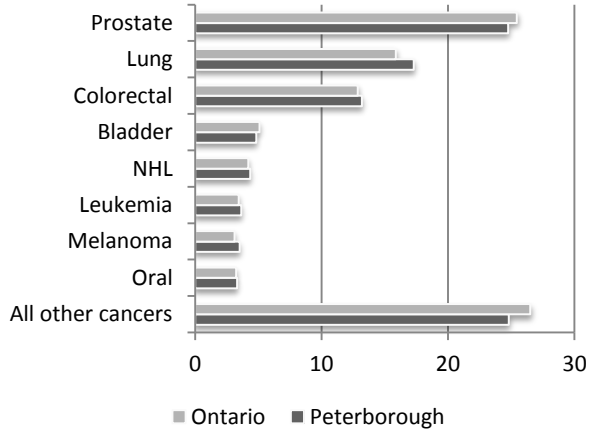


Figure 2. Proportion of new cases for selected cancer sites in Peterborough and Ontario males; 1986-2007

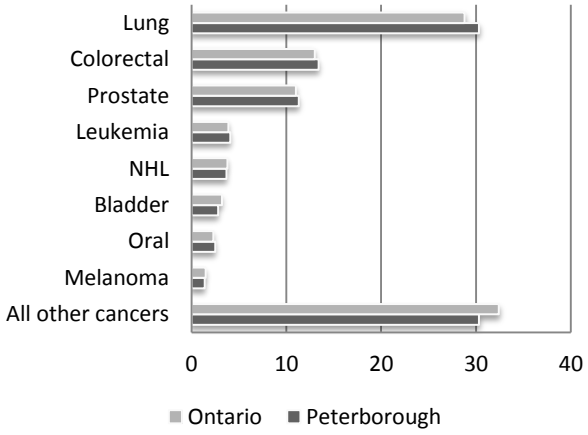


Figure 3. Proportion of selected cancer site deaths in Peterborough and Ontario males; 1986-2007

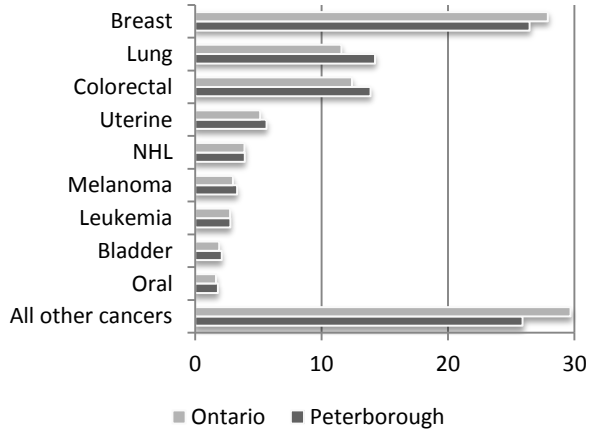


Figure 4. Proportion of new cases for selected cancer sites in Peterborough and Ontario females; 1986-2007

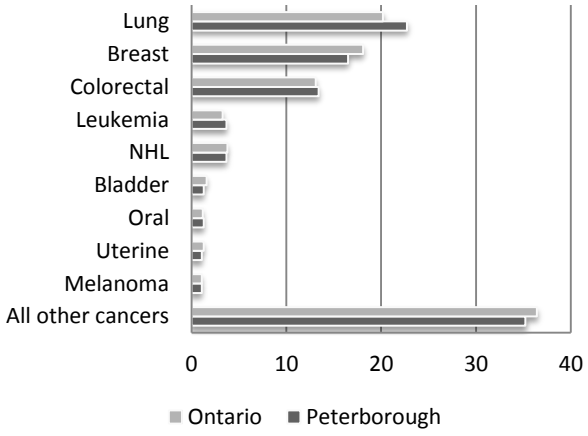


Figure 5. Proportion of selected cancer site deaths in Peterborough and Ontario females; 1986-2007

All Cancers Combined

Incidence

Since 1986, the incidence rate of all cancers combined has been increasing in both males and females in Peterborough and the province, although the difference in rates between Ontario and Peterborough during this frame was not significantly different – Figure 6. Between 1986 and 2007, relative to Ontario males, Peterborough males had significantly higher incidence rates of lung cancer (6.5%) and melanoma (24.4%); however, the incidence rate of prostate cancer was significantly lower than the province by 5.6% - Table 3. During the same time frame, incidence rates of lung (21.9%), melanoma (21.5%), and uterine cancers (14.7%) were significantly higher among Peterborough women compared to those in Ontario.

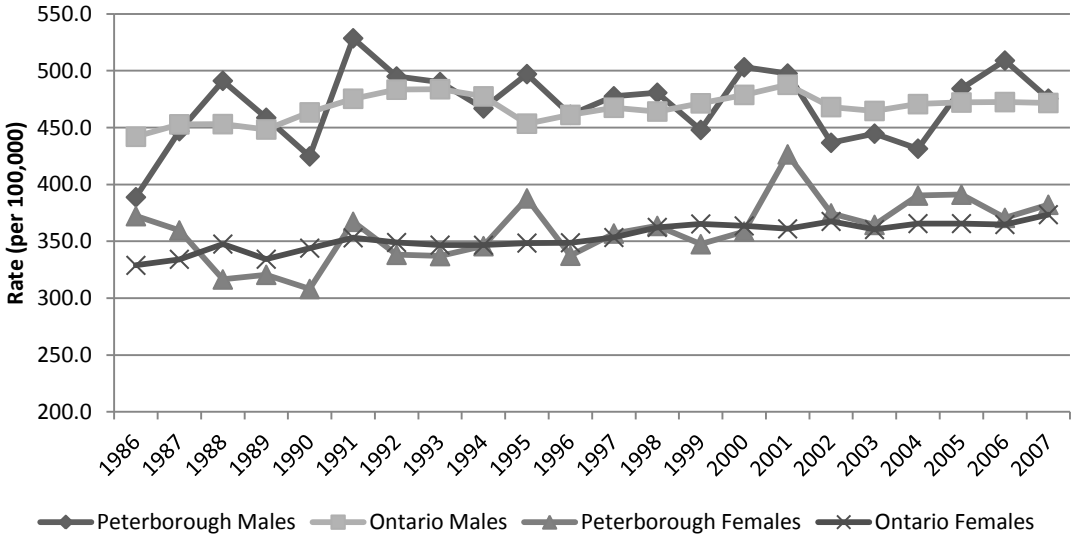


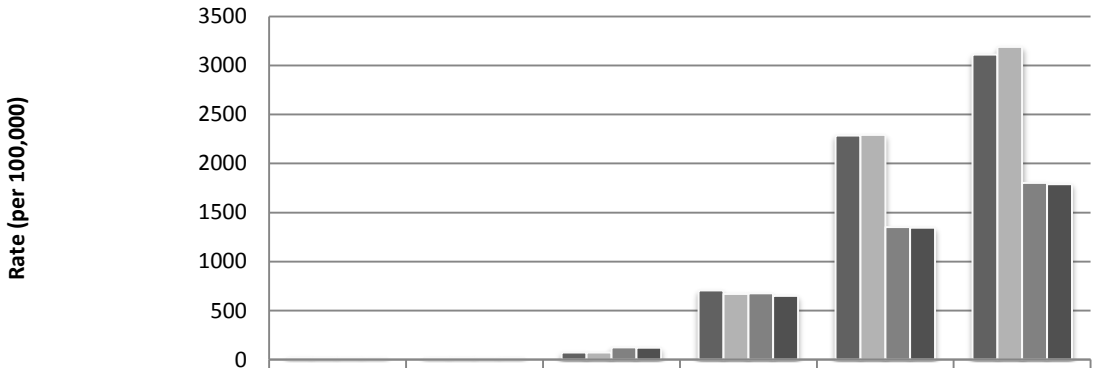
Figure 6. Incidence rates for all cancers combined in Peterborough and Ontario by sex; 1986-2007

Table 3. Incidence rates and rate ratios (RR) of selected cancers in Peterborough and Ontario by sex; 1986-2007

Cancer Type	Males			Females		
	Peterborough	Ontario	RR	Peterborough	Ontario	RR
All Cancers Combined	470.8	467.5	1.00	361.6	354.9	1.02
Lung	79.1	74.3	1.07*	49.6	40.7	1.22*
Colorectal	61.3	38.9	1.04	44.0	42.0	1.05
Breast	1.2	0.9	1.36	98.5	100.1	0.98
Prostate	113.8	120.5	0.94*	-	-	-
NHL	21.5	19.3	1.15	13.9	13.9	1.00
Leukemia	17.9	16.2	1.10	10.0	9.8	1.02
Bladder	22.1	24.4	0.91	6.9	6.4	0.91
Melanoma	17.6	14.2	1.24*	13.6	11.2	1.22*
Uterine	-	-	-	21.2	18.5	1.15*
Oral	15.9	14.7	1.08	6.4	5.9	1.09

* significantly different ($p<0.05$)

The incidence of cancers increases as individuals age: in Peterborough between 1986 and 2007, 66.0% of all new cancers among men and 58.5% among women occurred in persons older than 65 years of age. Figure 7 illustrates the differences in incidences rates of all cancers combined in Peterborough and Ontario by sex. In Peterborough, females ages 20 to 44 are significantly more likely to be diagnosed with cancer than males (RR=1.71); however, females 65 to 74 and 75 years of age and older are less likely than males to be diagnosed with any new cancer (RR=0.59 and 0.58, respectively). Peterborough males aged 45 to 64 had significantly higher incidence rates compared to those in the same cohort in Ontario (RR=1.05); there were no other significant differences in incidence rates between Peterborough and Ontario among age groups.



	0-09	10-19	20-44	45-64	65-74	75+
Peterborough Males	19.7	18.7	72.5	705.3	2,283.8	3,110.2
Ontario Males	18.5	17.5	71.3	670.9	2,291.7	3,189.7
Peterborough Females	15.9	14.6	124.2	674.9	1,351.6	1,800.9
Ontario Females	15.4	16.9	121.3	650.0	1,346.0	1,790.4

Figure 7. Age-specific cancer incidence rates for all cancers combined in Peterborough and Ontario by sex; 1986-2007

Mortality

Mortality rates for all cancers combined in Peterborough and Ontario males have been in decline since 1986. However, mortality rates in Peterborough females have remained relatively consistent compared to rates in the province which have been declining slowly – Figure 8. Between 1986 and 2007, relative to Ontario, men in Peterborough had significantly higher mortality rates of lung cancer by 6.6% – Table 3. Similarly, during the same time frame, mortality rates of lung cancer were significantly higher by 14.9% among Peterborough women relative to those in Ontario.

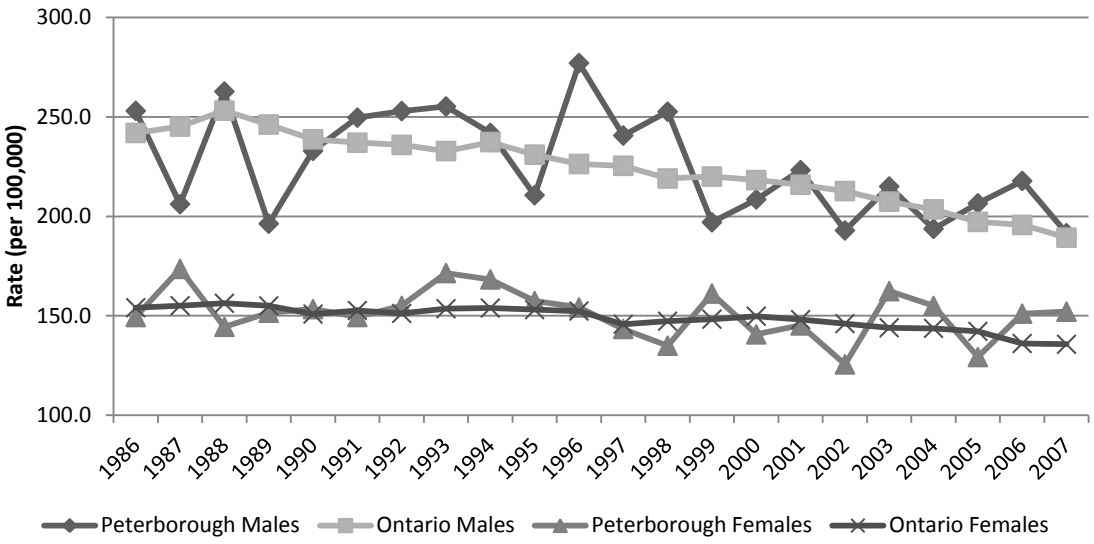


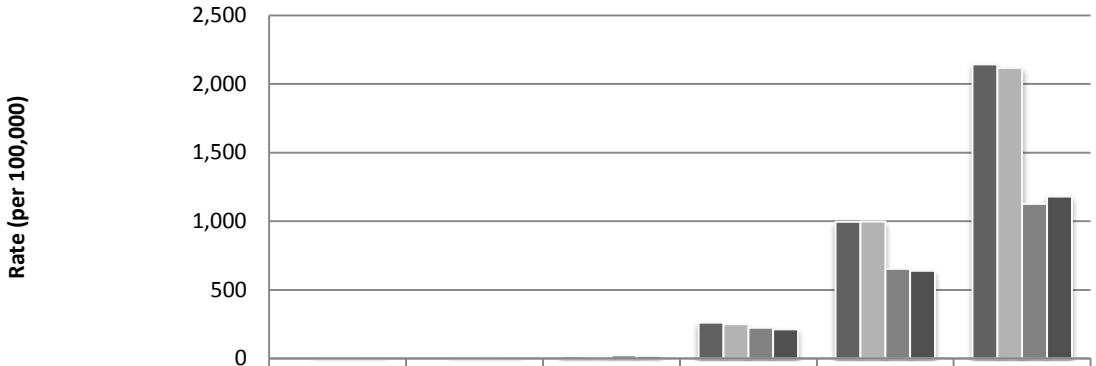
Figure 8. Mortality rates for all cancers combined in Peterborough and Ontario by sex; 1986-2007

Table 4. Mortality rates and rate ratios (RR) of selected cancers in Peterborough and Ontario by sex; 1986-2007

Cancer Type	Males			Females		
	Peterborough	Ontario	RR	Peterborough	Ontario	RR
All Cancers Combined	225.2	221.5	1.01	150.9	187.2	1.02
Lung	66.8	62.7	1.07†	35.2	30.6	1.15†
Colorectal	30.2	28.9	1.05	18.6	18.7	1.00
Breast	0.5	0.2	1.87	26.4	27.3	0.97
Prostate	25.5	26.4	0.97	-	-	-
NHL	8.5	8.3	1.02	5.3	5.6	0.93
Leukemia	9.6	8.7	1.11	5.4	4.9	1.11
Bladder	6.3	7.4	0.85	1.8	2.1	0.84
Melanoma	3.2	3.2	1.00	2.0	1.7	1.18
Corpus uteri	-	-	-	1.7	1.9	0.89
Oral	5.8	4.9	1.19	2.0	1.8	1.12

† significantly different ($p<0.05$)

Mortality from cancers also increases with age and Figure 9 illustrates differences in mortality rates of all cancers combined in Peterborough and Ontario by age group and by sex. Between 1986 and 2007, 75.3% and 72.6% of all deaths among Peterborough males and females, respectively, occurred among those aged 65 and older. Women in Peterborough aged 20 to 44 were more likely to die of cancer than men (RR=1.39). Conversely, women aged 45 to 64, 65 to 74, and those aged 75 and older were less likely to die from all cancers combined then men (RR=0.85; 0.66; and 0.53, respectively). There were no significant differences in cancer mortality rates by age group between Peterborough and Ontario in either sex.



	0-09	10-19	20-44	45-64	65-74	75+
Peterborough Males			17.2	262.7	995.7	2,143.5
Ontario Males	3.3	3.7	15.9	250.6	998.7	2,116.0
Peterborough Females	3.7	4.3	23.9	224.2	654.0	1,126.8
Ontario Females	2.6	2.7	20.0	213.4	639.0	1,179.9

Figure 9. Age-specific cancer mortality rates for all cancers combined in Peterborough and Ontario by sex; 1986-2007

Key Points

- *Peterborough males have higher incidence rates of lung cancer and melanoma but lower incidence rates of prostate cancer compared to the province*
- *Peterborough females have higher incidence of lung, melanoma, and uterine cancers compared to the province*
- *Mortality rates due to lung cancer are higher in Peterborough than Ontario*

Lung Cancer

Lung cancer occurs when cells develop abnormally in one or both of the lungs and grow out of control to form a tumour. There are two major types of lung cancer: non-small cell and small cell; over 75% of all people diagnosed with lung cancer have non-small cell lung cancer. Risk factors associated with developing lung cancer include current or former smoking, second-hand exposure to smoke, and environmental factors such as increased exposure in the home or in the workplace to harmful substances such as radon or asbestos.

In both sexes, lung cancer is the second most common cancer, accounting for approximately 4,100 (12.3%) and 3,700 (11.6%) cancer diagnoses in Ontario in 2010, respectively. Lung cancer is the leading cause of cancer deaths in males (3,700, or 25.3%) and females (3,000, or 22.0%) in Ontario.

Incidence

In 2007 there were 116 cases of lung cancer diagnosed in Peterborough; 64 (55.2%) of these cases were female. The incidence of lung cancer between 1986 and 2007 was significantly higher among Peterborough men than women by 59.5% (average incidence 79.1 per 100,000 compared to 49.6 per 100,000, respectively) – Figure 10. While the incidence of lung cancer among men (in both Peterborough and Ontario) has been decreasing since 1986, incidence among women has been increasing.

Older adults, that is, those aged 65 and older, accounted for the majority of cancer cases in Peterborough between 1986 and 2007. Older men accounted for 70.3% of male lung cancer cases and approximately 64.8% of female cases were aged 65 or older. Peterborough women aged 45 to 64, 65 to 74, and those aged 75 and older were less likely to be diagnosed with lung cancer than men between 1986 and 2007 (RR=0.80; 0.59; and 0.45, respectively) – Figure 9. During the same time frame, incidence rates among Peterborough men aged 45 to 64 were significantly higher compared to Ontario by 12.5%. Similarly, lung cancer incidence rates among women 45 to 64 and 65 to 74 were significantly higher compared to Ontario by 33.4% and 23.6%, respectively – Figure 11.

