Board of Health for the
Peterborough County-City Health Unit
AGENDA
Board of Health Meeting
Wednesday, October 14 2015 - 4:45 p.m.
Council Chambers, City Hall
500 George St. N., Peterborough

1. Call to Order

2. Confirmation of the Agenda

3. Declaration of Pecuniary Interest

4. Delegations and Presentations

4.1. **Branding Project Update**
Jonathan Bennett, Laridae Communications
Brittany Cadence, Communications Supervisor

5. Confirmation of the Minutes of the Previous Meeting

5.1. **September 9, 2015**

6. Business Arising From the Minutes

6.1. **First Nations Working Group**
Dr. Rosana Pellizzari, Medical Officer of Health

6.2. **Presentation: Public Health Funding Model: 2015 and Beyond**
Larry Stinson, Interim Director, Corporate Services

6.3. **Public Health Funding Advocacy**
Dr. Rosana Pellizzari, Medical Officer of Health

7. Staff Reports

7.1. **Staff Report and Presentation: Tobacco Retail Availability: Options for Regulation and Implications for Public Health**
Keith Beecroft, Health Promoter
Presentation Link

7.2. **Staff Report: Food Insecurity in Peterborough**
Carolyn Doris, Public Health Nutritionist

8. Consent Items

All matters listed under Consent Items are considered to be routine, housekeeping, information or non-controversial in nature and to facilitate the Board's consideration can be approved by one motion.

Board Members: *For your convenience, circle the items you wish to consider separately: 8.1a 8.1b 8.2a 8.3a*

8.1. **Correspondence**

a. Correspondence for Direction

b. Correspondence for Information

8.2. **Staff Reports and Presentations**

a. Health Care Worker Influenza Immunization, 2014-15
Edwina Dusome, Manager, Infectious Disease Programs

8.3. **Committee Reports**

a. Fundraising
Kerri Davies, Chair, Fundraising Committee

9. New Business

10. In Camera to Discuss Confidential Matters

In accordance with the Municipal Act, 2001:
- *Section 239(2)(a) the security of the property of the municipality or local board;*
- *Section 239(2)(d) labour relations or employee negotiations;*

11. Motions for Open Session

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

Motion required for change in location:

Date: November 11, 2015, 4:45 p.m.
New Location: Board Room, Peterborough County-City Health Unit, 10 Hospital Drive, Peterborough

13. <u>Adjournment</u>

Board of Health for the
Peterborough County-City Health Unit
DRAFT MINUTES
Board of Health Meeting
Wednesday, September 9, 2015 – 4:45 p.m.
Lower Hall, Administrative Building
123 Paudash Street, Hiawatha First Nation

In Attendance:

Board Members:	**Councillor Lesley Parnell, Chair**
	Mr. Scott McDonald, Vice Chair
	Deputy Mayor John Fallis
	Mr. Gregory Connolley
	Ms. Kerri Davies
	Councillor Henry Clarke
	Councillor Gary Baldwin
	Councillor Trisha Shearer
	Mr. Andy Sharpe
Staff:	**Dr. Rosana Pellizzari, Medical Officer of Health**
	Ms. Alida Tanna, Administrative Assistant
	Mr. Larry Stinson, Interim Director, Corporate Services
	Ms. Natalie Garnett, Recorder
	Brittany Cadence, Supervisor, Communication Services
	Donna Churipuy, Manager, Environmental Health Program
	Hallie Atter, Manager, Community Health Programs
	Sarah Tanner, Project Manager, Facility Relocation
Regrets:	**Chief Phyllis Williams**
	Mayor Mary Smith
	Mayor Rick Woodcock

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1. Welcome

Councillor Trisha Shearer welcomed everyone to Hiawatha First Nation.

2. Call to Order

Councillor Lesley Parnell, Chair called the meeting to order at 4:46 p.m.

3. Confirmation of the Agenda

It was noted that agenda items 5.3 and 9.4 will be deferred to an upcoming Peterborough County-City Health Unit meeting.

MOTION:
That the Agenda be approved as amended.
Moved: Mr. Sharpe
Seconded: Deputy Mayor Fallis
Motion carried. (M-2015-098)

4. Declaration of Pecuniary Interest

Councillor Clarke declared an interest in correspondence item 11, "Energy Drinks", as his employer is involved in the energy drink business.

5. Delegations and Presentations

5.1. Hiawatha First Nations Update

Councillor Shearer provided a verbal update on heath matters at Hiawatha First Nation.

MOTION:
That the oral report on health activities/services at Hiawatha First Nation be received for information.
Moved: Councillor Clarke
Seconded: Deputy Mayor Fallis
Motion carried. (M-2015-099)

5.2. Program Profile: Tobacco-Use Prevention

Donna Churipuy, Manager, Environmental Health Program, provided a presentation on the Tobacco-Use Prevention program.

MOTION:
That the presentation on Tobacco-Use Prevention be received for information.
Moved: Mr. Connolley
Seconded: Deputy Mayor Fallis
Motion carried. (M-2015-100)

5.3. Ontario Association of Communicators in Public Health

This item was deferred.

6. Confirmation of the Minutes of the Previous Meeting

6.1. June 10, 2015

MOTION:

That the minutes of the Board of Health meeting held on June 10, 2015, be approved as circulated.

Moved: Mr. McDonald
Seconded: Ms. Davies
Motion carried. (M-2015-101)

7. Business Arising From the Minutes

8. Correspondence

MOTION:

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

1. *Email dated June 11, 2015 from the Association of Local Public Health Agencies (alPHa) to all Ontario Boards of Health regarding the disposition of resolutions from the 2015 Annual General Meeting.*
2. *Letter dated June 16, 2015 from Minister MacCharles in response to the Chair's original letter dated May 14, 2015, regarding funding for the Healthy Babies, Healthy Children program.*
3. *Letter dated July 6, 2015 to Premier Wynne from the Board Chair regarding alcohol availability.*
4. *Letter Dated July 10, 2015 from Premier Wynne in response to the Chair's original letter dated July 6, 2015, regarding alcohol availability.*
5. *Letter dated July 15, 2015 from the Hon. Rona Ambrose in response to the Chair's original letter dated May 7, 2015, regarding a national alcohol strategy.*
6. *Letter dated July 27, 2015 from the Hon. Charles Sousa in response to the Chair's original letter dated July 6, 2015, regarding alcohol availability.*
7. *Letter dated August 10, 2015 from the Hon. Eric Hoskins in response to the Chair's original letter dated February 4, 2015, regarding the Low Income Dental Integration.*
8. *Letter dated August 19, 2015 from CUPE Local 4170 to the Board Chair regarding advocacy for public health funding.*
9. *Email newsletter dated September 1, 2015 from alPHa.*
10. *Letter dated September 4, 2015 from the Hon. Eric Hoskins to the Board Chair regarding funding for PCCHU for 2015-2016.*

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

<u>Alcohol Availability</u>

- *Durham*
- *Windsor Essex County*

<u>Health Babies Healthy Children</u>

- *Bruce Grey*
- *Sudbury*

<u>National Alcohol Strategy</u>

- *Durham*

<u>Sexual Health Curriculum</u>

- *Perth*

<u>Smoke-Free Multi-Unit Housing</u>

- *Bruce Grey*

Moved: Councillor Clarke
Seconded: Ms. Davies
Motion carried. (M-2015-102)

Item 8 - Dr. Pellizzari advised that this letter was signed by the Presidents of all three Unions and the Unions and two Board representatives (Deputy Mayor Fallis and possibly Mayor Woodcock) will have a meeting to discuss this issue. This matter will come back to the Board as a Business Arising Item on a future agenda.

Item 10 - Larry Stinson, Interim Director, Corporate Services, provided an update on funding from the province and advised that detailed information on the budget was just received and will be analyzed.

MOTION:
That a letter be provided to the Hon. Eric Hoskins advising that the Board of Health supports the letter dated June 30, 2015 from the Sudbury and District Health Unit regarding the enforcement of the <u>Immunization of Schools Pupils Act</u>.
Moved: Mr. Sharpe
Seconded: Deputy Mayor Fallis
Motion carried. (M-2015-103)

The Chair requested that staff provide a report on the above item.

MOTION:
That the Board of Health for the Peterborough County-City Health Unit endorse the Bruce Grey Food Charter, and that feedback be requested from the Peterborough Poverty Reduction Network.
Moved: Councillor Clarke
Seconded: Councillor Baldwin
Motion carried. (M-2015-104)

MOTION:
That the Board of Health for the Peterborough County-City Health Unit support the resolution of the Windsor Essex County Health Unit regarding support for a basic income guarantee.
Moved: Deputy Mayor Fallis
Seconded: Ms. Davies
Motion carried. (M-2015-105)

MOTION:
That the Board of Health for the Peterborough County-City Health Unit support the resolution of the Sudbury and District Health Unit regarding the Northern Ontario Evacuation of First Nations Communities.
Moved: Ms. Davies
Seconded: Councillor Shearer
Motion carried. (M-2015-106)

Due to his previously declared conflict, Councillor Clarke did not discuss or vote on the Energy Drink matter.

MOTION:
That the Board of Health for the Peterborough County-City Health Unit support the resolution of the Windsor Essex County Health Unit regarding concerns with Energy Drinks.
Moved: Ms. Davies
Seconded: Councillor Shearer
Motion carried. (M-2015-107)

9. New Business

9.1. Staff Report: Q2 2015 Program Report

Larry Stinson, Interim Director, Corporate Services provided an overview of the Q2 2015 Program report.

MOTION:
That the Board of Health for the Peterborough County-City Health Unit receive the staff report, Q2 Program Report, for information.
Moved: Deputy Mayor Fallis
Seconded: Mr. McDonald
Motion carried. (M-2015-108)

9.2. **Staff Report: Q2 2015 Corporate Services Report**
Larry Stinson, Interim Director, Corporate Services provided an overview of the staff report.

MOTION:
That the Board of Health for the Peterborough County-City Health Unit receive the staff report, Q2 Corporate Services Report, for information.

Moved: Councillor Baldwin
Seconded: Mr. McDonald
Motion carried. (M-2015-109)

9.3. **Healthy Kids Community Challenge Update**
Hallie Atter, Manager, Community Health Programs, provided a presentation on the Healthy Kids Community Challenge program.

MOTION:
That the Board of Health for the Peterborough County-City Health Unit receive the staff report, Healthy Kids Community Challenge Update, for information.
Moved: Councillor Baldwin
Seconded: Mr. McDonald
Motion carried. (M-2015-110)

The meeting recessed at 6:35 p.m. and reconvened at 7:02 p.m.

9.4 Working Group Report: First Nations
This item was deferred to a future meeting.

9.7 Committee Report: Property
Mr. Sharpe, Chair of the Property Committee, and Sarah Tanner, Project Manager, Facility Relocation, provided an update on the King Street property.

MOTION:
That the Board of Health for the Peterborough County-City Health Unit receive for information, meeting minutes of the Property Committee for March 17, 2015.
Moved: Mr. Connolley
Seconded: Mr. McDonald
Motion carried. (M-2015-111)

MOTION:
That the Board of Health for the Peterborough County-City Health Unit receive the oral report, Jackson Square Update, for information.
Moved: Deputy Mayor Fallis
Seconded: Mr. Connolley
Motion carried. (M-2015-112)

9.5 <u>Committee Report: Fundraising</u>

Kerri Davies, Chair of the Fundraising Committee, provided an update on the Fundraising Committee.

MOTION:
That the Board of Health for the Peterborough County-City Health Unit approve the Terms of Reference for the Fundraising Committee.
Moved: Councillor Baldwin
Seconded: Councillor Clarke
Motion carried. (M-2015-113)

MOTION:
That the Board of Health for the Peterborough County-City Health Unit receive the oral report on the Fundraising Committee for information.
Moved: Mr. McDonald
Seconded: Deputy Mayor Fallis
Motion carried. (M-2015-114)

Councillor Shearer left the meeting at 7:43 p.m. due to a previous commitment.

9.6 <u>Committee Report: Governance</u>

Mr. Scott McDonald, Chair of the Governance Committee, provided an update on the work being done by the Governance Committee.

MOTION:
That the Board of Health for the Peterborough County-City Health Unit receive for information, meeting minutes of the Governance Committee for May 19, 2015.
Moved: Deputy Mayor Fallis
Seconded: Councillor Parnell
Motion carried. (M-2015-115)

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

- *2-185 By-Law Number 10, Open and In-Camera Meetings*
- *2-280 Complaints, Public*
- *2-345 Medical Officer of Health Absence (no changes)*

Moved: Mr. Sharpe
Seconded: Councillor Parnell
Motion carried. (M-2015-116)

MOTION:
That the Board of Health for the Peterborough County-City Health Unit approve 2-120 By-Law 3, Calling of and Proceedings at Meetings.
Moved: Deputy Mayor Fallis
Seconded: Councillor Parnell
Motion carried. (M-2015-117)

MOTION:
That the Board of Health for the Peterborough County-City Health Unit receive for information, the Executive Summary and Full Assessment Report on Algoma Public Health.
Moved: Councillor Baldwin
Seconded: Councillor Clarke
Motion carried. (M-2015-118)

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

MOTION:
That the Board of Health for the Peterborough County-City Health Unit go In Camera to discuss confidential property and personal matters at 7:54 p.m.
Moved: Councillor Clarke
Seconded: Ms. Davies
Motion carried. (M-2015-119)

MOTION:
That the Board of Health for the Peterborough County-City Health Unit rise from In Camera at 8:35 p.m.
Moved: Mr. McDonald
Seconded: Mr. Connolley
Motion carried. (M-2015-120)

11. Motions from In Camera for Open Session

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

- *receive the in camera staff report, Non-Union Compensation, for information;*
- *approve the adoption of a policy position directing senior management to strive for achieving and maintaining compensation levels comparable to the 50th percentile among our peer health units for the non-union group; and,*
- *endorse the proposed salary grid for non-union classifications; the proposal to eliminate the Supervisor classification and move the current incumbents to a Manager classification with expanded responsibilities; and the adoption of option A for achieving the 50th percentile wage target for non-union compensation.*

Moved: Mr. Sharpe
Seconded: Mr. McDonald
Motion carried. (M-2015-121)

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

October 14, 2015 – Council Chambers, City of Peterborough, 500 George Street North, 4:45 p.m.

13. Adjournment

MOTION:
That the meeting be adjourned.
Moved by: Mr. Connolley
Seconded by: Mr. McDonald
Motion carried. (M-2015-122)

The meeting was adjourned at 8:38 p.m.

Chairperson

Medical Officer of Health

To: All Members
Board of Health

From: Dr. Rosana Pellizzari

Subject: **Working Group Report: First Nations**

Date: October 14, 2015

The First Nations Working Group, struck out of discussions arising from the May Board/Management Planning Session, had its inaugural meeting on July 16, 2015. Minutes from that meeting have been attached for your information.

First Nations Working Group - Minutes, July 16, 2015

Recommendation:

That the Board of Health for the Peterborough County-City Health Unit receive for information, meeting minutes of the First Nation Working Group for July 16, 2015.

BOH-Management First Nations Follow-Up
Meeting Minutes

Date:	Thursday, July 16, 2015
Time:	4:30 pm
Location:	Board Room, Hospital Drive
Present:	Mary Smith, Greg Connelley, Phyllis Williams, Patti Fitzgerald, Sarah Tanner, Rosana Pellizzari (recorder)
Regrets:	John Fallis, Trish Shearer

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1. **Call to Order**
   The meeting was called to order at 4:30 p.m.

2. **Approval of Agenda**
   Rather than create an agenda, it was decided that the notes from the May 30th Board-Management Planning Session would be reviewed and that today's meeting would be used as a brainstorming session.

3. **Brainstorming Ideas**
   - 3.1. Cross-Cultural Issues for FN board members: This was raised at the planning session in May and further explored. There can be challenges for FN representatives on the board to "fit" with the discussions and issues that come to the table. Sometimes it is very hard to relate to city or even county realities. It was agreed that the lens at the table is weighted towards the city and that is the experience of county representatives. But the difference and disconnect is even greater for representatives of FN communities where their culture is much more "service" related and where it takes more time to develop by-laws. This makes the FN representatives much more aware of the health status of their members, including mental health – in contrast to other municipal members who would not have such direct contact.
   - 3.2. How can the PCC board of health be a stronger ally and advocate for its FN members? Although this topic was not discussed, it could be one that the board, or another meeting of this subcommittee, could explore more fully at a future time.
   - 3.3. Should there be a FN Subcommittee of the BOH? This question was raised at the May 30th session and merits more consideration. It was decided that rather than attempt to this now, we would spend the time brainstorming and then come back to this.
   - 3.4. Is there any merit to the idea of having dedicated PCCHU staffing to strengthen the relationships with Curve Lake and Hiawatha? Are there existing staff who could have this responsibility added to their role? Would we fund a pilot, perhaps as a one-time funding request next year, and then evaluate whether it is something we would want to continue?
   - 3.5. On reserve and Off reserve Aboriginal Public Health: This was raised at the planning session and further explored. For example, Curve Lake FN is aware that at least 400 of its members live off reserve, in Peterborough City. It was felt that we needed a broader aboriginal public health strategy that would be inclusive of the indigenous population living in the city and county. This would mean entering into a dialogue with other stakeholders and potential partners. We might have to secure additional funding or we could assign one of our SDOH nurses to lead this work, as has been done by other boards of health such as Algoma. One place to focus might be the Truth and Reconciliation Recommendations. We could ask Tracy at the Chiefs of Ontario (COO) to share their list of action items with us.
   - 3.6. Cultural Competency: There was recognition that this needs to be developed among board members and all staff. There is an existing module for new staff that was created in cooperation with Curve Lake and Hiawatha and it has sparked provincial interest in developing a cultural competency course that would be customized through collaboration between public health staff and local FN communities. COO

has been funded to do this work and eight modules have now been developed. There is a meeting next week and Rosana indicated that there is a possibility that PCCHU-CLFN-HFN will be asked to pilot the modules and process.

3.7. 185 King Street: We would like to make our new home inclusive and welcoming to people of FN heritage, as well as use it as a way to showcase the local story and culture. The new fire hall in Keene was seen as a positive example that we would like to look at more closely. **Action: Rosana will ask Trish to send us photos and contact information on the designer.** We thought the best way to proceed was to engage key community members in an information gathering process. It was mentioned that integrating the Medicine Wheel and perhaps even displays of indigenous medicine would be desirable. The question about the need to fundraise for art work was raised. There is a movement that has identified 1% of total capital costs as being a good target for spending on art. The following names were brainstormed:

- Anne Taylor at the CLFN Cultural Centre (also works with Elders)
- Mike Whetung at the Whetung Gallery
- Adam Hopkins, at Trent University
- Someone from the Canoe Museum and Peterborough Museum?
- Gail McIntyre and/or Sandra Depret (**Action: Greg volunteered to follow-up with Fleming College and sent these names after discussion with Tony Tilley)**
- The person who did the petroglyph art at the Fleming College Whetung Theatre
- Someone from the FHT (tenants in the building)

Action: Sarah Tanner will contact these individuals and invite them to engage with us on this activity.

3.8. Could we do a better job of informing ourselves about public health programs and services in FN communities? The idea of doing a check-in with health and social service staff, perhaps by way of a survey, was explored. Perhaps we could ask them what public health gaps or needs may exist? Which PCCHU delivered services have been successful and well received? Who is currently doing what in each community (to avoid duplication or determine who has the lead). In addition to staff, another group that could be consulted at CLFN would be the members of the Health and Family Service Committee, which has council members and others on it.

3.9. Opening Statement at BOH meetings? The idea of starting each board of health meeting with a recognition that we are on land that was the home of original First Nations peoples in the area was discussed. There was agreement that this would be a respectful practice. **Action: Phyllis will provide language that could be recommended to the board to include.** ***NOTE: The following statement was later provided by Phyllis which she obtained from a representative from the Kawartha Pine Ridge District School Board: "We would like to acknowledge that we are meeting on the traditional territory of the Mississauga First Nations."***

3.10. Next Steps: **Sarah will move ahead with the consultation on the new building. Rosana will check with Brittany to suggest that the branding RFP be sent to indigenous groups as well. Staff will review these minutes for possible next steps and they will also be brought back to the board in September.**

4. Adjournment

The meeting was adjourned at 5:45 p.m.

Chair

Recorder

Public Health Funding Model: 2015 and Beyond

Presentation to: Board of Health

By: Larry Stinson, Director of Corporate Services

Date: October 14, 2015

Purpose of Presentation

- Why a funding formula
- How does the funding formula work
- What are the implications for Peterborough County-City Health Unit

Why a Funding Formula

- improves accountability and transparency of provincial public health funding
- aligns public health funding with other ministry funding approaches
- supports a more equitable approach to public health funding

Funding Challenges

- continuing to experience tight fiscal constraints, with increased scrutiny and expectations regarding value for public expenditures and investments.
- acknowledged historical funding inequities among boards of health.
- boards of health are dealing with infrastructure issues and the funding pressures associated with their capital needs.

