BOARD OF HEALTH AMENDMENT OF AGENDA ON APRIL 11/18, ADDITION OF STEWARSHIP COMMITTEE REPORT, FUTURE FUNDING OF PUBLIC HEALTH (PAGES 121-126)

Board of Health for
Peterborough Public Health
AGENDA
Board of Health Meeting
Wednesday, April 11, 2018 – 5:30 p.m.
Council Chambers, Township of Cavan Monaghan
Municipal Office, 988 County Road 10, Millbrook

1. **Call to Order**
   Councillor Henry Clarke, Chair

   1.1. **Opening Statement**
   We respectfully acknowledge that Peterborough Public Health is located on the Treaty 20 Michi Saagiig territory and in the traditional territory of the Michi Saagiig and Chippewa Nations, collectively known as the Williams Treaties First Nations, which include: Curve Lake, Hiawatha, Alderville, Scugog Island, Rama, Beausoleil, and Georgina Island First Nations.

   Peterborough Public Health respectfully acknowledges that the Williams Treaties First Nations are the stewards and caretakers of these lands and waters in perpetuity, and that they continue to maintain this responsibility to ensure their health and integrity for generations to come.

   1.2. **Welcome**
   Mayor Scott McFadden, Township of Cavan Monaghan

2. **Confirmation of the Agenda**

3. **Declaration of Pecuniary Interest**

4. **Consent Items to be Considered Separately**

   Board Members: *Please identify which items you wish to consider separately from section 9 and advise the Chair when requested. For your convenience, circle the item(s) using the following list: 9.2 a b 9.4.1 a b c 9.4.2 a b 9.4.3 a b c*

5. **Delegations and Presentations**

   5.1. **Delegation: GE Production Facility Exposures**
   Jim Gill, Retired Occupational Health and Safety Director, CAW/Unifor

- Cover Report (p. 5)

a. Presentation
b. Excerpt, Report of the Advisory Committee
c. OHCOW Brochure
d. WSIB Numbers as of March 19, 2018
e. Public Town Hall Invitation – April 18, 2018

6. Confirmation of the Minutes of the Previous Meeting

6.1. March 14, 2018

- Cover Report (p. 39)

a. Minutes, March 14, 2018

7. Business Arising From the Minutes

7.1. Staff Report: Smoke-Free Movies

- Staff Report (p. 46)

8. Staff Reports

8.1. Staff Presentation: Ontario Public Health Standards – Chronic Disease Prevention and Wellbeing; Substance Use and Injury Prevention

Hallie Atter, Manager, Local Program Standards
Donna Churipuy, Director of Public Health Programs

- Cover Report (p. 49)

a. Presentation

8.2. Staff Presentation: Website Redevelopment Project

Brittany Cadence, Manager, Communications and I.T.
Kerri Tojcic, Computer Technician Analyst

- Cover Report (p. 55)

a. Presentation

8.3. Committee Report: 2017 Audited Financial Statements

Mayor Rick Woodcock, Chair, Stewardship Committee
Richard Steiginga, Partner, Collins Barrow Chartered Accountants

- Cover Report (p. 59)

8.4. Staff Report: Summary of Peterborough Public Health's Annual Service Plan Submission
Larry Stinson, Director of Operations

- Staff Report (p. 60)

8.5. Presentation: Cancer Care Ontario Report - Prevention System Quality Index: Health Equity
Dr. Rosana Salvaterra, Medical Officer of Health

- Cover Report (p. 68)

a. Presentation
b. CCO Report Executive Summary
c. CCO Full Report **(NOTE: WEB HYPERLINK)**

9. Consent Items

9.1. Correspondence for Direction

9.2. Correspondence for Information

- Cover Report (p. 81)

a. Ministers Couteau / Milczyn – NFB and Income Security
b. alPHa – 2018 Provincial Budget Summary

9.3. Staff Reports

9.4. Committee Reports

9.4.1. First Nations Committee
Councillor Kathryn Wilson, Vice-Chair, First Nations Committee

- Cover Report (p. 88)

a. Minutes, September 6/17
b. Minutes, January 13/18
c. Draft Letter re: TRC #8

9.4.2. Governance Committee
Mayor Mary Smith, Chair, Governance Committee

- Cover Report (p. 99)

a. Minutes, February 6/18

b. 2-80 Accessibility

9.4.3. Stewardship Committee

Mayor Rick Woodcock, Chair, Stewardship Committee

- Cover Report (p. 106)

a. Minutes, March 8/18
b. By-Law 2 Banking and Finance
c. By-Law 9 Procurement of Goods and Services

10. New Business

10.1. Association of Local Public Health Agencies Resolution for Submission

Dr. Rosana Salvaterra, Medical Officer of Health

- Cover Report (p. 117)

a. Public Health Support for a Minimum Wage that is a Living Wage

11. In Camera to Discuss Confidential Matters *(nil)*

12. Motions for Open Session *(nil)*

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

Date: May 9, 2018
Location: Dr. J.K. Edwards Board Room, 3rd Floor, Peterborough Public Health, Jackson Square, 185 King Street, Peterborough

14. Adjournment

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To: All Members
Board of Health

From: Dr. Rosana Salvaterra, Medical Officer of Health

Subject: **Delegation: GE Production Facility Exposures**

Date: April 11, 2018

Proposed Recommendation:

That the Board of Health for Peterborough Public Health receive the following for information:
Delegation: GE Production Facility Exposures
Presenter: Jim Gill, Retired Occupational Health and Safety Director, CAW/Unifor

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Background:

With respect to delegations, the Board of Health's By-Law #3, Calling of and Proceedings at Meetings states:

> *6.5 All delegations appearing before the Board shall be permitted to speak only once on an item, unless new information is being brought forward, and/or unless permission is given by the Chairperson of the Board, in consultation with the Medical Officer of Health.*
>
> *6.6 Delegations and presentations of general interest shall not exceed ten minutes except when answering questions posed by the Chairperson for clarification.*
>
> *6.7 Unless otherwise directed by resolution, no action respecting a delegation will be taken until the Board has had an opportunity to discuss the delegation and to receive advice from the Medical Officer of Health.*

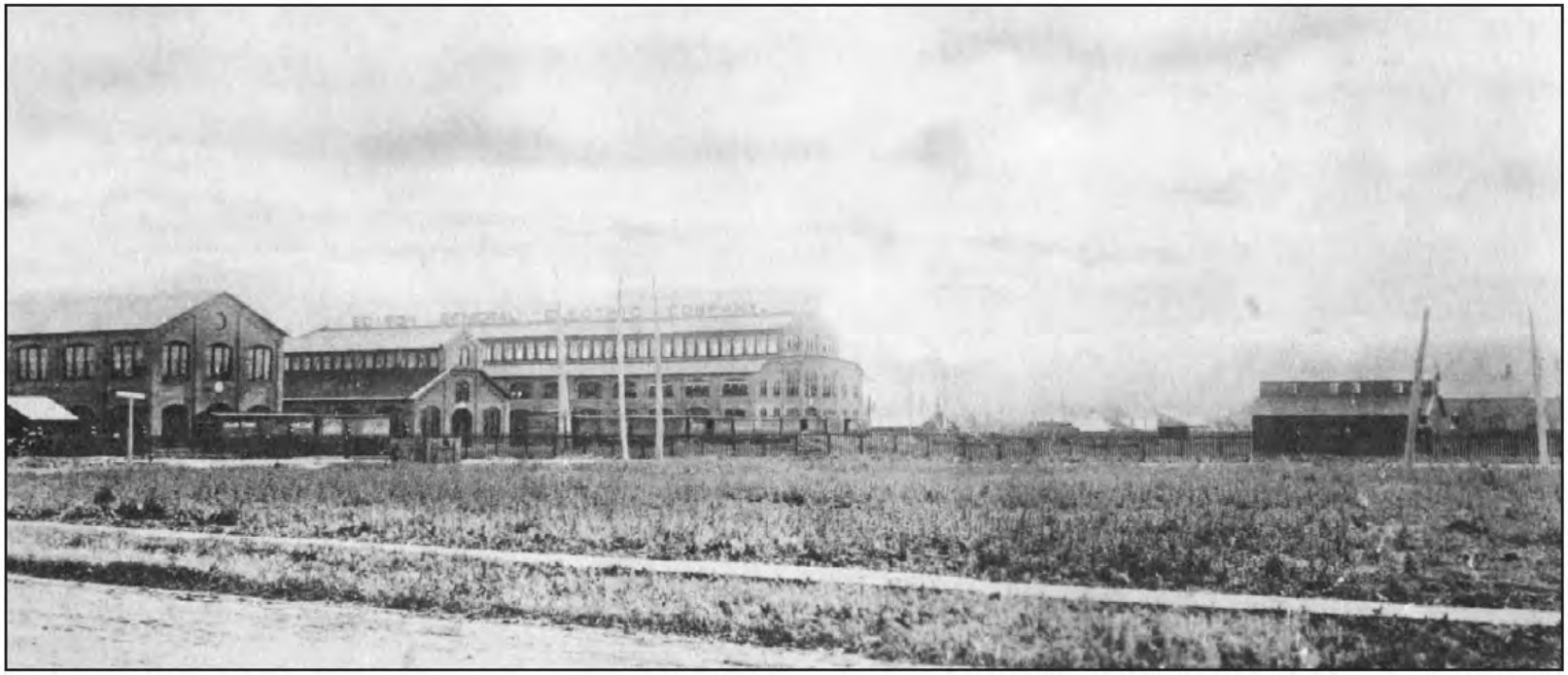
The delegation is seeking support and advocacy from the Board of Health for the Occupational Health Clinics for Ontario Workers (OHCOW) to open an office to assist GE workers and families with the occupational disease cluster, as well as pursuing the idea of holding a Grand Rounds with the Family Health Team and the importance of taking an occupational history and the GE legacy.

Attachments:

Attachment A – Presentation

Attachment B – Excerpt, The Report of the Advisory Committee on Retrospective Exposure Profiling of the Production Processes at the General Electric Production Facility in Peterborough, Ontario 1945-2000
Attachment C – OHCOW Brochure
Attachment D – WSIB Numbers as of March 19, 2018
Attachment E – Public Town Hall Meeting Invitation

GE Facility was opened in 1891



The GE facility will be shut down in 201

History of GE-Peterborough

Health and Safety Issues have been raised by the Local 524 for years:

- **1995** OHCOW "Risk Mapping Exercise
- **2004** Intake clinic supported by Local 524, CEP 599-O, CAW, and OHCOW
- Clinic process registered over 700 workers
- Of the 700 workers registered, over 200 WSIB claims were generated (does not include hearing loss claims)

History of GE-Peterborough

- **2004-2012**, local 524 with assistance from Unifor filed a number of appeals to denied claims,
- **2012** Summit meeting of Unifor, OWA, MOL, WSIB , Retiree Chapter and the OEHC of Peterborough (the Coalition)
- **2013** Unifor send in a team to review the claim status of all Local 524 files and claim files concerning occupational illness. Data base (excel) of all files updated.
- **2015** Summit meeting of Unifor, OWA, MOL, WSIB, Retiree Chapter and the OEHC of Peterborough (the

History of GE-Peterborough

In 2013 our records showed the following:

- 777 workers recorded in the files
- 80 approved claims
- 126 denied claims
- 493 closed claims
- 54 claims have no information other than a name and intake number

History of GE-Peterborough

2015 Unifor GE-Peterborough advocate meeting. After review of files and evidence associated with the claim files the decision where made to:

a. Obtain more detailed mapping of the facility,

b. Obtain 3rd party information

c. Build critique of the GE- Health Study of GE-Peterborough workers (2003).