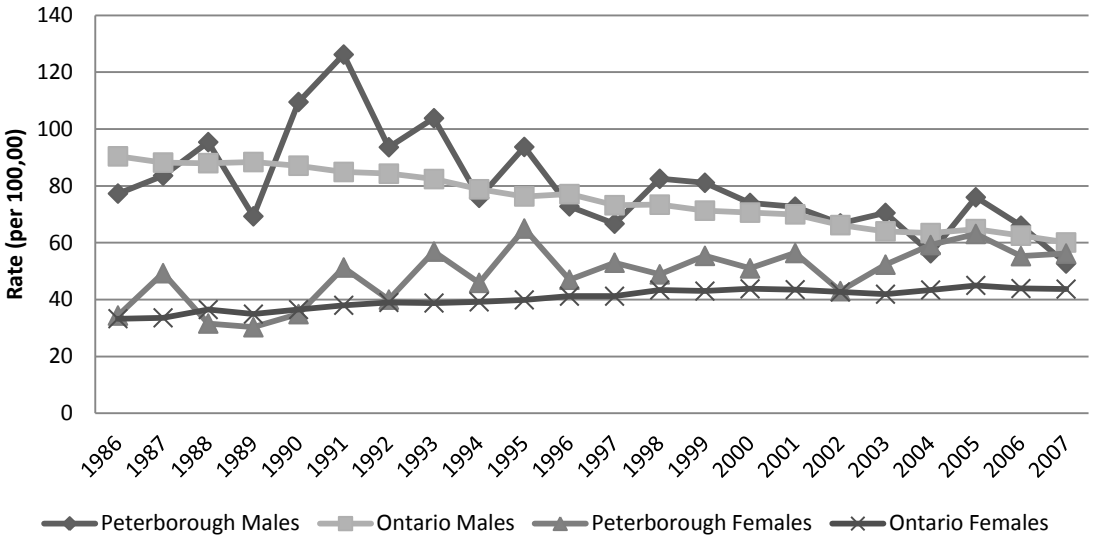
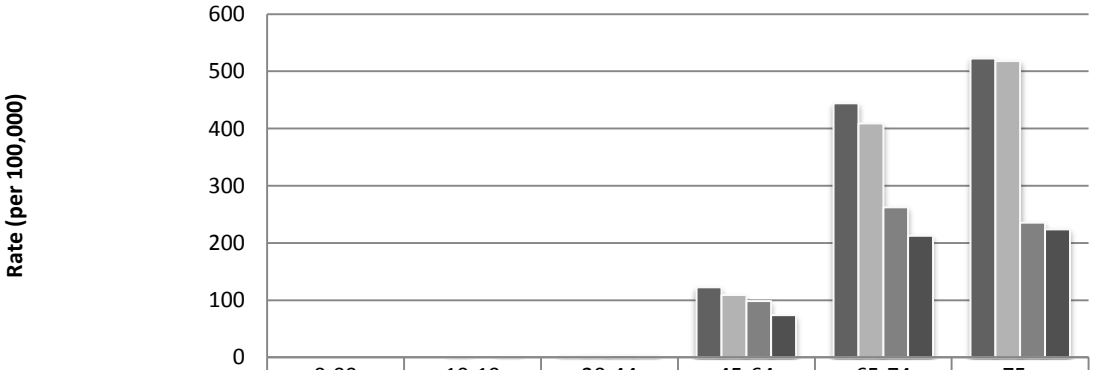


Figure 10. Incidence rates of lung cancer in Peterborough in Ontario by sex; 1986-2007



	0-09	10-19	20-44	45-64	65-74	75+
Peterborough Males	0	0	2.5	122.8	444.3	522.9
Ontario Males	0	0.1	3.5	109.1	409.0	518.4
Peterborough Females		0	4.0	98.6	262.7	235.5
Ontario Females	0	0.1	3.7	73.9	212.6	224.2

Figure 11. Age-specific lung cancer incidence rates in Peterborough and Ontario by sex; 1986-2007

Mortality

There were 109 deaths attributable to lung cancer in Peterborough in 2007, 56.0% (n=61) of those occurred in women. Since 1986, 2007 was the first year that there were more lung cancer deaths among females than males. Lung cancer mortality rates between 1986 and 2007 were significantly higher among Peterborough men than women by 89.8% (66.8 per 100,000 compared to 35.2 per 100,000, respectively) – Figure 12. Lung cancer mortality rates among men (in both Peterborough and Ontario) have been decreasing since 1986. However, similar to incidence rates, mortality among women has been increasing. Whereas rates among women in Peterborough show continued increases,

the rates among Ontario women stabilized around 2000. Compared to the province, Peterborough males and females had 6.6% and 14.9% higher mortality rates between 1986 and 2007, respectively. Lung cancer mortality rates increase with age and between 1986 and 2007, 75.1% of lung cancer deaths among men and approximately 69.5% of deaths among women occurred in persons aged 65 or older. Figure 13 illustrates differences in lung cancer mortality rates in Peterborough and Ontario by age group and sex. Peterborough women aged 45 to 64, 65 to 74, and those aged 75 years and older were less likely to die of lung cancer than Peterborough men (RR=0.74; 0.54; and 0.37, respectively). Peterborough males aged 75 and older were 10.7% more likely to die from lung cancer than their provincial counterparts. Compared to Ontario, Peterborough women aged 45 to 64 and those 65 to 74 years of age were more likely to die of lung cancer by 30.6% and 14.0%, respectively.

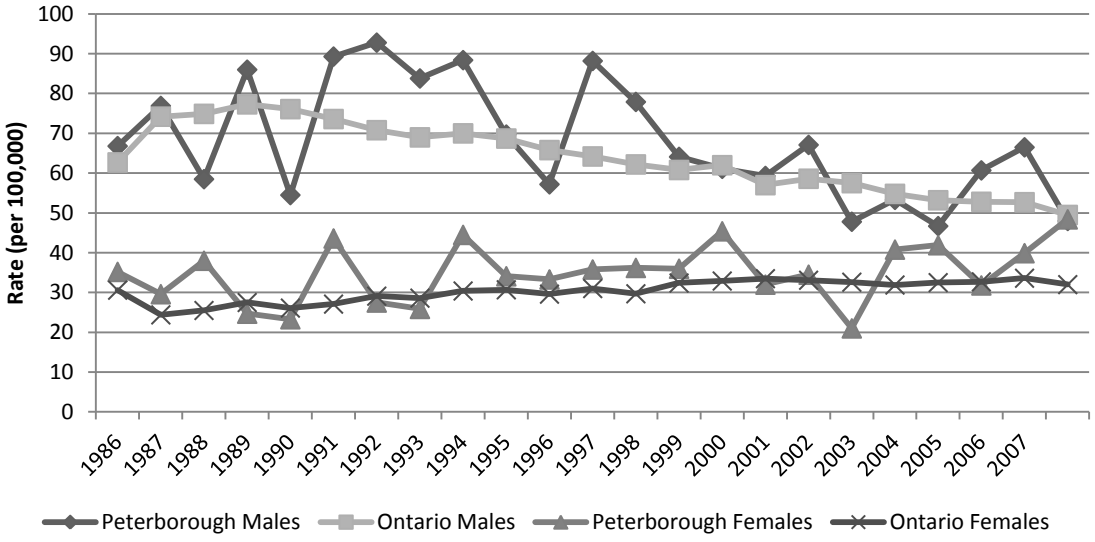
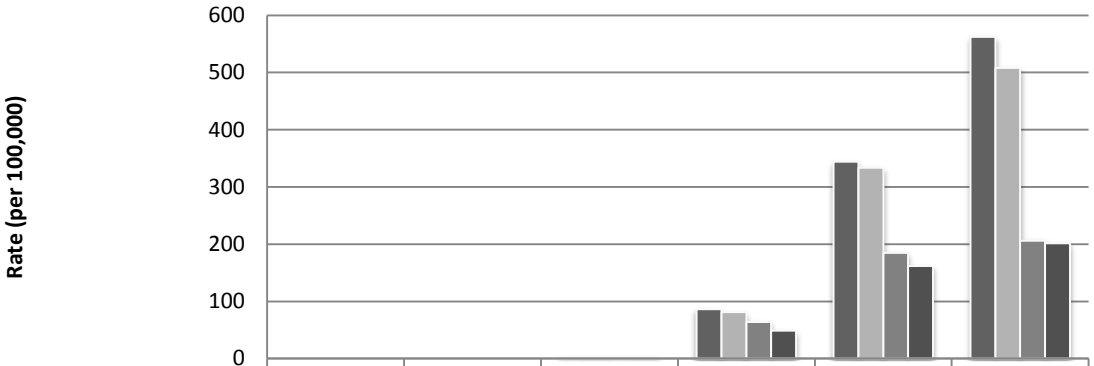


Figure 12. Lung cancer mortality rates in Peterborough in Ontario by sex; 1986-2007



	0-09	10-19	20-44	45-64	65-74	75+
Peterborough Males	0	0	1.8	86.5	344.0	562.3
Ontario Males		0	2.0	81.1	333.6	507.8
Peterborough Females		0	1.7	63.9	184.6	206.3
Ontario Females		0	2.0	48.9	162.0	201.7

Figure 13. Age-specific lung cancer mortality rates in Peterborough and Ontario by sex; 1986-2007

Key Points

- *While lung cancer incidence and mortality rates are decreasing in men, rates are increasing in women*
- *2007 marked the first year since 1986 that more women died of lung cancer in Peterborough than men*
- *Both incidence and mortality rates are significantly higher in Peterborough than in Ontario*

Colorectal Cancer

Colon and rectal cancers arise from the same type of cell and have many similarities and are often referred to collectively as "colorectal cancer". The cells lining the colon or rectum can sometimes become abnormal and divide rapidly forming benign tumours or growths called polyps. Not all polyps will develop into colorectal cancer; however, colorectal cancer almost always develops from a polyp. Many factors such as age, diet and smoking increase the risk of developing colorectal cancer.

In Ontario, an estimated 4,500 males and 3,800 females were diagnosed with colorectal cancer in 2010 (13.5% and 11.9% of cancer diagnoses, respectively). Colorectal cancer also has a significant impact on mortality in men and women accounting for an estimated 12.7% (n=1,850) and 11.4% (n=1,550) of all cancer deaths in 2010, respectively.

Incidence

There were 111 new cases of colorectal cancer in Peterborough in 2007 with a small majority (65, or 58.6%) of cases occurring in men. The incidence of colorectal cancer between 1986 and 2007 was significantly higher among Peterborough men than women by 39.3% (average incidence 61.3 per 100,000 compared to 44.0 per 100,000, respectively) – Figure 14. Incidence of colorectal cancer among Peterborough males appears to be increasing slightly while rates in Ontario are relatively stable. Rates of colorectal cancer in women have been decreasing in both Peterborough and the province. There were no significant differences in rates between Peterborough and Ontario in either sex.

Between 1986 and 2007, 70.4% of cases in men, and approximately 77.3% of cases among women occurred in those aged 65 years of age and older. Peterborough females aged 45 to 64, 65 to 74, and those aged 75 and older were less likely to be diagnosed with colorectal cancer than males (RR=0.69; 0.63; and 0.83, respectively) – Figure 15. Compared to Ontario during the same time frame, incidence rates among women 75 years of age and older were significantly higher by 11.1%.

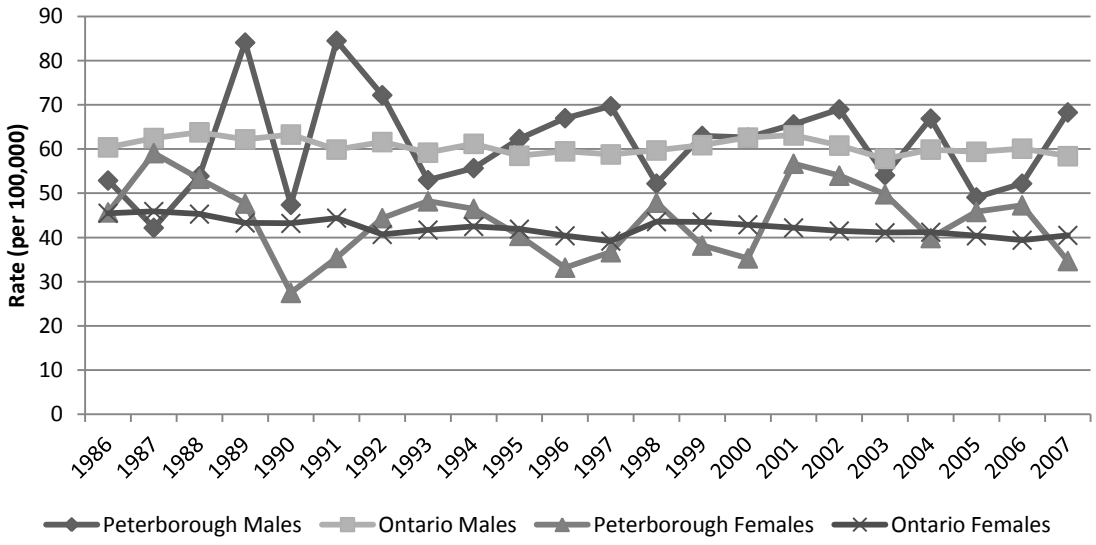
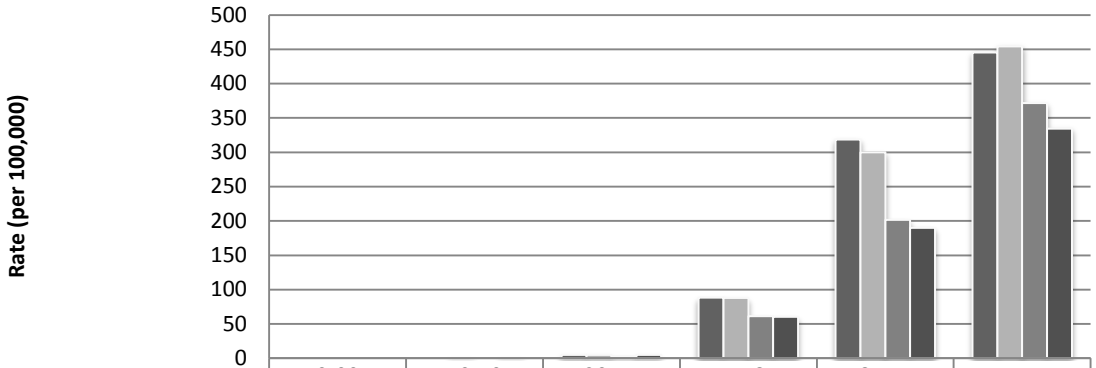


Figure 14. Incidence rates of colorectal cancer in Peterborough in Ontario by sex; 1986-2007



	0-09	10-19	20-44	45-64	65-74	75+
Peterborough Males	0	0	5.0	88.2	318.7	445.1
Ontario Males		0.1	4.9	87.7	299.9	454.2
Peterborough Females	0		3.0	61.3	201.4	371.5
Ontario Females		0.2	4.7	60.5	189.8	334.6

Figure 15. Age-specific colorectal cancer incidence rates in Peterborough and Ontario by sex; 1986-2007

Mortality

There were 45 deaths attributable to colorectal cancer in Peterborough in 2007, 25 of which (55.6%) occurred in men. Male colorectal cancer mortality rates between 1986 and 2007 in Peterborough were significantly higher than rates in women by 62.4% (30.2 per 100,000 compared to 18.6 per 100,000, respectively) – Figure 16. Colorectal cancer mortality rates in both Peterborough and Ontario have been decreasing since 1986; compared to the province, there were no significant differences in mortality rates between in either sex.

The majority of colorectal cancer deaths among men (75.1%) and women (69.5%) occurred in older adults aged 65 and older. Peterborough women aged 45 to 64 (RR=0.55), 65 to 74 (RR=0.61), and those aged 75 years and older (RR=0.63) were less likely to die of colorectal cancer than men of the same age groups. Compared to Ontario, there were no significant differences among different age groups in either sex – Figure 17.

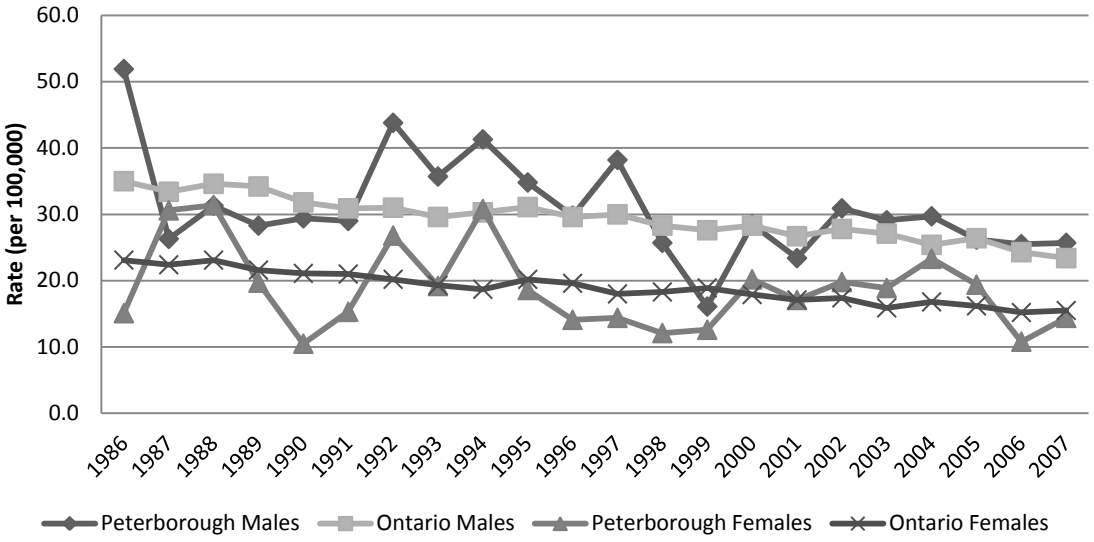
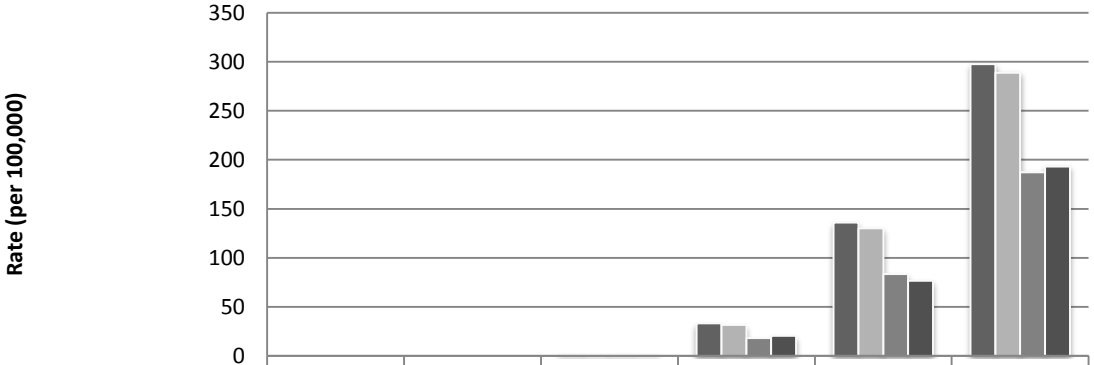


Figure 16. Colorectal cancer mortality rates in Peterborough in Ontario by sex; 1986-2007



	0-09	10-19	20-44	45-64	65-74	75+
Peterborough Males	0	0	1.9	33.4	136.3	297.6
Ontario Males		0	1.4	31.7	130.4	288.9
Peterborough Females	0	0	1.7	18.5	83.6	187.4
Ontario Females		0	1.3	20.7	76.8	193.2

Figure 17. Age-specific colorectal cancer mortality rates in Peterborough and Ontario by sex; 1986-2007

Key Points

- *Peterborough men were more likely to get and die from colorectal cancer than women*
- *Mortality rates in both men and women in Peterborough and the province have been decreasing since 1986*
- *In general, incidence and mortality rates of colorectal are similar in Peterborough and Ontario; however, there appears to be a slow increase in incidence rates in Peterborough men*

Breast Cancer

While breast cancer can occur in men, this report will focus on female breast cancer. There are many types of breast cancer with the most common forms beginning in the milk ducts, lobules or glands. A woman's risk of developing breast cancer is increased if she has a family history of the disease. Other risk factors include age, smoking, and diet. Breast cancer is the most common female cancer and is the second leading cause of cancer deaths in women.