Health System Funding Reform

87 Hospital Corporations

14 Community Care Access Centers (CCACs)

637 Long-Term Care (LTC) Homes

Hospitals and Community Care Access Centres

Health Based Allocation Model (HBAM)

- Evidence, health-based funding formula
- Enables government to equitably **allocate available funding** for health services
- **Estimates future expense** based on past service levels and efficiency, as well as population and health information

Quality-Based Procedures (QBPs)

- Clusters of patients with clinically related diagnoses / treatments with an evidence-based framework as providing opportunity for:
  - Align incentives to **facilitate adoption of best clinical practices**
  - Appropriately **reducing variation in costs and practices** across the province to improve outcomes

Long-Term Care Homes

Case Mix Index (CMI)

- Evidence-based funding approach that uses **resident profiles**
- Reflects resident needs by considering factors such as diagnosis and functional capacity
- Enables the government to equitably **allocate available funding** for resident services

Summary of Funding Models

	Hospitals (HBAM)	Hospitals (QBP)	CCACs (long stay)	Long-Term Care	Public Health Units
Approach	Pie	Volume	Pie	Pie	Pie
Issue/Objective	Equity	Efficiency	Equity	Equity	Equity
Amount Distributed	40%	13%	30%	75%	Growth
Implementation Date	2012	2012	2012	2009	2015
Data	Utilization	Utilization	Utilization	Utilization	Need & Utilization
Factors	- Socio Economic Status - Population Growth - Clinical characteristics - Teaching activity - Rural geography - Economies of Scale	- Population Growth - Clinical characteristics	- Population Growth - Clinical characteristics - Activities of daily living	- Activities of Daily Living	- Socio Economic Status - Marginalization Index

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

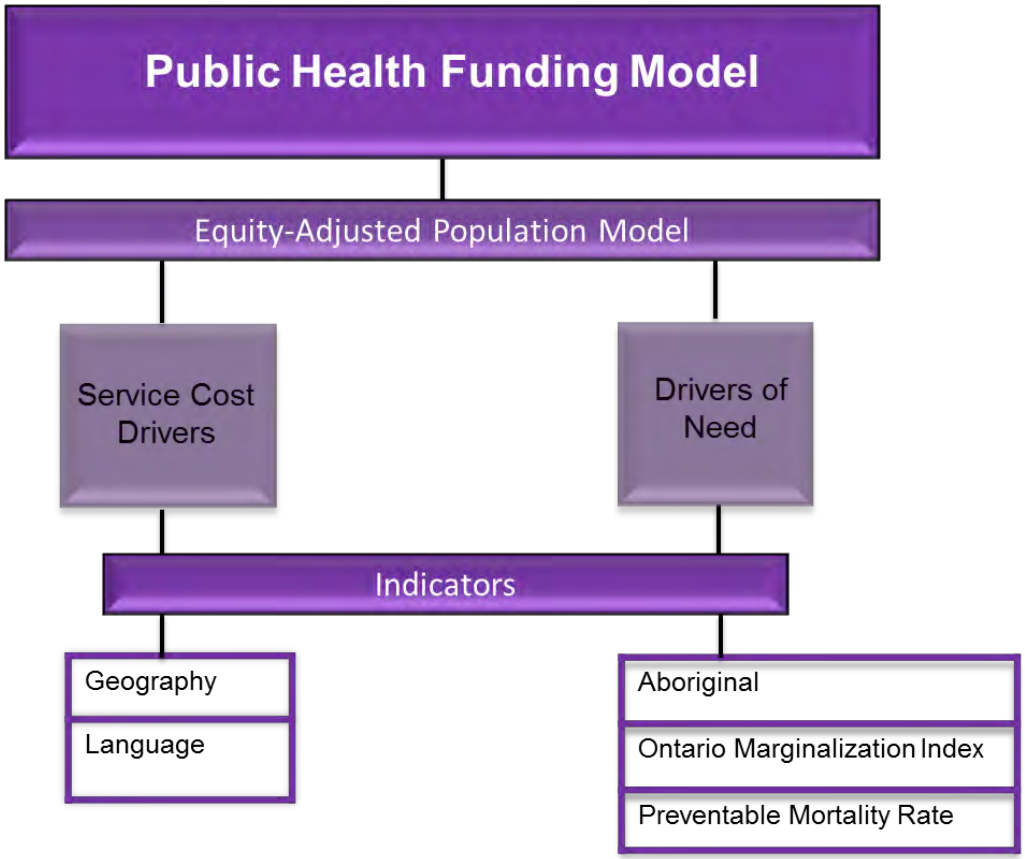
Creating a Funding Formula

- initiated a process to review provincial funding provided to boards of health in an effort to ensure a fair, transparent, and consistent method of funding.
- FRWG was struck with a mandate to provide advice to the ministry on a future public health funding model.
- membership consisted of representation from boards of health, public health units, alPHa, AMO, and the City of Toronto.

Funding Review

- The overall objectives of the review were to:
  - Develop a needs-based approach to public health funding;
  - Improve funding responsiveness to service needs through the inclusion of equity and population adjustment factors; and,
    - Reduce funding inequities among boards of health over time.

The Funding Formula

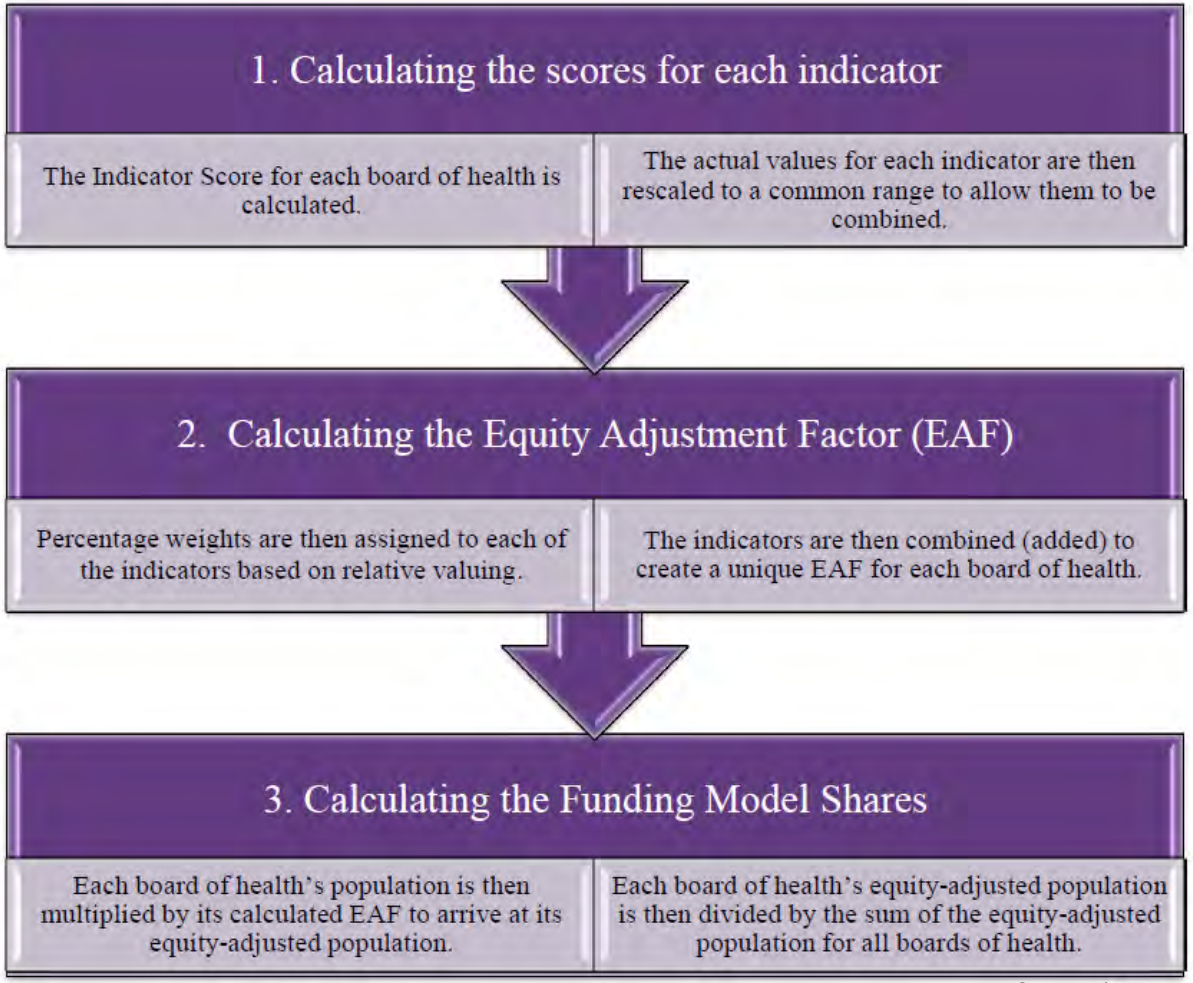


Public Health Funding Model:
Summary of Model Construction

The public health funding model identifies an appropriate share for each board of health that reflects its needs in relation to all other boards of health.

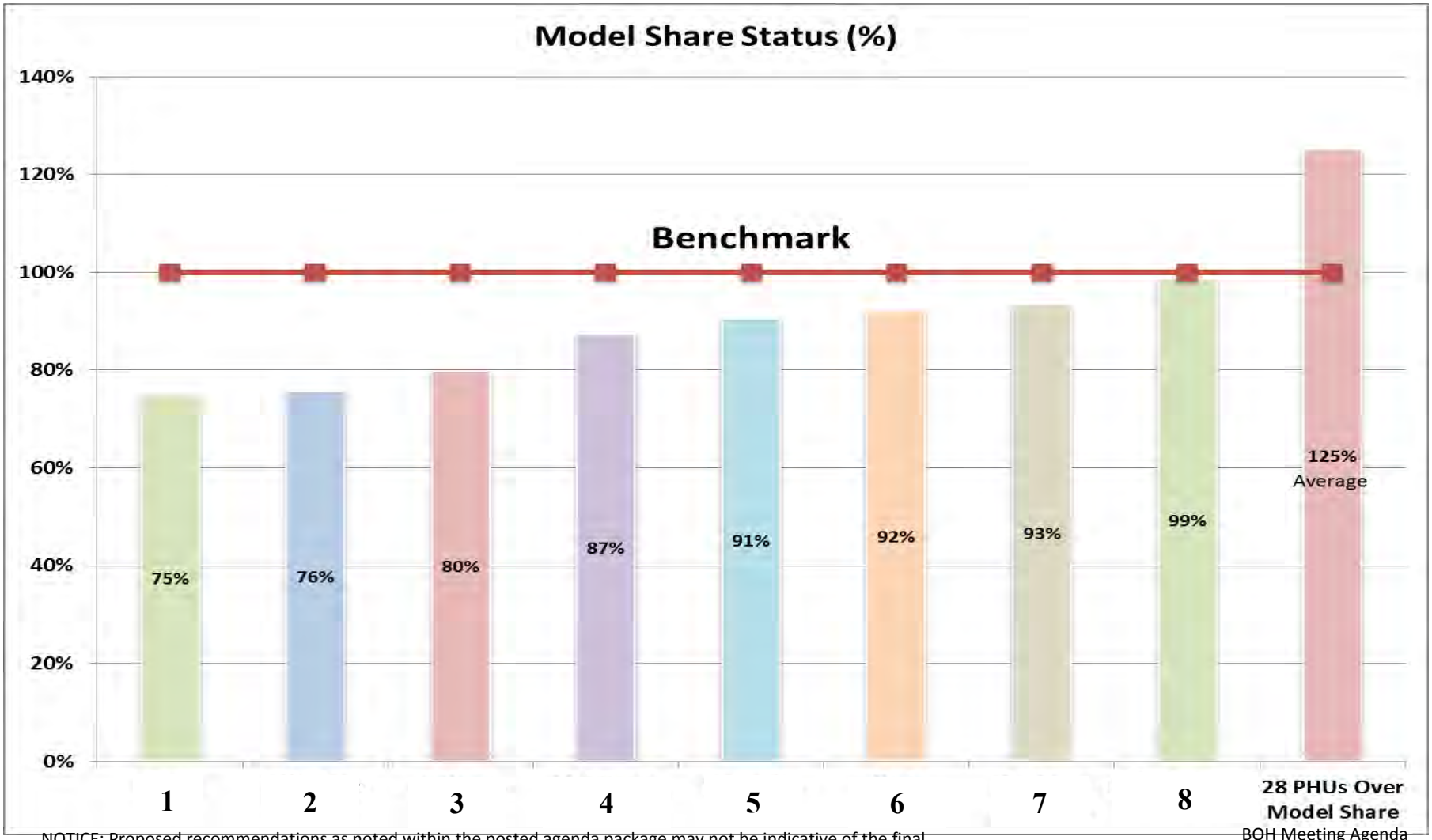
There are a number of steps to calculate each board of health's equity-adjusted funding share.

See **Appendix 1** for updated public health funding model data.



Public Health Funding Model:

Mandatory Programs Funding Model Share Status



NOTE: Compares actual shares (based on 2014 mandatory programs funding) to public health funding model shares.

Considerations for Future

- By using this approach, it will take several years for boards of health to reach their model-based share.
- Growth funding may or may not be available in future years.
- Indicator data will be revised with each new census and population estimates will be revised annually
- 0% increases to base funding levels will impose significant financial hardships on health units at or above the baseline.

alPHa Position

- No formula would be able to satisfy all interests and perspectives.
- Since this formula is not proven, it will be important to evaluate outcomes and assess impacts (especially on those where increases are not received)
- Focus should be on the size of the funding pie and less on how the pie is divided
- Need to continue to be engaged

Questions

Staff Report

Tobacco Retail Availability: Options for Regulation and Implications for Public Health

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

Original approved by	***Original approved by***
Rosana Pellizzari, M.D.	Keith Beecroft, Health Promoter

Recommendations

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

- receive the staff report, *Tobacco Retail Availability: Options for Regulation and Implications for Public Health,* for information; and
- support PCCHU engagement with the City and County of Peterborough with regards to possible licensing of tobacco retailers.

Financial Implications and Impact

There are no financial implications arising from this report.

Decision History

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

Background:

What is "retail availability" and why is it a problem?

Retail availability simply refers to the number of commercial tobacco vendors in a given area, such as convenience stores, grocery stores, and gas stations that sell tobacco products like

cigarettes, cigars, and chewing tobacco. Melody Tilson, Policy Director from the Non-smokers Rights Association argues that the retail availability of commercial tobacco products poses many challenges for public health, but most notably that "there is no question that the ubiquity of retail stores that sell tobacco products, particularly in urban environments, serves to normalize tobacco products and hence tobacco use."[1] Tilson then goes on to argue that "the widespread availability of tobacco products undermines the health risk messaging of government authorities and health groups". That is to say there is a perception created that tobacco products are safe, when they can be purchased in the same place as bread, milk, and candy.

Furthermore, "A number of tobacco-specific studies on retail availability indicate that increased availability contributes to increased tobacco use among youth."[2]

In an effort to denormalize tobacco use, reduce the availability of commercial tobacco products, and subsequently reduce the use of tobacco by youth, the Non Smokers' Rights Association has put forth three policy options to reduce retail availability:

1) "Licensing: Requiring all tobacco retailers to possess a valid license and imposing various conditions on the license to gradually reduce the availability of tobacco products."
2) "Zoning: Zoning is another means by which the availability of tobacco products could be reduced, for example, by setting limits on the number of retailers per zone"
3) "Government-controlled outlets: A third policy option is to restrict tobacco sales to a limited number of controlled outlets, a model that is used for the sale of alcoholic beverages (with limited exceptions) in the province of Ontario."[3]

For the purpose of this Staff Report, we will be exploring the first option, licensing of tobacco retail vendors, with examples specific to Peterborough City and County.

In an effort to frame the conversation about tobacco retail licensing, and highlight the burden of this product on our community, we wanted to provide you with an overview of the current tobacco status in our country, province, and community.

An overview of Tobacco Use in Canada, Ontario, and Peterborough

A brief glossary of terms taken from the Tobacco Use in Canada Report:

- Current smoker: includes daily and non-daily (occasional) smokers. Determined from the response to the question "At the present time do you smoke cigarettes every day, occasionally, or not at all?"
- Current daily smoker: refers to those who respond "every day" to the question "At the present time do you smoke cigarettes every day, occasionally or not at all?"
- Current non-daily smoker: often referred to as "occasional" smoker, refers to those who respond "Occasionally" to the question "At the present time do you smoke cigarettes every day, occasionally or not at all?"[4]

The 2015 *Tobacco Use in Canada* Report, published by Propel notes that in Canada as a whole:

- 14.6% of Canadians aged 15 years and older (approximately 4.2 million) were current smokers;
- the majority of smokers reported smoking daily (An average of 13.9 cigarettes were smoked per day);
- although smoking prevalence was at its lowest since measurement began [in 1999], the observed prevalence decline appears to have slowed;
- smoking prevalence was highest among young adults aged 25-34 and 20-24, at 18.5% and 17.9%, respectively;
- four out of five (80%) youth reported never having smoked a whole cigarette;
- 10.7% of youth aged 15-19 were current smokers overall;[5] and
- 64% of smokers intend on making a quit attempt in the next six months.[6]

The same report notes that in Ontario:

- In 2013, smoking prevalence in Ontario aged 15 years and older was 12.6%. (1,412,000 smokers);
- of the 12.6%, 13.6% are male (751,000 smokers) and 11.6% are females (662,000 smokers);
- on average, smokers consumed 13.0 cigarettes per day; and
- 9.5% of Ontarian youth aged 15-19 were current smokers.[7]

Statistics for Peterborough indicate:

- 25.4% of residents aged 15+ are daily or occasional smokers;
- 88.7% of youth aged 12-18 have never smoked a whole cigarette (79% provincially, and 76% nationally);[8]
- in 2011, the Youth Smoking Survey indicated that 9% of Peterborough high school aged youth report being current smokers;[9]
- a greater proportion of people with lower income smoked compared to persons with higher incomes (32.7% compared to 17.3%);[10] and
- 72% of youth have made a quit attempt in the last year; 50% of those youth have made multiple quit attempts.[11]

What do the numbers mean?

In plain language Peterborough's smoking rates are above the provincial and national averages.

Associated Health Effects of Commercial Tobacco Use

Experts from the World Health Organization, the Center for Disease Control in the United States, the Canadian Cancer Society, and the Ontario Lung Association unilaterally agree that

the tobacco epidemic is the leading cause of preventable death and disease in the world.[12,13,14,15]

Furthermore, in addition to the health effects, and 13,000 deaths caused by commercial tobacco products in Ontario, the economic toll is equally as burdensome with "tobacco-related disease cost[ing] Ontario's health care system an estimated $2.2 billion in direct health care costs and an additional $5.3 billion in indirect costs such as lost productivity."[16]

For all of those reasons, Ontario's Premier Kathleen Wynne has pledged to have the lowest smoking rates in Canada.[17]

Rationale for Tobacco Retail Licensing

The Non-Smoker's Rights Association summarizes the need for retail reform.

"1. Greater availability [of tobacco products] increases consumption.

Fundamental laws of supply and demand tell us that the widespread availability of tobacco products increases tobacco use.

2. The ubiquity of tobacco retailers normalizes tobacco products and tobacco use.

The proximity of tobacco products to everyday consumer goods like candy, gum, and the daily paper renders them commonplace by association. The pervasiveness of tobacco outlets and the size and prominence of (covered) gantries of tobacco products contribute to the widely-held belief among youth that "everyone" smokes.

3. The widespread availability of tobacco products undermines health warnings.

Youth access initiatives and retail display bans have helped to correct public perceptions of the dangers of tobacco use, but much more needs to be done when tobacco products are available for purchase around the clock in virtually every convenience store, gas station and supermarket.

4. Fewer outlets would enhance enforcement efforts.

It is clear that the more outlets there are the thinner enforcement resources are spread, leaving authorities less able to monitor compliance with the laws intended to restrict the promotion and sale of tobacco products."[18]

In a recent presentation by the Non-Smokers' Rights Association, Melodie Tilson concluded that despite tobacco products being removed from 'plain sight' in retail environments, the evidence is clear, availability of commercial tobacco products:

- undermines tobacco control
- influences community norms
- affects consumption and cessation
- affects youth initiation.[19]

Furthermore, Health Canada's recent report, "Evaluation of Retailers' Behaviour Towards Certain Youth Access-to-Tobacco Restrictions" summarized "results from the latest independent investigation into retailer behaviour with respect to key aspects of Canadian tobacco legislation, in particular that part of the laws regarding youth access to tobacco." That is to say, they wanted to understand if Canada's tobacco vendors were in compliance with current youth access laws. The research indicated that "since the last retailer behaviour study conducted five years ago, in 2009, there has been no change in the national retailer compliance rate."[20] Specifically, "although the high level of compliance is encouraging, approximately one in seven retailers did not check for ID and would allow a minor to buy cigarettes."[21]

In addition, there is a growing body of evidence that indicates "that the density of [tobacco] outlets within walking distance of the home may reduce cessation activity among all smokers. Further, the impact of outlets closest to home may be most detrimental for cessation among smokers in higher poverty areas".[22]

Similarly, recent research by Chaiton et al in 2014 notes that "among heavily addicted smokers, the effect of living within 250m of a tobacco outlet was an important correlate of smoking behavior."[23]

<u>Why retail reform is needed in Peterborough</u>

Currently, tobacco vendors are only required to possess a valid tobacco retail dealer's permit which is issued by the Ministry of Finance. There is no fee for this permit, no consultation with neighbors or other stakeholders (as there is with alcohol sales), and no system in place to alert Tobacco Enforcement Officers of new retailers selling tobacco in an area.[24]

Requiring licensing "would enable authorities to maintain a relatively accurate database of vendors in their jurisdiction that sell tobacco" which would make enforcement of tobacco laws more efficient.[25] Licenses could further be used to reduce availability to minors and reduce exposure to tobacco products. In areas where tobacco use prevention is a priority, such as in neighbourhoods located near schools, and in neighbourhoods where residents are most exposed to tobacco products, the restricted granting of tobacco retail licensing could be used as a tool to reduce the high density of tobacco vendors.

Appendix A shows the proximity of tobacco vendors to schools.

- In the City of Peterborough, there are 26 tobacco vendors within 400m of an elementary school, and 68 within 800m.
- In the City of Peterborough, there are 12 tobacco vendors within 400m of secondary schools and 34 within 800m.
- In the County of Peterborough, there are 23 tobacco vendors within 400m of elementary schools and 31 within 800m.
- In the County of Peterborough, there is one tobacco vendor within 400m of a secondary school, and 6 within 800m.