History of GE-Peterborough

The 2015 decision leads to:

- The creation of the Advisory Committee on Retrospective Exposure GE - Peterborough
- Reviewed and catalogued all MOL reports from 1944 - 2004, and thousands of GE related reports /correspondence.
- Enlisted services of an independent review of the GE Health Study. Dr. Markowitz report is now in the WSIB and advocates files.

“The overall GE Peterborough study is of mediocre quality”

“The Phase II Study is too poorly conducted to install any faith in its results”

The Creation of RAWC

Retrospective Analysis of Workplace Conditions is a Unifor proprietary data base that incorporates:

- MOL Reports
- MSDS
- JHSC Minutes
- Other GE documents
- Advisory Committee Report

Where are we at today?

Diagnosis	Allowed	Pending	Voluntary	Denied	Withdrawn / Abandoned	Total Registered
Total Cancer Claims	**73**	11	0	121	61	**266**
Total Nervous System Claims	139	4	0	58	17	218
Total Respiratory System Claims	**47**	5	0	85	8	145
Total Signs and Symptoms	14		1	4	3	22
Total Skin and Tissue Diseases	7	0	0	3	4	14
Total Claims	**284**					**685**

February 5, 2017

THE REPORT OF THE ADVISORY COMMITTEE ON RETROSPECTIVE EXPOSURE PROFILING OF THE PRODUCTION PROCESSES AT THE GENERAL ELECTRIC PRODUCTION FACILITY IN PETERBOROUGH, ONTARIO 1945-2000

Prepared by

Robert DeMatteo, B.A., M.A., D.O.H.S and Dale DeMatteo, B.A., MSc.

with

GE Retiree Members of the Advisory Committee:
John Ball, Linda Brown, Jim Dufresne, Roger Fowler, Marilyn Harding, Sue James, Carl Jenson, Don McConnell, Gordon Terry, Bill Woodbeck, and Jim Gill (retired Unifor National Health and Safety Director)

INTRODUCTION

The purpose of this research project was to develop retrospective exposure profiles of the work processes at the GE electrical production facility in Peterborough, Ontario between 1945 and 2000. As such, it involved a systematic effort to collect and analyze empirical information about how production was carried out in this very complex heavy industrial operation. Historically, this workplace is an example of the intersection of 20th century industrial and chemical "revolutions". This work was undertaken to document the extent and nature of chemical and physical exposures that are possibly linked with the various cancers and other diseases that many GE employees and their families suffered over the years.

The major source of this information came from the workers themselves through a series of intensive focus group and key informant interviews that went on for over 8 months. This information was corroborated by government inspection reports from 1945 to 2000 in addition to joint health and safety committee minutes, internal memoranda, and industrial hygiene literature.

Before proceeding to the substance and findings of the retrospective exposure study, it is important to situate this study in the broader social and scientific context that frames the results and how they may be viewed and used in Ontario's occupational health system.

The study was meant to address employees' concerns that the extent and nature of their exposures and working conditions were being subject to misrepresentation. Indeed, with the exception of a very comprehensive exposure profile study of two departments at GE by industrial hygienist, Sonya Lal of the Occupational Health Clinics for Ontario Worker (OHCOW), there was little systematic empirical study of exposure conditions.

There was an uneasy sense that what was perceived as an extraordinarily high incidence of cancer among GE employees was not being addressed to ascertain whether there was a workplace connection. Given the large number of carcinogenic chemicals used at the plant, their suspicions that there was a connection cannot be viewed as unfounded. It was also their view that the company's efforts to study the problem misrepresented the exposure conditions at the plant, and that such misrepresentation under-mind their disease claims before the Workplace Safety and Insurance Board (WSIB).

Occupational disease remains a largely under-addressed public health problem. Only a small fraction of work-related accepted claims are for occupationally caused diseases. And, an even smaller fraction are for occupationally caused cancers (Yassi 1981; Ison 1989). Yassi estimated in her background study for the Weiler inquiry into occupational disease in Ontario, that a total of 6,000 occupationally related deaths occur annually in Ontario from 3 major sources alone that are related to toxic exposures, but go unreported to the government and the workers compensation system. Some of this is explained by the rather long latency period for cancer to develop...sometimes not appearing until after retirement and therefore missed as work-related.

Over the years several investigators have identified a number of the major obstacles to workplace disease recognition (Yassi 1981; Ison 1989). Some of these include:

- Burden of proof requiring scientific certainty
- "Legalized" Threshold requirements rather than guidelines
- Dismissing patient's doctors' assessment of work-relatedness
- Over-emphasis on claimant's medical history rather than work process interactions
- Lack of exposure data
- Paucity of occupational health research generally
- Lack of occupational health training for physicians

By far, the most influential obstacle to disease recognition and its consequences has been the onerous burden of proof placed on the worker coupled with an outdated view of how diseased is produced by work, one that is out of sync with advances in occupational health and cancer research (Clapp et al. 2008; Hanahan and Weinberg 2011); Hanahan and Weinberg 2000; Welshons et al. 2003; Kortenkamp et al. 2011; Trosko and Upham 2005; Diamanti-Kandarakis et al. 2009; Kortenkamp 2008; Ewertz et al. 2001; Hardell et al. 1997; Senn 1991; Yassi 1981; Ziem and Davidoff 1992) and what the law requires for work-related disease (Supreme Court of Canada [2016] Court file No. 36300; Ison 1989; Law Reform Commission of Canada 1986). This obstacle to disease recognition is imposed by social policy and has its source in the predominant paradigm of "scientific certainty" that requires definitive proof that "X" causes "Y" in a world that by nature is complex and multi-causal. This paradigm is imbedded in current scientific research and standard setting processes and is expressed in our obsession with protecting against "false positives" without thinking about the consequences of "false negatives" (Scott 2005). Unfortunately, this mindset has permeated into administrative tribunals and standard setting bodies, which has produced its own set of detrimental consequences including unjust denial of compensation for diseases caused by work and delayed regulatory action for disease prevention.

With respect to the issue of burden of proof, it is important to note the Supreme Court of Canada's recent ruling rendered on June 24, 2016 regarding a lower court ruling on a breast cancer cluster case among a group of health technologists working at a British Columbia health facility. In this decision, the Supreme Court found that the standard of proof set by laws governing workers' compensations systems do not require a standard of scientific certainty, nor that imposed upon plaintiffs in a civil tort claim (i.e., the balance of probabilities). According to the Supreme Court, these are too stringent a standard of proof, and "... wholly inapplicable to determining causation in the workers' claims..." (Supreme Court of Canada, Docket: 36300, 2016). In essence, in worker compensation law, insufficient evidence is not "no" evidence, and inconclusive evidence may suffice in determining causation in the case of occupational disease claims. In contrast, the current approach extends the presumption of innocence to chemicals and physical agents in the light of scientific uncertainty. The real

question is "What do we do in the face of scientific uncertainty?" This is not simply a scientific question, but rather has to do with social values and ethics, and to what extent we value human life.

The current approach to occupational disease recognition results in a distorted view of the extent of occupational disease and its causes. This has led to questionable policy outcomes with respect to long delays in needed regulatory action and the protection of workers from hazardous chemical and physical agents (Watterson 1999; Scott 2005).

BACKGROUND TO THE GE PETERBOROUGH PRODUCTION FACILITY

In contrast to studying industries associated with a single manufacturing process with few chemicals and relatively few job tasks and exposure patterns, the GE plant in Peterborough undertook production on a massive scale with a complex mix of industrial processes utilizing huge quantities of some 3000 chemicals (Lal 2005/6). Some of these industries included: the manufacture of small to massive electric motors and generators; appliance manufacturing; small and large electrical components for urban electrical utilities; and a nuclear facility that produced nuclear fuel bundles for CANDU nuclear reactors. These involved a complex mix of industrial products that included: massive welding operations throughout the plant; plastics and rubber production for wire insulation; production/preparation of copper wire of various sizes and specifications; and machining and pouring molten metals for large motors and turbines to drive locomotives, ships, and large electrical utilities. The size of production is illustrated by the fact that GE Peterborough's PVC production facility used 40,000 pound of lead per week just in the PVC pelletizing operation (Tidey 1968), not to mention massive amounts of epoxy and polyester resins used to coat and insulate nearly every product it produced. GE was "product" driven with new chemicals and work processes introduced regularly. GE Peterborough retirees describe the plant as a changing "industrial mall" with many units independently run and managed.

In these production processes, large amounts of solvents were used as cleaners and degreasers including: toluene, benzene, trichloroethylene (TCE), 1,1,1-Trichloroethane (TCNU), methyl ethyl keytone (MEK), MEK Peroxide, perchloroethylene, acetone, xylene, naphtha gas, carbon tetrachloride, among others. For example, TCE was used in large heated vats that could measure 8'x10'x6' as well as applied by hand by hundreds of workers to wipe down large surfaces with rags soaked in TCE and toluene. Adding to this chemical mix was the generation of large volumes of welding fumes from welding operations going on throughout the Peterborough complex. Many of these products were massive structures that would take weeks to fabricate with 5 to 10 welders working three shifts daily. In addition, machining operations produced large amounts of metal working fluid (MWF) mists and aerosols from heated fluids used to cool and lubricate materials and cutters. The machining involved large 25' and 40' boring machines. Huge volumes of dust, comprised of asbestos, fibreglass, epoxy/polyester resin, and heavy metals, were continually generated from cutting, grinding, sanding and buffing tasks. Peterborough GE admitted to using as much as 500 lbs. of asbestos daily (Rajhans 1971).

Adding to the complex mix of chemicals was a constant off-gassing of volatile organic compounds from the wood block floors (consisting of creosote-impregnated 3" x 4" wooden blocks set on end grain) throughout the building complex. This flooring continually oozed creosotes, especially during periods when ground water would rise through the subfloor. These floors were re-treated periodically and sometimes coated with glyptol paint. Creosotes are highly volatile and classified by the International Agency for Research on Cancer (IARC) as a 2A carcinogen that is 'probably carcinogenic to humans'. As well, because of the floor's structure, various other chemicals spilled, including lead and mercury, became trapped in the crevices between the blocks. Given the widespread use of this flooring in the plant, such spills contributed to the toxic burden experienced by workers.

A significant factor that conditioned production and the safety culture at GE Peterborough was a work organizational approach that included the piece rate system, in operation until 1988, encouraging employees to work to their physical optimum and, often circumvent safe work practices to maintain production rates.

Another variable contributing to GE Peterborough's uniqueness is the physical structure itself. GE motor production was carried out primarily in the century old "Edison" building that is approximately 1,030' by 1,629' with a building area of 38.5 acres occupying more than 50 acres in downtown Peterborough. This is an "open concept" building typical of the time with saw-tooth windows at roof level to maximize sunlight and allow natural ventilation of the intense heat created by the various work processes. As these work processes shifted from the manufacture of lighting products in the Edison era to that of motors and generators during the GE era, this natural source of ventilation was totally inadequate for this enormous production mix. Despite work areas referred to as "buildings" or "departments" they were, in fact, designated areas separated by indoor-vehicle roadways and walking aisles. There were few truly isolated structures, since additions were connected to the main building by huge doorways, to accommodate trucks and cranes. Ceiling heights reached some 60' to 70' high to allow overhead cranes to pass from section to section. In effect, most departments shared the same, mainly natural, ventilation system and thus the same contaminated atmosphere. There was insufficient make-up air, which created an atmosphere of negative pressure throughout the main building. Consequently, what was generated in dusts, fumes, or vapors flowed readily to neighboring departments. In effect, there was major cross contamination between, and within, departments.