In 2010, it is estimated that 8,900 Ontario women were diagnosed with breast cancer and that 2,100 died from the disease accounting for 28% of all female cancers and 15.4% of female cancer deaths.

Incidence

There were 108 new cases of breast cancer in Peterborough in 2007. Between 1986 and 2007 the incidence of breast cancer among Peterborough women decreased slightly, whereas rates in Ontario have been relatively stable since the early 1990's – Figure 18. There were no significant differences in rates between Peterborough and Ontario.

Similar to other cancers, incidence of breast cancer peaks in older age groups: 66.4% of cases between 1986 and 2007 in Peterborough occurred in women aged 65 years and older. The greatest number of breast cancers between 1986 and 2007 occurred among women 65 to 74 years of age with 371 cases or 39.9% – Figure 19. There were no significant differences between rates in Peterborough compared to Ontario by age group.

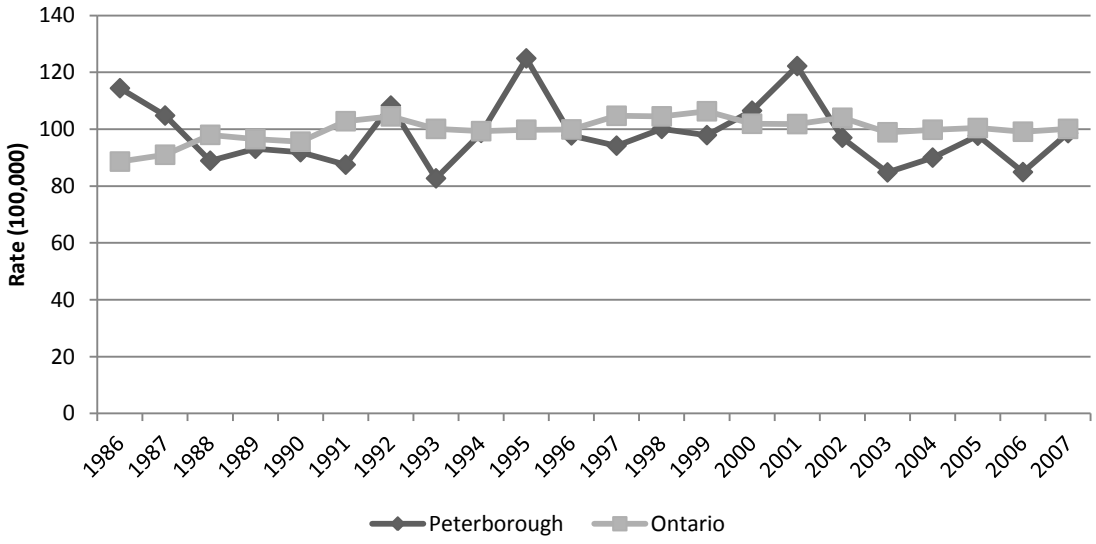
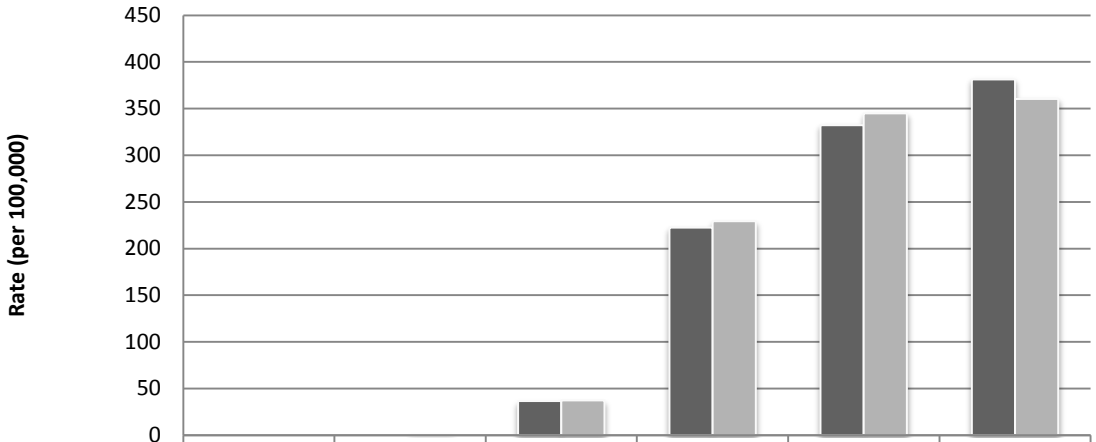


Figure 18. Incidence rates of breast cancer in Peterborough in Ontario; 1986-2007



	0-09	10-19	20-44	45-64	65-74	75+
Peterborough	0	0	36.5	222.5	332.4	381.3
Ontario	0	0.1	37.4	229.3	344.8	360.5

Figure 19. Age-specific breast cancer incidence rates in Peterborough and Ontario; 1986-2007

Mortality

In 2007, there were 26 deaths attributable to breast cancer in Peterborough. Mortality rates in both Peterborough and Ontario decreased considerably between 1986 and 2007: rates decreased by 87.6% in Peterborough and 49.5% in the province – Figure 20.

Approximately 63.0% of breast cancer deaths in Peterborough between 1986 and 2007 occurred in women aged 65 and older. Similar to the number of new cases, the greatest number of deaths (n=263, or 29.9%) occurred in women aged 65 to 74 years old. However, age-specific mortality rates indicate that the highest mortality rates occur in women aged 75 and older – Figure 21. Age-specific mortality rates were not significantly different comparing Peterborough and Ontario.

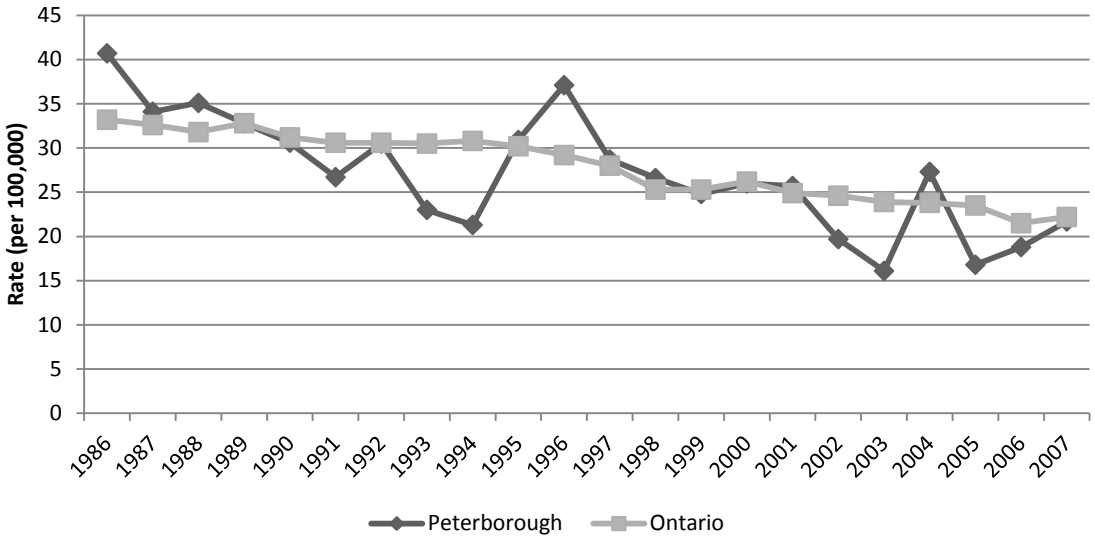
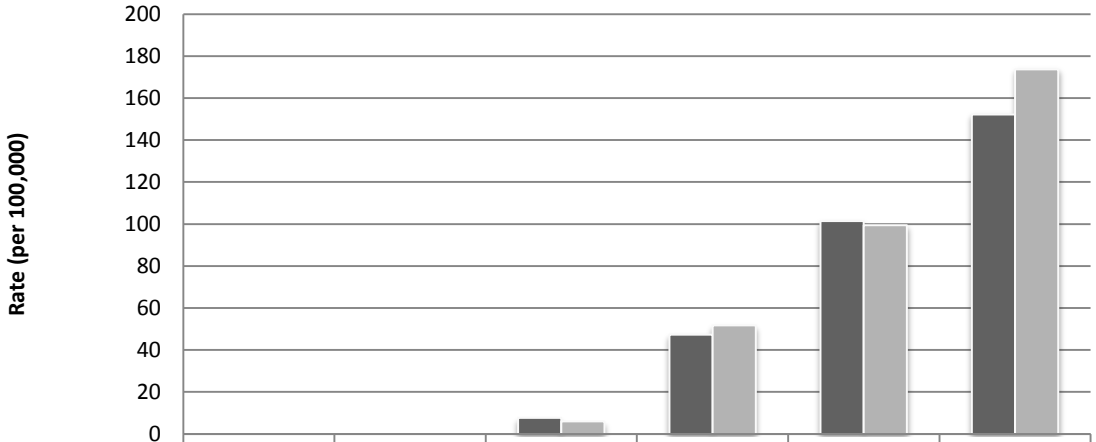


Figure 20. Breast cancer mortality rates in Peterborough in Ontario; 1986-2007



	0-09	10-19	20-44	45-64	65-74	75+
Peterborough		0	7.7	47.4	101.5	152.3
Ontario	0		6.0	51.8	99.5	173.8

Figure 21. Age-specific breast cancer mortality rates in Peterborough and Ontario; 1986-2007

Key Points

- *Incidence rates of breast cancer in Peterborough women were lower in 2007 compared to 1986*
- *Peterborough women exhibited significant reductions in breast cancer mortality between 1986 and 2007*
- *There were no significant differences between incidence or mortality rates when comparing Peterborough to Ontario*

Prostate Cancer

Most prostate cancers are adenocarcinomas (i.e.: a tumour of a gland or gland-like structure) and begin as either of two precursor lesions. Increased age, family history, ethnicity, and lifestyle factors such as diet and physical activity are all considered risk factors.

Prostate cancer is the most common cancer among men, though many more men are diagnosed with prostate cancer than die from it. There were an estimated 10,200 new cases and 3,700 deaths due to prostate cancer among Ontario men in 2010, representing 30.6% of all male cancers and 11.3% of cancer deaths in men.

Incidence

There were 124 cases of prostate cancer diagnosed among Peterborough men in 2007. The incidence of prostate cancer has been increasing in both Peterborough and Ontario since 1986 – Figure 22. Incidence rates in Peterborough have doubled during this time frame and rates in the province have increased by approximately 70%. However, incidence rates of prostate cancer in Peterborough between 1986 and 2007 were significantly lower than Ontario by 5.6%.

Age-specific prostate cancer incidence rates increase dramatically after the age of 65 and, in Peterborough, men aged 65 to 74 years of age accounted for 42.8% of all new prostate cancer cases between 1986 and 2007. Incidence of prostate cancer among males aged 75 and older was significantly lower by 13.1% in Peterborough compared to Ontario – Figure 23.

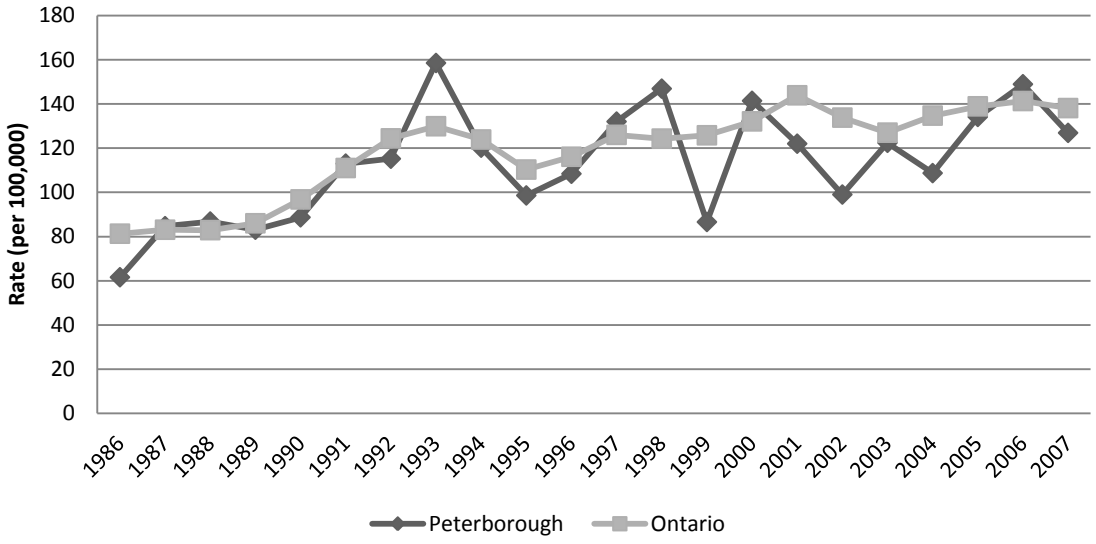
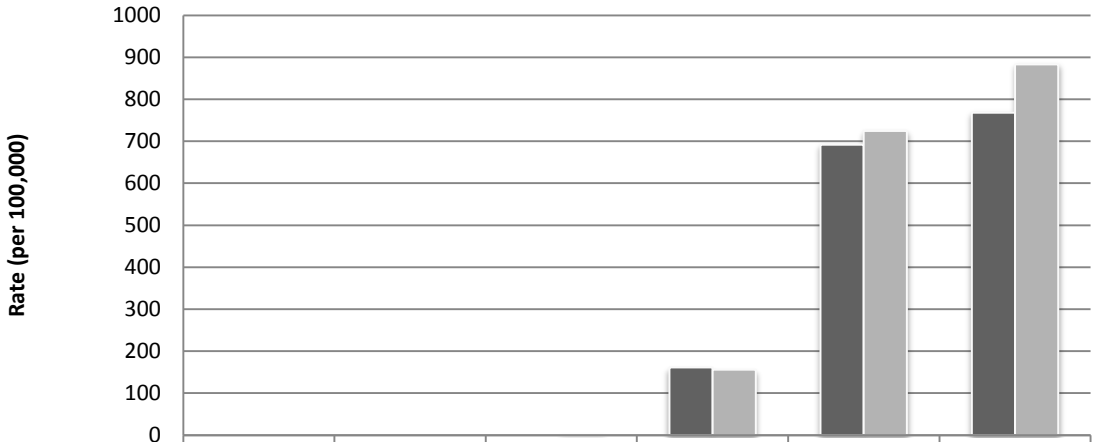


Figure 22. Incidence rates of prostate cancer in Peterborough in Ontario; 1986-2007



	0-09	10-19	20-44	45-64	65-74	75+
Peterborough	0	0		161.0	691.5	768.2
Ontario			0.7	155.9	724.9	883.5

Figure 23. Age-specific prostate cancer incidence rates in Peterborough and Ontario; 1986-2007

Mortality

In 2007, there were 24 deaths attributable to prostate cancer in Peterborough. Mortality rates in Ontario have been declining since the early 1990's whereas recent trends in Peterborough indicate rates have been increasing since 2000 – Figure 24. Rates in Peterborough between 1986 and 2007 were not significantly different than the province.

Almost all, or 92.8%, of prostate cancer deaths in Peterborough between 1986 and 2007 occurred in men aged 65 years and older. Deaths from prostate cancer are extremely rare among males younger than 45 years of age and mortality rates quadruple when comparing rates among men aged 65 to 74 to those 75 years and older – Figure 25. Compared to the province, there were no significant differences between age groups.

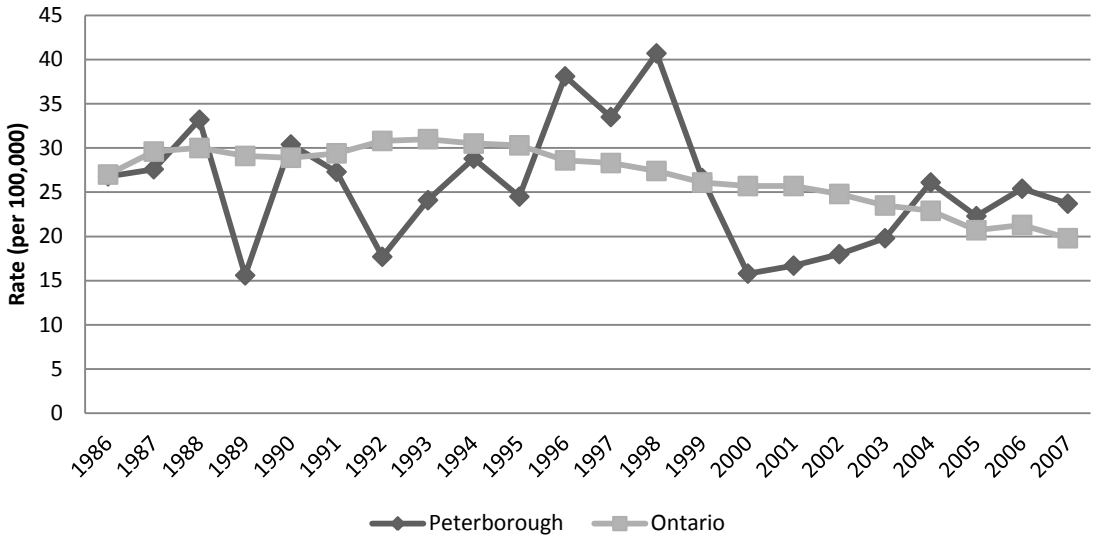
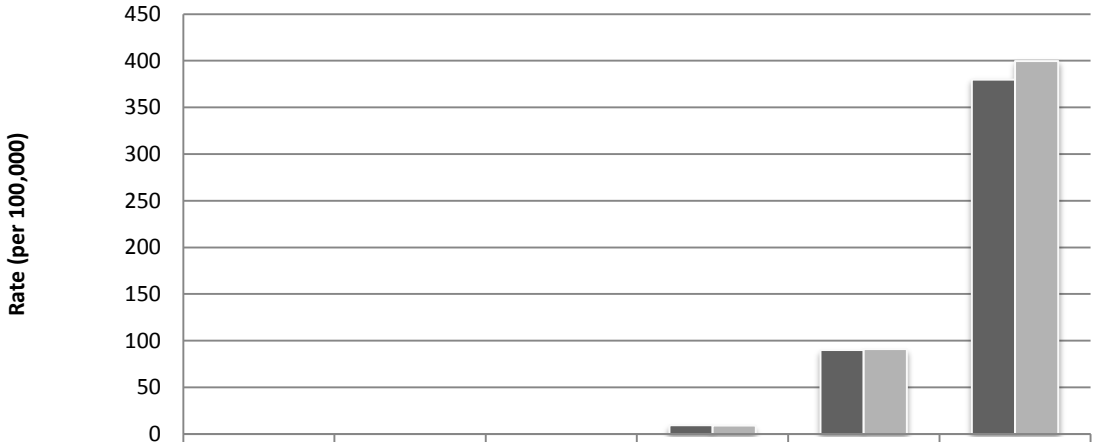


Figure 24. Prostate cancer mortality rates in Peterborough in Ontario; 1986-2007



	0-09	10-19	20-44	45-64	65-74	75+
Peterborough	0	0	0	9.6	90.2	379.9
Ontario	0		0	9.0	91.2	399.7

Figure 25. Age-specific prostate cancer mortality rates in Peterborough and Ontario; 1986-2007

Key Points

- *Incidence rates of prostate cancer have been increasing since 1986*
- *Peterborough men have significantly lower rates of prostate cancer compared to Ontario*
- *Since 2000, there has been an increasing trend in mortality rates among Peterborough men*
- *Males over the age of 75 were most likely to die from prostate cancer*

Non-Hodgkin Lymphoma (NHL)

There are many different types of NHL which are any of a large group of cancers of lymphocytes (white blood cells). These types can be divided into aggressive (fast-growing) or indolent (slow-growing) and they can be formed from either the B-cells or T-cells of the immune system. Risk factors include chronic disorders of the immune system or the chronic administration of drugs to suppress the immune system, increasing age, and prior exposure to radiation or chemotherapy.