As noted above, the smoking rates in Peterborough of those with less income are higher than those with more income. This pattern of tobacco use is widely supported in the literature as well. Wood et al noted that "findings are consistent with a number of United States studies that report higher tobacco outlet densities in lower socioeconomic or minority neighbourhoods. The results underscore the importance of policy approaches to limit the number of tobacco retail licenses granted, and to reduce the geographic density of [tobacco] outlets in more disadvantaged [areas]."[26]

Appendix B examines the density of tobacco vendors in or within 400m of Dissemination Areas* where 25% of the population in private households has an income which is below the Low Income Cut-Off (LICO**), after tax, in 2005.

*Dissemination Area – Small area composed of one or more neighbouring dissemination blocks, with a population of 400 to 700 persons. All of Canada is divided into dissemination areas.

**The LICO is the income threshold below which a family will likely devote 20% more of its income to the necessities of food, shelter and clothing than the average family. In 2005, the LICO for an urban area the size of Peterborough for a single person was $14,674. For a family of 4, the LICO was $27,745.

- In the City of Peterborough there are 24 tobacco vendors in dissemination areas where 25% of the population has an income below the LICO.
- In the City of Peterborough there are 41 tobacco vendors within 400m of dissemination areas where 25% of the population has an income below the LICO.

In plain language, the map as illustrated in Appendix B indicates that in the City of Peterborough, there is a higher density of tobacco vendors within walking distance of census tracts where at least 25% of the population is reporting low income.

Moreover, the 2014 Smoke-Free Ontario Strategy Monitoring Report notes that "cessation outcomes can be achieved through a number of evidence-based pathways such as: decreasing access and availability of tobacco products, increasing knowledge of tobacco harm and awareness of available cessation supports, promoting and supporting quit attempts, and limiting physical and social exposure to tobacco products."[27]

Results from a 2011 student survey found that 72% of current secondary school students that smoked were trying to quit.[28] Likewise provincial statistics show that 60% of smokers intend to quit in the next six months.[29] As there is already a high level of desire to quit smoking in Peterborough, tobacco retail licensing would support those making quit attempts in all census tracts across the county and city; regardless of what area they lived in.

Existing Ontario Initiatives in Licensing

In a recent address for World No Tobacco Day, Dr. Robert Schwartz, Principal Investigator and Executive Director from the Ontario Tobacco Research Unit noted that "measures that reduce youth uptake and encourage smoking cessation are vital to avoiding billions of dollars in healthcare costs from sickness caused by tobacco use and could save the lives of tens of thousands of Ontarians," likewise, "bold measures are crucial to jumpstart a decline in Ontario's smoking rate, which has stalled at 18 per cent, with no significant change since 2008."[30]

Several other jurisdictions are already taking steps to further protect their residents from the tobacco industry through tobacco vendor licensing, including (but not limited to): Ottawa ($445 annual license fee), Markham ($362 license fee), Hamilton ($176), Kingston ($220 license fee), Brampton ($215 license fee), Richmond Hill ($150 license fee), North Bay and ($50 license fee).

Working towards an endgame solution for the Tobacco Industry: Final Thoughts and Recommendations

Mitch Zeller in his recent paper *Reflections on the 'Endgame for Tobacco Control'* notes that "there was convergence around the notion that we need new approaches to dramatically reduce consumption of conventional combusting cigarettes," and that "product regulation can play an important role in any endgame approach."[31]

A tobacco retail licensing system speaks to this 'endgame' approach, and would protect residents from the tobacco industry, support those making quit attempts and prevent youth from starting to smoke. A tobacco licensing system would also enhance our tobacco control efforts, supporting a system that is more efficient and effective to enforce.

Lipperman-Kredal et al, perhaps put it most succinctly, "Our results suggest that tobacco outlet density is related to youth smoking".[32] As such, a simple solution to reduce youth smoking would be to reduce the number of licensed tobacco retailers.

As Peterborough is regularly at the forefront of progressive tobacco control measures, setting what often become provincial norms, requiring that tobacco retailers possess a valid tobacco retail license would further position Peterborough among provincial leaders in tobacco use prevention while protecting our residents.

Strategic Direction

This report applies to the strategic directions of:

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

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(705)743-1000 x238
kbeecroft@pcchu.ca

Attachments:

Appendix A: Proximity of Tobacco Retail Vendors to Schools
Appendix B: Tobacco Vendors in Proximity to Low Income Areas

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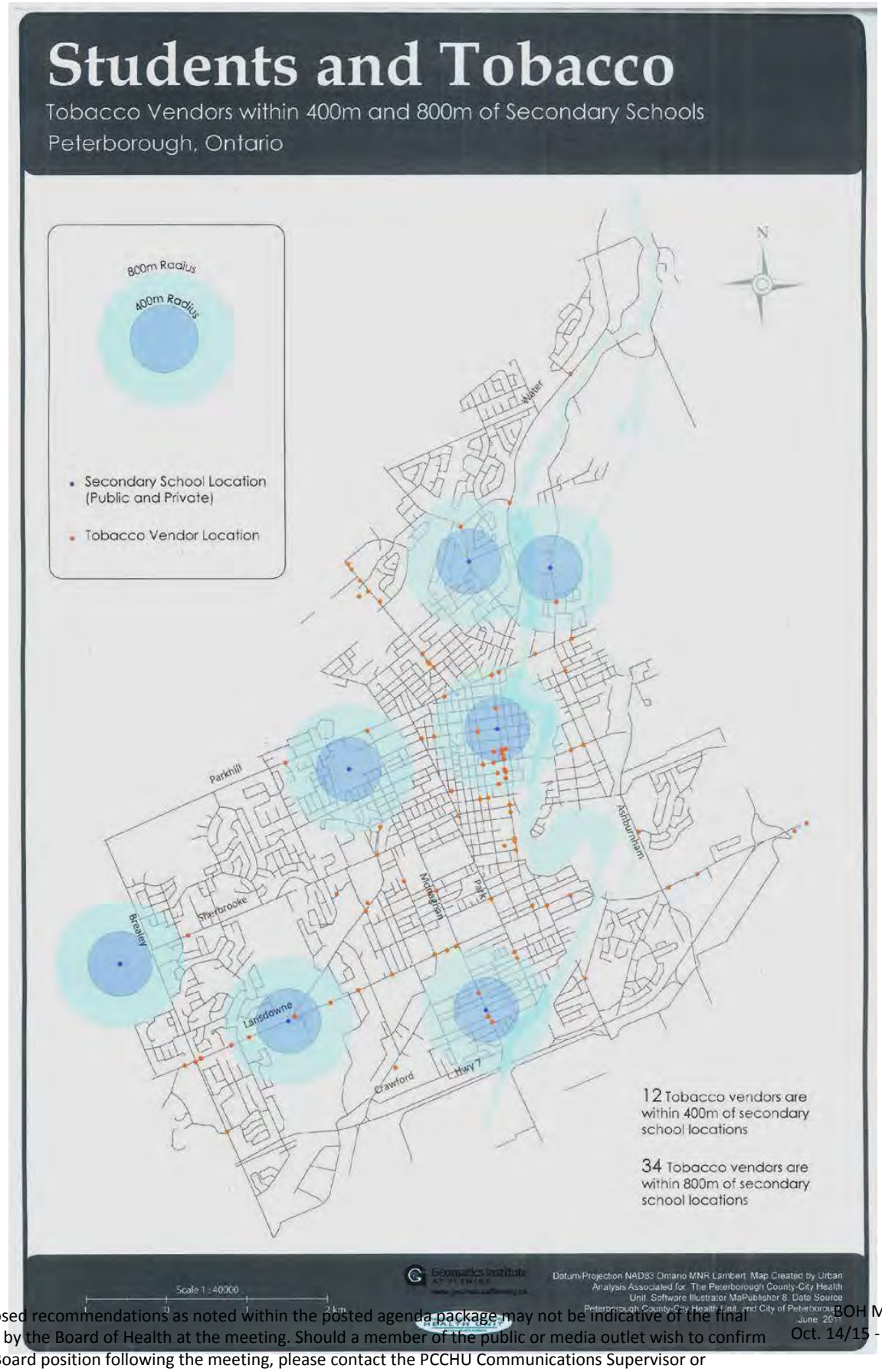
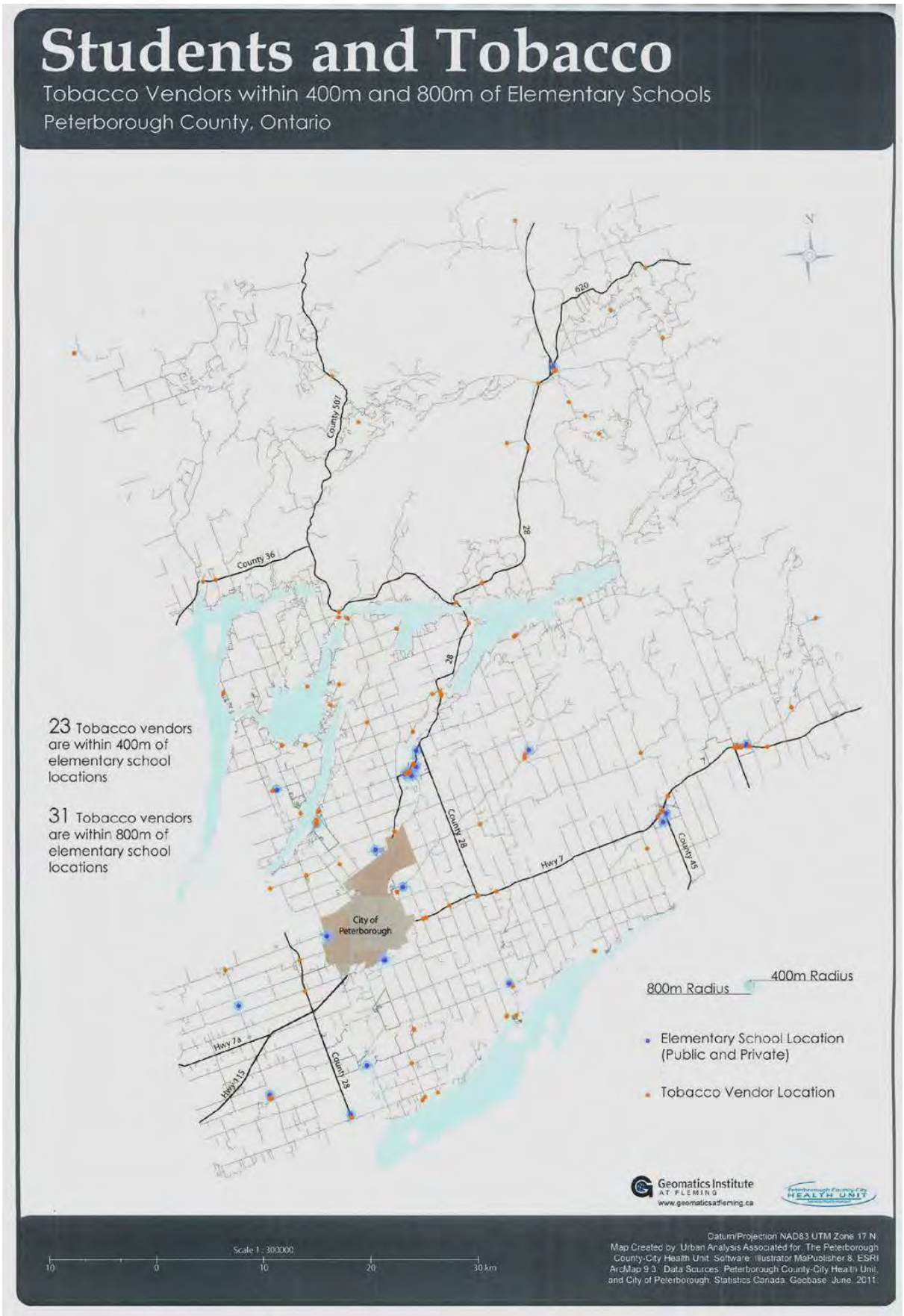
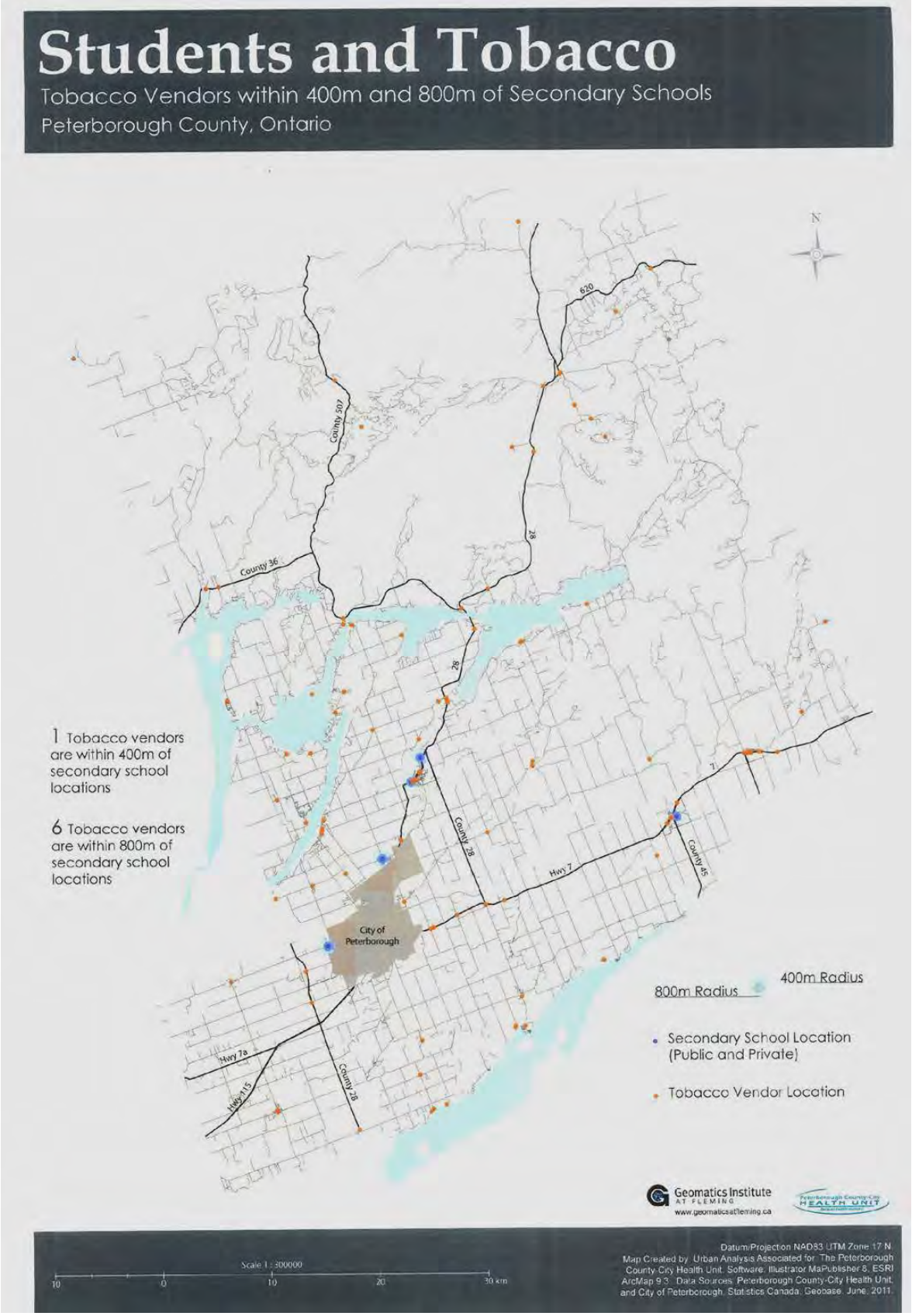
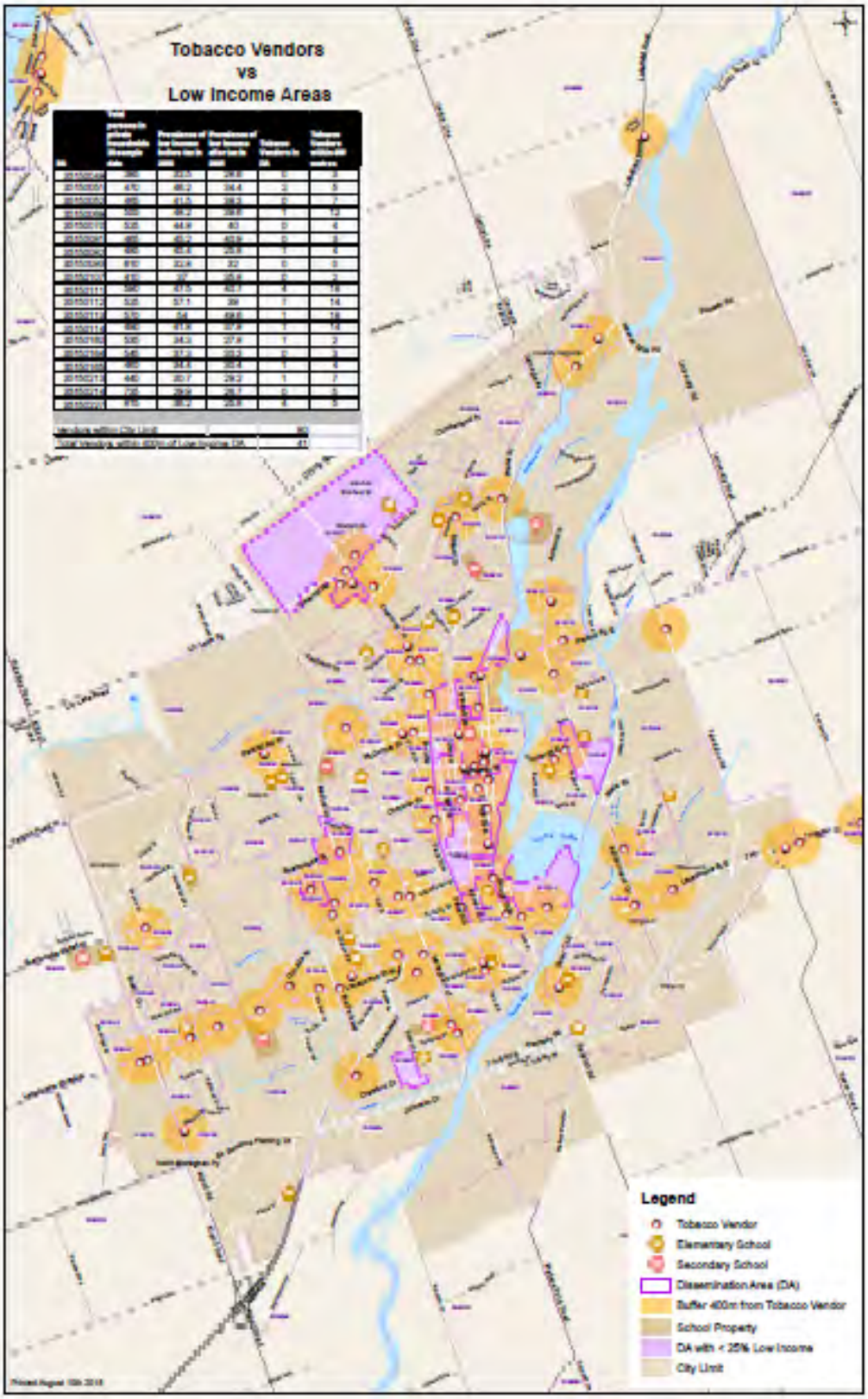
APPENDIX A: **Tobacco use prevention and cessation efforts are hampered by the ubiquity of tobacco retail outlets. The following maps explore the proximity of tobacco retail vendors to schools.**




Students and Tobacco
Tobacco Vendors within 400m and 800m of Elementary Schools
Peterborough County, Ontario
N
620
County 507
28
County 36
28
23 Tobacco vendors are within 400m of elementary school locations
31 Tobacco vendors are within 800m of elementary school locations
County 28
Hwy 7
County 45
City of Peterborough
Hwy 7a
Hwy 115
County 28
800m Radius
400m Radius
Elementary School Location (Public and Private)
Tobacco Vendor Location
Geomatics Institute AT FLEMING
www.geomaticsatfleming.ca
Scale 1 : 300000
10 0 10 20 30 km
Datum/Projection NAD83 UTM Zone 17 N.
Map Created by: Urban Analysis Associated for: The Peterborough County-City Health Unit. Software: Illustrator MaPublisher 8, ESRI ArcMap 9.3. Data Sources: Peterborough County-City Health Unit, and City of Peterborough, Statistics Canada, Geobase. June, 2011.


Students and Tobacco
Tobacco Vendors within 400m and 800m of Secondary Schools
Peterborough County, Ontario
N
620
County 507
28
County 36
28
1 Tobacco vendors are within 400m of secondary school locations
6 Tobacco vendors are within 800m of secondary school locations
County 28
Hwy 7
7
County 45
City of Peterborough
Hwy 7a
Hwy 115
County 28
800m Radius
400m Radius
Secondary School Location (Public and Private)
Tobacco Vendor Location
Geomatics Institute AT FLEMING
www.geomaticsatfleming.ca
Peterborough County-City HEALTH UNIT
Scale 1 : 300000
10 0 10 20 30 km
Datum/Projection NAD83 UTM Zone 17 N
Map Created by: Urban Analysis Associated for The Peterborough County-City Health Unit. Software: Illustrator MaPublisher 8, ESRI ArcMap 9.3. Data Sources: Peterborough County-City Health Unit, and City of Peterborough, Statistics Canada, Geobase, June, 2011.