Workforce Considerations:

While the GE Peterborough workforce has remained predominantly male, during World War II women replaced men in the GE workforce and production shifted to the war effort. It was during this time that the plant became unionized. As the war ended, men returned and the workforce settled into a relatively stable ratio of 70-75% men and 25-30% women – which has continued to the present. (Older retirees reported that in their early years at the plant there was also a category of work designated "boys work" done by youths, prior to the introduction of child labour legislation).

Until the mid-1990s, women performed what were generally viewed as "women's work" or occupations – with most working in manufacturing production and approximately 1/3 working in office or clerical jobs. Women's work was described as "light" work involving detailed, fine repetitive tasks that required close up, manual work. Some of the major categories of women's jobs included: "winders" who manually wound copper wire for coils, or cores for capacitors; "tapers" who wound insulating tape composed of adhesives and fiber glass/ asbestos around coils and other electrical components; spray painters in powder paint operations; hand work that included soldering, brazing, and etching circuit cards and semi-conductors; the assembly and production of electric cords (which involved stripping insulated wire containing asbestos and silver soldering) and work forming plastic/ceramic plugs and sockets. Winding operations in the capacitor department involved exposures to toxic adhesives as well as exposure to PCBs.

Women's jobs were generally performed at work benches with 5 to 10 women involved in manually stripping and degreasing wire in preparation for soldering and brazing (which incurred heavy exposure to asbestos/ fiberglass dusts, and lead and solvent fumes). These work areas were poorly or not ventilated. In addition, women could be subject to significant by-stander exposures since many of these tasks were performed on mezzanine levels in departments directly above both intense welding operations and epoxy dipping, baking, and grinding operations where dense fumes, gases, and dusts from these operations would rise to work areas above. This was especially serious in armature (bldg. 7), bus ducts (bldg. 30), and machine shop (bldg. 8). Office and clerical personnel did not fare much better. Toxic dusts generated from many of the manufacturing operations made its way into the offices of clerical workers as evidenced by large accumulations of dusts on

workers' desks and other work stations. Focus group participants reported that office workers would find their desks covered in a blanket of dust when they arrived in the morning -- and find another buildup of dust when they came back from lunch.

Problems Estimating Exposures Using GE Records:

In the course of this research, retirees identified serious problems with the information GE Peterborough sent to the WSIB regarding their work histories and work exposures. This included: wrong or incomplete information, missing health reports, and no consideration of overtime in determining work exposures. Focus group discussions identified broader systemic problems related to the fact that employee records were linked to the company's accounting system -- in particular, time and product costing -- rather than specifically to document work histories. Work was recorded by employee (job code) and location (unit/clock#) classifications. There were categories of employees whose work demanded constant movement throughout the plant including: dispatchers, 'chasers', mobile welders, labour gangs, and maintenance workers. With large motor production, workers were required to move to the location of the product thus their unit designation could be in a different building or department from where they actually worked. Employees working in some areas, such as fractional motors, or on final production assembly, could accumulate as many as 40 tickets (i.e. 40 different jobs) performed in a day. The product-driven nature of production required a flexible work force and employees could be: loaned out to different departments to meet production schedules or deadlines; shifted to other departments and jobs during down time; and offered alternative 'clean up' work during plant shutdowns or holidays -- much, or all, of which was not documented in employee work histories. Relying on company documents as the sole source for determining exposures may significantly underestimate the degree and nature of worker exposures.

What GE Knew About Chemical Hazards:

Companies often attempt to excuse themselves from culpability for occupational diseases by claiming that "we just didn't know about the toxic effects" of the substances their workers were exposed to at the time. This oft-repeated defense by GE for not having taken adequate precautions for the protection of its employees is no longer credible given recent historical revelations of just what GE knew about the hazards of the chemicals its employees used without adequate protection.

In the course of our research we came across a book by respected occupational health researcher, Dr. Barry Castleman (2005), identifying the fact that US General Electric knew about the harmful effects of asbestos, lead, and other chemicals used in its production facilities as far back as the 1920s and 1930s. In his book, Castleman documents the work of Dr. Alice Hamilton, renowned occupational health scholar, who conducted numerous health surveys of the working conditions at GE's plants in the U.S from 1922 to 1934 -- including literature reviews on the harmful health effects of industrial chemicals in use. Based on this research she warned Gerard Swope, the president of US GE at the time, of the hazards and health effects of asbestos and other industrial chemicals affecting GE's workforce. Dr. Hamilton continued to personally advise Swope (over a period of 12 years) about chemical risks to workers as well as recommendations for improving health conditions at GE facilities. In one of Hamilton's letters to GE Vice President, CE Eveleth, dated May 9, 1929, she reports meeting a Mr. Dalton of the GE Schenectady Works, who suggested she visit two GE foundry plants in Canada, "all of which, he said, are pretty bad." She then asks Eveleth: "Do you wish me to do this?" (We have found no evidence that Hamilton was given the opportunity to visit GE plants in Canada).

Published letters and reports kept at the GE Museum in Schenectady, New York (Castleman 2005), document that in addition to asbestos, Dr. Hamilton identified the health impact of a number of chemicals used by GE including: oil smoke, gasoline as a solvent, acids, paint spraying, benzene, cyanide, nitrobenzene,

aniline, formaldehyde, phenol, numerous silica hazards including sandblasting, mercury, lead compounds, radium, carbon tetrachloride, sulfur dioxide, acetone, kerosene, toluene, hydrogen fluoride, asphalt, x-rays, chromium and nickel plating, welding, soldering, as well as issues related to eye and skin irritants, ventilation, ergonomics, lighting, sanitation and medical service. Hamilton emphasized the importance of substituting harmful chemicals as the first level of controlling harmful exposures.

Importantly, Dr. Hamilton described 'by-stander' hazards to those working near welders and sandblasters without wearing protective equipment. When her book, "Industrial Poisons in the United States," was published in 1925, copies were to be sent to 10 doctors at GE plants around the country. As early as 1929, based on Hamilton's recommendations for controlling lead exposures, one GE plant provided separate lockers for work and street clothes, boots and underwear. Boots were removed before the men left the work area through a washroom for lunch or before leaving at the end of the shift. In describing conditions for workers at the plant, Hamilton said: "It is like a first class men's club house" (Pittsfield, May 1929 in: Castleman 2005). There is tragic irony to this story given the battle Peterborough GE conducted during the 1980s over an inspector's order to institute separate locker and wash facilities for employees working with lead under the designated lead regulation. GE Peterborough appealed, and the order was rescinded.

GE was made aware of the hazards of asbestos by 1930 when Dr. Hamilton described hazardous conditions at GE plants where there was significant airborne contamination and accumulated asbestos fibers on work surfaces (Castleman 2005). US General Electric made attempts to control asbestos exposure through exhaust ventilation and by distributing literature to employees on the safe handling of asbestos in the 1930s and 1940s. Hamilton also noted that GE received advice in the 1970s from asbestos fibre and product suppliers on the hazards of using asbestos in the manufacture of phenolic resins (Castleman 2005). Other investigators have also identified and documented how major corporations have suppressed information about the hazards. (Rosner and Markowitz 2002; Michaels 2008).

Given that GE officials in the U.S. were advised of the known hazards of asbestos in their U.S. operations in the 1920s and 1930s, and that they were aware of the poor conditions in Canadian plants, it is highly likely that GE officials at the Peterborough plant would have been aware of the hazards of asbestos. Yet, testimony from focus group participants and government inspection reports indicate that workers were handling asbestos in a friable state without any respiratory protection, nor were workers warned about the hazards. This was evidenced in various tasks that workers performed including: "plucking the goose" that involved the manual removal of waste asbestos without protection from holding bins in the wire and cable department; the band sawing of asbestos sheets without protection in the armature department; and the dismantling of the asbestos covered compounding tank without protection in coil impregnation, to mention a few. Given these exposure conditions it is highly likely that these contributed significantly to the extent of work-related disease at the GE plant. They also reflect a generalized lax safety culture that would have broad ramification for workers' health.

Exposure to Carcinogens:

A partial-list of chemicals routinely used in GE Peterborough production classified as carcinogens, or strongly suspected of being carcinogenic, include (IARC 2017):

IARC Group 1-Carcinogenic to humans: wood working, welding fumes, asbestos, silica, arsenic, benzene, beryllium, cadmium, chromium VI, 4,4-methylene-bis(2chloroanilene)(a.k.a. MOCA), nickel, trichloroethylene, vinyl chloride, formaldehyde, bis-chloromethylether (a.k.a. BCME), polychlorinated biphenols (PCB), diesel engine exhaust, rubber production, painters, mineral oils, n-ntrosodiethanolamine, inorganic acid mists, uranium, wood dusts, shift work.

IARC Group 2A-Probably Carcinogenic to humans: lead, epichlorohydrin, styrene oxide, tungsten carbide, creosotes, 1,3 butadiene.

IARC Group 2B-Possibley Carcinogenic to humans: Styrene, carbon tetrachloride, tungsten cobalt, diethanolamine, magnetic fields, asphalt fumes, methyl ethyl ketone.

Others, not yet classified as carcinogenic but whose properties disrupt the endocrine system and can mimic the hormone estrogen, include bisphenol-A and phthalates used in the production of plastics and epoxy resins. In the latter case, these are suspected of being breast carcinogens and tumour promoters. (DeMatteo et al. 2012; Keith et al. 2015; vom Saal and Hughs 2005; Diamanti-Kandarakis et a.l 2009; Ibarluzea et al. 2004; Ewertz et al. 2001; Hardell et al. 1997; Crisp et al. 1998; Kortenkamp 2008; Kortenkamp et al. 2011; Welshons et al. 2003)

Many of the chemicals used in GE production processes are subjected to high heat stress resulting in thermal decomposition by-products that are highly toxic and carcinogenic as well.

In summary, the fact that there was a complex mix of various contaminants, and that departments shared the same atmospheric contaminants that involved significant by-stander exposures, presents major challenges for the classification of individual exposures through traditional methods employed in industrial hygiene and epidemiological research. In fact, such approaches to complex exposure situations are largely responsible for the misclassification and/or misrepresentation of exposures that tend to underestimate the extent of exposure (Teschke et.al. 2002; dos Santos Silva 1999; Flegal et al. 1986; Greeenland 1982).

METHODS

Qualitative and Participatory Research Methods:

The research team used a qualitative approach to gathering and assessing information necessary to develop rich, detailed, exposure profiles of the industrial processes undertaken at the facility (MacEachen et al. 2016; Institute for Work and Health 2011; Kidd and Parshall 2000; Needleman and Needleman 1996; Lincoln and Guba 1985). Qualitative and "mixed" research methods in industrial hygiene and epidemiology have been successfully used in similar industrial circumstances where there are: diverse groups of workers holding multiple jobs, numerous, complex industrial processes, and exposures that have changed over the years (McDonald et al. 2004; Marano et al. 2000; Morgan et al. 1998; Alexander et al. 1996). Rather than rating individual exposures, this research focuses on profiling the production processes and their exposure points, along with workplace factors that put workers at greater/less risk of being exposed. This approach is best able to address the challenges presented by the nature of GE's production system and limitations in the availability and reliability of "hard' exposure data from industrial hygiene monitoring. As well, detailed descriptions of worker exposures in many of these industries are limited at best. Published research seldom contains data reflecting the typical, day-to-day conditions experienced by the workers, themselves.