Approximately 1,600 (4.8%) males and 1,400 (4.4%) females were diagnosed with NHL in Ontario in 2010; provincially, NHL accounted for 4.9% (n=710) of male and 4.3% (n=590) of female cancer deaths in the same year.

Incidence

There were 43 cases of NHL diagnosed in Peterborough in 2007, the majority of which (28, or 65.1%) occurred in women. The incidence rates of NHL between 1986 and 2007 was significantly higher in Peterborough men than women by 54.7% (average incidence 21.5 per 100,000 compared to 13.9 per 100,000, respectively) – Figure 26. Incidence rates of NHL have been increasing among both males and females in Peterborough and Ontario. Rates among Peterborough women increased sharply beginning in the early 2000's and, as a result, by 2007 women had higher incidence of NHL than men. Between 1986 and 2007 incidence rates in Peterborough were similar to the province.

Just over half of new NHL cases among Peterborough men between 1986 and 2007 and 63.5% of cases among women were aged 65 or older. A third of cases among males occurred in those aged 45 to 64 years old, whereas women over the age of 75 accounted for the most cases (35.5%). Age-specific rates of NHL, however, are larger among older age groups – Figure 27. Incidence rates of NHL among Peterborough women aged 20 to 44 (RR=0.44), 45 to 64 (RR=0.66) and those 75 years and older (RR=0.68) between 1986 and 2007 were significantly lower than men of those age groups. Rates in Peterborough males aged 20 to 44 years old were significantly greater than their provincial counterparts by 41.6%, while there were no significant differences between Peterborough and Ontario females by age group.

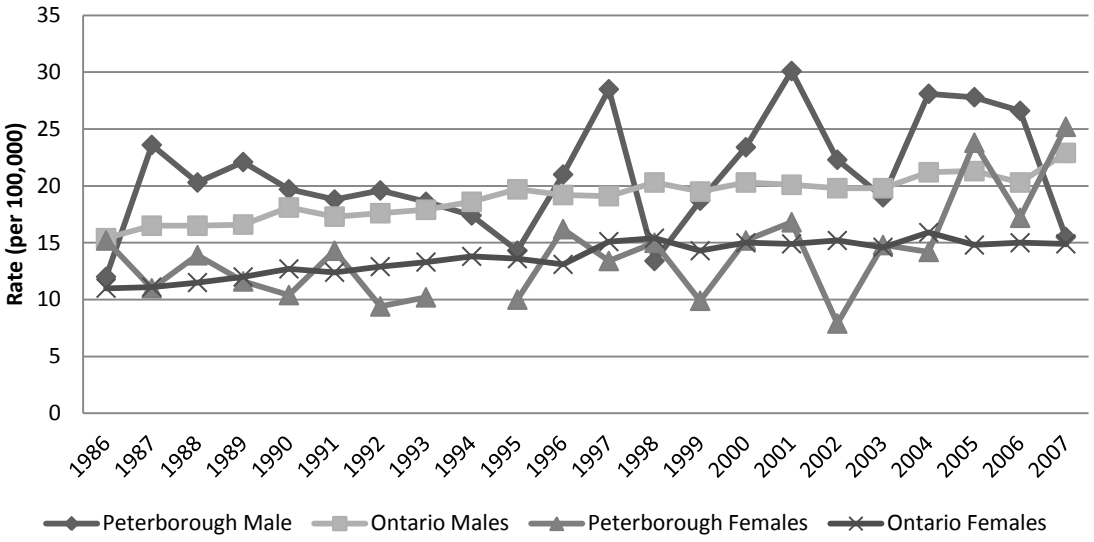
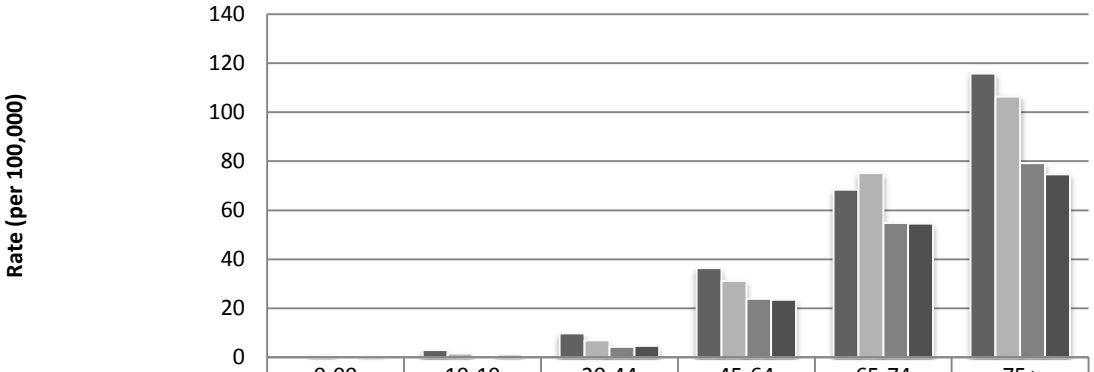


Figure 26. Incidence rates of NHL in Peterborough in Ontario by sex; 1986-2007



	0-09	10-19	20-44	45-64	65-74	75+
Peterborough Males	0	3.1	9.8	36.4	68.4	115.8
Ontario Males	0.9	1.6	6.9	31.2	75.2	106.4
Peterborough Females	0		4.3	23.9	54.8	79.3
Ontario Females	0.5	1.1	4.7	23.6	54.6	74.7

Figure 27. Age-specific NHL incidence rates in Peterborough and Ontario by sex; 1986-2007

Mortality

There were 18 deaths attributable to NHL in Peterborough in 2007, the majority of which (11, or 61.1%) occurred in women. NHL mortality rates between 1986 and 2007 were significantly higher in Peterborough men than women by 60.4% (8.5 per 100,000 compared to 5.3 per 100,000, respectively) – Figure 28. There are many years where fewer than five deaths resulted from NHL and therefore it is difficult to interpret trends in Peterborough, though it appears mortality rates in men have decreased since 1986. However, Ontario data suggest that rates rose through the 1980's and 1990's, but began to

decline in the early 2000's. Mortality rates of NHL among Peterborough men and women were similar to the province between 1986 and 2007.

Between 1986 and 2007, 67.6% of NHL deaths in Peterborough men occurred in persons 65 years of age and older. The large majority (83.9%) of NHL deaths during the same time frame occurring in Peterborough women were also aged 65 and older. Peterborough women aged 45 to 64 (RR=0.51) and those 65 to 74 years of age (RR=0.61) were significantly less likely to die of NHL than men in those age cohorts – Figure 29. There were no significant differences between Peterborough and Ontario males or females by age group.

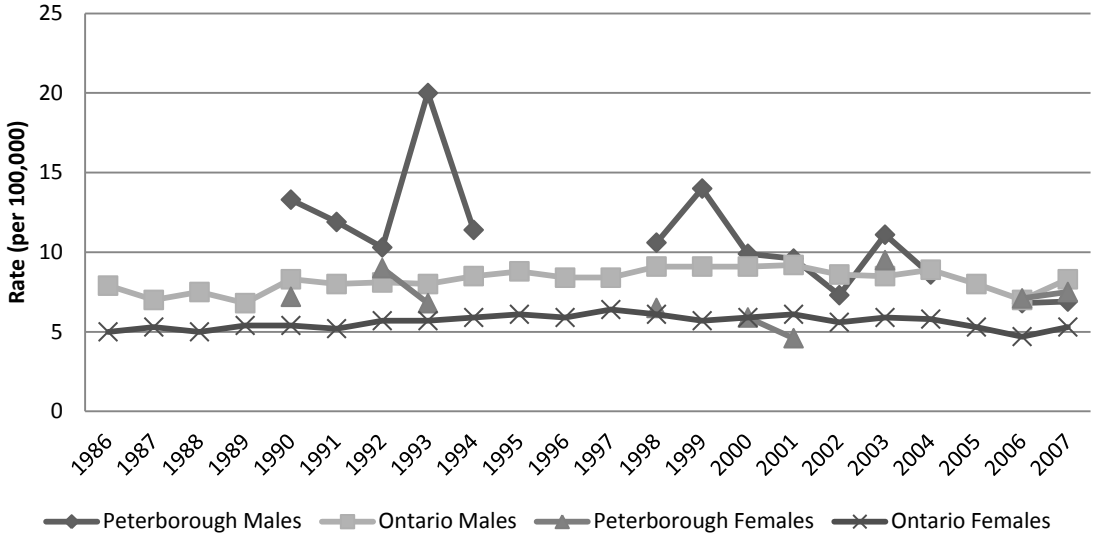
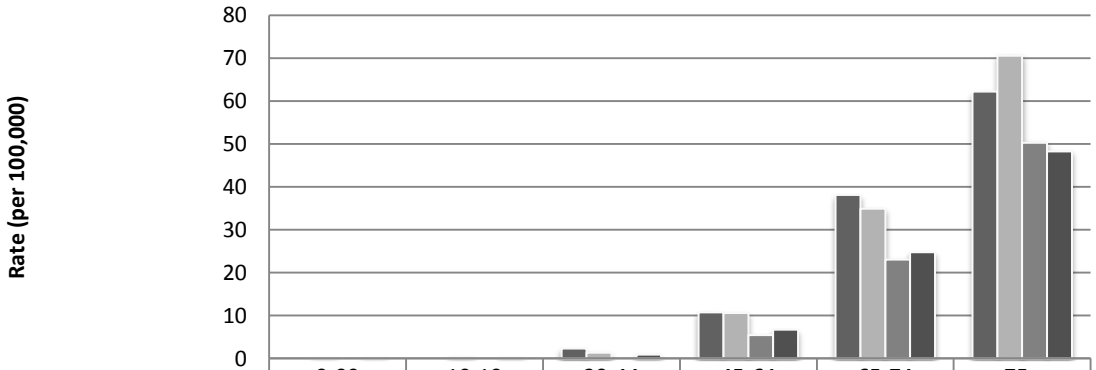


Figure 28. NHL mortality rates in Peterborough in Ontario by sex; 1986-2007



	0-09	10-19	20-44	45-64	65-74	75+
Peterborough Males	0	0	2.3	10.8	38.1	62.2
Ontairo Males	0.1	0.3	1.4	10.6	34.9	70.6
Peterborough Females	0	0		5.5	23.1	50.3
Ontario Females	0.1	0.2	0.9	6.7	24.8	48.3

Figure 29. Age-specific NHL mortality rates in Peterborough and Ontario by sex; 1986-2007

Key Points

- *Incidence rates of NHL are increasing in men and women; incidence in women increased sharply after 2000*
- *Men were more likely to get and die from NHL than women*
- *Trends in NHL mortality in Peterborough are difficult to interpret due to small numbers*

Leukemia

Leukemia is the general term for any of four different types of blood cancer, all of which begin in the bone marrow. The ways in which patients are affected and how they are treated are different for each type of leukemia. Smoking, radiation or chemotherapy, Down's syndrome and some other genetic diseases, and chronic exposure to benzene are some of the acknowledged risk factors. Leukemias are the most common cancers in the young.

In Ontario an estimated 1,100 men and 750 females were diagnosed with leukemia in 2010, representing 3.3% and 2.4% of all new cancers. In the same year, approximately 4.1% (n=600) and 3.0% (n=410) cancer deaths across the province were due to leukemia among men and women, respectively.

Incidence

There were 38 cases of leukemia diagnosed in Peterborough in 2007, the majority of which (28, or 65.1%) occurred in men. The incidence rate of leukemia between 1986 and 2007 was significantly higher among Peterborough men than women by 79.0% (average incidence 17.9 per 100,000 compared to 10.0 per 100,000, respectively) – Figure 30. Incidence rates of leukemia among Peterborough men decreased slightly between 1986 and the early 2000's, however, since 2003 rates appear to have increased. Among Peterborough women, similar patterns in incidence rates also appear to exist. Ontario rates were relatively consistent between 1986 and 2007 and were not significantly different from Peterborough.

Between 1986 and 2007, three out of five new cases of leukemia in Peterborough men and 68.4% of cases among women were aged 65 or older. However, unlike most cancers, age specific incidence rates for leukemia are relatively large for children under the age of nine – Figure 31. Between 1986 and 2007 there were ten and 13 new cases of leukemia among boys and girls under the age of nine in Peterborough. Incidence rates of leukemia among Peterborough females aged 45 to 64 (RR=0.40), 65 to 74 (RR=0.60) and those 75 years and older (RR=0.49) were significantly lower than males. There were no significant differences between Peterborough and Ontario by age group.

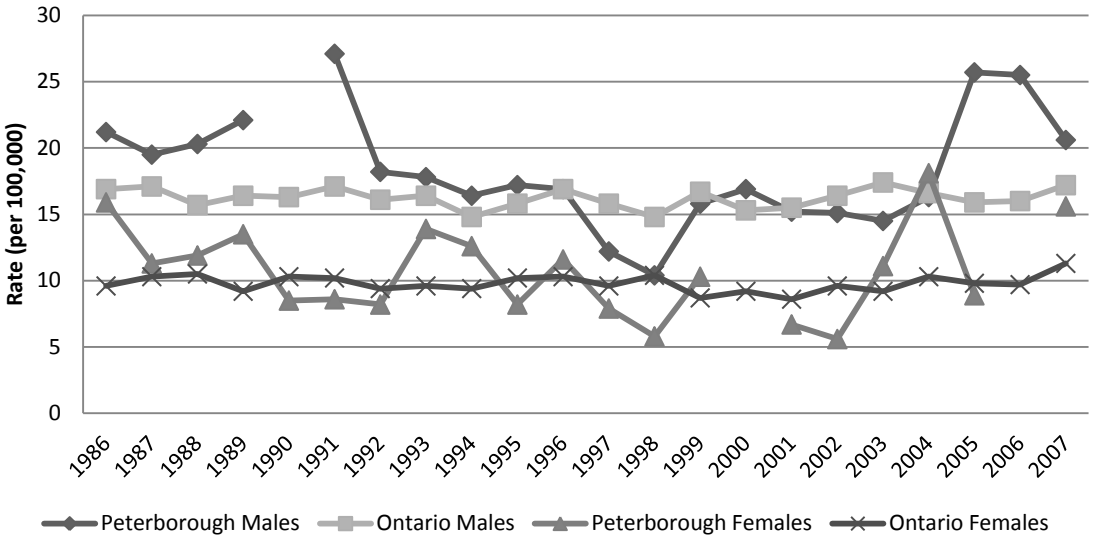
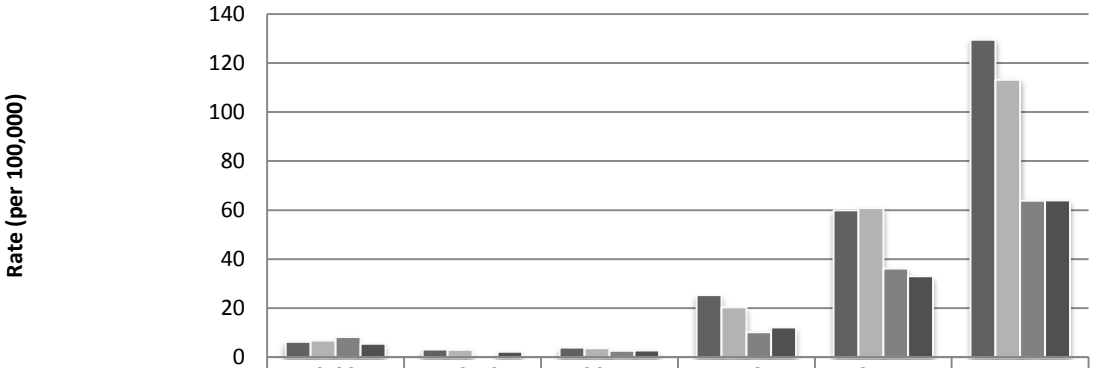


Figure 30. Incidence rates of leukemia in Peterborough in Ontario by sex; 1986-2007



	0-09	10-19	20-44	45-64	65-74	75+
Peterborough Males	6.3	3.2	3.9	25.4	59.9	129.5
Ontario Males	6.8	3.0	3.7	20.4	60.8	113.2
Peterborough Females	8.2		2.6	10.2	36.2	63.8
Ontario Females	5.5	2.2	2.8	12.2	33.0	64.0

Figure 31. Age-specific NHL incidence rates in Peterborough and Ontario by sex; 1986-2007

Mortality

There were 18 deaths attributable to leukemia in Peterborough in 2007, the majority of which (13 or 72.2%) occurred in males. Mortality rates of leukemia in Peterborough men between 1986 and 2007 were significantly higher in men compared to women by 77.8% (average mortality 9.6 per 100,000 compared to 5.4 per 100,000, respectively) – Figure 32. Similar to NHL data, there are many years where fewer than five deaths resulted from leukemia and therefore it is difficult to interpret trends in Peterborough. Ontario data suggest that rates declined slightly between 1986 and 2007 in both men

and women. There were no significant differences in mortality rates of leukemia when comparing Peterborough and Ontario by sex.

The majority of leukemia deaths between 1986 and 2007 in Peterborough males and females occurred in persons 65 years of age and older (78.3% and 87.9%, respectively). There were no deaths due to leukemia in male children (less than nine years of age); however, there were deaths among girl children (less than five; data suppressed). Peterborough women aged 65 to 74 years of age (RR=0.54) and those older than 75 years of age (RR=0.47) were significantly less likely to die of leukemia than men in those age groups – Figure 33. There were no significant differences between Peterborough and Ontario males or females by age group.