APPENDIX B: Tobacco vendors in proximity to low income areas



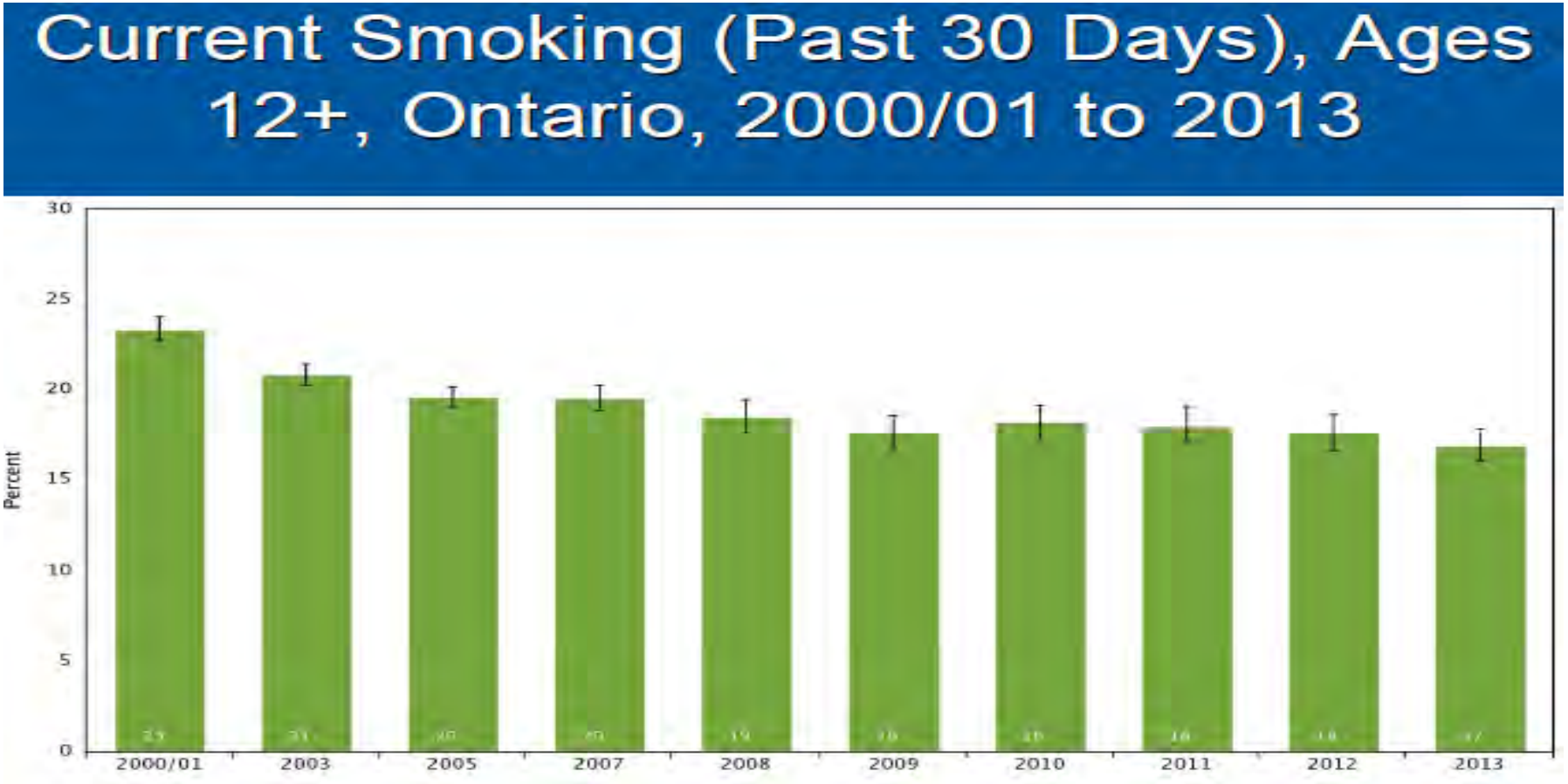
Tobacco Retail Licensing

Presentation to: Board of Health
By: Keith Beecroft
Health Promoter, Tobacco Use Prevention
Date: October 14, 2015

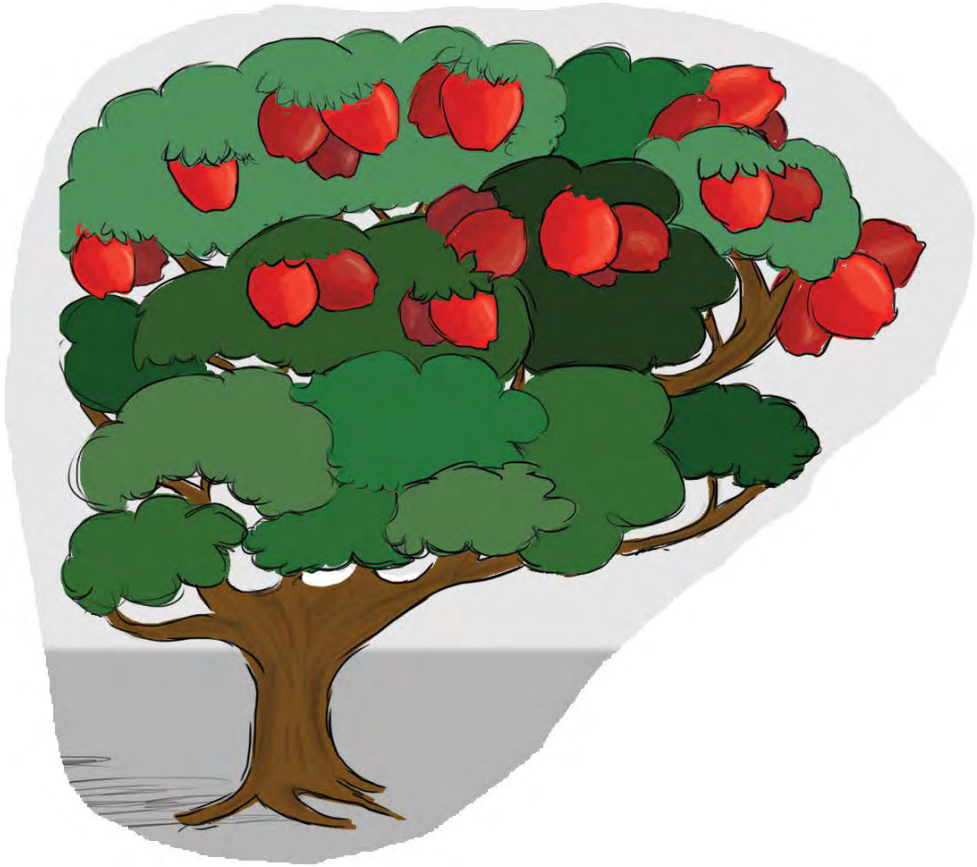
What we know about commercial tobacco use?

- It is the leading cause of preventable death and disease on Ontario
- It costs our health care system $2.2 billion in direct costs, and an additional $5.3 billion in indirect costs (absenteeism from work, etc.)
- Most smokers want to quit smoking
- The goal is for Ontario to have the lowest smoking rate in the country (18% Ontario; 14% BC)

What does smoking look like in Ontario?



Normalizing “not smoking”



- Smoking in cars with kids
- Smoking in indoor public spaces
- Smoking in many outdoor public spaces (parks, playgrounds, sports fields, hospital properties, patios)
- Tobacco advertising and sponsorship
- Power walls in convenience stores
- Flavoured tobacco products

How can policy prevent tobacco use, and help cessation?

How can upstream policy prevent tobacco use, and help cessation?

Out of sight ...

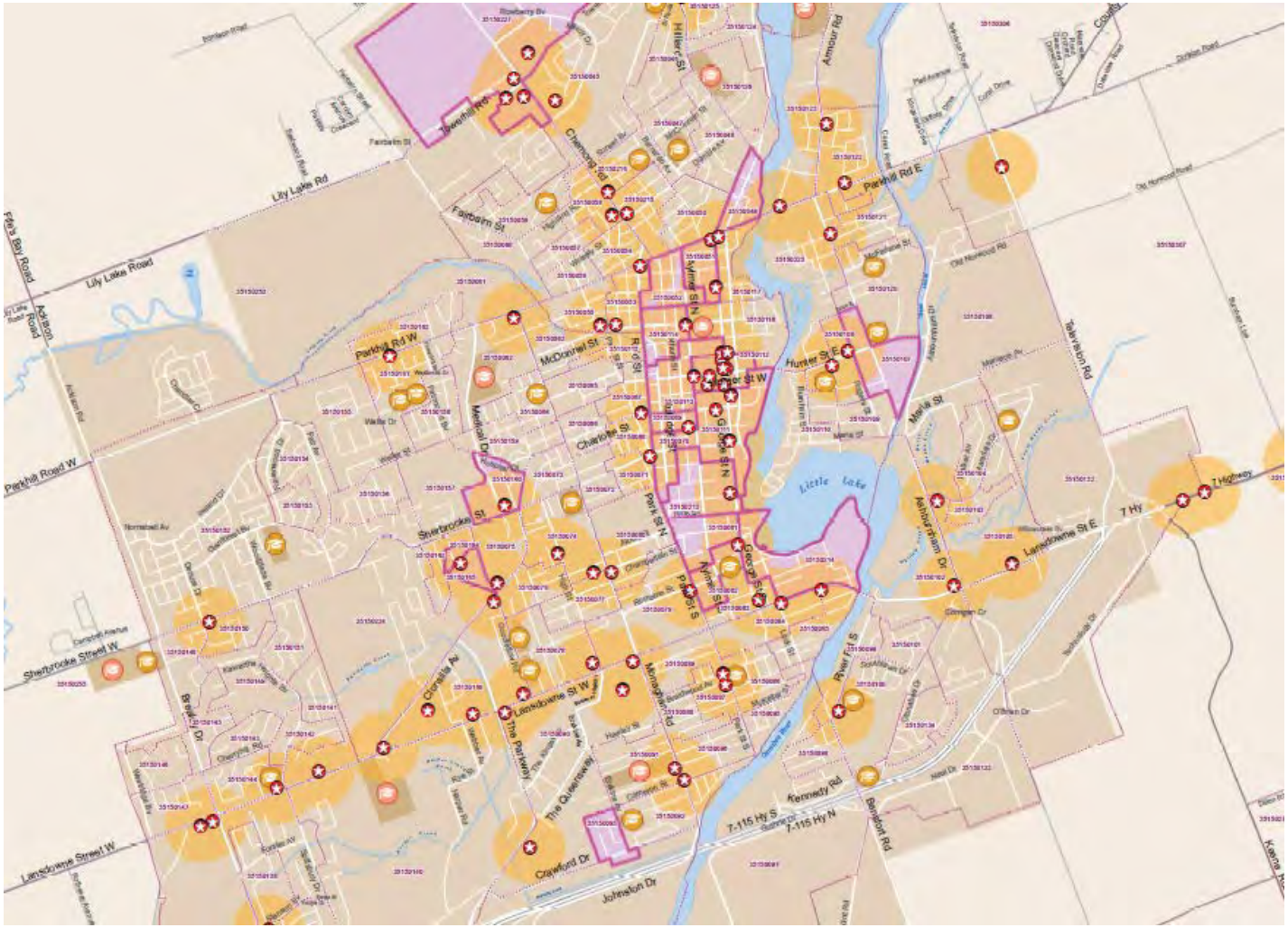
… but not out of mind

- What do we know about tobacco retail?
  - Greater availability of tobacco products increases consumption.
  - The ubiquity of tobacco retailers normalizes tobacco products and tobacco use.
  - The widespread availability of tobacco products undermines health warnings.
  - Fewer outlets would enhance enforcement efforts.

… but not out of mind cont'd.

- What do we know about tobacco retail?
  - Greater density of tobacco vendors, decreases cessation attempts
  - Among heavily addicted smokers, the effect of living within 250m of a tobacco outlet was an important correlate of smoking behavior

Tobacco retail in Peterborough



How can policy prevent tobacco use, and help cessation?

- Licenses could further be used to:
  - reduce availability to minors
  - reduce exposure to tobacco products
  - reduce tobacco initiation among youth

- In neighbourhoods where residents are most exposed to tobacco products, tobacco retail licensing could be used as a tool to reduce the high density of tobacco vendors.

Licensing: Part of a comprehensive solution

- The three pillars of tobacco use prevention
  - Prevention: Helps youth not start smoking
  - Protection: Increases efficiency and effectiveness of vendor compliance
  - Cessation: Helps those making quit attempts

Thank you!

Keith Beecroft

Health Promoter,

Tobacco Use Prevention

Phone: (705) 743-1000 ext. 238

kbeecroft@pcchu.ca

Staff Report

Food Insecurity in Peterborough

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

Original approved by	***Original approved by***
Rosana Pellizzari, M.D.	Carolyn Doris RD Public Health Nutritionist

Recommendations

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

- receive the staff report, *Food Insecurity in Peterborough,* for information;
- receive the Limited Incomes Report for information and share with the community;
- send a letter to The Honourable Helena Jaczek, Minister of Community and Social Services requesting an update on the transformation of social assistance in Ontario noting that currently, social assistance rates do not reflect the actual costs of nutritious food and adequate housing; and,
- endorse the Ontario Society of Nutrition Professionals in Public Health Position Statement on Responses to Food Insecurity.

Financial Implications and Impact

There are no financial implications for the board of health arising from this report.

Decision History

- At the November 9, 2005 Board of Health meeting, the Board of Health recommended that all low income and social assistance recipients receive an increase that will cover the cost of nourishing food in addition to a Special Diet Allowance for those with specified medical conditions. Letters were sent to Premier McGuinty, the Provincial

Ministers of Child and Youth Services, Community and Social Services, Finance, Health and Long-Term Care, Health Promotion and local municipal government officials.

- On July 30, 2008, members of the Board of Health and PCCHU staff met with M.P.P. Jeff Leal to discuss the need for 2008 funding for the Food Security Community Partnership Program (FSCPP). Board members explained that poverty and health are strongly related and that this initiative supported community members who clearly want to make healthier food choices but cannot afford to due to low incomes. The FSCPP complemented local food security programs by filling in identified gaps in services and using local resources effectively.

- At the October 8, 2008 Board of Health meeting, the Board endorsed the Ontario Public Health Association resolution passed in November 2007 calling for a comprehensive poverty reduction strategy; endorsed the 25-in-5 Declaration; and requested the Minister of Community and Social Services and the Minister of Children and Youth Services respond to the recommendations made in the Special Diet Expert Review Committee Final Report regarding the increases and expansions to the current Special Diet Schedule.

- At the May 9, 2012 Board of Health meeting, Susan Hubay and Joëlle Favreau provided a comprehensive update on food security, which included details for the Nourish project which seeks to build community connections and reduce isolation from poverty through skills sharing opportunities. Deputy Mayor Sharpe offered to champion the initiative in the County of Peterborough.

- At the September 12, 2012 Board of Health meeting, the Board received the 2012 Nutritious Food Basket results, "Limited Incomes: A Recipe for Hunger" and strategies to improve food security among individuals and families living on low incomes locally.

  At that same meeting, following a Staff Report on "Cuts to Social Assistance Benefits: A Public Health Perspective", the Board sent a letter to John Milloy, Minister of Community and Social Services, Dr. Eric Hoskins, Minister of Children and Youth Services, Kathleen Wynne, Minister of Municipal Affairs and Housing, and Deb Matthews, Minister of Health and Long-Term Care, with copies to MPPs Jeff Leal and Laurie Scott, Ontario Boards of Health and the Association of Local Public Health Agencies (alPHa), to request enhanced provincial funding of discretionary benefits for people receiving social assistance, and continued support for housing retention, moving, and home maintenance expenses.

- At the December 12, 2012 Board of Health meeting, the Board sent letters to the Premier of Ontario, the Minister of Community and Social Services, and the Minister of Health and Long-Term Care requesting:
  - that the government increase social assistance rates to a level that reflects the true costs of nutritious food and housing. In the interim, providing an immediate

increase of $100 per month is critical, for every adult in receipt of social assistance.
- o that any revisions to the Special Diet Program be developed in collaboration with Dietitians of Canada - Ontario.

The Board also requested a presentation from staff about a proactive strategy to address the long-term funding situation for the Food for Kids Peterborough and County Student Nutrition Programs (breakfast clubs and snack programs). This was presented in January, 2013.

As well, in December 2012 the Board sent a letter to the federal Minister of Health and the Chief Public Health Officer requesting that the Public Health Agency of Canada enhance funding for the Canada Prenatal Nutrition Program.

- At the November 12, 2014 Board of Health meeting, the Board received a Food Insecurity in Peterborough staff report focusing on the 2014 Nutritious Food Basket Costing for information and requested that contents of the report be shared with members of the City of Peterborough Joint Services Steering Committee, Peterborough County and City Councils, local Rotary clubs, Ministry of Finance and AMO. Presentations were made to eight township councils, Joint Social Services, the Board of Kawartha Food Share and letters were sent to local Rotary Clubs.

Background

Boards of Health are mandated to monitor food affordability annually by the Ontario Public Health Standards.[1] Health Unit staff price out local food costs required to provide a basic nutritious diet. These costs are compared to a variety of income scenarios to determine affordability. According to the 2015 PCCHU Nutritious Food Basket results, the monthly cost of feeding a family of four is $865 in Peterborough City and County. The report notes that local food prices have increased 16.6% past five years; however, the issue is not primarily the cost of food, but that incomes are too low.[2]

People living on low incomes find that after paying for rent and utilities there is not enough money to buy nourishing food. For example, a single male living on Ontario Works would find himself $220.51 in the negative at the end of the month, if he purchased nourishing food as recommended in Canada's Food Guide. A number of factors impact on the ability to choose nourishing food, however income and the cost of housing are by far the most significant. Under current conditions, the result is food insecurity, which is the inadequate or insecure access to healthy food in the context of financial constraints.[3]

Table 1: 2015 Nutritious Food Basket Case Scenarios

Monthly Income/ Expenses	Single Man	Single Man	Single Elderly Woman	Single Parent, 2 children	Family of 4	Family of 4
Monthly Income – after tax; includes federal & provincial benefits and tax credits	$740 (Ontario Works)	$1,193 (Ontario Disability Support Program)	$1,544 (Old Age Security & Guaranteed Income Supplement)	$1,988 (Ontario Works)	$2,882 (Minimum Wage)	$6,952 (Ontario median, after tax)
Estimated Shelter Cost	$670	$819	$819	$963	$1,173	$1,173
Food – based on Canada's Food Guide	$290.51	$290.51	$211.74	$654.51	$865.44	$865.44
What's Left?	**-$220.51**	**$83.49**	**$513.26**	**$370.49**	**$843.56**	**$4,913.56**
% Income Required for Shelter	90%	68%	53%	48%	41%	17%
% income required for nutritious food	39%	24%	14%	33%	30%	12%

Note: Shelter costs may or may not include utilities.

Unfortunately, the financial pressure on families and individuals living on low incomes in Peterborough continues to increase. Clearly Nutritious Food Basket costing shows that over the years, although food costs are rising, the lack of income, especially for those living on fixed incomes or are minimum wage earners have little, it any money left over to cover basic monthly expenses after paying for shelter and food.

Food insecurity is associated with inadequate nutrient intakes. Literature shows that Canadian adults, adolescents and children in food-insecure households consume less fruit, vegetables, and milk products and have lower vitamin and mineral intakes, when compared with those in food-secure households.[4] Adults in food insecure households have poorer self-related health, poorer mental and physical health, poorer oral health, greater stress, and are more likely to suffer from chronic conditions such as diabetes, high blood pressure, and anxiety.[5] Food insecurity also makes it difficult to manage chronic diseases and conditions through diet. Household food insecurity increases the risk of mental health problems in children and puts teenagers at greater risk of depression, social anxiety and suicide.[6] Being food insecure is

strongly associated with becoming a high-cost user of health care.[7] Access to a healthy diet can impact positively all of the aforementioned.

Food Insecurity in Peterborough

There is significant concern in Peterborough that many people in the community are not food secure. About 11.5% of people in Peterborough households experience some degree of household food insecurity, defined as worrying about running out of food; compromising food quality or not having a variety of food choices on hand. For 5% of people in Peterborough households the situation is severe, and people, including children, do not have enough to eat because of a lack of money.[8] Preliminary analysis suggests that one in four children (under 18 years of age) in Peterborough now live in a food insecure home.[9] These statistics show a trend of increasing food security rates from past years.[10]

In Ontario and Canada, food insecurity continues to be more common in households with lower incomes, those on social assistance, those headed by a lone female parent[11] and households with children under the age of 18.[12]

Impact of food charity on food security

The Ontario Society of Nutrition Professionals in Public Health (OSNPPH) recently released a Position Statement on Responses to Food Security (Appendix B). It provides background on how the growth of the charitable food response, which began as a temporary relief by a recession in the 1980's, has become a well-established part of communities, including the City and County of Peterborough. The OSNPPH Position Statement states that "the growth in food charity has been linked to a reduction in social programs, as governments abandon previously held responsibilities for the well-being of citizens and rely on community based charities to fill the gap" (Appendix B, pg. 7).

Although the food charity response is well meaning, there are many issues. Food banks operate under many constraints, relying on volunteers and inconsistent food and monetary donations from the public and corporate sponsors. Demand for food always exceeds the current supply and the balance between demand and supply is achieved only when the amount of food provided per visit or the frequency of visits is restricted. Preferences (cultural, religious, health-related etc.) are seldom able to be met while still maintaining dignity of those visiting food banks. Locally, the recent announcement of the closure in October 2015 of the food cupboard run by the Ontario Public Interest Research Group in the City of Peterborough, illustrates the challenges of operating a food bank with increasing demands and limited resources.[13]

Income Response to Food Insecurity

Clearly, lack of insufficient income is the root cause of food insecurity and poverty and a charitable response, although well meaning, is not enough. Improved incomes are the most important response to food insecurity and must be foremost of advocacy efforts towards putting food on the table for our most vulnerable community members.

It is critical to support advocacy efforts at the municipal, provincial, and federal level for improved social assistance and minimum wage rates, increased employment opportunities and increased access to affordable housing.