To address these issues a participatory research approach was employed using qualitative research methods including: focus group sessions and key informant interviews, and reviews of industrial hygiene data, government inspection reports, joint committee minutes, and occupational health literature.

The core research team consisted of 10 retirees from the GE facility, the union's former National Health and Safety Director and two retired researchers with occupational and public health research experience. This group formed **a permanent focus group known as the Advisory Committee on Exposure Profiling at GE**. The activity of this Advisory Committee was coordinated by one of the retirees and facilitated by the two health

researchers. Each retiree worked at the GE plant for at least 35 years primarily in the manufacturing sectors. All had worked at the facility between 1945 to 2000 with most starting their work with GE in the early 1960s.

The Advisory Committee played a dual role in this participatory research endeavor. It acted as a permanent focus group consisting of informants with detailed knowledge of the production processes at GE over a period of 35 to 40 years. It also served as an active research team who gathered detailed information and brought in key informants with more specialized information to fill in information gaps or expand the group's knowledge base. In this latter role all members took an active part in leading the interview process with key informants.

The Advisory Committee met twice a week for 4 to 5 hours per session where the Committee documented detailed information about the various productions processes and working conditions department by department. This intense activity went on for over 8 months and the group continues to meet regularly. In the course of their work, the group would seek out and review various documents, locate processes on the hazard maps of the entire complex, and obtain industrial hygiene reports where available. The committee interviewed and documented information from more than 75 former GE employees whose names are recorded in the appendix.

The two researchers along with the coordinator were responsible for documenting the information gathered at meetings providing 3 sets of data notes that were compiled and checked for accuracy and then reworked into the resource template that forms the body of this report. Discussions were guided by a set of both open ended and structured questions (for a list of these questions see the expanded methodology section in ADDENDUM 1 at the end of this report).

The focus group process can be described as a relaxed, egalitarian atmosphere with a sense of shared ownership at meetings reflective of the retirees shared work history at GE. Importantly, the overlap of common work experiences among retirees facilitated a questioning, challenging, confirming, consensus dialogue that was both productive and confirming of the reliability of the information provided. For example, participants would often tell similar stories independent of one another, serving to reinforce confidence in the accuracy of individual recollections. Moreover, the dialogue among the participants and informants involved a consensus building process regarding the accuracy of the information being discussed. This approach was both productive and personally satisfying due to a strongly shared commitment that we do this task well (Kidd and Parshall 2000). Discussions would continue until agreement was reached about the accuracy and completeness of the information. Where agreement was lacking, efforts were made by the committee to track down alternative sources of information including other retirees and industrial hygiene literature reviews.

Risk-Based Approach:

This approach is in line with that of Sonia Lal, industrial hygienist with the Occupational Health Clinics for Ontario Workers, who undertook a very thorough retrospective exposure assessment of the production processes in the Armature and Wire & Cable departments at the GE production facility in Peterborough from 2005 to 2006 (Lal 2005/6). Similar to Lal's (2005/6) work, this current retrospective assessment relies upon a number of qualitative risk factors in assessing exposures, comparative to that used by Marano in the aircraft industry (Marano 2000). In this regard, we assessed the production processes and working conditions with regard to their potential to have significantly exposed workers. The risk factors framework included:

- The physical states of the chemicals (liquid, mist, gas, vapors, solid, dust),
- Route of entry (inhalation, absorption, ingestion),
- The quantity of the chemical used, e.g., volume of chemicals, solvents, resins, etc.,
- Size of the materials and surface areas being worked upon or fabricated,

- Proximity to the source of exposure,
- Direct/indirect handling of the chemicals,
- Duration of exposure, e.g., use of overtime,
- State of ventilation systems, e.g., effectiveness of general, natural, local exhaust ventilation,
- Provision of make-up (fresh air circulation) air,
- Provision of personal protective equipment (PPE), e.g., respiratory protection, protective clothing (gloves, coveralls), eye protection,
- Safe work practices/procedures,
- State of housekeeping practices,
- Eating and drinking at workstations,
- Work organization factors, e.g., piece-rate system, physical effort, impact on safe work practices,
- Workers knowledge of and training re: chemicals used including access to, and understanding of, MSDS precautions.

In addition to relying on qualitative findings based on the above, effort was made to include quantitative measures available including those found in the Ontario Ministry of Labour's GE hygiene reports/investigations, GE Peterborough joint health and safety committee minutes, and worker/union documentation with the employer. Additionally, the Industrial Hygiene literature was reviewed for exposure assessments involving similar industries/processes.

Information Sources and Research Process:

This project relied upon three basic sources of information on industrial processes, working conditions, and the nature and extent of exposures for this retrospective exposure assessment:

Focus Group (Advisory Committee) Information Source:

Focus Group meetings were organized with reference to the industrial processes and working conditions for each department with attention to details on: chemicals, equipment and materials being fabricated, the volume of production, the work tasks and how materials were handled, descriptions of work conditions, exposure controls, access to information, work practices, housekeeping, sensory experiences, and adverse health symptoms. Additional information was generated by members of the focus group through phone calls, informal discussions, and sharing primary/historical documents among the group.

The dynamic associated with focus group methods is one that lends itself to both enriching and challenging the veracity of information collected and providing in-depth understanding of the complex work environment at the GE facility. Throughout the research team applied the "constant comparative" method associated with qualitative research, where information collected is constantly contrasted and compared for consistency and reliability.

Supportive Documentation:

Additional documentation of exposure conditions at GE Peterborough was obtained from 1) the Ontario Ministry of Labour (MOL) Inspectorate reports/investigations 1945-2000; 2) Joint Health and Safety Committee (JHSC) minutes/reports, 3) union or employee/employer correspondence, all of which provided a cross check on the reliability and validity of focus-group generated information about the industrial processes and exposure conditions at CGE; 4) Other information sources, including: The previous hazard mapping of GE carried out by Gary Lane and OCHOW, historical documents, GE product materials, worker medical reports

and documents, local newspaper articles, GE Peterborough newsletters, motor production process videos, and broad ranging literature and internet searches.

Industrial Hygiene, Occupational Health, and other Literature Reviews:

Additional documentation was sought through reviews of the scientific literature documenting industrial processes and observed exposures from published studies of similar work environments as well as general information identifying and describing various industrial processes.

In this way, we were able to corroborate the description of work processes and exposure conditions through the process of "triangulation" (Lincoln and Guba 1985; Needleman and Needleman 1996; Patton 1990), a major validation technique used in qualitative analysis. A sense of informational reliability was achieved through this use of different approaches to information gathering including 1) The richness and dynamic of focus group-based discussion and consensus; 2) A review of official government (MOL) reports, JHSC minutes, and employer documents; and 3) A review of industrial hygiene, occupational health, and other literatures.

LIMITATIONS OF THE SCIENCE

In considering the retrospective exposure profiles, some perspective is in order with regard to current interpretations attached to numerical exposure levels to various chemicals as well as results of epidemiological studies. Firstly, there is the assumption that no harm should have come to workers if exposure levels were below the regulated occupational exposure limits or Threshold Limit Values set by the American Conference of Government Industrial Hygienist (ACGIH). Secondly, there is the interpretation of negative epidemiological studies as indicating that there is no association between the disease and the chemical exposures studied.

In response to these assumptions it is important to recognize that the validity of these approaches is being challenged by a large and growing number of researchers in the field of occupational and environmental medicine. In the case of exposure standards, these research efforts have provided evidence that exposure standards are not health-based limits. Researchers have shown that the standard setting process and science upon which these are based are significantly compromised by industry influence. Further, they show that the "science" upon which these limits are based is, itself, seriously flawed. At best, these limits are what industry has determined to be economically and technically feasible rather than protective of workers' health.

Importantly, the misuses of the science of epidemiology and the misrepresentation of epidemiological study results have come under increasing critical scrutiny that can no longer be ignored. Here again a growing body of critical investigation has uncovered the questionable manipulation of data and analysis as well as serious flaws in research design shown to be the result of industry influence on the researchers. Many epidemiological studies suffer from inherent limitations such as poor design, misclassification of exposures, and insufficient statistical power to detect an elevated risk to health. The classic example involves concluding that there is no association between disease and exposures when the study did not have the statistical power, due to small sample size, to detect a risk that may be present. These unacknowledged limitations of science have serious consequence for the protection of occupational and public health.

For a fuller treatment of these limitations and detailed citations, please see ADDENDUM 2 - LIMITATIONS OF THE SCIENCE.

February 5, 2017

BRIEF OUTLINE OF RESEARCH FINDINGS

Information was gathered on the production processes and extent and nature of exposures for 22 departments/buildings. Numerous departments or processes went through changes in location over the years and some were discontinued as a result of outsourcing products, being moved to other areas, or being closed down due to toxic contamination. In total, 22 GE Peterborough departments are reviewed in the detailed exposure profiles that represent the body of this report including:

- Building #4: Capacitors
- Building #5: Coil Impregnation
- Building #7: Armature
- Building #8: Machine Shop
- Building #9: Fractional Horse Power Motors
- Building #10: Generator Assembly/Babbitt
- Building #12: Punch Press
- Building # 14A: Tank Shop
- Building # 14: Structural Steel
- Building # 16: Switch Gear
- Building # 16A: Transportation Equipment
- Building # 17: Non-Metallic Machine Shop (aka Carpentry)
- Building # 18: Induction Motors
- Building # 20: Drive Systems
- Building # 21: Nuclear
- Building # 22: Wire & Cable (until 1980)
- Building # 24: Wire & Cable (Formex until 1980)
- Building # 26: Wire & Cable (until 1980)
- Building # 22: Traction Motors (1994-2004)
- Building # 23: Plating Department
- Building # 30: Bus Ducts
- Building # 34: Steel Cutting

It is impossible to summarize all that is contained in the detailed exposure profiles. However, it is useful to identify some of the general conditions, and the nature and extent of exposures shared by most employees. The following are major working-condition features, commonly experienced throughout the plant, that raise the level of risk for significant chemical exposures.

These common conditions were also confirmed by the independent multiple source of documentation the researchers reviewed e.g. MOL, JHSC reports, etc. In addition to supporting the reliability of the focus group-based data, the multiple sources of documentation exposed a pattern of recalcitrance on the part of GE towards making necessary improvements and repairs to protect worker health and, often, outright refusal to adhere to the law with regard to providing workers and their union with information they requested and to which they were entitled. There was also evidence of an unclear relationship between the Ontario Ministry of Labour inspectorate and a very powerful multinational corporation, one with widespread influence both locally and internationally. What else could explain the inspectorate's seeming reluctance to issue orders preferring instead to give "advice to management" or issue unenforceable "recommendations" -- rather than write "orders" where compliance is mandatory.