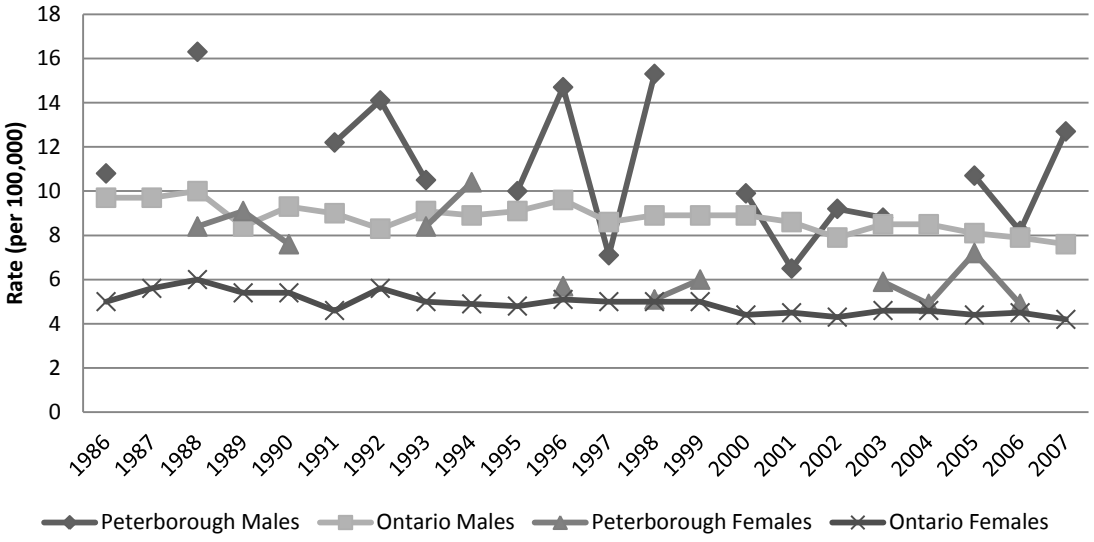
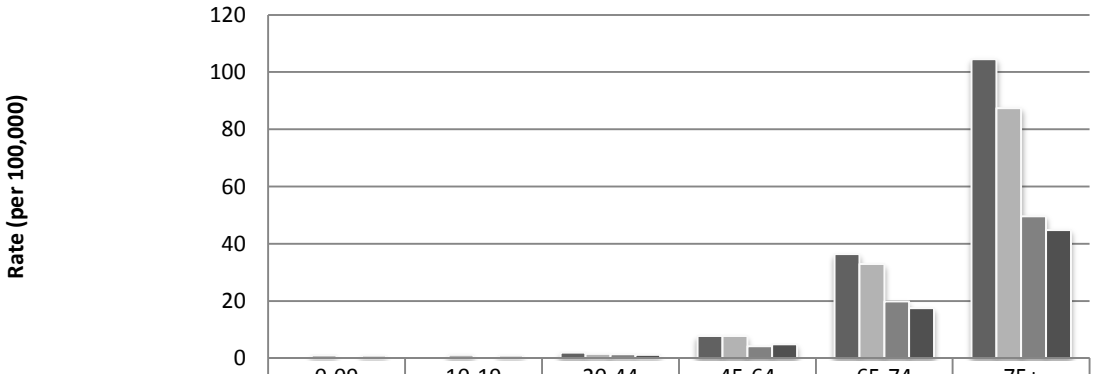


Figure 32. Leukemia mortality rates in Peterborough in Ontario by sex; 1986-2007



	0-09	10-19	20-44	45-64	65-74	75+
Peterborough Males	0		1.9	7.8	36.4	104.5
Ontario Males	1.0	1.2	1.5	7.8	32.9	87.4
Peterborough Females			1.4	4.2	19.8	49.6
Ontario Females	0.8	0.8	1.1	4.8	17.5	44.8

Figure 33. Age-specific leukemia mortality rates in Peterborough and Ontario by sex; 1986-2007

Key Points

- *Incidence rates of leukemia in Peterborough appear to increase sharply in the early 2000's*
- *Unlike most cancers, incidence rates of leukemia are relatively large in children*
- *Leukemia mortality rates are decreasing in Ontario and data from Peterborough suggests similar trends*

Bladder Cancer

Nearly all bladder cancers start in the lining of the bladder. Cancer that is only in the lining is called superficial bladder cancer. If the cancer spreads into the muscle wall of the bladder, it is called invasive bladder cancer. Smoking is the most common risk factor for bladder cancer; other risk factors include: diet, increased age, exposure to certain chemicals including industrial dyes and arsenic, and a family or personal history of bladder cancer.

Bladder cancer accounted for an estimated 1,300 (3.9%) new cancer cases diagnosed in men in 2010; among women, bladder cancer is slightly less common, accounting for only 1.5% (n=470) of cancer cases. Similarly, deaths from bladder cancer among males in Ontario occur more frequently than in women (510, or 3.5%; and 220, or 1.6%, respectively).

Incidence

There were 34 new cases of bladder cancer diagnosed in Peterborough in 2007 which occurred predominantly in males (26, or 76.5%). The incidence rate of bladder cancer between 1986 and 2007 was significantly higher among Peterborough males than females by 320.3% (average incidence 22.1 per 100,000 compared to 6.9 per 100,000, respectively) – Figure 34. Incidence rates of bladder cancer in Peterborough men decreased between 1986 and the mid-1990's, however, since that time, rates have increased. Among women in Peterborough, due to the small number of cases, trends in bladder cancer incidence rates are difficult to interpret. In Ontario, rates have been decreasing since 1986 in both males and females. Incidence rates of bladder cancer over this period in Peterborough were not significantly different from the province in either sex.

Between 1986 and 2007, approximately 79.1% of new bladder cases among Peterborough men and 74.1% of cases among women were aged 65 or older. It was rare for cases of bladder cancer to occur in persons younger than 65 years old during this time frame. Incidence rates of bladder cancer among Peterborough females aged 45 to 64 (RR=0.38), 65 to 74 (RR=0.30) and those 75 years and older (RR=0.25) were dramatically lower than males of those ages – Figure 35. There were no significant differences between Peterborough and Ontario by age group in either sex.

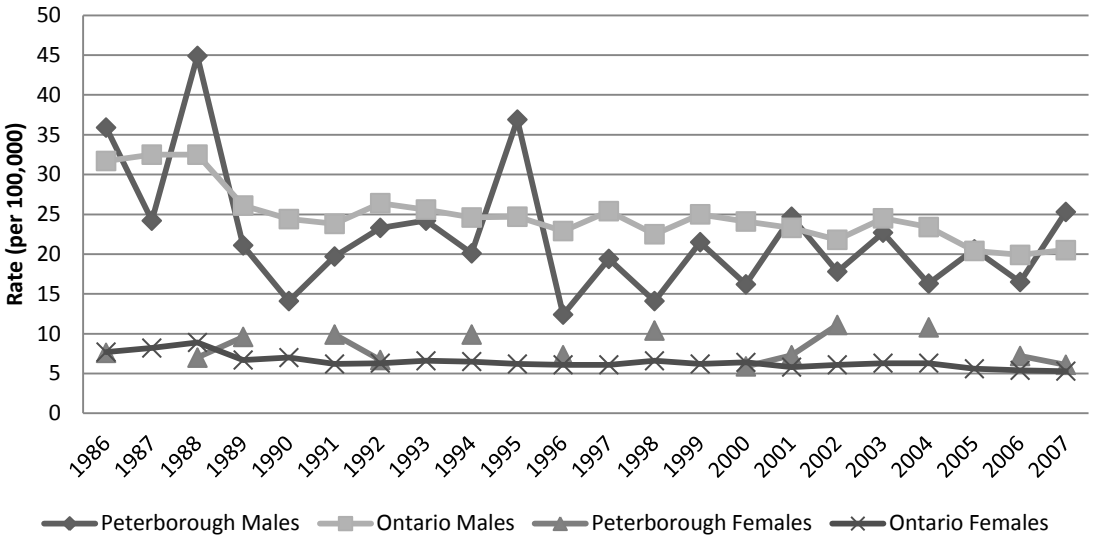
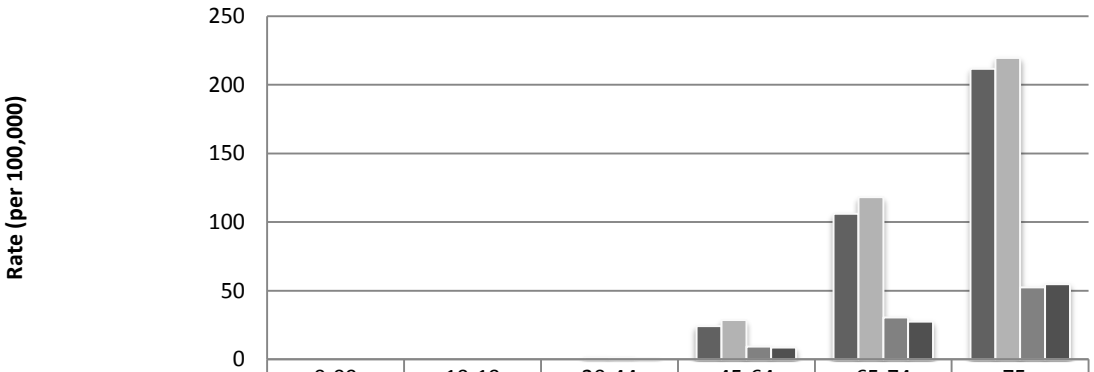


Figure 34. Incidence rates of bladder cancer in Peterborough in Ontario by sex; 1986-2007



	0-09	10-19	20-44	45-64	65-74	75+
Peterborough Males	0	0		24.4	106.2	211.6
Ontario Males			1.6	28.7	118.2	219.7
Peterborough Females	0	0	1.4	9.4	30.7	52.5
Ontario Females			0.7	8.7	27.6	54.8

Figure 31. Age-specific bladder cancer incidence rates in Peterborough and Ontario by sex; 1986-2007

Mortality

There were 12 deaths attributable to bladder cancer in Peterborough in 2007; due to small counts, the sex distribution of deaths will not be disclosed. As deaths due to bladder cancer are relatively uncommon in Peterborough, mortality rates in males between 1986 to 2007 are difficult to interpret and rates in females have been suppressed entirely – Figure 36. Mortality rates among Peterborough men were three and a half times greater than rates among women during this time frame (6.3 per 100,000 compared to 1.8 per 100,000, respectively). Ontario data suggest that mortality rates among

males have decreased slightly, whereas rates among females have been stable. Compared to the province, mortality rates between 1986 and 2007 were not significantly different in either sex.

The large majority of bladder cancer deaths among Peterborough men (82.4%) between 1986 and 2007 occurred in older adults. Nearly all of the deaths among females during this time frame occurred in older adults (data suppressed). Figure 37 illustrates differences in bladder cancer mortality rates in Peterborough and Ontario by age group and sex. Peterborough women aged 65 to 74 and those aged 75 years and older were significantly less likely to die of bladder cancer than men (RR=0.31 and 0.23, respectively). Peterborough men aged 75 and older were less likely to die from bladder cancer than their provincial counterparts by 29.9%. Peterborough females in the same age cohort were significantly less likely to die of bladder cancer compared to women of the same age in Ontario by 60.6%.

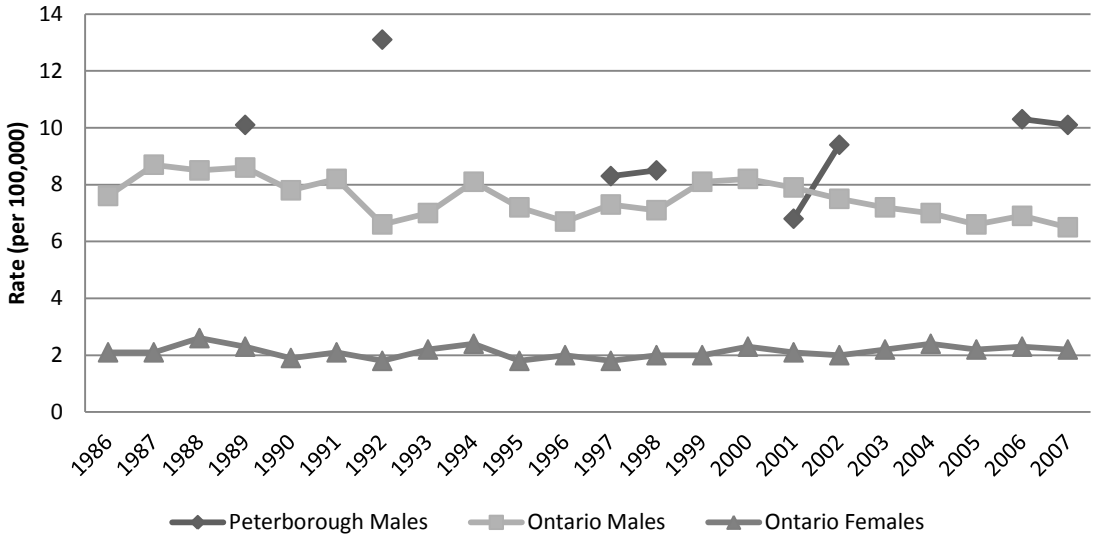
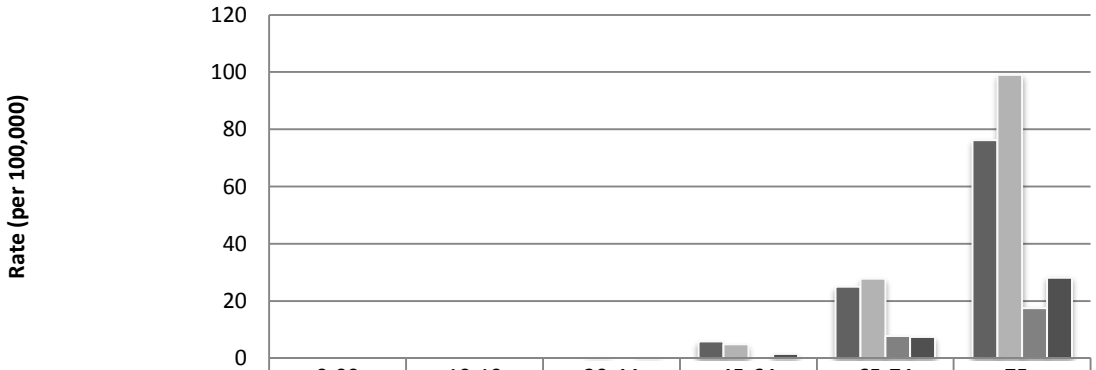


Figure 36. Bladder cancer mortality rates in Peterborough in Ontario by sex; 1986-2007



	0-09	10-19	20-44	45-64	65-74	75+
Peterborough Males	0	0	0	5.9	25.0	76.2
Ontario Males	0		0.1	4.8	27.8	99.0
Peterborough Females	0	0			7.7	17.5
Ontario Females	0	0	0.1	1.5	7.4	28.1

Figure 37. Age-specific bladder cancer mortality rates in Peterborough and Ontario by sex; 1986-2007

Key Points

- *Men exhibit dramatically higher incidence and mortality rates of bladder cancer than women*
- *The incidence of bladder cancer among men in Peterborough has been increasing since the mid 1990's*
- *Men and women over aged 75 years and older were less likely to die of bladder cancer than those of the same age across the province*

Melanoma

Melanoma is a cancer that starts in the cells that produce melanin, called melanocytes, which is responsible for giving colour to the skin. Most melanocytes are located in the skin; almost all melanomas are skin cancers. Melanoma is most frequently found on the back of men and on the back and legs of women. It is the least common, but most serious, type of skin cancer. Risk factors include: personal or family history of melanoma; sun sensitivity (i.e.: sun burning easily); history of excessive sun exposure; and occupational exposure to coal tar, pitch, creosote, arsenic compounds, or radium.

Melanoma accounted for 3.9% (n=1,300) and 3.3% (n=1,050) of new cancers in Ontario in 2010 among males and females, respectively. While melanoma is diagnosed with relative frequency, deaths are rare, accounting for only 1.7% (n=250) and 1.1% (n=150) cancer deaths among men and women in Ontario in 2010.

Incidence

There were 47 new cases of melanoma diagnosed in Peterborough in 2007 with a nearly equal distribution of cases occurring in men and women (24, or 51.1%; and 23, or 48.9%, respectively). Incidence rates of melanoma in Peterborough increased between 1986 and 2007 and during this time frame rates were significantly higher among men compared to women by 32.3% (average incidence 17.6 per 100,000 compared to 13.6 per 100,000, respectively) – Figure 38. In Ontario, rates have also increased since 1986 in both males and females, however, rates in Peterborough were significantly higher by 24.4% and 21.5%, respectively.

Between 1986 and 2007, 47.3% of new cases of melanoma among Peterborough males and approximately 44.1% of cases among females were aged 65 or older. Persons aged 45 to 64 accounted for most of the cases over this time frame (38.8% and 33.5%, respectively). Figure 39 illustrates the differences in incidence rates by age group in Peterborough and Ontario between 1986 and 2007. Incidence rates of melanoma among Peterborough women aged 45 to 64 (RR=0.70), 65 to 74 (RR=0.58) and those 75 years of age and older (RR=0.56) were significantly lower than men of the same ages. Peterborough men aged 45 to 64 had incidence rates 36.2% higher than their provincial counterparts, whereas women aged 75 and older had rates 41.5% higher than the province.

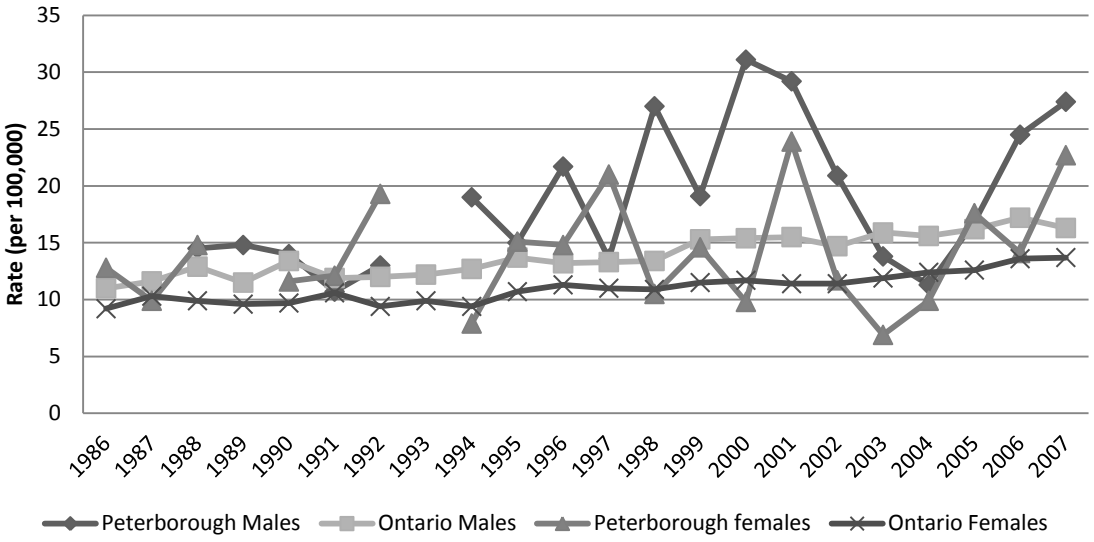
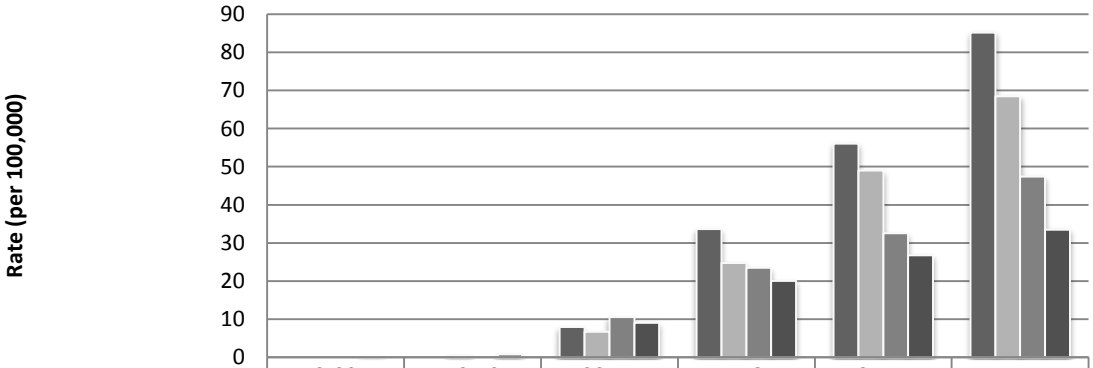


Figure 38. Incidence rates of melanoma in Peterborough in Ontario by sex; 1986-2007



	0-09	10-19	20-44	45-64	65-74	75+
Peterborough Males	0	0	8.0	33.7	56.1	85.2
Ontario Males	0	0.5	6.7	24.8	49.0	68.5
Peterborough Females	0		10.6	23.5	32.6	47.4
Ontario Females	0.1	0.8	9.1	20.1	26.8	33.5

Figure 39. Age-specific melanoma incidence rates in Peterborough and Ontario by sex; 1986-2007

Mortality

There were less than five deaths attributable to melanoma in Peterborough in 2007. Therefore, due to small counts, the sex distribution of deaths will not be disclosed. As deaths due to melanoma are relatively uncommon in Peterborough – only 90 in total between 1986 and 2007 and less than five per year by sex in most years during this time frame – trends over time are difficult to interpret. Mortality rates among males were 60.0% higher than rates among females during this time frame (3.2 per 100,000 and 2.0 per 100,000, respectively). Ontario data suggest that mortality rates among both men

and women have increased slightly since 1986 – Figure 40. Compared to the province, Peterborough mortality rates due to melanoma between 1986 and 2007 were not significantly different in either sex. The majority of melanoma deaths among Peterborough men (60.0%) between 1986 and 2007 occurred in persons aged 65 and over. Similarly, a large majority of deaths among females during this time frame occurred in older adults (84.2%). Figure 37 illustrates differences in melanoma mortality rates in Peterborough and Ontario by age group and sex. There were no significant differences between Peterborough men and women, nor were there differences between Peterborough and the province by age group.