The Commission for the Review of Social Assistance Reform, led by Commissioners Frances Lankin and Munir Sheikh released Brighter Prospects: Transforming Social Assistance in Ontario in 2012 calling for transformation of social assistance in Ontario.[14] In September 2014, the Premier's Mandate letter to the Minister of Community and Social Services in September 2014, listed as specific priorities the need to focus efforts on drive long-term transformation of the social assistance system.[15] Small changes and increases have been implemented to date, but clearly, as Nutritious Food Basket and related income scenarios show, people in Peterborough living on Ontario Works or Ontario Disability Support Program still struggle to make ends meet. Food insecurity is rising and steps must be taken to address income (see Appendix A).

Garnering attention across Ontario, Canada and internationally is the concept of Basic Income Guarantee (BIG). In June 2015, the Board of Health endorsed Simcoe Muskoka District Health Unit's resolution to alPHa's Annual General Meeting to support advocacy for BIG. Locally, a group of interested individuals and organizations have formed the Basic Income Peterborough Network and are affiliated with Basic Income Canada Network. The Peterborough Poverty Reduction Network, including the Peterborough Food Action Network and Income Security Workgroup are considering/have endorsed BIG as a policy option that needs to be considered. The Peterborough Board of Health has also supported motions related to BIG including the endorsement of the Windsor Essex Health Unit's resolution on September 9, 2015.

BIG has the potential to eliminate poverty and would ensure income at an adequate level to meet basic needs for people to live with dignity, regardless of work status. Other health and social benefits such as reduced health inequalities leading to better overall health of the population, reduced crime and higher rates of student success could be realized by lifting people out of poverty.

As noted in the OSNPPH Position Statement, the cost of implementing a basic income program would be a significant public expenditure.[16] However, even conservative estimates of the indirect costs of poverty are far higher than the costs of actually bringing Ontarians out of poverty.[17]

In the interim, local community food programs need to improve access to nourishing foods with an emphasis on vegetables, fruit, and milk products. Funding may be necessary from the community or government to ensure this is possible and does not rely upon further charity. In the long term, it would seem reasonable that the Nutritious Food Basket results provided annually to the Ministry of Health and Long-Term Care be used as a starting point in determining the rates for adequate social assistance rates.[18]

Rationale

The Board of Health has been an effective and credible advocate for food security in Peterborough. Health unit staff continues to play leadership roles in addressing food insecurity and advocating for change. There are several actions that the board of health may want to take at this point to continue its efforts on this important community issue.

The board can continue to advocate to the province to address food insecurity by increasing social assistance rates, investigate Basic Income Guarantee and be a voice for the provision of nutritious food in local food security programs

Strategic Direction

This report applies to Determinants of Health and Health Equity by providing current evidence related to the impacts of poverty and food insecurity.

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Attachments:

Appendix A – Limited Incomes: A Recipe For Hunger, October 2015, Peterborough County-City Health Unit

Appendix B – Ontario Society of Nutrition Professionals in Public Health, Position Statement on Responses to Food Insecurity, October 2015.

Limited Incomes: *A Recipe For Hunger*

October 2015

Poverty is the Reason People are Going Hungry in Peterborough

Imagine you have worked for the same factory for 10 years. Two years ago, the company was bought out and production moved. Since then, you have taken a skills training program and found some temporary jobs, but nothing permanent. In between jobs, you are forced to go on social assistance.

After you pay rent and utilities, the money you receive leaves you with very few options. You will have other expenses such as telephone, clothing, transportation costs, cleaning supplies, and personal care items like toothpaste and toilet paper.. It is likely that you will have to borrow from your food budget to make ends meet. Will you be able to afford to eat? Will you be able to choose healthy foods? Being in this difficult situation is often referred to as "food insecurity."

Food Insecurity and Peterborough

Food insecurity – inadequate or insecure access to food because of financial constraints – is a serious social and public health problem in Ontario. In 2013, 12.5% of Ontario households or almost 1.6 million people, experienced food insecurity. Food insecurity is also a local issue, with 11.5% of Peterborough households being food insecure.

This means that they:

- worry about not having enough to eat,
- compromise the quality of food eaten, or
- do not have a variety of food choices on hand.

For an estimated 5% of Peterborough households the situation is severe and people, including children did not have enough to eat because of a lack of money. In local households with children under 18 years of age, 23.6% experience food insecurity compared to 8.7% in Ontario. **This means that one in four children in Peterborough live in a food insecure household.**

The root cause of food insecurity is lack of sufficient income. Food insecurity is more common in households with lower incomes, in those receiving social assistance or those headed by a lone-female parent.

Working together to eliminate poverty in Peterborough is the most important thing we can do to increase food security in our community.

Low Incomes Don't Add Up

- People living on social assistance find that, after paying for rent and utilities, there is not enough money to buy nourishing food. Food insecurity affects 64.5% of Ontario households on social assistance.
- 36% of children living in poverty in Ontario have at least one parent who is working full time year round but not earning enough to lift their families out of poverty.
- 58% of Ontario families struggling to put food on the table are part of the labour force but are trapped in low-paying or unstable jobs.

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

About the Nutritious Food Basket

In May 2015, the Peterborough County-City Health Unit priced the Nutritious Food Basket (NFB). The NFB is Ontario's standardized food costing tool used by Health Units to measure the cost of healthy eating, based on Canada's Food Guide. The food costs are recorded according to the lowest available price at the grocery store.

Understanding the Nutritious Food Basket

Generally, highly processed foods and food with little or no nutritional value (such as soft drinks and potato chips) are not included. The food basket does not contain any foods for special diets, such as gluten-free products. Personal and household care items, like toothpaste, soap and cleaning supplies are not included.

The Nutritious Food Basket design assumes:

- most people have the necessary time, food skills and equipment to be able to prepare most meals from scratch; and
- people have access to quality grocery stores.

How Do We Know Some People Don't Have Enough Money For Food?

A summary of some real life situations for people living in Peterborough appears in Table 1. These scenarios illustrate that after paying for shelter and food, minimum wage earners and households on fixed incomes have little, if any money left over to cover other basic monthly expenses.

Table 1: May 2015 Peterborough Nutritious Food Basket Scenarios

Monthly Income/Expenses	**Single Man** (Ontario Works)	**Single Man** (Ontario Disability Support Program)	**Single Elderly Woman** (Old Age Security/ Guaranteed Income Supplement)	**Single Parent 2 Children** (Ontario Works)	**Family of 4** (Minimum Wage)	**Family of 4** (Income Median)
Monthly Income including Benefits & Credits	$740	$1,193	$1,544	$1,988	$2,882	$6,952
Estimated Shelter Cost	$670	$819	$819	$963	$1,173	$1,173
Cost of a Nutritious Diet	$291	$291	$212	$655	$865	$865
What's Left?	**-$221**	**$83**	**$513**	**$370**	**$844**	**$4,914**
% Income Required for Shelter	91%	69%	53%	48%	41%	17%
% Income required for nutritious food	39%	24%	14%	33%	30%	12%

REMEMBER: People still need to pay for utilities, phone, transportation, cleaning supplies, personal care items, clothing, gifts, entertainment, internet, school essentials, medical and dental costs and other purchases.

References available by emailing *cdoris@pcchu.ca*.

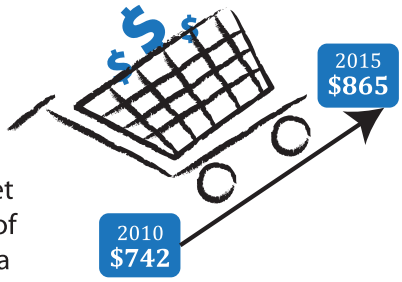
NOTE: Shelter costs may or may not include utilities.

How Do People Cope?

- Research tells us that people know which foods are essential for good health. However, when money is tight, people are forced to adapt by cutting into their food budget.
- People are forced to skip meals or fill up on cheap foods that are not necessarily nutritious.
- They may eat less fruit, vegetables and milk products because they can't afford them.
- Parents living on low incomes feed their children first. They will go without eating to ensure that their children can eat. As a result, the parents' nutrition and health suffers.
- As a last resort, people are forced to use food banks. Food banks can only offer about three days worth of food per month.

How much do you spend on food in a month?

The cost of feeding a family of four in Peterborough was $865 in May 2015. That represents 12% of an average family's income.



In contrast, the Nutritious Food Basket monthly cost ($865) represents 30% of the income of a family supported by a minimum wage earner.

To calculate your own food costs, see page 4.

Does Food Cost Too Much?

Local food costs have increased by 16.6% over the past five years. However, the cost of food is not the issue for most people. The issue is that incomes are too low. For people living on low incomes, there is not enough money left to buy healthy food after paying rent and utility bills.

What Can We Do About Poverty and Hunger?

1. Learn more about poverty and hunger. Check out these websites:
   - Peterborough Poverty Reduction Network - *http://ptbopovertyreduction.com/*
   - Poverty Free Ontario - *www.povertyfreeontario.ca*

2. Speak up! Ask for change. Write to your local MP, MPP or Council member. Use this report to increase their understanding of poverty and its impacts on the most vulnerable in our community.

3. Learn more about the concept of Basic Income Guarantee (BIG) and help spread the word. BIG provides an income sufficient for life's basic needs, guaranteed by the government to all. *www.basicincomecanada.org*

4. Support local food programs while working to end poverty. Food programs include community gardens, collective kitchens, gleaning, community meal programs, student nutrition programs, and food box initiatives. Help by fundraising or volunteering your time. Visit *www.foodinpeterborough.ca*.

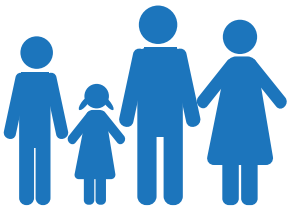
5. Buy local foods whenever possible to support local farmers and our local economy.

6. The Nourish Project, through innovative programs focused on growing, cooking, eating and advocating for good food, cultivates health, builds community and promotes fairness. Learn more about the Nourish Project at *www.nourishproject.ca*.

Poverty and Health... Did You Know?

- People living on low incomes have more health problems and die younger than people with higher incomes.
- Children living in low income households are more likely to get sick and are less able to do well at school.
- Being food insecure is strongly associated with becoming a high-cost user of health care.

Calculating Food Costs Based on the Nutritious Food Basket



Follow the steps below to find out the cost of a weekly Nutritious Food Basket:

STEP 1:
Write down the age and sex of all the people you are feeding.
For example: Man, 37 years old; Woman, 37 years old; Boy, 14 years old; and Girl, 8 years old.

STEP 2:
Using Table #2, write down the cost of feeding each person. Add up these costs. This is your subtotal.

STEP 3:
It costs a little more to feed a small group of people and less to feed a large group. So your subtotal estimated in Step 2 will need to be adjusted. Use the following adjustments for household size and record this figure in the "TOTAL (per week)" row below.

1 person - multiply by 1.20
2 people - multiply by 1.10
3 people - multiply by 1.05
4 people - make no change
5-6 people - multiply by 0.95
7+ people - multiply by 0.90

STEP 4:
To determine the cost per month, multiply your total cost by 4.33.

In this example, it would cost $865.44/month to feed this family.

	Sex	Age (years)	Cost Per Week ($)
EXAMPLE	Man	37	$ 55.91
	Woman	37	$ 47.36
	Boy	14	$ 63.98
	Girl	8	$ 32.62
	Subtotal		$199.87
	Total (per week) $199.87 x no adjustments		
	Total (per month) $199.87 x 4.33 = $865.44		

	Sex	Age (years)	Cost Per Week ($)
YOUR HOUSEHOLD	Man		
	Woman		
	Boy		
	Girl		
	Subtotal		
	Total (per week)		
	Total (per month)		

Table 2: Food Costs

	Age/Sex	Cost Per Week
Boy	2-3	25.98
	4-8	33.57
	9-13	44.70
	14-18	63.98
Girl	2-3	25.50
	4-8	32.62
	9-13	38.20
	14-18	45.89
Man	19-30	62.02
	31-50	55.91
	51-70	53.86
	Over 70	53.32
Woman	19-30	47.96
	31-50	47.36
	51-70	41.59
	Over 70	40.75
Pregnant Woman	Younger than 18 yrs	51.37
	19-30	52.01
	31-50	50.72
Breastfeeding Woman	Younger than 18 yrs	53.40
	19-30	55.36
	31-50	54.07
Family of 4*		$199.87

**Man and woman 31-50; boy 14-18 years; girl 4-8 years*

For food cost details and references, please call the Nutrition Promotion Program, Peterborough County-City Health Unit, at **705-743-1000** or visit our website at ***www.pcchu.ca***.

Ontario Society of Nutrition Professionals in Public Health
La société ontarienne des professionnel(le)s de la nutrition en santé publique

www.osnpph.on.ca
@RDsPubHealthON

Position Statement on Responses to Food Insecurity

It is the position of the Ontario Society of Nutrition Professionals (OSNPPH) that food insecurity is an urgent human rights and social justice issue for local, provincial and federal public policy agendas. Food charity is an ineffective and counterproductive response to food insecurity because it does not address the root cause which is poverty. An income response is required to effectively address food insecurity.

Background

Food insecurity – inadequate or insecure access to food because of financial constraints – is a serious social and public health problem in Ontario. In 2013, 642,200 Ontario households (12.5%) experienced food insecurity.[1] This translates into 1,598,200 people, of which 485,700 were under the age of 18 (Valerie Tarasuk, PhD, email communication, August 27, 2015).

The root cause of food insecurity is poverty.[2] The magnitude of poverty in the country contravenes Canada's commitment to ensure the basic human right to food for all citizens.[3] The majority (57.5%) of Ontario families struggling to put food on the table are part of the labour force but trapped in low-paying or unstable jobs.[1] Food insecurity affected 64.5% of Ontario households reliant on social assistance in 2012.[4]

Adults in food insecure households have poorer self-rated health, poorer mental and physical health, poorer oral health, greater stress, and are more likely to suffer from chronic conditions such as diabetes, high blood pressure, and anxiety.[5] Food insecurity also makes it difficult to manage chronic diseases and conditions through diet. Household food insecurity increases the risk of mental health problems in children and puts teenagers at greater risk of depression, social anxiety and suicide.[6] Being food insecure is strongly associated with becoming a high-cost user of health care.[7,8]

The Ontario Society of Nutrition Professionals in Public Health (OSNPPH) is the independent and official voice of over 200 Registered Dietitians working in Ontario's public health system. OSNPPH provides leadership in public health nutrition by promoting and supporting member collaboration to improve the health of Ontario residents through the implementation of the Ontario Public Health Standards.

While the terms 'food insecurity' and 'hunger' may be used interchangeably, they are not the same thing. Food insecurity has been defined as, "household-level economic and social condition of limited or uncertain access to adequate food," while hunger has been defined as, "an individual-level physiological condition that may result from food insecurity."[9]

The Food Charity Response

Food charity is not new, and in most cultures offering food to hungry people is considered the right thing to do. Currently, food charity in Canada includes a variety of ad-hoc community-based programs, including food banks and meal programs.

Food banks are the primary community response to household food insecurity. They were originally intended as temporary food relief operations necessitated by the recession in the early 1980s; however, demands for charitable food assistance did not diminish as the economy improved and numbers using food banks continued to expand.[10] Over the past 30+ years, food banks have become a well-established part of the fabric of many communities across Ontario and Canada. Food banking has grown and evolved into an extensive charity-based secondary food distribution system specifically for impoverished people.

The growth of food charity has been linked to a reduction in social programs, as governments abandon previously held responsibilities for the well-being of citizens and rely on community-based charities to fill the gap.[10,11,12] People in need of food are routinely directed to charitable food programs by government websites, case workers and health care providers.

In March of 2014, Ontario food banks were visited by 374,698 adults and children.[13] The number of households accessing food banks for the very first time increased by 20%, from 14,206 in 2013 to 17,182 households in March 2014.[13] Although a considerable number of people go to food banks, they represent only a small proportion – about 25% – of those who experience food insecurity.[14,15] For this reason, food bank usage statistics are not a valid measure of food insecurity.[16]

Food banks operate under many constraints, relying on volunteers and inconsistent food and monetary donations from the public and corporate sponsors.[10,17] Demand for food always exceeds the supply. Balance between supply and demand is achieved only when the amount of food provided per visit and/or the frequency of visits is restricted.[17] Because of supply limitations, food banks are typically not able to meet the preferences, religious restrictions, nutritional or health-related dietary needs of clients.[10,15,18,19] Access can be challenging with limited operating hours, long line-ups, and lack of transportation to get to a food bank.[15] Despite the best intentions of volunteers and staff, the experience of accessing food banks undermines people's dignity.[11,15] All of these limitations and challenges may explain, at least in part, why only a minority of people who experience food insecurity access food banks. In summary, food banks are an ineffective response to food insecurity.

The government plays a supportive role in the charitable food model by permitting and encouraging donations while absolving donors of liability for the safety of donated food.[20] Food Banks Canada has lobbied the federal government to provide tax credits to corporate donors but this proposal has not been adopted.[11] However, Ontario's Local Food Act, introduced in 2013, includes tax credits for farmers who donate agricultural produce to community food programs.[21]

Corporations exert significant control and influence over charitable food programs in many ways, while reaping the benefits of participating in corporate social responsibility initiatives. Corporations participate as board members for food charity organizations at the provincial and national levels[22,23] and provide significant food and monetary donations.[19,22,24] Corporations directly benefit from supporting food charity, as market research has shown that companies who contribute to a good cause build brand loyalty, attract new customers, drive word of mouth advertising and grow revenue.[25] They also benefit from donating unsaleable food by avoiding landfill disposal fees.[24] Corporate self-promotion of their food charity efforts and associated media coverage further promote the public perception that food charity is an acceptable and appropriate response to food insecurity.[12,22]

The media perpetuate a positive illusion of the benefits of food charity.[12,22] Actively drawing attention to fund-raising and food drive efforts enables people to 'feel good' when they contribute. However, the media rarely acknowledge the inadequacies of food charity or that the underlying problem of persistent poverty is the root cause of food insecurity. Well-intentioned people are persuaded to believe that those who don't have enough food are in the good hands of charity.[22]

By contributing to the institutionalization of food charity and feeding the public perception that food insecurity is a matter for charity, the media and corporations have become a major obstacle in advancing public policy to address poverty and food insecurity. [22] The current charitable food model absolves governments of their responsibility to ensure the basic right to food security for all.[12]

The Income Response

Current evidence indicates the need for targeted and sustainable approaches to address the root causes of food insecurity.[26] Implementation of a basic income guarantee (also known as guaranteed annual income) would ensure income at an adequate level to meet basic needs and for people to live with dignity, regardless of work status.[27]

A basic income guarantee has the potential to eliminate poverty and spending on its consequences. The Guaranteed Income Supplement (GIS), a form of guaranteed income for Canadians 65 years and older, has resulted in a substantial decline in seniors living below the poverty line and one of the lowest rates of elder poverty in the world.[26] The rate of Canadians experiencing food insecurity has been found to be fifty percent less among low income people aged 65 to 69 compared to those aged 60 to 64, and self-reported rates of physical and mental

health improved significantly after moving from low-wage, insecure employment to a guaranteed income at the age of 65.[28] Implementing a guaranteed income program for those of working age would reduce steep income inequalities and contribute to better health and fewer societal problems, leading to long-term savings in health care and other public services.[29]

Guaranteed income is a simpler and more transparent approach to social assistance than the current system. Furthermore, it would extend protection to those who are currently not covered or poorly covered by social assistance programs. [30]

The cost of implementing a basic income program would involve substantial government spending.[31] However, even conservative estimates of the indirect costs of poverty (e.g., health care, remedial education, crime, and social assistance programs) are far higher than the costs of actually lifting people out of poverty.[32]

Position

It is the position of the Ontario Society of Nutrition Professionals in Public Health (OSNPPH) that food insecurity is an urgent human rights and social justice issue for local, provincial and federal public policy agendas. Food charity is an ineffective and counterproductive response to food insecurity because it does not address the root cause which is poverty. An income response is required to effectively address food insecurity.

OSNPPH calls on:

- Ontario Public Health Units to promote and support implementation of the "Income Security - the effective response to food insecurity"campaign.
- Ontario Boards of Health to officially endorse OSNPPH's Position Statement on Responses to Food Insecurity
- Municipal governments to urge provincial and federal governments to prioritize and investigate a basic income guarantee.
- Individuals to contact or meet with local politicians at all levels about their concerns with the food charity response to food insecurity and the potential benefits of a basic income guarantee.
- Schools, faith-based organizations, emergency services, local businesses, and community organizations to become aware of and promote income security as the effective response to food insecurity.
- Media to support campaigns for adequate income security, affordable social housing and child care, enhanced mental health services, together with an integrated national food policy, instead of food drives.
- Federal and provincial governments to consider and investigate a basic income guarantee as a policy option for reducing poverty and income insecurity and for providing opportunities for people with a low income.

Additional Information

"Food insecurity is a serious public health issue" infographic
http://www.osnpph.on.ca/

Income-Related Policy Recommendations to Address Food Insecurity. Ontario Society of Nutrition Professionals in Public Health, September 2015.
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click on: Resolutions passed at the most recent AGM

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Basic Income Canada Network
http://www.basicincomecanada.org/

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To: All Members
Board of Health

From: Dr. Rosana Pellizzari, Medical Officer of Health

Subject: **Correspondence for Direction**

Date: October 14, 2015

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1. Letter dated September 10, 2015 from Wellington-Dufferin-Guelph Public Health regarding Electronic Participation for Board of Health Meetings.

   Recommendation: That the correspondence from Wellington-Dufferin-Guelph Public Health regarding electronic participation be received for information; that the Board engage the Association of Local Public Health Agencies (alPHa) to request that the Ministry of Health and Long-Term Care approach the Ministry of Municipal Affairs and Housing to propose a statutory change to the Municipal Act; and, that staff propose revisions to By-Law 3: Calling of and Proceedings at Meetings, for consideration by the Governance Committee at their next meeting.