Common Physical and Work Conditions:

1. The GE facility had little in the way of effective local exhaust ventilation. Most ventilation was by natural means and there was not enough make-up (fresh) air provided. There were locations in which contaminated exhausted air would re-enter the building atmosphere because of the location of exhaust and intake ports.
2. The lack of adequate replacement air resulted in negative air pressure throughout the building leading to the migration of air contaminants within and among departments (Kyselka 1979).
3. Asbestos for insulations on electrical wires and motor parts was used universally throughout the plant. The large size of products required large amounts of asbestos in various forms. Much work with asbestos was done by hand and in confined spaces. Asbestos was drilled, cut with a band saw, and milled by hand, resulting in the dispersal of asbestos fibres/dust. Overhead piping throughout the plant was covered with friable asbestos insulation, contributing to asbostos air contamination. It is documented that GE employed over 500 lbs. of asbestos per day (Rajhan 1971).
4. In addition to chemical exposures associated with industrial work processes, workers were exposed to diesel, propane, and gas fumes as well as dust from transportation vehicles within and outside the plant. Often vehicles were left idling for hours during loading and unloading. Numerous complaints about these fumes are contained in MOL and JHSC reports. Creasote impregnated wood block floors throughout the building were also a common source of chemical exposure for workers.
5. The absence, and poor quality, of hygiene and housekeeping practices within the GE plant are documented including: lack of showers and lockers, the use of recycled rather than potable water, non-functioning water fountains, inadequate lunch room facilities, poor containment and handling of dust, dirt, spills, fumes, vapors, and workers required to provide their own work clothes. Retirees reported that it was once discovered that soft drink and coffee machines had been hooked up to a recycled water source rather than potable drinking water.
6. Nearly every department or area had a curing oven and/or heated resin or solvent tank resulting in employees working under high heat stress and exposed to heavy solvent and resin vapors. Retirees made reference to the "GE smell" which referred to a distinct odor carried on workers' bodies and clothing that family, friends and health professionals detected.
7. The large size and surface areas of materials being fabricated required the use of large volumes of solvents, paints, and resins as well as extensive welding which took place in open areas. This translated into higher levels of vapors and fumes associated with these processes.
8. The large size of products fabricated resulted in employees working with chemicals for prolonged periods of time in close proximity and confined spaces, for example while degreasing and welding. Some parts were over 40 feet in diameter. At peak, these operations demanded higher use of overtime. Some pieces took weeks, sometimes months, to complete.

The following constellation of risk factors was identified as contributing to significant exposure of workers to a wide spectrum of toxic and carcinogenic chemicals:

- Working closely to the source of exposure,
- Prolonged exposure to the toxic chemicals used or generated during production,
- Absence or inadequacy of exposure controls at the source, e.g. local exhaust system,
- Absence or inadequacy of personal protective equipment,
- Inadequate provision of make-up air and consequent negative air pressure in the complex,
- Application of large volumes of solvents, resins, PAHs, and paints due to large size of products,

- Long duration of exposure because of size and production schedule pressure,
- Inadequate knowledge about the health hazards and exposure controls for worker protection,
- Poor enforcement of safe-work procedures,
- Poor housekeeping practices,
- Eating and drinking and smoking at workstations,
- Inadequate hygiene facilities, and generally poor housekeeping.

Common Chemical Exposures:

Solvents: No matter what department one worked in, there was enormous use of solvents for cleaning and degreasing materials. Degreasers were used in large volumes and often applied by bare hands on large surface areas. Almost every department provided degreasers in the form of trichloroethylene (TCE) in very large tanks that measured upwards of 24 sq. ft. in surface area. Some were vapor degreasers that at times did not function properly. Residues of degreasers were drained on the floor producing large amounts of solvent vapor. Routinely, solvent vapors would migrate to areas where arc welding was performed thus producing HCL gas. Workers routinely washed down large metal surfaces with rags saturated with (TCE) or toluene in preparation for fabrication leading to inhalation and absorption of solvents. Workers frequently registered complaints about vapors and/or adverse effects such as eye, nose and throat irritation as well as narcotic effects. Other commonly used solvents included: toluene, perchloroethylene, MEK, acetone, trichloroethane, xylene, and naphtha gas. Many solvents, when heated, produced thermal decomposition by-products that were equally toxic. Some, including toluene, were highly contaminated with benzene, a group 1 carcinogen.

It is interesting to note that in one instance, an MOL inspector issued orders to protect workers from exposure to toluene despite concentrations below the TLV and protests from management, because the worker's adverse health symptoms were an indicator that the worker was over exposed to the solvent (regardless of the TLV reading). Solvents were used in every department under review (Advisory Committee Meeting notes).

Welding Fumes: Every department had some form of welding and/or soldering operation going on. These were usually large-scale operations involving from 1 to 8 welders working at fabricating electrical housings and parts for motors and generators. Mobile welding operations were also carried out in almost every area of the plant. Welding "booths," contained only by (frayed and friable) asbestos curtains, had little in the way of effective local exhaust ventilation. Welding work areas were commonly described as "thick with welding smoke-plumes," with many complaints related to irritating gases such as phosgene and ozone. MOL reports list many complaints about TCE vapors migrating from degreasing operations to aluminum welding areas (due to negative air pressure) producing phosgene gas. These were reported in focus groups then confirmed in MOL reports and JHSC minutes, as well as internal memorandum from GE Peterborough management. Management also indicated that workers suffered symptoms of COPD as a result of welding exposures. Workers themselves described being "surrounded by clouds of blue smoke so thick you couldn't see the person working next to you" (Advisory Committee meeting notes).

Welding operations included all forms of welding including oxy-acetylene torch cutting and welding, electric arc welding such as MIG, TIG, CO2, and plasma welding. Depending on the type of welding and materials used, both welders and by-standers were exposed to: 1) Welding fumes containing aluminum, beryllium, cadmium oxides, chromium, copper, fluorides, iron oxide, lead, manganese, molybdenum, nickel, vanadium, or zinc oxides; 2) Welding gases including carbon monoxide, hydrogen fluoride, nitrogen oxide, oxygen deficiency, and ozone; 3) Organic vapors such as aldehydes (e.g. formaldehyde), isocyanate, phosgene, phosphine and from metals coated with isocyanate paints, epoxy resins, polyester resins, solvents, or rust inhibitors.

As a result of the large volume of welding going on in every area of the plant and poor exposure controls and housekeeping, exposure to welding fumes was significant throughout the plant for both welders and by-standers. Significant exposure to ozone as well as phosgene gas was reported in some areas of the plant. Focus groups identified eating at workstations, poor housekeeping, and little effective exhaust ventilation. Smoke eaters were reported to "not be very effective," thus with limited utility for controlling exposures. Welding, in some form, was performed in every department under review.

Epoxy, Polyester and Asphalt Resins: Epoxy and polyester resins were used in more than 70% of plant operations. The resin dipping and curing operations involved dipping, often very large, motor components (including huge coils, armatures and stators) in open vats of resin or in Vacuum Pressure Impregnation (VPI) tanks. In the case of VPI tanks, significant exposure to epoxy and polyester resin vapors occurred when: tanks were open for dipping, lift cables were attached by hitchers, and crane operators sitting above the tanks manipulated large items to and from curing ovens. Workers who squeegeed excess resin were also exposed. Finally, excess cured/hardened resins were ground off motor parts and the oven surfaces during grinding and cleaning operations. Retirees described "thick blue smoke" in the atmosphere during such operations, and "plumes of smoke" surrounding the crane operator's cage. Workers described the grinding operations as particularly "dirty" operations where workers were covered in dust -- and thick layers of grinding dust covered all surfaces. Under heat, epoxies and resins break down into constituents such as bisphenol-A (BP-A/ endocrine disrupter) and epichlorohydrin (IARC 2A –probably carcinogenic to humans) and various aldehydes. Focus group discussions identified: workers using compressed air to blow off dust; eating and drinking at workstations; and poor housekeeping. Also identified was the absence of effective local exhaust ventilation and lack of respiratory protection for exposures to epoxy/resins, which was corroborated by inspectors' reports and JHSC minutes. Retirees described an "overheated VPI tank exploding and catching fire after city firefighters sprayed water on it resulting in highly toxic, fumes -- the result of thermal decomposition -- quickly spreading through the plant and overcoming workers (Advisory Committee meetings notes).

Asbestos Exposures: For years, asbestos was the primary material used to (electrically) insulate nearly every component in the multitude of electrical products produced at GE. Along with PVC, lead, and rubber coverings, asbestos -- in various forms -- was made into electrical insulation in stators, armatures, rotors, and various wires and coils. Asbestos was carded, braided, cut, sawed, shaved, and embedded in plastic resin and rubber wire coatings. The Wire and Cable department was a major user of asbestos fibre. Its presence was apparent as airborne dust ("snow storms" as workers described them), on floors and machines, and in storage bins. Some departments shaved and or sanded asbestos-impregnated insulation from wires in preparation for brazing and soldering. Asbestos was used as protective curtains around welding operations and ovens, and as heat insulation blankets to protect welders and/or parts during welding. Workers used asbestos gloves for moving hot materials and parts. All of these were reported to be in tattered, friable condition and a significant source of additional exposure to asbestos. The Armature Department and Carpenter Shop performed major cutting of asbestos boards with band saws. These were pre-drilled and shaped with grinders and sanders, producing large amounts of asbestos dust. Asbestos was ubiquitous and frequently blown (off surfaces and clothing) with compressed air. Workers classified as labourers were assigned to clean out asbestos waste bins on the roof of the Wire and Cable department without respiratory or other protection. The company was cavalier about this hazard since it advertised the sale of waste asbestos for 13 cents a pound as "home insulation" (Advisory Committee Meeting notes and Local newspaper clipping). Exposures were significant for those directly handling asbestos as well as by-standers. As mentioned previously, negative pressure in the plant contributed to the migration of asbestos to other parts of the plant. Given the large volume used in production and the manner in which it was used, workers would be significantly exposed through inhalation.

Polychlorinated Biphenols (PCBs): The use of PCBs at the GE plant has left a long lasting legacy as witnessed by widespread contamination throughout the plant and the surrounding community of Peterborough well after its discontinued use in 1977. This highly toxic, carcinogenic chemical was used as a dielectric fluid in the production of capacitors in building #4 and in transformers and circuit breakers in building #16 and #10. In the process of filling and draining PCB oil from these very large tanks, there was a great deal of spillage and splashes on floors and on workers. This toxic fluid was used in very large volumes not only in the production of new electrical devices but also in the process of dismantling old, or damaged, tanks and in draining them and wiping down the tanks by hand with solvents such as toluene or TCE. PCB was used under the trade names of Pyranol, Askarel, and Inerteen. Workers from several areas (Bldgs #4, #16 and #10) reported heavy exposures to PCBs during the production of transformers, breakers and capacitors. The Ontario Department of Health reported levels ranging from 70 mg/10m^3 to 130 mg/10m^3 (Johnston July 20, 1945). These exposures included others working in the vicinity. Workers in these shops indicated exposure to decomposition by-products, including substances known to be even more toxic than PCB itself. These have been identified as chlorinated dibenzodioxins (CDD) and chlorinated dibenzofurans (CDF). Research indicates that PCB is not only carcinogenic but also acts as a tumor promoter, in combination with other carcinogens (IDSP, December 1987).

Documentation of contamination levels and exposures was the subject of ongoing discussion at JHSC meetings over the high levels found, at or above the TLV, at the time (JHSC Minutes October,1981). Also documented was an incident of contractors "failing to follow prescribed safety procedures" while handling PCB waste oils (JHSC minutes September 26, 1985). An internal company memorandum identified several areas as "highly contaminated." Levels as high as 90,600 ug/100cm^2 were reported in lab test reports (Baker January, 18, 1989; Baker December 1, 1986).