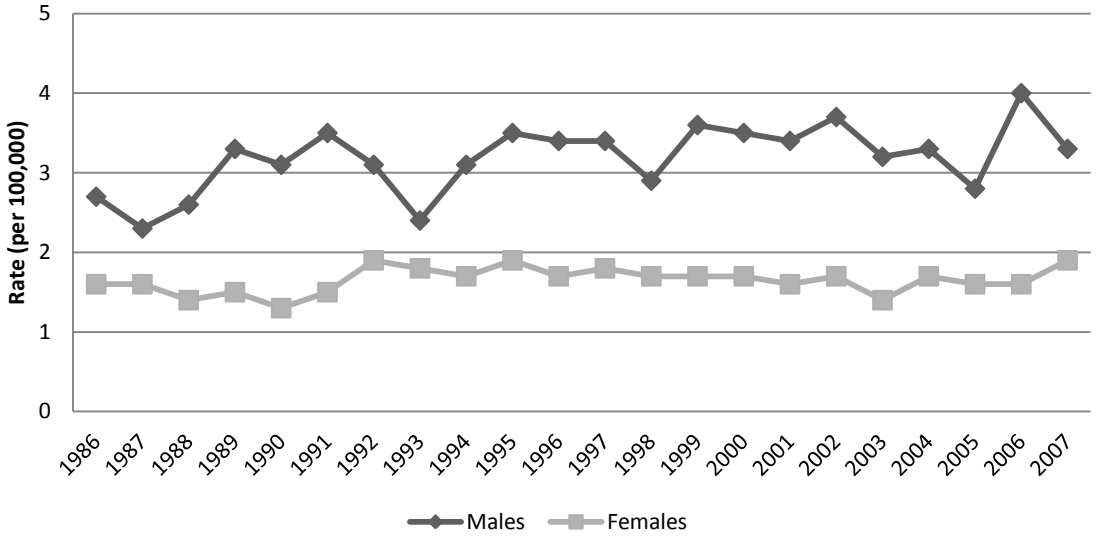
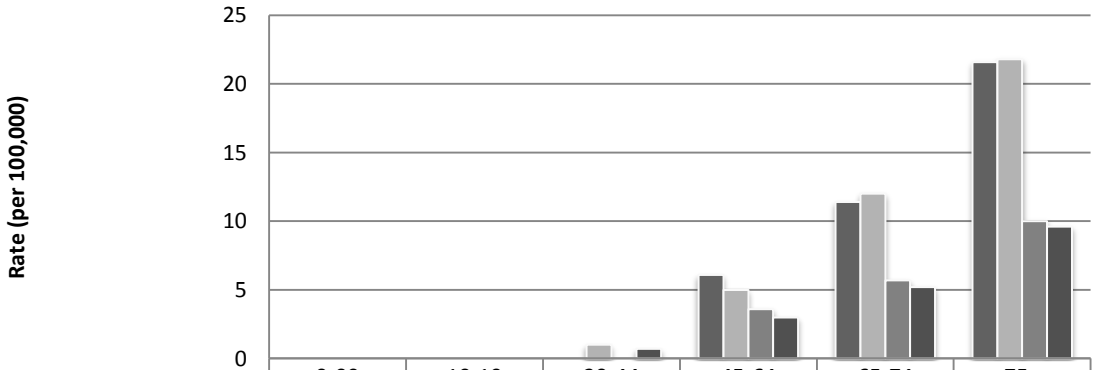


Figure 40. Melanoma mortality rates in Ontario by sex; 1986-2007



	0-09	10-19	20-44	45-64	65-74	75+
Peterborough Males	0	0		6.1	11.4	21.6
Ontario Males	0		1.0	5.0	12.0	21.8
Peterborough Females	0	0		3.6	5.7	10.0
Ontario Females	0	0	0.7	3.0	5.2	9.6

Figure 41. Age-specific melanoma mortality rates in Peterborough and Ontario by sex; 1986-2007

Key Points

- *Incidence rates of melanoma are increasing in Peterborough and Ontario and rates are significantly higher in Peterborough*
- *Persons aged 45 to 64 accounted for the most melanoma cases*
- *While melanoma deaths are rare, mortality from melanoma is also increasing*

Uterine Cancer

Cancer that starts in the lining inside the uterus in called uterine cancer or endometrial carcinoma whereas cancer that starts in the layers of the uterus is called uterine sarcoma. The term uterine cancer and endometrial cancer are often used interchangeably. Most women with uterine cancer are post-menopausal and between 45 and 70 years old. There is no single cause of uterine cancer, but some risk factors include: taking estrogen replacement therapy after menopause; obesity; exposure to radiation or chemotherapy; and never having given birth. Uterine cancer is the fifth most common cancer among women, accounting for 5.8% (n=1,850) of new cancers in Ontario in 2010. Deaths due to uterine cancer are relatively uncommon; however, there were 350 deaths due to uterine cancer in Ontario in 2010, accounting for 2.6% of all female cancer deaths. For the purposes of this report, uterine cancers "not otherwise specified", which originate in an unknown tissue, are not considered.

Incidence

There were 26 new cases of uterine cancer diagnosed in Peterborough in 2007. Between 1986 and 2007 the incidence of uterine cancer among Peterborough women was sporadic and did not exhibit a noticeable temporal trend; incidence rates of uterine cancer in Ontario were relatively stable – Figure 42. Incidence rates of uterine cancer in Peterborough during this time frame were significantly greater than the province by 14.7%.

Slightly less than half (45.9%) of the cases of uterine cancer that occurred among Peterborough women between 1986 and 2007 were 65 years and older. Nearly half (48.6%) of the cases that occurred during this time frame were between the ages of 45 and 64; the age cohort that had the largest age-specific incidence rate of uterine cancer were women aged 65 to 74 years of age – Figure 43. Peterborough females ages 45 to 64 had significantly higher incidence rates than their provincial counterparts by 27.3%.

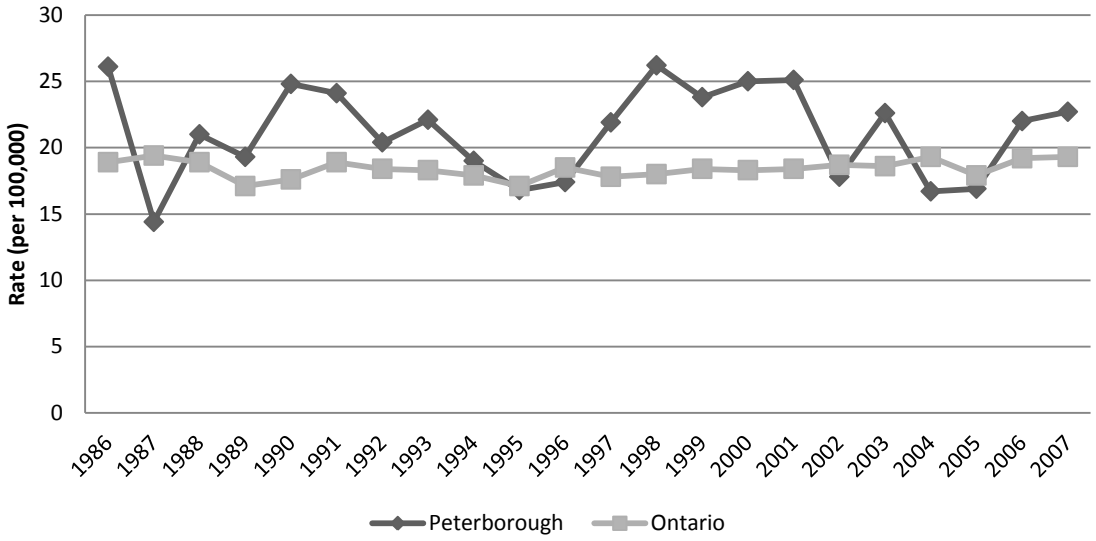
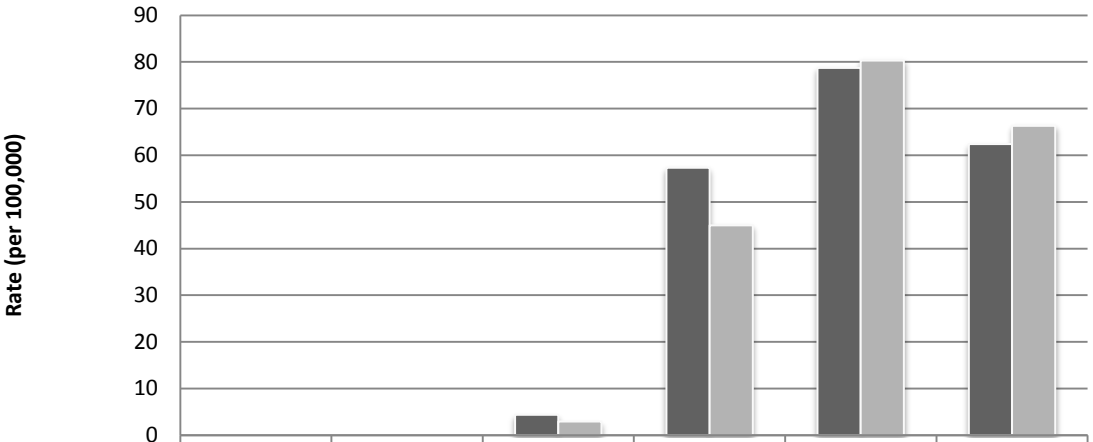


Figure 42. Incidence rates of uterine cancer in Peterborough in Ontario; 1986-2007



	0-09	10-19	20-44	45-64	65-74	75+
Peterborough	0	0	4.4	57.3	78.7	62.4
Ontario	0		2.9	45.0	80.3	66.3

Figure 43. Age-specific uterine cancer incidence rates in Peterborough and Ontario; 1986-2007

Mortality

Fewer than five deaths were attributable to uterine cancer in Peterborough in 2007. Due to the small number of deaths per year due to uterine cancer in Peterborough, trends are difficult to identify. Ontario data suggest that mortality rates decreased considerably towards the end of the 1980's and have remained relatively consistent since that time – Figure 44.

Between 1986 and 2007, nearly all deaths due to uterine cancer in Peterborough occurred in women aged 65 and older. Mortality rates of uterine cancer were similar in women aged 65-to 74 and those over 75 years of age and older – Figure 45. Age-specific mortality rates were not significantly different between Peterborough and Ontario.

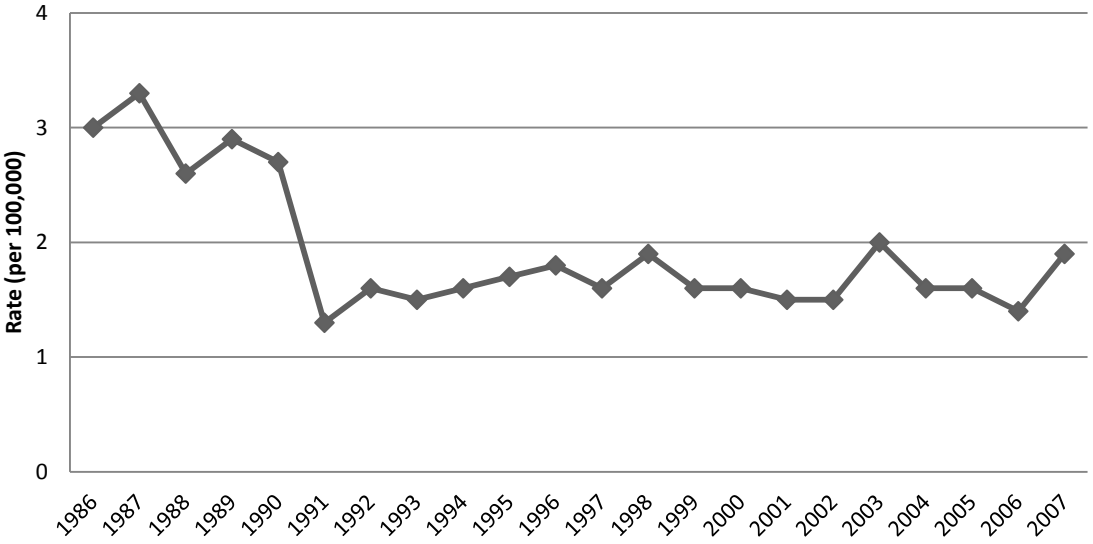
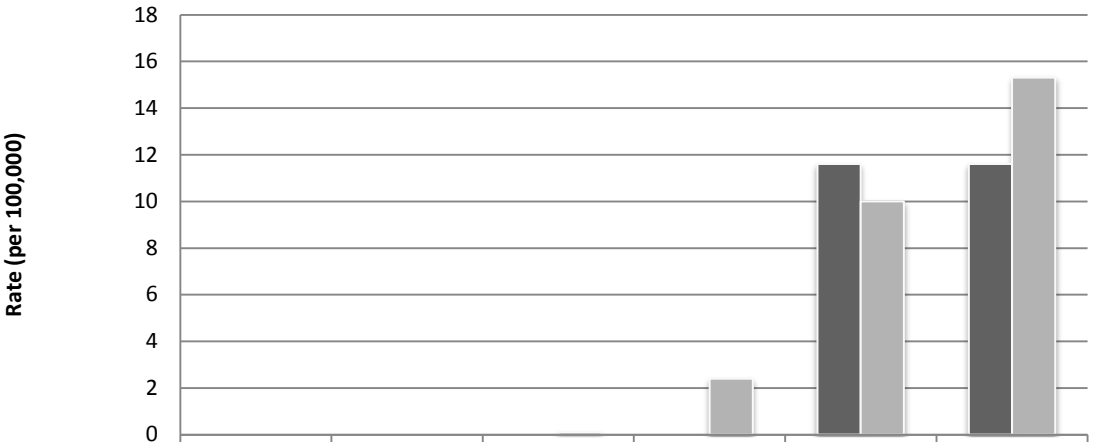


Figure 44. Uterine cancer mortality rates in Ontario; 1986-2007



	0-09	10-19	20-44	45-64	65-74	75+
Peterborough	0	0			11.6	11.6
Ontario		0	0.1	2.4	10	15.3

Figure 45. Age-specific uterine cancer mortality rates in Peterborough and Ontario; 1986-2007

Key Points

- *Incidence rates of uterine cancer in Peterborough are significantly greater than Ontario*
- *Women aged 45 to 64 account for the differences in incidence rates between Peterborough and the province*
- *Deaths from uterine cancer are rare in Peterborough*

Oral Cancer

Oral cancer is any abnormal growth and spread of cells occurring in the mouth cavity including the lips, tongue, roof of the mouth, under the tongue, gums, inside the lips and cheeks, and the oropharynx. Most people diagnosed with oral cancer are over the age of 50. Smoking, chewing tobacco, drinking alcohol, infection with the human papillomavirus (HPV), and sun exposure to the lips are some of the major risk factors. Oral cancers accounted for 2.6% (n=870) and 1.4% (n=440) of new cancer diagnoses in Ontario in 2010 among males and females, respectively. Deaths related to oral cancer in Ontario in 2010 were rare: there were 280 men and 150 women who died of oral cancer, accounting for 1.9% and 1.1% of cancer deaths, respectively.

Incidence

In Peterborough in 2007, 23 new cases of oral cancer were diagnosed, the majority of which (18, or 78.2%) occurred in males. Incidence rates of oral cancer among Peterborough men between 1986 and 2007 have been sporadic but have decreased slightly; similarly, rates among Ontario males have decreased slightly during this time frame – Figure 46. Trends in Peterborough female incidence rates are also difficult to identify, though rates are two and a half times lower than males (average incidence 6.4 per 100,000 and 15.9 per 100,000, respectively). In Ontario, female incidence rates have been stable. Incidence rates in Peterborough were not significantly different from the province in either males or females.

A slight majority (51.1%) of males diagnosed with oral cancer between 1896 and 2007 were 65 years of age or older; most cases (42.0%) were between the age of 45 and 64. Similar patterns existed among females during this time frame (56.5% and 43.5%). Peterborough women between the ages of 45 to 64 (RR=0.46), 65 to 74 (RR=0.33), and those aged 75 and older (RR=0.44) had significantly lower rates of oral cancer than men in those age groups – Figure 47. Peterborough women aged 45 to 64 had significantly higher incidence rates than their provincial counterparts by 45.8%, however.