PublicHealth
WELLINGTON-DUFFERIN-GUELPH
Stay Well.

September 10, 2015

VIA E-MAIL

Ministry of Municipal Affairs & Housing
777 Bay Street, 17th Floor
Toronto, ON M5G 2E5

Attention: Mr. Ted McMeekin, Minister

Ministry of Health and Long-Term Care
Public Health Division
393 University Ave., Suite 2100
Toronto, ON M5G 2M2

Attention: Dr. Eric Hoskins, Minister

Dear Minister McMeekin & Minister Hoskins:

Re: Request for Changes to the *Municipal Act* to Authorize the Use of Electronic Means of Participation of Local Boards and Committees of Local Boards

The Board of Health for the Wellington-Dufferin-Guelph Health Unit (WDGPH) is a large autonomous Board of Health with a geographic area covering 4,142Km^2, which includes the County of Wellington, the County of Dufferin and the City of Guelph. Due to this large geography, and sometimes severe weather conditions, the WDGPH Board of Health considered how best to fulfil its governance obligations with respect to attendance at Board of Health meetings.

Boards of Health are considered a local board under the *Municipal Act* and the *Act* does not provide for electronic participation at meetings. A letter dated June 30, 2015, from David L. Mowat, the Interim Chief Medical Officer of Health, identified that in order for WDGPH to use electronic participation for meetings, the *Municipal Act* needs to be amended (see attached). Therefore, WDGPH has passed a Resolution (see attached) requesting that the *Act* be amended to specifically authorize the use of electronic means of participation at meetings of local boards and committees of boards with prescribed measures in place.

.../2

160 Chancellors Way, Guelph, ON N1G 0E1
Telephone: 519-822-2715 | **Fax:** 519-836-7215 | **www.wdgpublichealth.ca**

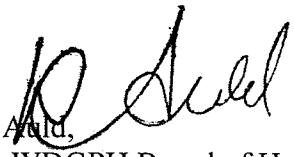
Public health emergencies may occur at any time and require Boards of Health to be able to convene a quorum and make decisions in a timely manner. Severe weather conditions within the Province of Ontario can also negatively impact the ability of a board to convene a quorum for regularly scheduled meetings which are necessary for Boards of Health to fulfill their legislative obligations. Large geographic distances also means that members of the public are not equally able to access open session Public Health meetings.

Electronic communication strategies continue to advance and are the preferred method of communication for business, education and Ontario youth. Additionally, many public and not-for-profit boards within the Province of Ontario are successfully utilizing electronic communication including; LHIN Boards, Boards of Education and Hospital Boards.

Electronic participation does not preclude public access and closed session content can be secured with encryption technologies. By specifically authorizing local boards to use electronic participation with prescribed measures in place this could increase public access and decrease some of the geographic and environmental challenges facing local boards of health.

Thank you in advance for your consideration of this matter.

Yours very truly,



Doug Arnold,
Chair, WDGPH Board of Health

Attachments (Letter of June 30/15 + Resolution)

c.c. Deputy Minister of Health (MOHLTC) – via e-mail
c.c. Chief Medical Officer of Health (MOHLTC) – via e-mail
c.c. Association of Municipalities of Ontario – via e-mail
c.c. Ontario Public Health Units (BOH Chairs) – via e-mail
c.c. Association of Local Public Health Agencies (alPHa) – via e-mail
c.c. Ted Arnott, MPP (Wellington-Halton Hills) – via e-mail
c.c. Liz Sandals, MPP (Guelph) – via e-mail
c.c. Sylvia Jones, MPP (Dufferin-Caledon) – via e-mail
c.c. Randy Pettapiece, MPP (Perth-Wellington – via e-mail

Ministry of Health and Long-Term Care

Chief Medical Officer of Health

Public Health Division
21st Floor, 393 University Avenue
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Ministère de la Santé et des Soins de longue durée

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Ontario

June 30th, 2015

Dr. Nicola Mercer, Medical Officer of Health, CEO
Wellington Dufferin Guelph Public Health
160 Chancellors Way,
Guelph, ON N1G 0E1

Dear Dr. Mercer:

RE: Proposed Changes to the Board of Health for the Wellington-Dufferin-Guelph Health Unit (WDGPH) By-Laws

Thank you for your letter of June 15th 2015, informing us of the proposed bylaw permitting electronic participation in committee meetings, and also for a copy of By-Law no. 1. We are only addressing the issue of electronic participation.

Legal Services of MOHLTC has consulted with their counterparts in MMAH concerning the requirements of the *Municipal Act*. We have been advised that the proposed approach is not consistent with that Act, which requires meetings to be open to the public. The *City of Toronto Act* has an exception that allows for electronic participation at board meetings. There is no similar exception in the *Municipal Act*. Boards of Health are defined as local boards for purposes of the *Municipal Act*. No distinction is made between board meetings and committee meetings.

We have no objection to the substance of your proposal, only its feasibility in law. You may wish to advocate for a change in the Act to permit electronic participation. In this case, I suggest that the most effective course would be to engage alPHa to request that the MOHLTC approach MMAH to propose a statutory change to the Municipal Act.

Yours truly,

David L. Mowat, MBChB, MPH, FRCPC
Interim Chief Medical Officer of Health

Support for Boards of Public Health Using Electronic Participation at Meetings

SPONSOR: Board of Health for the Wellington-Dufferin-Guelph Health Unit (WDGPH).

WHEREAS Boards of Health are required to meet on a regular basis to fulfill their obligations under the *Health Protection and Promotion Act* and Ontario Public Health Organizational Standards;

AND WHEREAS Boards of Health are also considered a local board under the *Municipal Act*;

AND WHEREAS the *Municipal Act* neither prohibits nor provides for electronic participation at meetings;

AND WHEREAS Boards of Health are comprised of appointees from the municipalities that legislatively govern the Board of Health;

AND WHEREAS many Boards of Health are composed of large geographic areas;

AND WHEREAS appointees to Boards of Health may have to travel long distances to attend Board of Health meetings or Standing Committee meetings of Boards of Health;

AND WHEREAS winter weather conditions make driving hazardous in many parts of the Province; and

AND WHEREAS public health emergencies may occur at any time and require Boards of Health to be able to convene a quorum and make decisions in a timely and occasionally on an emergency basis;

AND WHEREAS electronic participation does not preclude public accessibility to meetings;

AND WHEREAS security of electronic participation for Closed Session matters can be ensured by encryption and hardware technologies;

AND WHEREAS many public and not-for-profit boards within the Province of Ontario, including hospital boards, LHIN boards, Boards of Education, and not-for-profit corporations incorporated under the Canada Not-for-profit Corporations Act and the Ontario Corporations Act are currently utilizing electronic participation at meetings successfully;

AND WHEREAS communication technologies continues to advance and be the preferred method of communication for business and education;

NOW THEREFORE BE IT RESOLVED THAT the Board of Health for the Wellington-Dufferin-Guelph Health Unit (WDGPH) requests that the Ontario Ministry of Municipal Affairs amend the *Municipal Act* to specifically authorize the use of electronic means of participation at meetings of local boards and committees of boards, with the following prescribed measures in place:

1. Public participation and access shall be ensured throughout any public meeting of a local board or committee of a board using electronic participation;
2. Encryption technologies shall be utilized to secure the content of information using electronic participation for Closed Session matters;
3. Policies and Procedures for electronic participation shall be publicly posted;
4. Notices and minutes of meetings using electronic participation shall clearly indicate the method of participation for attendees;
5. All participants in a meeting which includes electronic participation shall be able to communicate instantaneously and simultaneously with each other;
6. Participants who attend a meeting by electronic means shall be deemed to be present, shall be counted for quorum, and shall be eligible to vote on all matters before the board.

BE IT FURTHER RESOLVED THAT the Minister and Deputy Minister of Health and Long-Term Care, the Chief Medical Officer of Health, Association of Municipalities of Ontario and all Boards of Health within the Province are so advised.

To: All Members
Board of Health

From: Dr. Rosana Pellizzari, Medical Officer of Health

Subject: **Correspondence for Information**

Date: October 14, 2015

Recommendation:

That the following documents be received for information.

---

1. Letter dated September 4, 2015 from Roselle Martino, Executive Director and Martha Greenberg, Assistant Deputy Minister (A), Ministry of Health and Long-Term Care (MOHTLC) regarding the Public Health Funding Review.

2. Email newsletter dated September 16, 2015 from the Association of Local Public Health Agencies (alPHa).

3. Letter dated September 21, 2015 from Roselle Martino, Executive Director, MOHLTC to Ontario Board of Health Chairs regarding 2014-16 Medical Officer of Health Compensation.

4. Email newsletter dated September 29, 2015 from alPHa.

5. Letter dated September 30, 2015 to Ministers Poilievre, Ambrose, Leitch, Flynn, Hoskins, MacCharles and Matthews from the Board Chair regarding the Basic Income Guarantee.**

6. Letter dated September 30, 2015 to Premier Wynne from the Board Chair regarding the Northern Ontario Evacuations of First Nations Communities. **

7. Letter dated September 30, 2015 to Dr. Hazel Lynn, Medical Officer of Health, Grey Bruce Public Health from the Board Chair regarding the Bruce Grey Food Charter.

8. Letter dated September 30, 2015 to Minister Hoskins from the Board Chair regarding energy drinks.**

9. Letter dated September 30, 2015 to Minister Hoskins from the Board Chair regarding enforcement of the Immunization of School Pupils' Act (ISPA). **

10. Email dated October 8, 2014 from alPHa to Board of Health Chairs regarding the Public Health Funding Review.

11. Email dated October 8, 2014 from alPHa to Ontario Boards of Health regarding the Fall 2015 Board of Health Section Meeting and In-Service.
**Board Members can send expressions of interest to the Administrative Assistant by October 16, 2015.*

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

    a. Healthy Babies Healthy Children
    Durham

    b. Immunization of School Pupils Act
    Durham

    c. Public Health Funding Review
    Grey Bruce
    Porcupine
    **Staff recommend receiving these for information in favour of awaiting further direction from alPHa (as outlined in item 10).*

**Enclosures available upon request.

Ministry of Health and Long-Term Care

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September 4, 2015

TO: Chairs, Boards of Health
Medical Officers of Health/Chief Executive Officers, Public Health Units

RE: Update on Public Health Funding Review

As you are aware, the Ministry of Health and Long-Term Care (the "ministry") launched a review of the provincial funding provided to public health units. The review looked at how provincial funding could be allocated in a more equitable, transparent, and accountable manner to support the provision of public health programs and services to all residents in Ontario.

A stakeholder committee, the Funding Review Working Group, was struck in 2010 with a mandate to investigate the current status of public health funding, advise the ministry on a potential public health funding model, and advise the ministry on principles that could guide the implementation of a future public health funding model.

We are pleased to provide you with the attached report, *Public Health Funding Model for Mandatory Programs: The Final Report of the Funding Review Working Group*. The recommendations in the report support the creation of a public health funding model with an "upstream" approach incorporating socio-economic determinants of health. The funding model, which takes into account population as well as equity measures, identifies an appropriate funding share for each public health unit that reflects its needs in relation to all other public health units.

As you may recall, field input sessions were held in January 2013 which provided the Funding Review Working Group with an opportunity to share its draft findings and obtain feedback from the field with respect to the public health funding model. At the field input sessions, the Funding Review Working Group committed to responding to your feedback, which we are also attaching for your information (see **Appendix 1**).

The ministry has accepted the report and recommendations. In 2015, the ministry will begin the process of implementing a new public health funding formula for mandatory programs that improves accountability and transparency of provincial public health funding, aligns public health funding with other ministry funding processes, and supports a more equitable approach to public health funding.

…/2

This year, two per cent growth funding (or approximately $11 million) for mandatory programs will be distributed proportionately to the public health units that have not reached their model-based share. No public health unit's current base funding for mandatory programs will be reduced to minimize disruption to current levels of service provision.

The ministry will also continue to maintain and/or enhance its funding for 75 per cent and 100 per cent provincially funded related public health programs and initiatives, such as increased investments for the Healthy Smiles Ontario Program, Smoke-Free Ontario Strategy, and Unorganized Territories.

The 2015 provincial funding approvals will be announced very shortly. Ministry staff will continue to work with boards of health and public health units to ensure that local and provincial priorities are taken into consideration in all funding decisions. Education and other transitional supports pertaining to the public health funding formula and implementation approach will be provided to assist boards of health and public health units.

We are also pleased to announce that the ministry will be undertaking a review of the Ontario Public Health Standards in an effort to ensure that the standards reflect current practice, are responsive to emerging evidence and priority issues in public health, and are aligned with the government's strategic vision and priorities for public health. The review will be initiated in 2015.

The ministry would like to thank the Funding Review Working Group members who contributed to the findings and recommendations of the report, and for the public health sector for providing input into the development of the funding model.

Should you have any questions and/or require further information, please contact Brent Feeney, Manager, Public Health Standards, Practice & Accountability Branch, at 416-212-6397 or by email at Brent.Feeney@ontario.ca.

Yours truly,

Original signed by

Roselle Martino
Executive Director

Original signed by

Martha Greenberg
Assistant Deputy Minister (A)

Enclosure

c: Business Administrators, Public Health Units
Giuliana Carbone, Deputy City Manager, City of Toronto
Linda Stewart, Executive Director, Association of Local Public Health Agencies
Pat Vanini, Executive Director, Association of Municipalities of Ontario
Dr. David Williams, Chief Medical Officer of Health (A)
Paulina Salamo, Director (A), Public Health Standards, Practice & Accountability Branch
Laura Pisko, Director, Health Promotion Implementation Branch

HYPERLINK TO PUBLIC HEATLH FUNDING REVIEW REPORT:
http://www.health.gov.on.ca/en/common/ministry/publications/reports/public_health/funding_report.pdf

From: info@alphaweb.org [mailto:info@alphaweb.org]
Sent: September-16-15 3:10 PM
To: Alida Tanna
Subject: alPHa Information Break - Sept. 16, 2015

alPHa
Association of Local
PUBLIC HEALTH
Agencies

Information Break

September 16, 2015

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

alPHa Visits Hastings-Prince Edward's New Main Office

Linda Stewart, executive director of alPHa, visited Hastings-Prince Edward Public Health on September 11 to help the health unit celebrate its grand re-opening of its main office in Belleville, Ontario. The new facility features energy efficient heating, ventilation and air conditioning, as well as greater space for client consultations, improved building access, a demonstration kitchen for food skills training, and better interior/exterior traffic flow.
Take a virtual tour of Hastings-Prince Edward Public Health here

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Report on Public Health Funding

Review

On September 4, the Ministry of Health and Long-Term Care released its *Public Health Funding Model for Mandatory Programs: The Final Report of the Funding Review Working Group*. The report comes after a process that began in 2010 to review the allocation of provincial funding to Ontario's 36 public health units.
View The Final Report of the Funding Review Working Group

Upcoming alPHa Events

Fall 2015 - Look for further details in this space on our upcoming 1-day workshop "Managing Uncertainty: Risk Management for Ontario Boards of Health", Toronto. Date and venue TBA soon!

June 5, 6 & 7, 2016 - alPHa Annual General Meeting and Conference, Novotel Toronto Centre, 45 The Esplanade, Toronto, Ontario. Details to come.

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alPHa Website Feature: Correspondence

alPHa recently wrote to the government on the Healing Arts Radiation Protection Act and the Retirement Homes Act in response to government's invitation to the public to provide input on legislation. alPHa continues to receive official replies from various ministers to its resolutions that were passed in June.
Read alPHa's recent correspondence here

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

Ministry of Health and Long-Term Care

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Ontario

September 21, 2015

MEMORANDUM

TO: Board of Health Chairs
Medical Officers of Health and Associate Medical Officers of Health
Chief Executive Officers
Business Administrators

RE: 2014-16 MOH/AMOH Compensation Initiative

I am writing to inform you about the application process for the 2014/15 and 2015/16 Medical Officer of Health (MOH)/Associate Medical Officer of Health (AMOH) Compensation Initiative.

As you know, a side letter to the 2008 Physician Services Agreement (2008 PSA) directed that a salary grid and funding be established to "top-up" MOH and AMOH salaries to levels stated in the side letter and effective from April 1, 2009 to March 31, 2012. This Initiative was continued under the 2012 PSA whereby the ministry provided boards of health with 100% of the additional funding required to fund eligible physicians within established salary ranges, including costs associated with additional benefits.

Following the expiration of the 2012 PSA on March 31, 2014, MOHs and AMOHs who remained in the same position have continued to receive additional funding for salaries and associated benefits via their boards of health based on 2013/14 levels established under the 2012 PSA. No adjustments have been made to the payments, for example, for movement up the salary grid or changes to the cost-shared base health unit salary, and no payments have been made for MOHs and AMOHs who were appointed to their current position after March 31, 2014. With the implementation of the Physician Services: 10 Point Plan for Saving and Improving Services (10 Point Plan), announced January 15, 2015, the ministry is now able to proceed with applications for funding under the MOH/AMOH Compensation Initiative for funding years 2014/15 and 2015/16.

The 10 Point Plan describes a payment discount of 2.65% which will be applied to the MOH/AMOH salary grid levels effective June 1, 2015 (see Appendix A of the attached Guidelines). As before, the decrease will not be applied to the ministry-funded stipends for MOHs and AMOHs or cost-shared base health unit salaries and benefits funded from board of health mandatory program base budgets.

The additional funding through this Initiative will assist boards of health in recruiting and retaining MOHs and AMOHs and will continue to be subject to the Public Health Funding and Accountability Agreement. Boards of health will add the additional funding to the eligible physician's current board of health annual base salary and benefits. This will enable the regular processing of MOH/AMOH salaries and benefits to be managed by the employer, with any additional costs identified through the application of the salary grid (and incremental benefits) to be borne by the ministry.

All boards of health that wish to continue to receive funding or to be considered for 2014/15 and/or 2015/16 funding under this Initiative must, with the consent of the eligible physician(s), complete and sign the 2014/15 and the 2015/16 Board of Health Application Forms for Medical Officer of Health and Associate Medical Officer of Health Compensation (attached) for each physician (i.e. a Board of Health Form per physician for each relevant funding year) and submit them to the ministry by **October 6, 2015**. The Board of Health Form has been automated and shortened for your convenience. If completed correctly, an estimate of the physician's entitlement will be calculated. Please note that for new MOH/AMOH physicians hired since March 31, 2014, the Board of Health Form requires the completion of an additional "experience" section and the submission of additional supporting documentation to the ministry.

Physicians are not required to sign the 2014/15 or 2015/16 Board of Health Form. Physicians who wish to be considered for and/or continue to receive funding under this Initiative must complete and sign a 2014/16 Physician Authorization and Consent Form for Medical Officer of Health and Associate Medical Officer of Health Compensation (attached) and submit it separately to the ministry by the deadline. Again, we may require that physicians who did not participate in this Initiative in 2013/14 or who have changed positions or full-time equivalency since March 31, 2014, provide the ministry with an up-to-date curriculum vitae and/or other supporting documentation.

Once the ministry receives the required forms, we will review the forms to determine eligibility and calculate the proposed amount of additional funding to be allocated to each eligible physician in accordance with the salary grid and the Guidelines for the Allocation of Additional Compensation for Medical Officers of Health and Associate Medical Officers of Health for Funding Years April 1, 2014 to March 31, 2015 and April 1, 2015 to March 31, 2016.

These guidelines have been reformatted and updated to reference the 10 Point Plan. The principles described for determining additional MOH/AMOH compensation under this Initiative have remained essentially unchanged from the 2013/14 Guidelines. Further follow up with boards of health may be necessary to work through any issues related to unique situations on a case by case basis.

Following funding approval, the ministry will provide the board of health with a letter (copied to the individual physician) that indicates the proposed allocation and outlines the terms and conditions of the funding. The board of health will be asked to review the proposed allocation and sign-back the letter to the ministry. Upon receipt of the signed letter, the ministry will process the payments accordingly. As noted earlier, the funding for this Initiative will be retroactive to April 1, 2014 and a decrease will be applied to the MOH/AMOH salary grid effective June 1, 2015. Once the funding is reconciled, the "top-up" funding will continue at 2015/16 levels until the next application cycle or the physician is no longer eligible to receive these funds.

It is important to note that participation in this Initiative is voluntary; however, to be considered for additional MOH/AMOH compensation, boards of health and eligible physicians must complete and submit the required forms by the deadline, e-mailing the electronic version of the forms along with a scanned signature sheet to Sheila Rennie, Public Health Practice Advisor at sheila.rennie@ontario.ca.

If you have any questions about these forms or this Initiative in general, please refer to the Guidelines for the Allocation of Additional Compensation for Medical Officers of Health and Associate Medical Officers of Health for Funding Years April 1, 2014 to March 31, 2015 and April 1, 2015 to March 31, 2016 and the Frequently Asked Questions (attached) or contact Sheila Rennie at 416-314-1739 or by e-mail.

Thank you for your attention to this matter.

Original signed by

Roselle Martino
Executive Director

Attachments (8):

1. 2014/15 Board of Health Application Form (Excel version)
2. Instructions for the 2014/15 Board of Health Form
3. 2015/16 Board of Health Application Form (Excel version)
4. Instructions for the 2015/16 Board of Health Form

5. 2014/16 Physician Authorization and Consent Form
6. Guidelines for the Allocation of Additional Compensation for Funding Years April 1, 2014 to March 31, 2015 and April 1, 2015 to March 31, 2016 (includes salary grid)
7. Frequently Asked Questions
8. 2014/16 Supervision Stipend Application Form

c: Dr. David Williams, Acting Chief Medical Officer of Health
Paulina Salamo, Acting Director, Public Health Standards Practice and Accountability Branch, Public Health Division

alPHa
Association of Local
PUBLIC HEALTH
Agencies

Information Break

September 29, 2015

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

Seeking Volunteers for 2016 Annual Conference Committee

alPHa is looking for volunteers from health units and boards of health to participate on the Program Committee for its 30th anniversary conference that will be held from June 5 to 7, 2016. The program committee will develop the conference agenda, including topics and speakers for all event sessions. Volunteers should be either a senior public health manager or board of health member with an interest in conference program planning and who can commit to attending monthly teleconference . Interested individuals should contact Susan Lee at by October 2, 2015.