At present, the widespread contamination of PCB waste oils is under the surveillance of the Ontario Ministry of the Environment, since PCB residues persist and have been identified in many areas of the plant -- as well as adjoining land where PCB waste oils were spread over parking lots and road ways as a "dust suppressant." The Ministry of Environment (MOE) has recently identified that plant roof debris is contaminated, and since roof drains run through the interior of the building, chronically leaking into work areas, workers continue to be exposed to waste PCBs (Stephenson MOE memo, April 21, 2016).

Metal Working Fluid (MWF) and Machining: Another major part of the GE Peterborough operation was large scale machining that went on in Traction Motors (Bldg. 22), Induction Motors (Bldg. 18), Switch Gear (Bldg. 16), Transportation Equipment (Bldg. 16A), Tank Shop (Bldg. 14A), Structural Steel (Bldg. 14), Generator Assembly (Bldg. 10), Babbitt Shop (Bldg. 10B), Punch Press (Bldg. 12), Machine Shop (Bldg. 8), Fractional Motors (Bldg. 9), Bus Duct (Bldg. 30) and Steel Cutting (Bldg. 34). All of these machining operations used very large boring, milling, drilling, and lathing machines. Some were as large as 40 feet in diameter. These machining operations used large quantities of MWFs consisting of cooling fluids and lubricating oils sprayed on the machine's cutters. There are several types of MWFs including straight oils, semi synthetic oils, and water-soluble fluids. Many water-soluble fluids are treated with biocides that contain arsenic. MWFs are heated by friction generated in cutting, thus producing mists and vapors containing thermal decomposition by-products as well as unused components of the fluids. Advisory Committee members describe machining operations as "overwhelmed with bluish smoke and mists, in addition to foul smelling vapors." Operator clothing would be saturated with fluids. In addition to MWFs' chemical components and thermal by-products, they would contain components of various metals being machined. Compressed air was used to clean surface areas -- further spreading MWF residue. Workers ate at workstations, thus were exposed to MWFs through inhalation, ingestion, and absorption.

Beryllium and Uranium Exposures: The nuclear department located in Building 21 was the source of exposure to beryllium and uranium oxide. The major source of beryllium exposure was the beryllium room where beryllium powder would be vacuum vapor-fused to zirconium sheets then cut into spacers and pads for the bundle tubes. In the early days of its use, levels as high as 41ug/m^3, are documented when workers "hand sawed" beryllium blocks into powder for processing (even though a letter from the Department of Health warned CGE to purchase its beryllium in powdered form). Despite efforts to keep levels as low as reasonably achievable, beryllium disease is on the rise, even as standard-setting bodies, such as the ACGIH, propose lower TLVs (e.g., 0.05 ug/m^3). Recent evidence indicates that this new standard is "unachievable," forcing producers to seek a safer alternative (Harmsen et al. 2010).

The identification of uranium risks has focused on measuring worker exposures (with personal dosimeters) to alpha particle emissions, yet indirect evidence in the form of suppressed monocyte production is reported to be an indication of worker exposure. A scientific study that included GE Peterborough workers identified that fuel bundle workers receive significant exposures to alpha radiation from uranium oxide (Chase 1992). The same study found that 44% of GE nuclear workers had reduced monocyte counts that were "abnormally" low -- 15-20 times lower than expected in a sample of healthy men and women. According to Dr. Chase "... therefore, there are valid and persuasive reasons to suspect that workers are being affected by their exposure to uranium."

What this description of "common exposures" indicates is that GE Peterborough workers were routinely exposed to a complex mix of toxic chemicals occurring throughout the plant with "business as usual."

HOW THE MAIN BODY OF THIS REPORT IS ORGANIZED, AND HOW TO USE IT

The body of this report contains twenty-two individual building/department profiles identifying in detail the work processes carried out and chemicals associated with these different processes. The information is presented in column form with "Production Process" listed on the left column and "Chemical Risk Exposure" listed on the right.

From the "Production Process" descriptions we formulate an exposure probability through identification of a constellation of risk factors for each process. In describing how work was carried out we are able to infer risk factors such as: was the worker directly involved, did the worker directly handle the materials, what was the physical state of the material(s), what volume was used, what was the production rate, how much time was spent on the tasks, were exposure controls available and adequate, and what is the toxicity rating of the material? From Advisory Committee notes, backed by MOL and JHSC reports, we were able to document adverse symptoms and complaints.

The "Chemical Exposure Risks" set out in the right hand column arise out of how production was carried out for each of the work processes described in the left hand column. The right hand column reflects a qualitative assessment of what the exposures were like, given the way production was carried out by workers and the existence of the risk factors identified above. These are accompanied by an explanation for the assessment in terms of the nature of the production process. Where reliable hard data is available this is presented, but always in conjunction with the experiences arising from the production process itself.

To inform the reader, each building profile is preceded by a "face sheet" identifying (in outline form) the different processes that went on in each building, and listing of (identifiable) chemicals associated with the various work processes. Readers will note the repetition of many individual chemicals/chemical groups as one reads through these profiles.

DISCUSSION

GE Peterborough employees were exposed to a multiplicity of carcinogens and other toxic chemicals. The chemicals used at the plant have well-known adverse health effects and are associated with occupational illnesses. Moreover, workers were exposed to multiple carcinogens simultaneously which further increases the risk of developing cancer.

However, from what is identified, with respect to significant worker exposures to toxic chemicals including a large number of carcinogens, it is hard not to conclude that such exposures have harmed the health of GE employees working at various processes throughout the plant. What has been demonstrated in these exposure profiles is that not only were carcinogenic chemicals present, but they were used in large quantities, in close proximity to the workers, and frequently and for long durations—conditions dictated by the large size and intricacies of the products and parts being fabricated.

What Sonia Lal, of OHCOW, found in her retrospective exposure profiles of the Armature Department and the Wire and Cable Department applies equally to all other departments and buildings throughout the GE facility. Her observations are worth repeating with respect to current findings in this retrospective profile that included an additional 21 buildings.

Ms. Lal (in executive summary, OHCOW file # G884) observed, "The constant dipping, baking, curing of these products and the exposure forms, i.e. solids, liquids, gases and their decomposition products have been demonstrated here to be of paramount importance when trying to assess and establish exposures. One process cannot be looked at as stand alone, as the processes all occurred in a building, namely Building 7-5-8-10, for armature employees. Most buildings at GE were similar in that they all relied on natural ventilation. Hence the above statement applies to all buildings, as all the processes within the buildings were close to one another, contaminants were heavy and accumulated, (as there was no forced make-up air) and thus bystander exposure to different contaminants from several processes were incurred by employees" (Lal 2005/6 p. i-a).

The current findings of this much extended exposure profile corroborate what Sonia Lal found in her comprehensive, detailed retrospective profile of the Armature and Wire & Cable departments and are detailed in the body of this report.

While this project does not assign precise quantitative measures to the extent of exposures it is possible to infer the extent of exposures from the nature of the production process, the size and intricacy of the production process, the tasks performed by the workers, the quantities and types of chemicals used or produced, the proximity to the materials, the extent of exposure controls, the characteristics of the ventilations systems, safe work practices and work organization characteristics. Here are a few examples: extensive welding and grinding operations fabricating huge breaker tanks in confined spaces generating large clouds of welding fumes consisting of a complex mixture of gases and heavy metal fumes in the Tank Shop; lapping (sanding) large lead Babbitt bearings bare handed immersed in toluene up to the forearms in Bldg. 8 and Babbitt Shop; crane operators hovering over plumes of vapors from degreaser tanks and epoxy resin VPI tanks in several departments; draining and pouring PCBs in the building of capacitors as well as welding caps on in the Capacitor department; women doing hand work continuously exposed to solvents, lead and cadmium during soldering operations; workers inhaling and being soaked with MWFs during machining of large metal plates, 25' to 40' in diameter; hand wiping of large coils and metal surfaces with rags soaked in toluene; stripping of asbestos coated wires; hand squeegeeing epoxy resin from coils after resin impregnation; band sawing asbestos boards generating large amounts of asbestos laden dust, to mention but a few. What is described here was carried out without effective local exhaust ventilation or adequate protective equipment under intense production schedules.

These findings are corroborated through review of Ministry of Labour reports, JHSC minutes, employer-records available, and industrial hygiene studies on similar production processes. The research team has no hesitation in concluding that most GE workers were significantly exposed to carcinogenic and other toxic chemicals, and that it is highly likely that these exposures have harmed, and continue to harm, their health. GE employees laboured under very poor working conditions marked by inadequate to non-existent exposure controls and lax enforcement. Additionally, these workers were chronically exposed to substances that are potent carcinogens, or strongly suspected carcinogens -- as well as being capable of disrupting the endocrine system. This condition is aggravated by the fact that workers were exposed to complex mixtures of hazardous chemicals that have additive and/or synergistic effects. What we don't know, and is not well documented in the scientific literature, is the synergistic effects of such a multiplicity of exposures.

In conclusion, it must be reiterated that manufacturing in the 20th century was characterized by an historic intersection of the industrial and chemical "revolutions." The GE plant in Peterborough is a classic example, in design and function, of that dynamic social experiment. As such, workers at GE were both participants in, and witnesses to, the horrific working conditions associated with this historical pairing – and its significant toll on workers and their families.

LIST OF GE WORKER/FAMILY PARTICIPANTS

Retiree Advisory Group: John Ball, Lynda Brown, Jim Dufresne, Roger Fowler, Marilyn Harding, Sue James, Carl Jensen, Don McConnell, Gord Terry, Bill Woodbeck, Jim Gill

Invited Retiree Contributors: Sharon Armstrong, Bill Drain, Steve Casey, Mel Crowe, Gary Dalton, Steve Deal, Paul Evans, Bob Gaspari, Paul Graham (Ptbo. Firefighter) Jim Heron, Joe Keating, Ron Lang, Gord Watson

Telephone/In Person Retiree Contributors: Cheryl Armitage, Frank Blakely, Earlene Byrne, Barry Bunn, Frank Chambo, Debbie Chute, Paul Corp, Dave Dettman, John Flannagan,Theresa Flaherty, Teena Flood, Peter Flood, Joe Fraser, Jan Goodbody, Jim Gooley, Peter Gooley, Rob Hayes, Neal James, Joe Keating, Doug Kirkcaldy, Roger Lathangue, Jack Lewington, Wally Moore, Roger Morton, Peter Newmaster, Rick Page, Wayne Parker, Keith Reil, Deb Reyner, Steve Shiels, Jim Stabler, Percy Traynor, Doug Wellman, Roger Wild, Tom Worr, Lee Vitarelli, "anonymous x 2"

Widow/family member contributors: Diane Carl, Sandra Condon, Steve and Cindy Crossley, Debbie Chute, Higgins Family, Aileen Hughes, Pat Huzinga, Sandy Lebeau, Joan McKinlay, Marcelle O'Connell, Arlene Petrany, Sara Sharpe, Lenore Shiels

ACKNOWLEDGMENTS

While it is hard to single out any one individual when so much depends on the collective action of workers, one cannot overlook the debt of gratitude to a very tough, dedicated, Worker Health & Safety Representative at GE Peterborough who passionately fought for more than 40 years to better working conditions at the plant. He meticulously saved every piece of communication that passed through his hands during his years at GE. He was courageous to a fault and both loved and hated. If there is a hero, among so many who participated in this project, it is John Ball. We acknowledge also the important work of Sue James, as coordinator of the project who kept us on track, and whose insights, broad knowledge of the plant, and constant "digging" for information was critical. Essential and invaluable was both the individual and group contributions of the Advisory Committee "mainstays" including: John Ball, Linda Brown, Jim Dufresne, Roger Fowler, Sue James, Marilyn Harding, Carl Jensen, Don McConnell, Gordon Terry, Bill Woodbeck, and Jim Gill. As retirees, our

advisory committee members were both willing and able to commit to the very significant time and hard work required to complete this project.