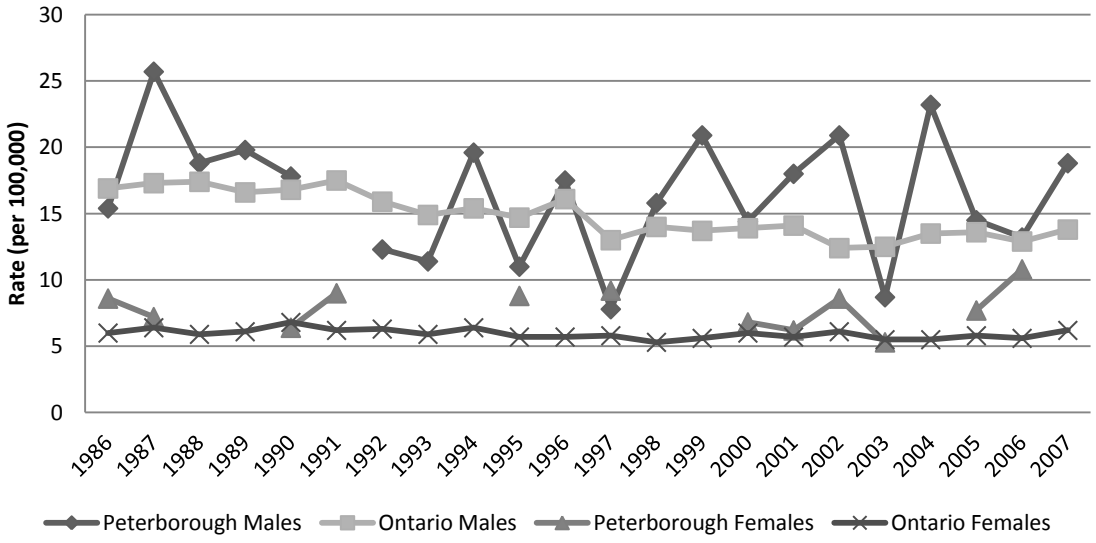
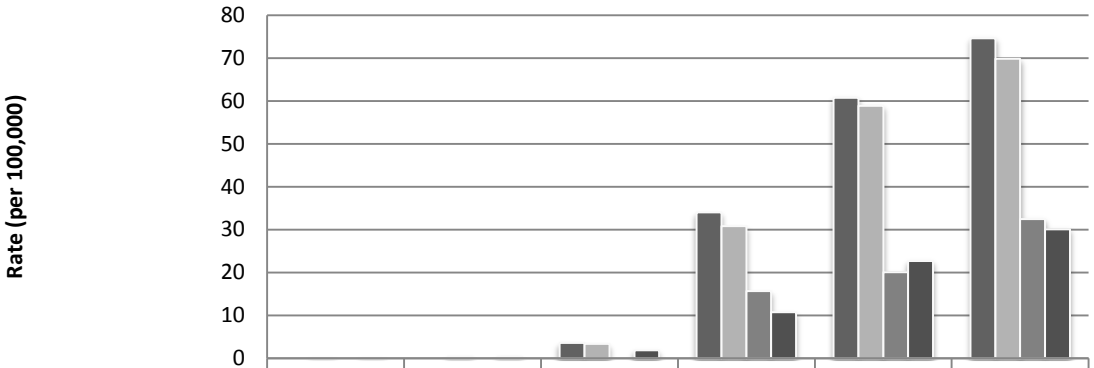


Figure 46. Incidence rates of oral cancer in Peterborough in Ontario by sex; 1986-2007



	0-09	10-19	20-44	45-64	65-74	75+
Peterborough Males	0		3.6	34.0	60.7	74.6
Ontario Males	0.1	0.4	3.4	30.8	58.9	69.8
Peterborough Females	0			15.7	20.1	32.5
Ontario Females	0.1	0.4	1.9	10.8	22.7	30.1

Figure 47. Age-specific oral cancer incidence rates in Peterborough and Ontario; 1986-2007

Mortality

In Peterborough in 2007 there were 12 deaths attributable to oral cancer; due to small counts, the sex distribution of deaths will not be disclosed. As relatively few oral cancer deaths occur in a given year when broken down by sex, it is difficult to interpret trends for Peterborough. Mortality rates in men (5.8 per 100,000) were nearly three times as large as rates among women (2.0 per 100,000) during this time frame. In Ontario, mortality rates of oral cancer have been decreasing among men since 1986, while rates among women have been stable – Figure 48. Mortality rates due to oral cancer were similar in Peterborough compared to the province between 1986 and 2007.

Approximately two thirds (64.2%) of oral cancer deaths in males between 1986 and 2007 occurred in those aged 65 and older; similar patterns of mortality occurred in females during this time frame (61.0% of oral cancer deaths occurred among women aged 65 and older). Figure 49 illustrates the differences in oral cancer mortality rates across age groups in Peterborough and Ontario. Peterborough women ages 45 to 64 (RR=0.44), 65 to 74 (RR=0.23), and those 75 and older (RR=0.36) had significantly lower oral cancer mortality rates than men – Figure 49. Peterborough women aged 45 to 64 had significantly higher rates than their provincial counterparts by 83.7%, however.

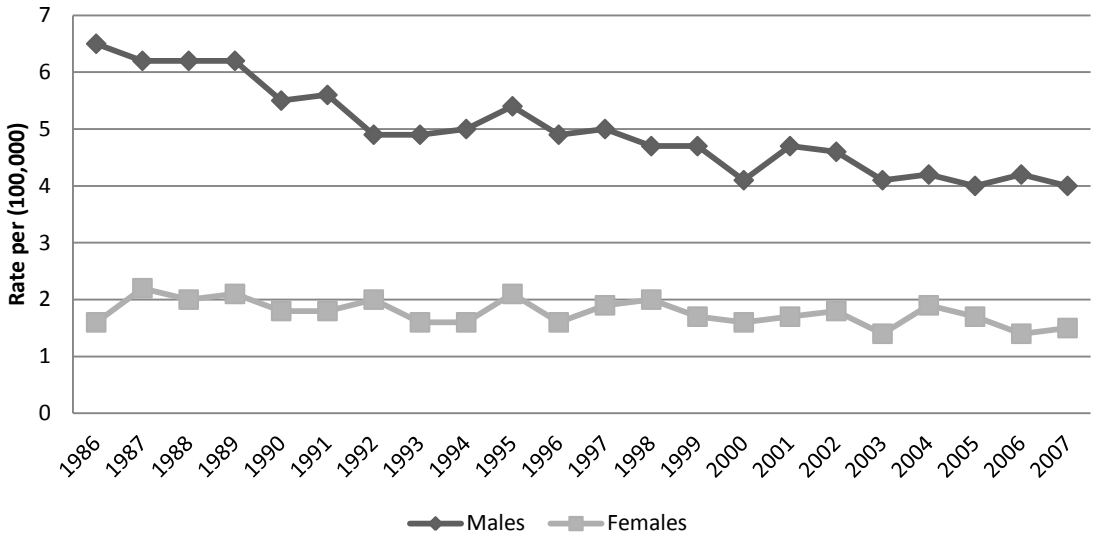
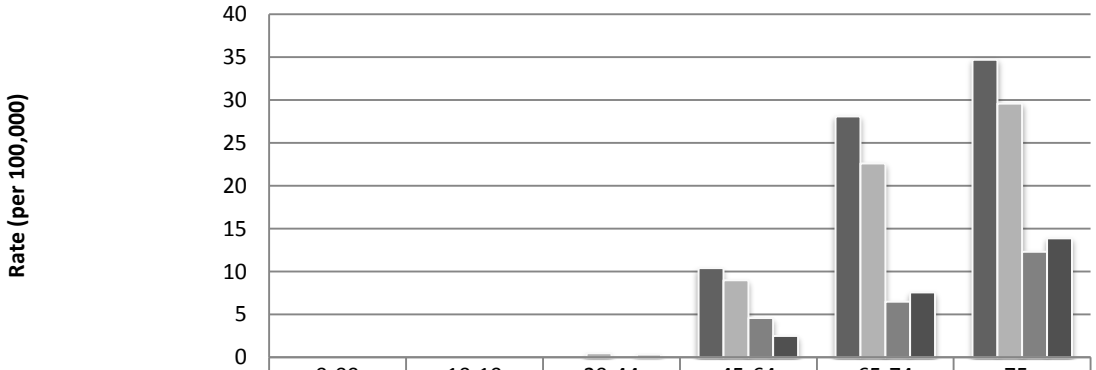


Figure 48. Oral cancer mortality rates in Ontario by sex; 1986-2007



	0-09	10-19	20-44	45-64	65-74	75+
Peterborough Males		0		10.4	28.1	34.7
Ontario Males		0	0.5	9.0	22.6	29.6
Peterborough Females	0	0		4.6	6.5	12.3
Ontario Females			0.3	2.5	7.6	13.9

Figure 49. Age-specific oral cancer mortality rates in Peterborough and Ontario; 1986-2007

Key Points

- *Peterborough men have significantly higher incidence and mortality rates of oral cancer than women*
- *Peterborough women aged 45 to 64 had significantly higher rates of oral cancer incidence and mortality compared to Ontario women of the same age*
- *Deaths from oral cancer are rare in Peterborough*

Risk Factors

Tobacco

The single most important risk factor associated with lung cancer is smoking. Smoking also contributes to numerous other cancers including breast, bladder, cervical etc..

Estimates of the prevalence of current smoking in Ontario men increased between 1925 and 1960, after which rates declined steadily – Figure 50. However, increases in the prevalence of current smoking among Ontario women occurred approximately 25 to 30 years later than men and peaked around 1975. Lung cancer develops long after an individual begins and sustains smoking, and given a lag period of approximately 50 years, the patterns of the prevalence of current smoking parallel reductions in lung cancer incidence and mortality among men between 1986 and 2007 and increases in the incidence and mortality of lung cancer in women during this time frame. More recently, data from the Canadian Community Health Survey (CCHS) indicate that the prevalence of current smoking has decreased in Ontario in both men and women between 2001 and 2007/08 – Figure 51.

The prevalence of male current smokers in Peterborough over that time frame did not change significantly. However, there is evidence to suggest that fewer Peterborough women smoked in 2007/08 compared to 2001. The prevalence of current smoking was lower in Peterborough men and higher among Peterborough women compared to the province in 2007/08, though the differences were not significantly different.

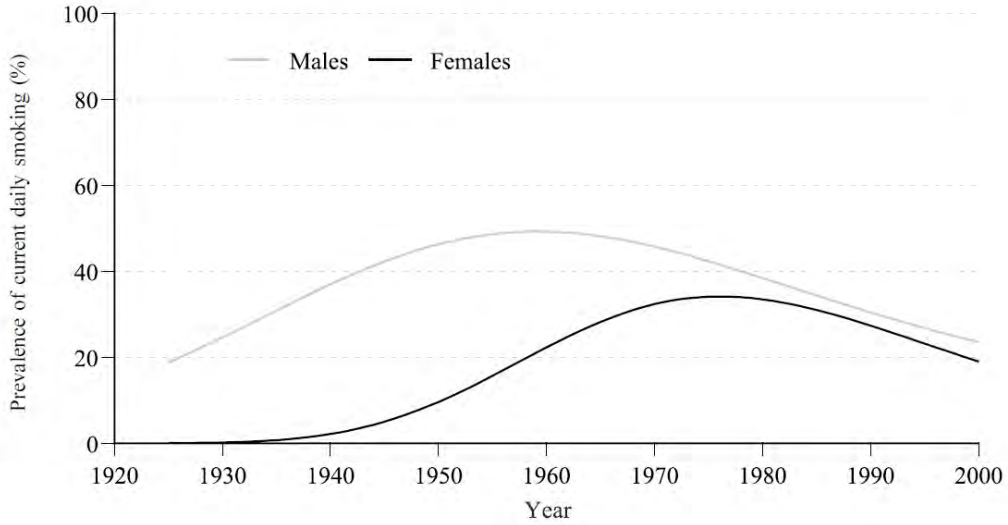
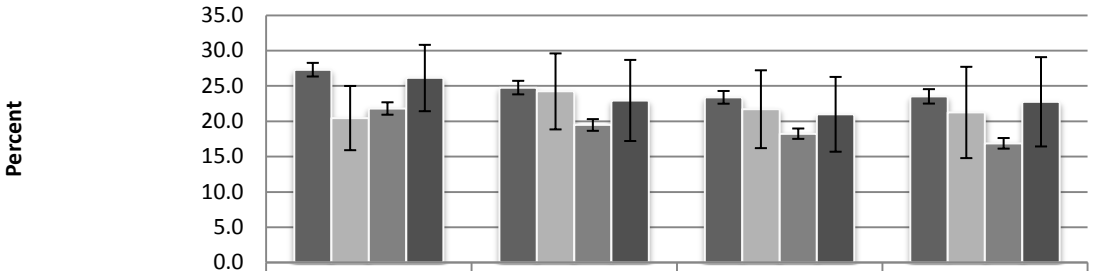


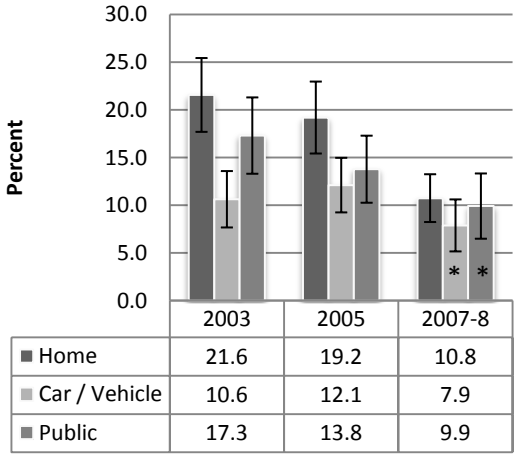
Figure 50. Age-standardized prevalence rate of current daily cigarette smoking in Ontario in persons aged 15 and older, 1925-2000 *(From: Holowaty E., et al. 2002)*



	2001	2003	2005	2007-8
Ontario Males	27.3	24.8	23.4	23.5
Peterborough Males	20.5	24.2	21.7	21.3
Ontario Females	21.8	19.5	18.2	16.9
Peterborough Females	26.1	23.0	21.0	22.8

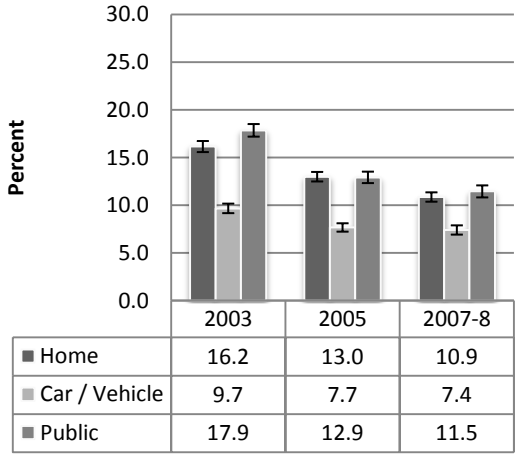
Figure 51. Prevalence of current smokers (aged 12 and older) in Ontario and Peterborough by gender; 2001-2008

Exposure to environmental tobacco smoke (ETS) also plays a role in the development of lung and other cancers. Between 2001 and 2007/08, the prevalence of exposure to ETS among both Peterborough and Ontario residents decreased – Figures 52 and 53. Significant progress has been made in Peterborough with exposure to ETS decreasing in the home by just over ten per cent and in public places by 7.4%. However, a recent sample of Peterborough youth (grades 7-12) indicate that 23% live in homes where there are none or few restrictions regarding smoking in the home and 28% of youth reported riding in a car with a smoker in the previous week.



	2003	2005	2007-8
Home	21.6	19.2	10.8
Car / Vehicle	10.6	12.1	7.9
Public	17.3	13.8	9.9

Figure 52. Prevalence of exposure to environmental tobacco smoke in Peterborough by location; 2001-2008



	2003	2005	2007-8
Home	16.2	13.0	10.9
Car / Vehicle	9.7	7.7	7.4
Public	17.9	12.9	11.5

Figure 53. Prevalence of exposure to environmental tobacco smoke in Ontario by location; 2001-2008

** estimates should be interpreted with caution due to large sampling variability.*

Sun Exposure

The most easily modifiable risk factor for melanoma is excessive sun exposure; skin cancer is largely preventable by decreasing sun exposure and increasing the use of sun protection. Given the prevalence of ultraviolet radiation (UVR)-related cancers people are advised to reduce their UVR exposure. Between 1996 and 2006, however, Ontarians increased their exposure to sunlight without increasing actions to protect themselves from its potentially harmful effects – Table 5. In 2006, more Ontarians travelled to a sunny climate during winter than a decade before and while travelling nearly three quarters of vacationers spent two or more hours in the sun.

Table 5. Comparison of sun exposure and protection from the sun in Ontario adults; 1996 and 2006

	1996 % (95% CI)	**2006 % (95% CI)**
Travel and Exposure		
Travel to sunny climate during winter	16.2 (13.8 – 18.7)	24.2 (20.3 – 28.0)
Two of more hours per day in sun during leisure time	24.5 (21.7 – 27.4)	23.1 (27.8 – 36.3)
Two or more hours per day in the sun while on winter vacation*	58.0 (50.1 – 65.8)	74.6 (66.7 – 82.5)
Protection		
Spends less than 30 minutes per day in sun during leisure time	23.3 (20.5 – 26.2)	17.3 (14.0 – 20.5)
Always/often wears protective clothing and head covering†	25.9 (22.6 – 29.2)	21.1 (17.2 – 25.0)
Always/often wears sunscreen (SPF 15 or greater) on face and body†	24.7 (21.4 – 28.0)	21.7 (17.8 – 25.6)
Tanning		
Uses artificial methods of tanning‡	6.6 (4.9 – 8.3)	9.7 (7.1 – 12.4)

Adapted from: Ontario Sun Safety Working Group, 2010

* among vacationers

† of those spending 30 minutes or more per day in sun during leisure time

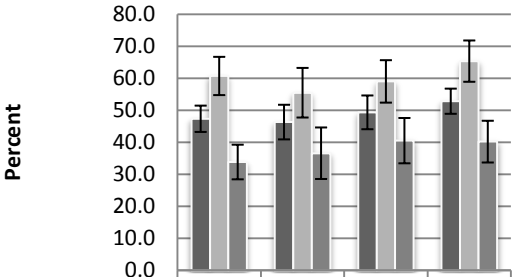
‡ any time of year

The Ontario Sun Safety Working Group found in its 2010 report that some subgroups of the Ontario population tend to have high UVR exposure and are less likely to protect themselves from the sun: young males spend the most time in the sun; young females are most likely to use tanning equipment; and older children are often not protected from the sun. Unfortunately, reliable local data on sun exposure and preventative practices are not available for Peterborough residents and it is therefore difficult to provide some evidence as to why incidence rates of melanoma are considerably higher than the province.

Alcohol, Nutrition and Physical Activity

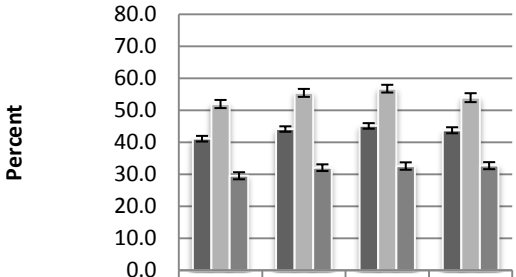
The World Health Organization (WHO) indicates that alcohol is the world's third largest risk factor for premature mortality, disability and loss of health. Alcohol use is associated with increased risk of oral, colorectal and breast cancers. All cancers showed evidence of a dose–response relationship, indicating that increased consumption of alcohol is associated with increased risk of developing one or more alcohol-related cancers. To that effect, hazardous drinking – consuming five or more drinks on one occasion – can be used as an effective indicator of increased alcohol consumption. Data from the CCHS indicate that significantly greater proportion of Peterborough men engaged in hazardous drinking episodes than Peterborough women. In addition, a significantly greater proportion of Peterborough men engaged in hazardous drinking compared to men in Ontario – Figures 53 and 54. While a larger fraction of Peterborough women reported hazardous drinking compared to women in Ontario, the

difference was not significant. Hazardous drinking is on the rise in both Ontario and Peterborough. The proportion of Peterborough adults who drink that reported at least one episode of hazardous drinking in the past 12 months increased from 60.8% in 2001 to 65.4% in 2007/08 among men and 33.9% to 40.3% among women.