Provincial Health Announcements

The past couple of weeks have seen a number of provinicial announcements on

health-related items that may be of interest to public health. They include the following:

Standing Committee Hearings on Bill 9, Ending Coal for Cleaner Air Act, 2015

Statement by the Minister of Health on the Auditor General's Report on Community Care Access Centres

Province Takes Next Steps to Modernize Beer Retailing

Ontario Providing Over 2,200 Parents Reaching Out Grants

Upcoming alPHa Events

November 5, 2015 - Managing Uncertainty: Risk Management Workshop for Ontario Boards of Health, Toronto. Venue and details TBA soon!

June 5, 6 & 7, 2016 - alPHa Annual General Meeting and Conference - 30th Anniversary, Novotel Toronto Centre, 45 The Esplanade, Toronto, Ontario.

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

September 30, 2015

The Honourable Pierre Poilievre
Minister of Employment and
Social Development
House of Commons
Ottawa, ON K1A 0A6
pierre.poilievre@parl.gc.ca

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

The Honourable Rona Ambrose
Minister of Health
Ministry of Health
House of Commons
Ottawa, ON K1A 0A6
rona.ambrose@parl.gc.ca

The Honourable Kevin Daniel Flynn
Minister of Labour
Ministry of Labour
400 University Avenue, 14th Floor
Toronto, ON M7A 1T7
kflynn.mpp@liberal.ola.org

The Honourable Eric Hoskins
Minister of Health and Long-Term Care
Ministry of Health and Long-Term Care
10th Floor, Hepburn Block
80 Grosvenor Street
Toronto, ON M7A 2C4
ehoskins.mpp@liberal.ola.org

The Honourable Tracy MacCharles
Minister of Children and Youth Services
Ministry of Children and Youth Services
56 Wellesley Street West, 14th Floor
Toronto, ON M5S 2S3
tmaccharles.mpp.co@liberal.ola.org

The Honourable Deborah Matthews
Minister Responsible for the
Poverty Reduction Strategy
Room 4320, 4th Floor, Whitney Block
99 Wellesley Street West
Toronto, ON M7A 1W3
dmatthews.mpp.co@liberal.ola.org

Dear Ministers:

Re: Public health support for a basic income guarantee

At its meeting held on September 9, 2015, the Board of Health for the Peterborough County-City Health Unit considered correspondence forwarded and supported by the Windsor-Essex County Health Unit regarding joint federal-provincial consideration for a basic income guarantee for Ontarians and all Canadians.

The Board echoes the recommendations originally outlined by the Simcoe Muskoka District Health Unit (letter attached) urging you to undertake this initiative in order to address the extensive health inequities in our province, and across the country.

Sincerely,

Original signed by

Councillor Lesley Parnell
Chair, Board of Health

/at
Encl.

cc: The Right Honourable Steven Harper, Prime Minister of Canada
The Honourable Kathleen Wynne, Premier of Ontario
Dr. David Williams, Ontario Interim Chief Medical Officer of Health
Association of Local Public Health Agencies
Ontario Public Health Association
Office of the Peterborough Member of Parliament
MPP Jeff Leal, Peterborough
MPP Laurie Scott, Haliburton-Kawartha Lakes Brock
Ontario Boards of Health

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

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

September 30, 2015

The Honourable Kathleen Wynne
Premier of Ontario
Legislative Building, Queen's Park
Toronto, ON M7A 1A1
premier@ontario.ca

Dear Premier Wynne,

Re: Northern Ontario Evacuations of First Nations Communities

At its meeting held on September 9, 2015, the Board of Health for the Peterborough County-City Health Unit considered correspondence forwarded and supported by the Sudbury District Health Unit regarding evacuations of First Nations communities in Northern Ontario.

The Board echoes the recommendations outlined in their letter (attached) and it is our hope that you will address the needs of these vulnerable communities and ensure their safe, efficient and effective temporary relocation when faced with environmental and weather-related threats.

Sincerely,

Original signed by

Councillor Lesley Parnell
Chair, Board of Health

/at
Encl.

cc: Hon. Dr. Eric Hoskins, Minister of Health and Long-Term Care
Hon. Yasir Naqvi, Minister of Community Safety and Correctional Services
Hon. David Zimmer, Minister of Aboriginal Affairs
Hon. Michael Gravelle, Minister of Northern Development and Mines
Hon. Bill Mauro, Minister of Natural Resources and Forestry
MPP Jeff Leal, Peterborough
MPP Laurie Scott, Haliburton-Kawartha Lakes Brock
Association of Local Public Health Agencies
Ontario Boards of Health

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

September 30, 2015

Dr. Hazel Lynn, MD, FCFP, MHSc
Medical Officer of Health
Grey Bruce Health Unit
101 - 17th Street East
Owen Sound, ON N4K 0A5
e.meneray@publichealthgreybruce.on.ca

Dear Dr. Lynn,

Re: Bruce Grey Food Charter

Congratulations on creating this important charter for your community, and thank you for sharing it with us!

At its meeting on September 9, 2015, the Board of Health for the Peterborough County-City Health Unit felt very strongly that this charter could support our own work in food security, and with your permission, we would like to adopt it and adapt it for our community.

We look forward to building on your work and using this tool with our local poverty reduction partners.

Sincerely,

Original signed by

Councillor Lesley Parnell
Chair, Board of Health

/at

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

September 30, 2015

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

Dear Minister Hoskins:

Re: Energy drinks

At its meeting held on September 9, 2015, the Board of Health for the Peterborough County-City Health Unit considered correspondence forwarded and supported by the Windsor-Essex County Health Unit regarding energy drinks.

The Board echoes the recommendations originally outlined by the Wellington-Dufferin-Guelph Public Health (letter attached) and urges you to take action to protect the health of our children.

Sincerely,

Original signed by

Councillor Lesley Parnell
Chair, Board of Health

/at
Encl.

cc: MPP Jeff Leal, Peterborough
MPP Laurie Scott, Haliburton-Kawartha Lakes Brock
Association of Local Public Health Agencies
Ontario Boards of Health

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

September 30, 2015

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

Dear Minister Hoskins:

Re: Enforcement of the Immunization of School Pupils' Act (ISPA)

At its meeting held on September 9, 2015, the Board of Health for the Peterborough County-City Health Unit considered correspondence forwarded and supported by the Sudbury District Health Unit regarding enforcement of the Immunization of School Pupils' Act

The Board echoes the recommendations outlined in their letter (attached) and urges you to consider amending the Act to require all healthcare providers to electronically report immunizations for all children attending school in Ontario in a timely and accurate manner.

Sincerely,

Original signed by

Councillor Lesley Parnell
Chair, Board of Health

/at
Encl.

cc: MPP Jeff Leal, Peterborough
MPP Laurie Scott, Haliburton-Kawartha Lakes Brock
Association of Local Public Health Agencies
Ontario Boards of Health

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

From: allhealthunits-bounces@lists.alphaweb.org [mailto:allhealthunits-bounces@lists.alphaweb.org] **On Behalf Of** Linda Stewart
Sent: October-08-15 12:33 PM
To: 'All Health Units'
Subject: [allhealthunits] Member Update re Public Health Funding

Please forward to the Chair of your Board of Health. Thank you.

Dear Public Health Colleague,

This is to provide you with an update on the actions alPHa is taking regarding the new funding formula in use by the MOHLTC for program-based grants to boards of health. alPHa's Board of Directors met with representatives from the Ministry at its meeting on October 2 and had the opportunity to clarify and provide comment on the road ahead.

The Ministry clarified that in order to apply an increase to program-based grants this year, they were required to use a funding formula. They made the decision to apply the formula recommended in the report of the Funding Review Working Group to the funds that were available to provide 2 percent growth. This resulted in 8 boards of health receiving increases while the remaining 28 were held to 2014 funding levels. At the meeting on October 2, the ministry communicated to alPHa's Board that they are open to reviewing the impacts of the funding formula and to possible alterations. They were also clear that there is no guarantee of any further funds being available in future years for increases and they have recommended to business administrators to plan for zero percent increases into the future.

As next steps, alPHa is undertaking the following:

1. Developing a resolution outlining action steps for alPHa Board endorsement that will be shared with boards of health for their consideration
2. A letter is being prepared to the Minister to provide a formal response to the application of the funding formula
3. alPHa will be collecting some key pieces of information through a short survey to assist with assessing the financial impact on public health units and municipalities of the funding formula
4. alPHa will be meeting with representatives of the Association of Municipalities of Ontario (AMO) to discuss areas of mutual concern
5. alPHa will be meeting with representatives from other parts of the health system that have already experienced funding changes to determine possible strategies forward
6. alPHa will continue to discuss member concerns with government decision makers
7. alPHa's Executive Committee and Board of Directors will continue to strategize and communicate with alPHa members on this issue

Please do not hesitate to contact me with any questions, comments or suggestions.

Linda

Linda Stewart
Executive Director

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

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

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

From: allhealthunits-bounces@lists.alphaweb.org [mailto:allhealthunits-bounces@lists.alphaweb.org] **On Behalf Of** Susan Lee
Sent: October-08-15 9:56 AM
To: All Health Units
Subject: [allhealthunits] Board of Health Risk Management Workshop, Nov. 5, 2015, Toronto

PLEASE ROUTE TO:

All Board of Health Members
All Senior Public Health Managers / Directors
****

Attached is information and an agenda for our upcoming workshop, **Managing Uncertainty: Risk Management for Boards of Health**. It will be held on Thursday, November 5, 2015, 8:30 AM-4:30 PM, at the DoubleTree by Hilton Hotel Toronto Downtown, 108 Chestnut Street (near University/Dundas). This interactive workshop will include special guest presentations, case studies and exercises on risk management as applied to boards of health. Key speakers include:

- Graham Scott, Algoma Public Health Assessor
- Corinne Berinstein, Senior Audit Manager, Treasury Board Secretariat
- Executive staff from Algoma Public Health and KFL&A Public Health

This event is ideal for board of health members, MOHs and AMOHs, and health unit directors and senior managers interested in learning more about risk management and governance practices.

Registration for the workshop is now open, so sign up by visiting the alPHa website – see links in the attached. In a few days, we will have more details on hotel guest accommodations and how to book. Stay tuned!

Regards,

Susan

Susan Lee
Manager, Administrative & Association Services
Association of Local Public Health Agencies (alPHa)
2 Carlton Street, Suite 1306
Toronto ON M5B 1J3
Tel. (416) 595-0006 ext. 25
Fax. (416) 595-0030
Please visit us at http://www.alphaweb.org

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Association of Local PUBLIC HEALTH Agencies

2 Carlton Street, Suite 1306
Toronto ON M5B 1J3
Tel: (416) 595-0006
Fax: (416) 595-0030
E-mail: info@alphaweb.org

Providing leadership in public health management

FALL 2015 MEETINGS

COMOH Section General Meeting
(ONE DAY ONLY)

Wednesday, November 4, 2015
9 AM – 3:30 PM (tentative)
Toronto Ballroom
DoubleTree by Hilton Hotel Downtown Toronto
108 Chestnut Street, Toronto
(near University/Dundas)

Open to:

- Member Medical Officers of Health
- Member Associate Medical Officers of Health
- Public Health & Preventive Medicine Residents*

$295 + HST per person

To register for the COMOH Section Meeting, please click here

** Note: PHPMRs – alPHa regrets it is unable to reimburse expenses related to attendance of this meeting*

Managing Uncertainty: Risk Management Workshop for Ontario Boards of Health
(ONE DAY ONLY)

Thursday, November 5, 2015
8:30 AM – 4:30 PM
Toronto Ballroom
DoubleTree by Hilton Hotel Downtown Toronto
108 Chestnut Street, Toronto
(near University/Dundas)

Open to:

- All Board of Health Members
- All Medical/Associate Medical Officers of Health
- All Senior Public Health Managers

$295 + HST per person

To register for the Board of Health Risk Management Workshop, please click here

See workshop agenda attached

Hotel guestroom reservations and registration details coming soon!

alPHa
Association of Local PUBLIC HEALTH Agencies

Managing Uncertainty. Risk Management for Boards of Health

- PROGRAM -

Thursday, November 5, 2015

Toronto Ballroom, DoubleTree by Hilton Hotel, 108 Chestnut Street, Toronto

8:30–9:00	**BOH Section Business Meeting**	*Mary Johnson*, alPHa Board of Health Section Chair
9:00-9:10	**Welcome and Introduction**	*Mary Johnson*, alPHa Board of Health Section Chair
9:10-10:10	**Introduction to Risk**	*Graham Scott*, Chair, Institute For Research in Public Policy, Canada Health Infoway / Algoma Public Health Assessor
10:10-10:30	**Individual Exercise**	Participant Self-Assessment – Part A
10:30-11:00	BREAK	
11:00–12:00	**Implementation of Risk Management**	*Corinne Berinstein*, Senior Audit Manager, Treasury Board Secretariat
12:00-12:30	**Exercise & Discussion**	Participant Self-Assessment – Part B
12:30-1:30	LUNCH	
1:30-2:30	**Case Studies**	*Tony Hanlon*, CEO & *Justin Pino*, CFO, Algoma Public Health *Hazel Gilchrist*, Director, Corporate Services, KFLA Public Health
2:30-3:00	**Exercise & Discussion**	Participant Self-Assessment- Part C
3:00-3:30	BREAK	
3:30-4:20	**Insights, Comments & Next Steps**	Group Discussion
4:20-4:30	**Wrap Up**	*Mary Johnson*, alPHa Board of Health Section Chair

DURHAM REGION

September 29, 2015

The Honourable Kathleen Wynne
Premier
Minister of Intergovernmental Affairs
Room 281
Main Legislative Building
Queen's Park
Toronto ON M7A 1A1

The Regional Municipality of Durham

Corporate Services Department - Legislative Services

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Matthew L. Gaskell
Commissioner of Corporate Services

RE: Memorandum from Dr. Robert Kyle, Commissioner & Medical Officer of Health, dated September 8, 2015 re: Healthy Babies Healthy Children (HBHC) Program (Our File No. P00)

Honourable Premier, please be advised the Health & Social Services Committee of Regional Council considered the above matter and at a meeting held on September 23, 2015 Council adopted the following recommendations of the Committee:

"A) That the correspondence dated June 30, 2015 from the Sudbury & District's Medical Officer of Health to the Minister of Children and Youth Services, urging the Ontario government to fully fund all program costs related to the Healthy Babies Healthy Children (HBHC) program, including all staffing, operating and administrative costs be endorsed; and

B) That the Premier of Ontario, Ministers of Children and Youth Services, Finance, and Health and Long-Term Care, Durham's MPPs, Interim Chief Medical Officer of Health, alPHa, and all Ontario Boards of Health be so advised."

Attached is a copy of the correspondence dated June 30, 2015 from the Sudbury & District's Medical Officer of Health to the Minister of Children and Youth Services.

Debi A. Wilcox, MPA, CMO, CMM III
Regional Clerk/Director of Legislative Services

DW/np

Attach.

c: The Honourable Tracy MacCharles, Minister of Children and Youth Services
The Honourable Charles Sousa, Minister of Finance
The Honourable Eric Hoskins, Minister of Health and Long-Term Care
Joe Dickson, MPP (Ajax/Pickering)
The Honourable Tracy MacCharles, MPP, (Pickering/Scarborough East)
Granville Anderson, MPP (Durham)
Jennifer French, MPP (Oshawa)
Laurie Scott, MPP (Haliburton/Kawartha Lakes/Brock)
Dr. David Williams, Interim Chief Medical Officer of Health
L. Stewart, Executive Director, Association of Local Public Health Agencies (alPHa)
Ontario Boards of Health
R.J. Kyle, Commissioner & Medical Officer of Health

Sudbury & District

Health Unit

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: 705.677.9611

Chapleau
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Box / Boîte 485
Chapleau ON P0M 1K0
: 705.860.9200
: 705.864.0820

Espanola
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Unit / Unité 100 C
Espanola ON P5E 1J3
: 705.222.9202
: 705.869.5583

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: 705.377.5580

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: 705.867.0474

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1.866.522.9200

www.sdhu.com

June 30, 2015

VIA ELECTRONIC MAIL

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

Dear Minister MacCharles:

Re: Healthy Babies Healthy Children Program

The Healthy Babies Healthy Children (HBHC) program is a 100% funded Ministry of Child and Youth Services (MCYS) program provided by all 36 Ontario Boards of Health. Established in 1998, HBHC supports healthy child development by identifying vulnerable families and providing or connecting them with appropriate supports.

As with many boards of health across the province, the Sudbury & District Board of Health has been increasingly challenged to meet Ministry expectations for HBHC service provision within the 100% funding envelope. At its meeting on June 18, 2015, the Board of Health carried the following resolution #28-15:

WHEREAS the Healthy Babies Healthy Children (HBHC) program is a prevention/early intervention initiative designed to ensure that all Ontario families with children (prenatal to age six) who are at risk of physical, cognitive, communicative, and/or psychosocial problems have access to effective, consistent, early intervention services; and

WHEREAS the Healthy Babies Healthy Children program is a mandatory program for Boards of Health; and

WHEREAS in 1997 the province committed to funding the Healthy Babies Healthy Children program at 100% and the HBHC budget has been flat-lined since 2008; and

WHEREAS collective agreement settlements, travel costs, pay increments and accommodation costs have increased the costs of implementing the HBHC program, the management and administration costs of which are already offset by the cost-shared budget for provincially mandated programs; and

WHEREAS the HBHC program has made every effort to mitigate the outcome of the funding shortfall, this has becoming increasingly more challenging and will result in reduced services for high-risk families if increased funding is not provided.

THEREFORE BE IT RESOLVED THAT the Sudbury & District Board of Health direct staff to prepare a budget and program analysis of the HBHC program, outlining pressures and options for mitigation, detailing program and service implications of these options as compared against MCYS expectations; and

FURTHER THAT the Sudbury & District Board of Health advocate strongly to the Minister of Children and Youth Services to fully fund all program costs related to the Healthy Babies Healthy Children program, including all staffing, operating and administrative costs.

FURTHER THAT this motion be forwarded to the Association of Local Public Health Agencies, the Chief Medical Officer of Health and all Ontario Boards of Health.

It remains our priority to ensure that the HBHC program can effectively identify and support children and families most in need throughout the Sudbury/Manitoulin District. We look forward to further dialogue with MCYS on how we can best achieve this goal together.

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

Sincerely,

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

cc: Chief Medical Officer of Health (Acting)
Linda Stewart, Executive Director, Association of Local Public Health Agencies
Ontario Boards of Health

DURHAM REGION

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Corporate Services Department - Legislative Services

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Matthew L. Gaskell
Commissioner of Corporate Services

September 29, 2015

The Honourable Kathleen Wynne
Premier
Minister of Intergovernmental Affairs
Room 281
Main Legislative Building
Queen's Park
Toronto ON M7A 1A1

RE: Memorandum from Dr. Robert Kyle, Commissioner & Medical Officer of Health, dated September 8, 2015 re: *Immunization of School Pupils Act (ISPA)* (Our File No. P00)

Honourable Premier, please be advised the Health & Social Services Committee of Regional Council considered the above matter and at a meeting held on September 23, 2015 Council adopted the following recommendations of the Committee:

"A) That the correspondence dated June 30, 2015 from the Sudbury & District's Medical Officer of Health to the Ministry of Health and Long-Term Care, urging the Ontario government to require health care providers to report to the local Medical Officer of Health all immunizations administered to patients under 18 years of age through a common electronic database be endorsed; and

B) That the Premier of Ontario, Minister Health and Long-Term Care, Durham's MPPs, Interim Chief Medical Officer of Health, alPHa, and all Ontario Boards of Health be so advised."

Attached is a copy of the correspondence dated June 30, 2015 from the Sudbury & District's Medical Officer of Health to the Ministry of Health and Long-Term Care.

Debi A. Wilcox, MPA, CMO, CMM III
Regional Clerk/Director of Legislative Services

DW/np

Attach.

c: The Honourable Eric Hoskins, Minister of Health and Long-Term Care
Joe Dickson, MPP (Ajax/Pickering)
The Honourable Tracy MacCharles, MPP (Pickering/ Scarborough East)
Granville Anderson, MPP (Durham)
Jennifer French, MPP (Oshawa)
Laurie Scott, MPP (Haliburton/Kawartha Lakes/Brock)
Dr. David Williams, Interim Chief Medical Officer of Health
L. Stewart, Executive Director, Association of Local Public Health Agencies (alPHa)
Ontario Boards of Health
R.J. Kyle, Commissioner & Medical Officer of Health

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June 30, 2015

VIA ELECTRONIC MAIL

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

Dear Minister Hoskins:

Re: Enforcement of the Immunization of School Pupils' Act (ISPA)

Enforcement by the Sudbury & District Board of Health of the July 2014 legislative changes to the ISPA has highlighted significant challenges for local public health with respect to duplicate and incomplete immunization records. This is in part due to the fact that health care providers are not required to report immunizations to the Medical Officer of Health.