UNIFOR, as the union representing workers at GE Peterborough (specifically Joel Carr, Nancy Clark, and National Health and Safety Director, Sari Sairanen, and staff at the national office) provided meeting space and support as well as undertaking the creation of a data base for the storage and retrieval of government inspection reports, minutes of JHSC, internal company communications and MSDS. UNIFOR has worked to coordinate occupational disease claims with the Office of the Worker Advisor and is assembling supportive documentation, generated by this retrospective study, to go before the WSIB. Special thanks to Local 599-O and its executives for providing meeting space for the committee's work. We thank Laura Hargrove for her work in the final preparation of the report.

The detailed chemical hazard mapping of the GE plant done by both Gary Lane and OHCOW was critical to this project providing a reference point, and supportive documentation for focus group discussions. The work of Sonia Lal and OHCOW identifying risk exposures at GE provided a starting point for this project, serving as a guide and inspiration. Her excellent retrospective profiles on Armature and Wire and Cable departments were substantially relied upon, and incorporated into this report.

We thank Dr. Noel Kerin of OHCOW for his commitment to GE families, especially his support for many claimants through the clinics of 2004.

And finally, we acknowledge the long fight for justice led by the Occupational and Environmental Health Coalition of Peterborough (OEHCP) for promoting their vision of "A healthy viable community in Peterborough and for generations to come," through their ongoing commitment to, and practical support for, GE families coping with occupationally related illness and death.

This broad community effort "to set the record straight" reflects a concerted collective effort on the part of many citizens and activists to get to the bottom of this occupational disease catastrophe.

Prevention Through Intervention

Occupational Health Clinics for Ontario Workers are dedicated to the identification and prevention of work-related injuries and illnesses. This includes musculoskeletal disorders, cancer and other diseases from workplace exposures and stress-related illnesses.

OHCOW provides medical, hygiene, ergonomic and health assessments for Ontario workers and workplaces. Staffed by an inter-disciplinary team of nurses, hygienists, ergonomists, coordinators and contracted physicians, each OHCOW clinic provides comprehensive occupational health services and information.

OHCOW is governed by a volunteer Board of Directors. At the local level each of the seven clinics has a volunteer Local Advisory Committee.

Education plays a central role in OHCOW's prevention activities. Workshops and presentations tailored to specific workplace issues may be developed and delivered.

At the core of each clinic are dedicated staff trained in occupational health, who are available to provide expert analysis for a full range of work-related illnesses.

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

Occupational Health Clinics for Ontario Workers Inc.
Centres de santé des travailleurs (ses) de l'Ontario Inc.

Toll-Free 1.877.817.0336

Eastern Region
Ottawa
1545 Carling Avenue, Suite 110,
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Tel: 613.725.6999
Fax: 613.725.1719
Email: ottawa@ohcow.on.ca

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Email: hamilton@ohcow.on.ca

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Occupational Health Clinics for Ontario Workers Inc.
Centres de santé des travailleurs (ses) de l'Ontario Inc.

Prevention Through Intervention

ohcow.on.ca
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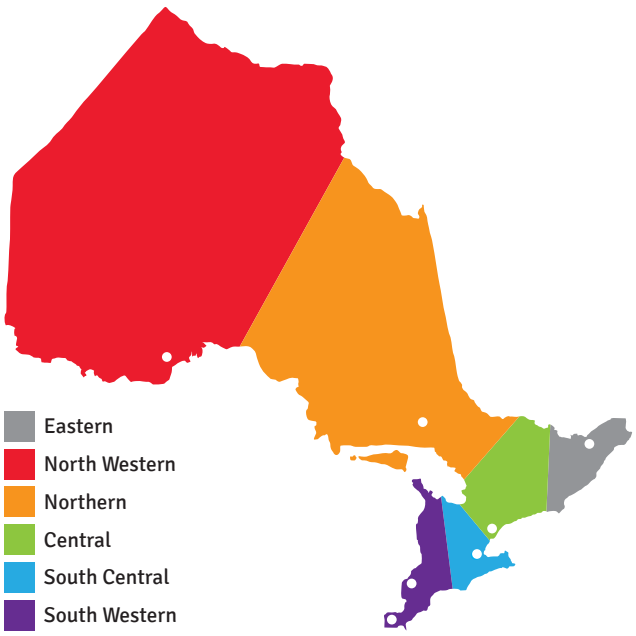
OHCOW Service Areas



Who We Are

Throughout the 1970's and 1980's workers in Ontario became increasingly aware of the toll of injury and disease caused by dangerous and unhealthy working conditions.

A groundswell of opinion demanded more effective diagnosis of work-related health problems and effective prevention strategies.

OHCOW was established in 1989 by the Ontario Federation of Labour (OFL) and is funded through the Ministry of Labour (MOL). The first clinic opened in 1989 in Hamilton, with subsequent clinics opened in Toronto, Windsor, Sudbury, Sarnia, Thunder Bay and Ottawa.

OHCOW Provides Five Types of Services

- ✔ **Medical diagnostic review** for workers who may have work-related health problems
- ✔ **Group service** for joint health and safety committees and groups to deal with workplace conditions that affect more than one worker
- ✔ **Inquiry service** to answer questions about exposures and possible workplace hazards
- ✔ **Outreach and education** to generate public awareness about health and safety issues
- ✔ **Research service** to investigate and report on illnesses and injuries to improve working conditions

Free Services Offered to...

- ✔ Workers, Unions, Employers, Students
- ✔ Joint Health & Safety Committees and Representatives
- ✔ Health Professionals, Legal Clinics
- ✔ Community Groups, General Public

OHCOW Can Help If...

- ✔ You think something about your work is putting you or your co-workers' health at risk
- ✔ You need occupational health and safety information
- ✔ Several people at your workplace have similar health problems
- ✔ Your Joint Health and Safety Committee has found a problem and needs help resolving it

Tracking – Overall recon

Disease	Total	OD&SBP	Claims with Appeals	Claims with WSIAT	Allowed	Denied	NFA	Pending
Kidney	6	6			4	2		0
Lung	25	21	3	1	14	6		5
Skin	4	4			3	1		0
Lymphoma	12	11	1		8	4		0
Leukemia	5	4	1		1	3		1
Mesothelioma	1	1			1			0
Gastrointestinal	26	22	3	1	4	13		9
Bladder	5	5			2	2		1
Brain	2	2				1		1
Liver	1	1						1
Pancreatic	5	5				5		0
Prostate	15	15				15		0
Upper respiratory	8	6	1	1	2	4		2
Other cancers	5	5				2		3
Subtotal Cancer	120	108	9	3	39	58		23
Wire & Cable	53	9			2		44	7
Non-Cancer	55	51	1	3	8		44	47
Grand total	328				49	58	44	77

Invitation to All GE Workers and Families, past and present to attend Public Town Hall Meeting

WHERE: Peterborough Navy Club, 24 Whitlaw St. Peterborough On. K9J1K9

WHEN : APRIL 18 2018 from 6:00 p.m. - 9:00 p.m.

The Unifor GE Retirees Occupational Health Advisory Committee is hosting a public town hall meeting for GE workers and families who have suffered from Occupational Disease. Come and learn about the new developments in the settlement of disease claims and the roadblocks to receiving just compensation. This is your chance to participate in developing solutions and an action plan for overcoming these obstacles. Representatives from Occupational Health Clinics for Ontario Workers(OHCOW), the Office of the Worker Adviser(OWA) and Unifor will be available to discuss their role and how best their resources can be accessed.

Topics for Discussion

New developments in the GE occupational disease file are evolving that have an important bearing on the fate of GE occupational disease claimants:

Will the OHCOW clinic resources be available in Peterborough and how can they be accessed?

What is going on with the WSIB's reconsideration of denied occupational disease claims?

What is happening to the new claims from the "information session" last March?

What is happening with "presumptive entitlement"? Will it help injured workers?

What difficulties are claimants and their families experiencing with the WSIB?

Do workers need to have the WSIB undergo a public inquiry into their policies and practices?

Hope to see you there!
UNIFOR Occupational Health Advisory Committee
For further information you may contact Sue James by email: suejames@cogeco.ca

To: All Members
Board of Health

From: Dr. Rosana Salvaterra, Medical Officer of Health

Subject: **Board of Health Minutes – March 14, 2018**

Date: April 11, 2018

Proposed Recommendation:

That the minutes of the meeting held on March 14, 2018, of the Board of Health for Peterborough Public Health, be approved as circulated.

Attachments:

Attachment A – Board of Health Minutes, March 14, 2018

Board of Health for
Peterborough Public Health
DRAFT MINUTES
Board of Health Meeting
Wednesday, March 14, 2018 – 9:00 a.m.
Dr. J.K. Edwards Board Room
Jackson Square, 185 King Street

In Attendance:

Board Members:	**Councillor Henry Clarke**
	Councillor Gary Baldwin
	Councillor Lesley Parnell
	Mr. Gregory Connolley
	Mayor Mary Smith
	Mr. Andy Sharpe
	Ms. Kerri Davies
	Deputy Mayor John Fallis
	Chief Phyllis Williams
	Councillor Wilson
	Mayor Rick Woodcock
Regrets:	**Ms. Catherine Praamsma**
Staff:	**Dr. Rosana Salvaterra, Medical Officer of Health**
	Ms. Alida Gorizzan, Executive Assistant
	Ms. Natalie Garnett, Recorder

1. Call to Order

Councillor Clarke, Chair, called the meeting to order at 5:30 p.m.

2. Confirmation of the Agenda

MOTION:
That the agenda be adopted as circulated.
Moved: Mr. Sharpe
Seconded: Deputy Mayor Fallis
Motion carried. (M-2018-017)

3. Declaration of Pecuniary Interest

4. Consent Items to be Considered Separately

MOTION:
That the following items be passed as part of the consent agenda: 9.1a, 9.2.a-g, 9.3.1, 9.3.2, and 9.4.1.a-d.
Moved: Councillor Wilson
Seconded: Mr. Williams
Motion carried. (M-2018-018)

MOTION (9.1a):
That the Board of Health for Peterborough Public Health:

- *receive for information, Resolution #2017-03 dated December 7, 2017 from the Board of Health for the Haliburton, Kawartha, Pine Ridge District Health Unit (HKPR) regarding the Repeal of Section 43 of the Criminal Code Refresh 2017; and,*
- *support their position and communicate this support to the Minister of Justice with copies to the Prime Minister, Local Members of Parliament, Local Members of Provincial Parliament, Local Government Councils, Local Boards of Education, Local Children's Planning Tables, Ontario Boards of Health, and the Association of Local Public Health Agencies.*

Moved: Councillor Wilson
Seconded: Mr. Williams
Motion carried. (M-2018-018)

MOTION (9.2a-g):
That the Board of Health for Peterborough Public Health receive the following for information:

a. *Letter dated February 23, 2018 from Minister Hoskins to MPP Leal regarding the Expert Panel report.*
b. *News release dated March 5, 2018 from cbc.ca regarding provincial funding for hepatitis C drugs*

Letters/Resolutions from other Local Public Health Agencies:
Food Insecurity / Nutritious Food Basket Costing
c. Grey Bruce

Income Security: Roadmap for Change
d. Middlesex London

Publically Funded Vaccine for Childcare Workers
e. Grey Bruce

Smoke-Free Modernization
f. Grey Bruce

Tobacco and Smoke-Free Campuses

g. Sudbury & Districts

Moved: Councillor Wilson
Seconded: Mr. Williams
Motion carried. (M-2018-018)

MOTION (9.3.1)

That the Board of Health for Peterborough Public Health receive the staff report, Assessing Attitudes for Developing Smoke-Free Policies on Post-Secondary Campuses, for information.