	2001	2003	2005	2007-8
Both Genders	47.4	46.4	49.4	52.9
Males	60.8	55.5	59.1	65.4
Females	33.9	36.7	40.6	40.3

Figure 53. Proportion of Peterborough adults who drink with at least one episode of hazardous drinking in the past 12 months; 2001-2008

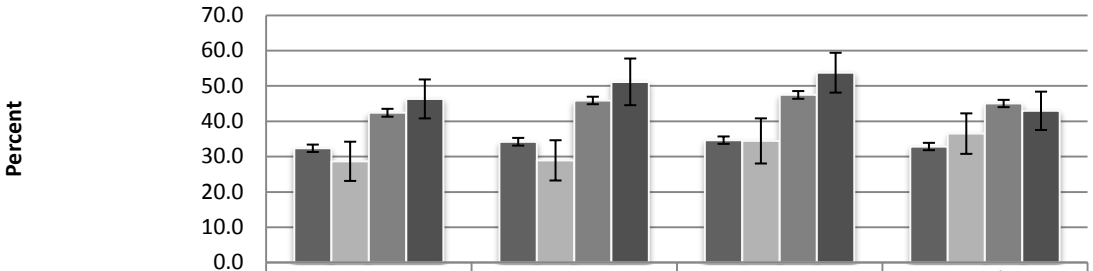


	2001	2003	2005	2007-8
Both Genders	41.2	44.2	45.2	43.8
Males	52.0	55.5	56.8	54.0
Females	29.6	32.1	32.7	32.8

Figure 54. Proportion of Ontario adults who drink with at least one episode of hazardous drinking in the past 12 months; 2001-2008

* analysis only includes adults of legal drinking age (>18 years of age) who answered "yes" to consuming alcohol in the past 12 months

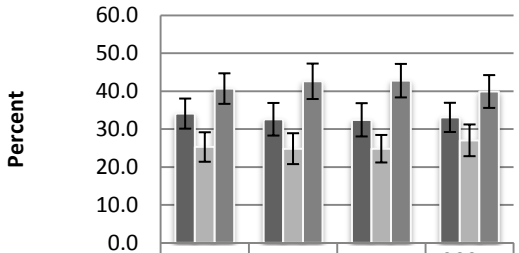
Diet can also play a role in reducing the risk of or contributing to the development of cancer. There is evidence to suggest a diet high in fruits and vegetables (F&V) can decrease the risk of developing oral and colorectal cancers. Conversely, a diet high in red meat and processed meats can increase ones risk of developing colorectal cancer. A significantly smaller fraction of men consume a diet high in F&V compared to women, with only one third of Ontario men getting the required number of servings of F&V compared to nearly half of Ontario women – Figure 55. In Peterborough, the proportion of men consuming five or more servings of F&V increased from 28.7% in 2001 to 36.5% in 2007/08. Conversely, after several years of increases, the proportion of Peterborough women consuming five or more F&V a day decreased from 53.8% in 2005 to 43.0% in 2007/08. The difference in F&V consumption in Peterborough men and women was no longer significant in 2007/08. In addition, in examining both men and women in Peterborough and Ontario, there were no significant differences in the proportion of people who consumed five or more F&V per day.
There is no local data available to estimate red or processed meat consumption.



	2001	2003	2005	2007/08
Ontario Males	32.4	34.2	34.7	32.9
Peterborough Males	28.7	28.9	34.4	36.5
Ontario Females	42.4	45.9	47.5	45.0
Peterborough Females	46.3	51.2	53.8	43.0

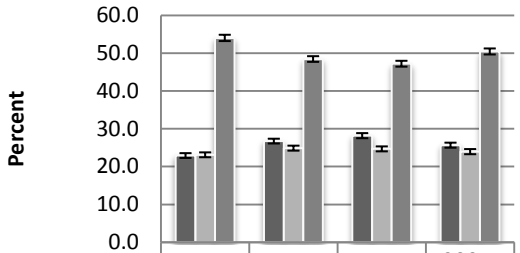
Figure 55. Proportion of males and females aged 12 and older in Ontario and Peterborough who consume five or more fruits and vegetables per day; 2001-2008

There is also good evidence to suggest that physical activity can reduce the risk of a number of cancers including colorectal and post-menopausal breast cancer. Regular physical activity can also reduce body and abdominal fatness which have been shown to increase the risk of developing colorectal and post-menopausal breast cancers. One third of Peterborough residents aged 12 and older were classified as active in 2007/08, which was significantly higher than the province at 25.6% – Figures 56 and 57. In addition, a significantly smaller fraction of Peterborough residents were inactive compared to Ontario (39.9% compared to 50.4%, respectively). In 2007/08, 64.2% of Peterborough men reported being active or moderately active, which was significantly higher than Ontario at 52.5%. A significantly greater proportion of Peterborough women also reported active or moderately active compared to the province (53.3% and 44.8%, respectively).(Data not shown)



	2001	2003	2005	2007-8
Active	34.1	32.6	32.4	33.1
Moderately Active	25.3	24.8	24.8	27.0
Inactive	40.7	42.6	42.8	39.9

Figure 56. Proportion of Peterborough population aged 12 and older who are active, moderately active, and inactive; 2001-2008



	2001	2003	2005	2007-8
Active	22.9	26.7	28.2	25.6
Moderately Active	23.1	24.9	24.7	23.9
Inactive	54.0	48.4	47.2	50.4

Figure 57. Proportion of Ontario population aged 12 and older who are active, moderately active, and inactive; 2001-2008

Screening

There are a number of cancers for which early screening measures exist, including breast, cervical, and colorectal. Unfortunately, for many common cancers such as lung cancer, there are no screening measures. While early screening for prostate cancer exists, recent reviews indicate that mortality rates from prostate cancer did not differ significantly between men who are screened and those who are not.

Breast

The *Ontario Breast Screening Program* (OBSP) makes breast cancer screening easily accessible: women with or without a family physician can be screened through the OBSP. Breast cancer screening is the regular examination of a woman's breasts by means of a breast x-ray – or mammogram – to detect breast cancer early on. Regular breast cancer screening can find cancer when it is small, which means there is a better chance of treating the cancer successfully; the cancer is less likely to spread; and, there may be more treatment options. Between 1989 and 2005, breast cancer mortality rates in Ontario women aged 50 to 69 decreased by 35% due to improved cancer treatments and increased participation in breast cancer screening. The OBSP targets women aged 50 to 69 to be screened with mammography every two years; the target in Ontario is to have 90% of women of this age participate in regular screening by the year 2020. In 2011, Ontario introduced a new screening program for women at higher risk for developing breast cancer.

Cervical

The Ontario Cervical Screening Program's (OCSP) objectives are prevention and early detection of cervical cancer screening with Pap tests, which can detect cell changes and pre-cancerous lesions associated with persistent infection with high-risk types of human papillomavirus (HPV). All women should have regular Pap tests within three years of starting any kind of sexual activity. Pap tests can find cell changes early, long before there are any symptoms and before a diagnosis of cancer. The most effective way or preventing cervical cancer is through vaccination against HPV before sexual debut. Ontario's public health units make the HPV vaccine available, free of charge, to all females in grade 8.

Colorectal

When colorectal cancer is caught early through screening, a person with colorectal cancer has a 90% change of being cured. A province-wide, population-based screening program launched in the spring of 2008 provides funding to screen:

- All asymptomatic, average risk men and women 50 years and older using a simple fecal occult blood test (FOBT) every two years; and
- Those at increased risk, which means those with a family history of colorectal cancer (a parent, sibling or child who have had colorectal cancer), by colonoscopy.

Prostate

There is no provincially funded screening program for prostate cancer. All men are encouraged to discuss with their primary care provider whether they should or should not have a blood test for PSA antigen. Given that many prostate cancers are not aggressive and will not reduce life expectancy, it is not yet clear whether screening with the current PSA antigen test improves outcomes. Research is ongoing.

Recommendations

This is the first time that the Peterborough County-City Health Unit has published a wide-ranging cancer-related report. This information was gathered to assist in developing understanding about incidence, mortality and trends of selected common cancers among Peterborough residents and to provide insight into issues that may be relevant within our local communities. The data presented here can be used to guide future action and suggest a number of recommendations for planning. The recommendations are either general and apply to all cancers and risk factor behaviours, or specific to areas where cancer trends in Peterborough differ significantly from the province:

1. *Advocate for enhanced risk factor surveillance data* to obtain a more comprehensive risk behaviour assessment for the community. For example: In order to advise Peterborough residents on how to enjoy the sun safely, information on their sun exposure habits is needed to support public health and policy makers in developing effective programs and policies to minimize harmful exposure to UVR. In addition, improved local surveillance of tobacco use particularly in youth populations will enable local target setting and allow ongoing monitoring of youth tobacco use and initiation rates.

2. *Further refinement and examination of sub-populations* that had significantly higher incidence/mortality of selected cancers. This includes additional analysis of risk factors and screening behaviours and identification of priority populations, for example: in low income, visible minorities, and older adults.

3. *Identification of additional indicators that may influence cancer outcomes*, for example investigation and measurement of environmental hazards/environmental risks factors for cancer such as radon exposure and examining how the social determinants of health affect local cancer incidence and mortality.

4. *Develop a communication plan to increase awareness and education of cancer risk factors* including smoking, diet, alcohol, sun exposure, and environmental exposures.

5. *Increase knowledge of local screening rates*, including analysis of self-reported screening rates from local data sources, meet with community stakeholders to develop a plan to increase screening rates locally, and advocate with partners to provide aggregate cancer screening data to public health units.

6. Ensure that *public health policies and resources are developed and directed at vulnerable populations*, for example shade policies targeted at outdoor workers and children, prohibiting tanning bed access for children and youth, and the integration of tobacco cessation resources into mental health, substance use, and anti-violence services, to name a few possible examples.

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Performance Targets Accountability Agreement

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

Funding Year 2011 - Obligations

1. The Province will:

a) Provide to the Board of Health technical documentation on the Performance Indicators set out in Table A including methodology, inclusions and exclusions for the Performance Indicators and their corresponding Performance Corridors; and,

b) Provide the Board of Health with the values for the Performance Indicators.

Funding Year 2011 - Obligations

2. Both Parties will,

a) By December 2011 (or by such later date as mutually agreed to by the Parties), establish appropriate BOH Baselines for all Performance Indicators;

b) Once BOH Baselines are established, develop Performance Targets for 2012 and 2013 for the Performance Indicators;

Indicator	Ontario median	Ontario Range	PCCHU Baseline	2012 Target	2013 Target
% HR Food premises q 4 months	82%	15% - 100%	86%	100%	100%
% pools and spas	73%	0 – 100%	57%	75%	100%
% HR SDWS inspected	N/A	N/A	N/A	100%	100%
% GC follow-up within 48 hrs	80%	0 – 100%	93%	100%	100%

Indicator	Ontario median	Ontario Range	PCCHU Baseline	2012 Target	2013 Target
% iGAS follow-up same day	94%	3% - 100%	87%	100%	100%
% vaccine wasted	0.1%	0.0 – 16.6%	0.0%	0.0%	0.0%
% influenza vaccine wasted	2.7%	0.0 – 33.3%	2.6%	Maintain or improve	Maintain or improve
% school children completed Hep B vaccines	80.3%	29% – 89.8%	77.9%	Maintain or improve	95.0%

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Indicator	Ontario median	Ontario Range	PCCHU Baseline	2012 Target	2013 Target
% school-aged females completed HPV	52.0%	1.7% - 65%	46%	Maintain or improve	90%
% school-aged children completed MGC	86.7%	52.5 – 93.8%	79.6%	Maintain or improve	90%
% youth never smoked	84.2%	67.3% - 92.5%	87.6%	No target	89.4%
% compliant tobacco vendors	94%	79% - 100%	86%	At least 90%	At least 90%

Indicator	Ontario median	Ontario Range	PCCHU Baseline	2012 Target	2013 Target
Fall-related ED visits rate for 65+ years	6,020	3817 - 8365	5,863	No target	5,687
% compliant with LRDGs	TBD	TBD	TBD	TBD	TBD
Baby Friendly Initiative Status	N/A	N/A	Designated	maintain	maintain

Process

- Seeking BOH direction for MOH to negotiate and BOH Chair to sign off on targets
- Webinar for all interested on January 16, 2012 from 12 pm to 1 pm
- January 16-20, 2012 set aside for discussions on targets
- January 31, 2012 submission

Questions?

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

Health, Not Health Care – Changing the Conversation

CMOH 2010 Annual Report

Ontario

Presentation Overview

- Key Messages
- Why We Need to Change the Conversation
- Making the Case for Change
- Health, Not Health Care
- Healthy Public Policy in Ontario Today
- Annual Report Recommendations
- Next Steps

Key Messages

- A new conversation about health is needed, and very little of that conversation is about health care
- Good health starts long before we visit doctors. It starts in childhood, in our homes, in our schools, our work places and our communities
- The factors that influence health lie, for the most part, outside of the health care and health promotion sectors
- All three levels of government, community levels, the private sector, and all Ontarians have a role to play
- A new initiative, or *Operation*, as successful and effective as *Operation Health Protection*, that is geared towards health promotion, chronic disease and injury prevention, is suggested

Why We Need to Change the Conversation

- Every year in Canada, more than two-thirds of all deaths result from chronic diseases – cardiovascular disease, cancer, type 2 diabetes, and respiratory disease.
- Four common risk factors – tobacco, healthy eating, regular exercise and harmful alcohol use accountable for most of them
    - Responsible for up to 60% of all cause mortality
- Trends are either flat (tobacco) or going in the wrong direction.
- If current health behaviour trends continue, the children of the next generation will have a lower life expectancy than their parents.
- We need work to make Ontario the healthiest place in North America in which to grow up and grow old.

Others Making the Case for Change

- UN High Level Meeting on the Prevention and Control of Non-Communicable Diseases (2011) - calling for “all of government” approach
- OECD and WHO – *Obesity and the Economics of Prevention* (2010)
- FPT Health Ministers’ *Declaration on Prevention and Promotion* (2010), Reports on Childhood Obesity, Sodium Reduction, Low Risk Drinking Guidelines (2011)
- Senate Subcommittee on Population Health (2009)
- Stakeholder Support: Health Council of Canada, OMA, RNAO, Ontario Heart and Stroke Foundation, CIHI, TD Bank/Drummond, PHO/CCO, other CMOHs, local public health

Health, Not Health Care

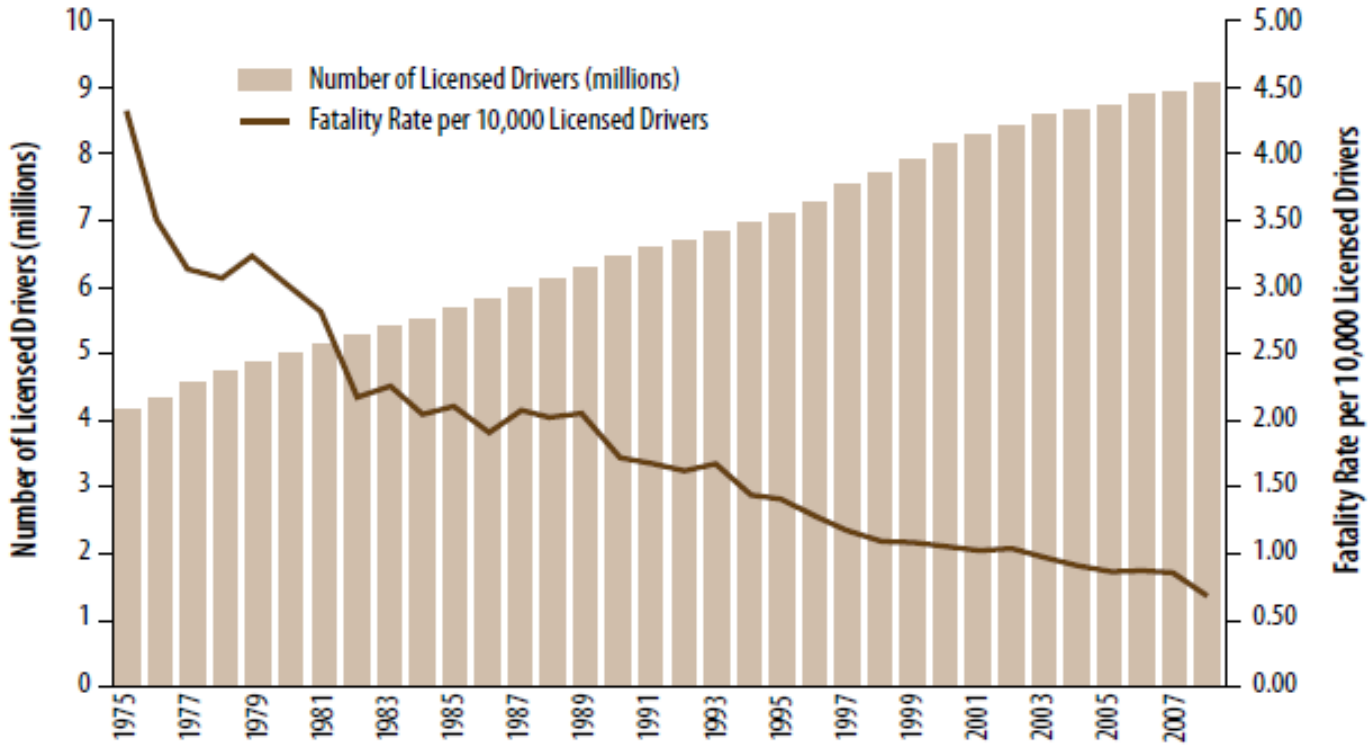
- Public health is the **organized efforts of society** to prevent illness, disease, and injury through a **sustained combination of approaches**:
    - One-on-one “clinical” interventions
    - Health promotion
    - Health protection
    - Healthy public policies
- Healthy public policies are profiled in my 2010 Annual Report. They are policies that generate positive health benefits which do not have health as the main policy objective.
- The ways in which we can improve health lie for the most part outside the traditional health care and health promotion sectors.

Healthy Public Policy in Ontario Today

- **Ontario Road Safety Successes**
- **Ontario Poverty Reduction Strategy**
- **Places to Grow**
- **Smoke-Free Ontario**
- **Ontario Public Service Diversity Office**

- **Peterborough Community Food Security Partnership**
- **Halton Our Kids Network**
- **Toronto Shade Policy and Guidelines**
- **Sudbury and District Health Unit Video**
    - ***Let's start a conversation about Health … and Not Talk about Health Care at All***

Ontario Fatality Rate per 10,000 Licensed Drivers



Source: Adapted from Ministry of Transportation. Ontario road safety annual report 2008. Toronto, ON: Queen's Printer for Ontario; 2008.

Annual Report Recommendations

- **Health lens** – Start applying a health lens to every program and policy in this province, so we can be clear on the health benefits or potential impacts of everything we do.
- **What gets measured gets done** - Goals and targets for every single health benefit we want to measure; finite list of health indicators.
- **More collaboration** - We need to tear down the boundaries between the municipal sector, health sector, education, social services, environment, transportation – some of the key sectors/ministries that need to work together to improve health.
- **Harness the full potential of our health system** – Use every patient interaction as an opportunity for disease prevention.
- **Catch people doing the right thing** - We need to recognize *health* achievements of both the health and non-health sectors.

Next Steps

- Public release of my 2010 Annual Report on December 1st.
- Ontario's *Operation Health Protection* (OHP) was launched in 2004, after SARS. We must sustain the infection, prevention and control and health emergency management agenda set by OHP.
- A new *Operation* that is geared towards the prevention of chronic diseases, cancer and injuries if we are to ensure that Ontario is the healthiest place in which to grow up and grow old … *Operation Healthy Ontario?*