At its meeting on June 18, 2015, the Sudbury & District Board of Health carried the following resolution #25-15:

WHEREAS each public health unit in Ontario is required to enforce the Immunization of School Pupils Act by assessing and maintaining immunization records of school pupils (students) each year; and

WHEREAS parents/guardians whose child(ren) receive vaccine at a health care provider other than public health are required to provide notification of their child's immunizations to their local public health unit; and

WHEREAS healthcare providers are not required under the provisions of the Health Protection and Promotion Act to report immunizations to the Medical Officer of Health; and

WHEREAS incomplete immunization records create significant challenges to the enforcement of the ISPA indicated by the numbers of students suspended from attendance at school under the Act, as well as parental and guardian frustration;

THEREFORE BE IT RESOLVED THAT the Sudbury & District Board of Health recommend to the Minister of Health and Long Term Care that amendments to provincial regulations be made requiring health care providers to report to the Medical Officer of Health all immunizations administered to patients under 18 years of age.

FURTHER THAT the Sudbury & District Board of Health advocate to the Minister of Health and Long Term Care for the integration of all health care provider electronic immunization records onto a common electronic data base to ensure efficient and accurate sharing of immunization records.

FURTHER THAT this motion be forwarded to the Association of Local Public Health Agencies, and to Ontario Boards of Health.

The Board of Health for the Sudbury & District Health Unit takes seriously its responsibility to promote and protect the health of children. The Board believes that measures to enable the accurate and timely reporting of immunizations by all health care providers for all children attending school in Ontario will greatly assist in the effectiveness and efficiency of the Board's responsibility.

Sincerely,

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

cc: Linda Stewart, Executive Director, Association of Local Public Health Agencies
Ontario Boards of Health

September 25, 2015

Hon Eric Hoskins
Ministry of Health and Long-Term Care
10th Floor, Hepburn Block
80 Grosvenor Street
Toronto, Ontario M7A 2C4
ehoskins.mpp@liberal.ola.org

Re: Public Health Funding

On September 25, 2015, the Board of Health for the Grey Bruce Health Unit considered the attached resolution from Porcupine Health Unit and passed the following resolution, #2015-88.

Moved by: Mitch Twolan Seconded by: David Shearman

WHEREAS, the Ministry of Health and Long-Term Care has, on September 4, 2015, released the 2013 report of the Funding Review Working Group with respect to a public health funding model for Mandatory Programs, which it has accepted for the 2015 budget year and beyond; and

WHEREAS, based upon current information, the model indicates that approximately 80% of Public Health Units in the Province of Ontario are overfunded, which in and of itself calls into question, the validity of said model; and

WHEREAS, in some large centres there is a possibility that these extra public health funds could effectively be consumed by larger municipal budgets and not utilized for additional public health services; and

WHEREAS, under this model, health units who have been identified as being overfunded, may have many years of shrinking public health services, in the face of higher costs, due to having to deal with a flatlined budget allocation;

NOW THEREFORE BE IT RESOLVED THAT, the Board of Health for the Grey Bruce Health Unit support the resolution from the Porcupine Health Unit and opposes this new funding model and the radical long-term shifting of public health resources to wealthier urban centres of the Province, at the direct expense of Northern and Rural Health Units in the Province, who are much less able to replace those lost funds than our growing urban centered health units, and

FURTHER THAT, the Board of Health for the Grey Bruce Health Unit calls for the Ministry of Health and Long-Term Care to reverse their decision to support this report, and revise the funding formula which appears biased against smaller, Northern and Rural Health Units; and

FURTHER THAT, this resolution be forwarded to the Premier of Ontario, the Minister of Health and Long-Term Care, AMO, ROMA, alPHa, Local MP's and MPP's, All Municipalities in Grey and Bruce Counties and All Ontario Boards of Health.

Carried

Together we build healthy communities,

Hazel Lynn, MD, FCFP, MHSc
Medical Officer of Health
Grey Bruce Health Unit

Porcupine
Health Unit • Bureau de santé

September 21, 2015

Head Office:
169 Pine Street South
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Dear Public Health Stakeholder,

Please find attached, a copy of Resolution #2015.39 adopted by the Board of Health for the Porcupine Health Unit, at its meeting held September 18, 2015.

The Board of Health for the Porcupine Health Unit strongly objects to the radical change in public health funding, in the Province of Ontario, which the Province has begun implementing in 2015.

It is the Board of Health's position that this drastic change will effectively transfer scarce public health financial resources to areas of the Province of relative health and wealth, and away from those areas of the Province such as Northern and rural areas, which have the greatest public health needs.

We would request your support in opposing this massive redistribution of public health funding in Ontario.

Yours very truly,

Donald W West BMath, CPA, CA
Chief Administrative Officer

DW:mc

Encl.

pc: Federation of Northern Ontario Municipalities (FONOM)
Northeastern Ontario Municipal Association (NEOMA)
Northern Ontario Municipal Association (NOMA)
Association of Local Public Health Agencies (alPHa)
Local Member Municipalities
Dr. Eric Hoskins, Minister of Health & Long-Term Care (MOHLTC)
Kathleen Wynne, Premier of Ontario
Provincial Party Leaders
Northern Members of Provincial Parliament
Ontario Nurses Association (ONA)
Canadian Union of Public Employees (CUPE)
Ontario Boards of Health

Date: 15 / 09 / 18
y m d

Porcupine
Health Unit • Bureau de santé

R-2015.39

MOVED BY: Gilles Chartrand

SECONDED BY: Claude Bourassa

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WHEREAS, the Ministry of Health and Long-Term Care has, on September 4, 2015, released the 2013 report of the Funding Review Working Group with respect to a public health funding model for Mandatory Programs which it has accepted for the 2015 budget year and beyond; and

WHEREAS, based upon current information, the model indicates that approximately 80% of Public Health Units in the Province of Ontario are overfunded, which in and of itself calls into question, the validity of said model; and

WHEREAS, this funding model will result in an inevitable significant long-term transfer of public health resources to relatively wealthier, and healthier, large urban settings, and will cause reductions in public health services in Northern and rural areas of the Province; and

WHEREAS, in some large centres there is a possibility that these extra public health funds could effectively be consumed by larger municipal budgets and not utilized for additional public health services; and

WHEREAS, under this model, health units who have been identified as being overfunded, may have many years of shrinking public health services, in the face of higher costs, due to having to deal with a flatlined budget allocation; and

WHEREAS, Unorganized Territories funding for public health services will not be allocated in the same manner as the Mandatory Programs funding, it appears that equitable access to public health resources depend on where you live in this Province, and since only Northern health units have Unorganized Territories funding, and the Ministry of Health and Long-Term Care has indicated that there will only be a one-time adjustment to that funding, this model, with its implementation inconsistencies, is particularly detrimental to those health units in Northern Ontario;

NOW THEREFORE BE IT RESOLVED THAT, the Board of Health for the Porcupine Health Unit opposes this new funding model and the radical long-term shifting of public health resources to wealthier urban centres of the Province, at the direct expense of Northern and rural health units in the Province, who are much less able to replace those lost funds than our growing urban centred health units; and

FURTHERMORE THAT, the Ministry of Health and Long-Term Care reverse their decision to support this report, which appears biased against smaller, Northern, and rural health units; and

FURTHERMORE THAT, this resolution be forwarded to FONOM, NEOMA, NOMA, alPHa, local member municipalities, the Minister of Health and Long-Term Care, the Premier of Ontario, Provincial Party leaders, Northern members of Provincial Parliament, ONA, CUPE, and Ontario Boards of Health.

(circle as appropriate)

CARRIED DEFEATED

Stan Black
Chair - Board of Health

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

Staff Report

Health Care Worker Influenza Immunization 2014-15

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

Original approved by	***Original approved by***
Rosana Pellizzari, M.D.	Edwina Dusome, Manager

Recommendations

That the Board of Health for the Peterborough County-City Health Unit receive the staff report, *Health Care Worker Influenza Immunization 2014-15,* for information.

Financial Implications and Impact

There are no financial implications for the board of health arising from this report.

Background

Influenza transmission and outbreaks in hospitals and long term care homes are well documented and can result in significant patient, resident and staff morbidity and mortality. Four randomized controlled trials have shown that HCW influenza immunization in chronic care/long term care home facilities for the elderly reduces patient mortality. The increased risk of influenza to residents and patients in these facilities is related to their advanced age and underlying health problems, as well as the settings in which they are cared for in close proximity to a range of HCWs. HCW can acquire influenza from patients/residents and the community and then may readily transmit infection to other patients/residents, other HCWs and their family members.[1]

Provincial Infectious Diseases Advisory Committee, Best Practices for Infection Prevention and Control Programs in Ontario in All Health Care Settings, May 2012, states that: All health care settings must have an immunization program in place appropriate to their clients/patients/residents.[2]

According to the Association of Medical Microbiology and Infectious Disease Canada (AMMI) position statement, 2012, 'annual influenza immunization should be required as a condition of new and ongoing employment or appointment for all workers who spend time in areas where patient care is provided and/or patients are present.[3]

The Canadian Nurses Association (CNA) believes that policies that place immunization as a condition of service should be introduced if health-care worker influenza immunization coverage levels are not protective of patients, and reasonable efforts have been undertaken with education and enhancing accessibility to immunization. CNA considers mandatory immunization policies by employers to be congruent with the *Code of Ethics for Registered Nurses* in Canada and the obligation to act in the public interest.[4]

The National Association of County and City Health Officials (NACCHO) urge health care employers and local health departments (LHDs) to require influenza vaccination for all staff as a condition of employment.[5]

The National Advisory Committee on Immunization (NACI) considers the provision of influenza vaccination for HCWs who have direct patient contact to be an essential component of the standard of care for the protection of their patients. Transmission of influenza between infected HCWs and their vulnerable patients results in significant morbidity and mortality. Randomized controlled trials conducted in geriatric long-term care settings have demonstrated that vaccination of HCWs is associated with substantial decreases in morbidity and mortality in the residents. Therefore, HCWs who have direct patient contact should consider it their responsibility to provide the highest standard of care, which includes annual influenza vaccination. In the absence of contraindications, refusal of HCWs who have direct patient contact to be immunized against influenza implies failure in their duty of care to patients.[6]

The College of Physicians and Surgeons of Ontario states, "All health care workers are strongly encouraged to be vaccinated annually against influenza. For those with a contraindication to vaccination, antiviral medications can be taken after close, unprotected contact with an infected individual."[7]

The College of Nurses of Ontario recognizes that immunization is a key measure in reducing nurses' susceptibility to certain diseases, including influenza and hepatitis.[8]

The Centre for Disease Control (CDC) prevention strategies for seasonal influenza in health care settings include achieving high influenza vaccination rates of health care providers (HCP) and patients as a critical step in preventing healthcare transmission of influenza from HCP to patients and from patients to HCP.[9]

Rationale

Laboratory confirmed cases of influenza represent the tip of the iceberg as most persons who develop influenza are not tested. A total of 70 influenza cases were reported for the 2014/2015 surveillance season. There were ten influenza long term care facility outbreaks reported to the Health Unit.

Influenza is a highly contagious acute viral infection of the respiratory tract which causes widespread illness, including outbreaks and pandemics. It is associated with complications such as bacterial pneumonia and death. Annual immunization of persons at high risk, and of HCWs and others, who are capable of transmitting influenza to those at risk, is the most effective measure for reducing the impact of influenza.

The Ministry of Health and Long-Term Care requires the collection of influenza vaccine coverage rates for staff from nursing homes (NH) and hospitals. The staff immunization coverage rates were collected as of December 15, 2014. Since outbreaks occur in retirement residences, the PCCHU actively collects immunization coverage rates from these facilities. The data are included in the following table:

Table 1: Influenza Immunization Rates for Peterborough Health Care Facility Staff, 2014-2015 Season

Facility	Total Coverage Rate				
	% Staff* Immunized 2013/2014	% Staff* Immunized 2014/2015	+ Change ≥5% but coverage ≤80%	Coverage ≥ 80%	+ Change ≥5% and coverage ≥ 80%
Applewood (RR)	84	51	-	-	-
Canterbury Gardens (RR)	100	96	-	X	-
Centennial Place (NH)	83	85	-	X	-
Empress Gardens (RR)	91	94	-	X	-
Extendicare Lakefield (NH)	82	76	-	-	-
Extendicare Peterborough (NH)	85	79	-	-	-
Fairhaven Home for Seniors (HFA)	70	76	X	-	-
Jackson Creek (RR)	40	58	X	-	-
Mapleview (RR)	84	68	-	-	-
Mount St. Joseph (RR and NH)	80	80	-	X	-
Peterborough Manor (RR)	98	53	-	-	-
Pleasant Meadow Manor (NH)	94	85	-	X	-
Princess Gardens (RR)	92	96	-	X	-
Riverview Manor (NH)	94	80	-	X	-
Royal Gardens (RR)	91	91	-	X	-
Rubidge Hall (RR)	74	53	-	-	-
Springdale Country Manor (LTCH)	62	70	X	-	-

Facility	Total Coverage Rate				
	% Staff* Immunized 2013/2014	% Staff* Immunized 2014/2015	+ Change ≥5% but coverage ≤80%	Coverage ≥ 80%	+ Change ≥5% and coverage ≥ 80%
St. Joseph's at Fleming (LTCH)	83	89	-	X	X
Peterborough Regional Health Centre Interim Long-Term Care Unit	80	71	-	-	-
Sherbrooke Heights		**			
Average reported rates	**83**	**79**			
Peterborough Regional Health Centre Hospital	50	76	X	-	-

NOTE: Retirement Residence (RR); Nursing Home (NH); Home for the Aged (HFA)
*Staff data includes employees on payroll, licensed independent practitioners, adult student/trainees, volunteer staff and other contract staff. Other retirement residences which did not provide immunization information are not included in this table.
** No data received.

The Board of Health has required annual immunization against influenza for all of its employees since 2002. For 2014/2015, the influenza vaccination coverage rate for eligible active staff (without medical exemptions) at the Peterborough County-City Health Unit was 96%.

Strategic Direction

The delivery of influenza immunization programs supports the Board of Health Strategic Direction: Community-Centred Focus.

Contact:

Edwina Dusome,
Manager, Infectious Diseases Programs
(705) 743-1000, ext. 271
edusome@pcchu.ca

References

[1] Toronto Public Health, 2014 Influenza Update: http://www.toronto.ca/legdocs/mmis/2014/hl/bgrd/backgroundfile-73633.pdf

[2] Provincial Infectious Disease Advisory Committee, Best practices for infection prevention and control programs in Ontario in all health care settings (3rd ed). May 2012. Available at http://www.publichealthontario.ca/en/eRepository/BP_IPAC_Ontario_HCSettings_2012.pdf

[3] Bryce E, Embree J, Evans G, Johnston L, Katz K, McGeer A, et al. AMMI Canada position paper: 2012 mandatory influenza immunization of health care workers. Can JInfect Dis Med Microbiol 2012; 23(4):e93-5. Available at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3597405/

[4] Influenza Immunization of Registered Nurses Position Statement: Canadian Nurses Association, November 2012 http://cna-aiic.ca/~/media/cna/page-content/pdf-en/ps_influenza_immunization_for_rns_e.pdf

[5] National Association of County and City Health Officials Statement of Policy: Influenza Vaccinations for Healthcare Personnel, November 2012 http://www.naccho.org/advocacy/positions/upload/12-14-Influenza-Vax-for-Healthcare-Personnel.pdf

[6] National Advisory Committee on Immunization Statement on Seasonal Influenza Vaccine for the 2015-2016 Influenza Season, CCDR, July 15, 2015.

[7] Infection Control in the Physician's Office, College of Physicians and Surgeons, 2004, (http://www.cpso.on.ca/policies/guidelines/default.aspx?id=1766)

[8] Influenza Vaccinations, Practice Guidelines, College of Nurses of Ontario, June 2009, (http://www.cno.org/Global/docs/prac/41053_fsInfluenza.pdf)

[9] Centre for Disease Control and Prevention: Prevention Strategies for Seasonal Influenza in Healthcare Facilities (http://www.cdc.gov/flu/professionals/infectioncontrol/healthcaresettings.htm).

To: All Members
Board of Health

From: Kerri Davies, Chair, Fundraising Committee

Subject: **Committee Report: Fundraising**

Date: October 14, 2015

The Fundraising Committee met last on September 16, 2015. At that meeting, the Committee requested that the following items come forward to the Board of Health for information:

Meeting Minutes – June 23, 2015

Recommendation:

That the Board of Health for the Peterborough County-City Health Unit receive for information, meeting minutes of the Fundraising Committee for June 23, 2015.

Board of Health for the
Peterborough County-City Health Unit
MINUTES
Fundraising Committee Meeting
Tuesday, June 23, 2015 – 6:00 – 7:00 p.m.
Meeting Held Via Teleconference

In Attendance:

Members:	**Councillor Gary Baldwin**
	Ms. Kerri Davies, Chair
	Councillor Lesley Parnell
	Councillor Trisha Shearer
Staff:	**Dr. Rosana Pellizzari, Medical Officer of Health, Recorder**

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1. Call To Order

The meeting was called to order at 6:00 p.m.

2. Elections

2.1. Chairperson

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

MOTION:
That Mr. Kerri Davies be appointed as Chairperson of the Fundraising Committee for the Peterborough County-City Health Unit for 2015.
Moved: Councillor Parnell
Seconded: Councillor Baldwin
Motion carried. (M-2015-001-FC)

Ms. Davies assumed the Chair.

2.2. Vice Chairperson

Ms. Davies, Chair, called for nominations for the position of Vice-Chairperson.

MOTION:
That Councillor Trisha Shearer be appointed as Vice-Chairperson of the Fundraising Committee for the Peterborough County-City Health Unit for 2015.

Moved:	Councillor Baldwin
Seconded:	Councillor Parnell
Motion carried.	(M-2015-002-FC)

3. Confirmation of the Agenda

MOTION:
That the Agenda be approved as circulated.

Moved:	Councillor Baldwin
Seconded:	Councillor Shearer
Motion carried.	(M-2015-003-FC)

4. Declaration of Pecuniary Interest

5. Delegations and Presentations

6. Confirmation of the Minutes of the Previous Meeting

7. Business Arising from the Minutes

8. Correspondence

9. New Business

9.1. Terms of Reference for Fundraising Committee

Terms of Reference

The draft Terms of Reference were reviewed. Two types of external members were identified: those that would join the Committee, and those that might come on for a particular project or campaign.

Board members will be encouraged to make an annual donation, according to his or her capacity. Some members may want to give monthly – this would have to be set up in the future. It allows for more people to assist in the fundraising endeavour.

ACTION: Dr. Pellizzari to bring forward any existing fundraising-related policies to the next Fundraising Committee (FC) meeting for review.

With respect to chairing, Kerri Davies noted that given her experience, she is happy to Chair for 2015 in order to establish the Committee, however would prefer that another Board member take on this task in 2016 as there is a potential conflict of interest with her fundraising work for the Canadian Mental Health Association (CMHA).

It was agreed that the recording of minutes would rotate amongst Committee members in alphabetical order.

MOTION:
That the Terms of Reference for the Board of Health Fundraising Committee, as amended, be provided to the Board for approval at its next meeting.
Moved: Councillor Baldwin
Seconded: Councillor Shearer
Motion carried. (M-2015-004-FC)

Fundraising Code of Ethics
Two links (Imagine Canada and the CMHA) were provided to Committee members. The Chair suggested they be reviewed prior to the next meeting and discussed as business arising for decision. **ACTION: This item will be added to business arising at the next meeting.**

Ms. Davies suggested that these should be integrated into FC meetings and will discuss this further with Dr. Pellizzari prior to the next meeting. **ACTION: Dr. Pellizzari will schedule a call to discuss this item with Ms. Davies.**

9.2. Recruitment of External Members

Ms. Davies commented that she may have some potential candidates willing to volunteer to be a part of the Jackson Square Kitchen Fundraising Campaign (JSKFC).

9.3. Current Status of Fundraising at PCCHU

ACTION: Dr. Pellizzari will provide an updated annual fundraising report to be reviewed at the next meeting.

Ms. Davies inquired about a donor list. It was suggested that perhaps a communication could go out to previous donors requesting permission to contact them (i.e., provide them future fundraising updates/requests). **ACTION: This will be discussed further at the next meeting.**

9.4. Identification of Organizational Needs for Donations (Funding Gaps, Special Projects)

Other organizational needs (i.e., the 'why' the Committee is fundraising) may need to be deferred until 2016 as efforts for this year must focus on the JSKFC.

9.5. Strategic Plan for Fundraising

Councillor Baldwin commented that retailers often feature fundraising boxes at store checkout counters. This item was noted for future reference.

Any additional planning will be deferred given the immediate priority of the JSKFC for 2015.

9.6. Current Fundraising Activities

9.6.1. Jackson Square Project Update (Pellizzari)

Current project costs were reviewed by the Committee. Dr. Pellizzari reported on a recent discussion with YWCA and their support. The YWCA will assist with establishing a case for support, the design of marketing materials as well as coordinating grant applications.

Ms. Davies suggested that Michael VanDerHerberg might be an ideal JSKFC Chair and she is willing to approach him to see if this would be of interest. Another potential candidate for this position would be Len Liftus (former Executive Director, United Way Peterborough and District). **ACTION: Ms. Davies and Dr. Pellizzari to follow up with these candidates prior to the next meeting.**

9.7. Other Business

10. In Camera to Discuss Confidential Personal Matters

11. Motions for Open Session

12. Date, Time and Place of Next Meeting

The following meeting dates were determined:

Next Meeting of the Jackson Square Kitchen Fundraising Sub-Committee:
Thursday, July 9, 2015 from 5:00 – 6:00 p.m.; Meeting Room 2, 10 Hospital Drive, Peterborough.

- **ACTION: Dr. Pellizzari will request materials from the YWCA by July 6 or 7.**

Next Fundraising Committee Meeting:
Wednesday, September 16 from 5:00 – 6:00 p.m.; Board Room, 10 Hospital Drive, Peterborough.

13. Adjournment

MOTION:
That the meeting be adjourned.
Moved by: Councillor Baldwin
Seconded by: Councillor Shearer
Motion carried. (M-2015-005-FC)

The meeting was adjourned at 6:00 p.m.

Chairperson

Recorder