Moved: Councillor Wilson
Seconded: Mr. Williams
Motion carried. (M-2018-018)

MOTION (9.3.2):

That the Board of Health for Peterborough Public Health approve the appointment of Dr. James R. Pfaff, former Associate Medical Officer of Health for the Simcoe Muskoka District Health Unit, as Acting Medical Officer of Health for Peterborough Public Health for the period of March 31 – April 8, 2018.

Moved: Councillor Wilson
Seconded: Mr. Williams
Motion carried. (M-2018-018)

MOTION (9.4.1a-d):

a. That the Board of Health for Peterborough Public Health receive meeting minutes of the Stewardship Committee from January 13, 2018, for information.

b. That the Board of Health for Peterborough Public Health approve revisions to the Stewardship Committee's Terms of Reference;

c. That the Board of Health for Peterborough Public Health:
- receive the staff report, 2018 Budget Approval - Healthy Babies, Healthy Children Program, for information; and
- recommend to the Board of Health approval the 2018 budget for the Healthy Babies, Healthy Children (HBHC) program in the total amount of $928,413

d. That the Board of Health for Peterborough Public Health:
- receive the staff report, 2018-19 Budget Approval - Infant and Toddler Development Program (ITDP), for information; and
- recommend to the Board of Health approval of the 2018-19 budget for the Infant and Toddler Development Program in the total amount of $242,423.

Moved: Councillor Wilson
Seconded: Mr. Williams
Motion carried. (M-2018-018)

5. Delegations and Presentations

5.1. Presentation: Inaakonigewin Andaadad Aki: Michi Saagiig Treaties

The Board watched a video produced by Curve Lake First Nation entitled "Inaakonigewin Andaadad Aki: Michi Saagiig Treaties", following an introduction by Chief Williams.

6. Confirmation of the Minutes of the Previous Meeting

6.1 February 14, 2018

MOTION:
That the minutes of the Board of Health for the Peterborough Public Health meeting held on February 14, 2018 be approved as circulated.

Moved:	Mr. Connolley
Seconded:	Councillor Parnell
Motion carried.	(M-2018-019)

7. Business Arising From the Minutes

8. Staff Reports

8.1 Staff Presentation: Community Dental Health Centre Move Update

Patti Fitzgerald, Manager, Child Health Services, provided a presentation on the Community Dental Health Centre move.

MOTION:
That the Board of Health for Peterborough Public Health, receive the presentation, "Community Dental Health Centre Move Update", for information.

Moved:	Councillor Wilson
Seconded:	Deputy Mayor Fallis
Motion carried.	(M-2018-020)

8.2 Staff Presentation: The Case for Smoke-Free Movies

Logan Kelly and Meagan Lecompte, Peer Leaders, provided an update on "The Case for Smoke-Free Movies".

MOTION:
That the Board of Health for Peterborough Public Health request staff to provide recommended wording at the April Board of Health meeting for a motion supporting the work on 'smoke-free movies'.
Moved: Deputy Mayor Fallis
Seconded: Ms. Davies
Motion carried. (M-2018-021)

MOTION:
That the Board of Health for Peterborough Public Health, receive the presentation, "The Case for Smoke-Free Movies", for information.
Moved: Councillor Parnell
Seconded: Mr. Williams
Motion carried. (M-2018-022)

8.3 Staff Presentation: Ontario Public Health Standards – New Foundational Standard for Public Health

Ms. Jane Hoffmeyer, Manager, Foundational Standards, provided a presentation on "Ontario Public Health Standards – New Foundational Standard for Public Health".

MOTION:
That the Board of Health for Peterborough Public Health, receive the presentation, "Ontario Public Health Standards – New Foundational Standard for Public Health", for information.
Moved: Councillor Baldwin
Seconded: Chief Williams
Motion carried. (M-2018-023)

9. Consent Items

10. New Business

10.1 Request for Stewardship Committee Appointment

Members interested in serving on the Stewardship Committee are asked to contact Ms. Gorizzan. The names of interested members will be provided to the Governance Committee for their consideration.

MOTION:
That the Board of Health for Peterborough Public Health, appoint an additional Board Member to the Stewardship Committee for 2018.
Moved: Mayor Smith
Seconded: Councillor Parnell
Motion carried. (M-2018-024)

10.2 Association of Local Public Health Agencies 2018 Winter Conference

Councillor Parnell provided an update on the alPHa conference.

MOTION:
That the Board of Health for Peterborough Public Health, receive the oral update, "Association of Local Public Health Agencies 2018 Winter Conference" for information.
Moved: Councillor Parnell
Seconded: Deputy Mayor Fallis
Motion carried. (M-2018-025)

11. In Camera to Discuss Confidential Matters

12. Motions from In Camera for Open Session

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

The next meeting will be held April 11, 2018 in the Council Chambers, Township of Cavan Monaghan Municipal Office, 988 County Road 10, Millbrook, at 5:30 p.m.

14. Adjournment

MOTION:
That the meeting be adjourned.
Moved by: Councillor Wilson
Seconded by: Deputy Mayor Fallis
Motion carried. (M-2018-026)

The meeting was adjourned at 5:43 p.m.

Chairperson

Medical Officer of Health

Staff Report

Smoke-Free Movies

Date:	April 11, 2018
To:	Board of Health
From:	Dr. Rosana Salvaterra, Medical Officer of Health

Original approved by	***Original approved by***
Rosana Salvaterra, M.D.	Nancy Pye, Youth Development Worker

Proposed Recommendations

That the Board of Health for Peterborough Public Health:

- *receive the staff report, Smoke-Free Movies, for information;*
- *communicate our concerns about smoking in youth-rated movies and advocate for the five policy changes indicated below to local MPPs;*
- *advocate in writing to the Ontario Film Review Board for the five policy changes outlined in the staff report; and,*
- *share these actions with the Association of Local Public Health Agencies, and Ontario Boards of Health.*

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.
- At its March 14th, 2018 meeting, the Board of Health requested that staff prepare a report with recommendations for action on smoking in movies.

Background

In Ontario, due to a combination of Federal and Provincial laws, commercial tobacco advertising and tobacco company sponsorship of events are no longer permitted, effectively cutting off any means of commercial tobacco promotion. Movies, however, remain an unregulated vehicle whereby tobacco companies have unfettered access to youth and where these companies continue to promote their products.

The tobacco industry has a long history of paying actors, production companies, and movie studios to use and endorse their products in movies. Nearly 60% of top movies made in the last 10 years contain onscreen commercial tobacco. Commercial tobacco images in movies recruit new smokers and subsequently lead to an increase in preventable tobacco related deaths and preventable disease.[1] The U. S. Surgeon General directly correlates youth watching movies that contain tobacco imagery with the uptake of smoking commercial tobacco.[2] According to the Surgeon General's report, adding a rating of 18A to movies with tobacco impressions would reduce the exposure to tobacco products, decrease the initiation of smoking among youth and adolescents, and avoid the deaths and disease associated with smoking in movies.

Rationale

According to the Ontario Tobacco Research Unit:

- at least 185,000 Ontario children and teens living today will become commercial tobacco consumers due to exposure to onscreen smoking in movies;
- throughout their lifespan, on screen tobacco exposure will amount to $1.1 billion in costs to the healthcare system; and,
- an estimated 59,000 individuals will die prematurely from a smoking related disease.[3]

In Ontario, the Province's *Film Classification Act* gives the Ontario Film Review Board (OFRB) the ability to review and classify films exhibited, rented, or sold in Ontario. There are currently over 20 different content advisor categories including sexual content, coarse language, mature themes, and tobacco use. However, approximately nine out of ten youth- rated movies with smoking did not include an OFRB "tobacco use" content advisory.[4]

The short term goal of the Smoke-Free Movies initiative is to gather public and stakeholder support for the five policy changes that have been endorsed by leading health organizations, including the World Health Organization, to protect children and youth from the promotion of tobacco products in movies.

The longer term objectives of the campaign include:

1. rating future films with tobacco impressions in them 18A in Ontario;
2. requiring strong anti-smoking ads to be shown prior to movies that have tobacco use in them (i.e., as a PSA or trailer before the movie starts);

3. requiring movie companies to certify that they have not been "paid-off" for displaying tobacco in their films;
4. prohibiting tobacco brands displayed in movies; and
5. restricting government grants and subsidies for youth-rated films that have tobacco imagery in them.

Strategic Direction

The staff report on Smoke-Free Movies applies to the following strategic directions:

- Determinants of Health and Health Equity

Tobacco control policies take a population-based approach to improving health. They have the potential to reach more people and can be particularly effective at reducing tobacco-related health disparities.

Contact:

Nancy Pye
Youth Development Worker
705-743-1000, ext. 321
npye@peterboroughpublichealth.ca

Keith Beecroft
Health Promoter
(705) 743-1000, ext. 238
kbeecroft@peterboroughpublichealth.ca

References:

[1] Luk, R., and Schwartz, R. *Youth Exposure to Tobacco in Movies in Ontario, Canada: 2004-2014* (2015).https://otru.org/wp-content/uploads/2015/09/special_movies.pdf

[2]U.S. Department Of Health And Human Services. *Preventing Tobacco Use Among Youth and Young Adults: A Report of the Surgeon General* (2012).https://www.surgeongeneral.gov/library/reports/preventing-youth-tobacco-use/full-report.pdf

[3] Luk, R., and Schwartz, R. *Youth Exposure to Tobacco in Movies in Ontario, Canada: 2004-2014* (2015).https://otru.org/wp-content/uploads/2015/09/special_movies.pdf

[4] Luk, R., and Schwartz, R. *Youth Exposure to Tobacco in Movies in Ontario, Canada: 2004-2014* (2015).https://otru.org/wp-content/uploads/2015/09/special_movies.pdf

To: All Members
Board of Health

From: Dr. Rosana Salvaterra, Medical Officer of Health

Subject: Staff Presentation: Ontario Public Health Standards – Chronic Disease Prevention and Wellbeing; Substance Use and Injury Prevention

Date: April 11, 2018

Proposed Recommendation:

That the Board of Health for Peterborough Public Health receive the following for information:
Staff Presentation: Ontario Public Health Standards – Chronic Disease Prevention and Wellbeing; Substance Use and Injury Prevention
Presenters: Hallie Atter, Manager, Local Program Standards; Donna Churipuy, Director of Public Health Programs

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Attachments:

Attachment A – OPHS Presentation

Ontario Public Health Standards
Chronic Disease Prevention and Well-Being, Substance Use and Injury Prevention

Presented by: Hallie Atter and Donna Churipuy
Date: April 11, 2018

Peterborough Public Health

Chronic Disease Prevention and Well-Being: Requirements

- Monitoring
- Public health interventions
  - Assessment
  - Consultation/Collaboration
  - Topics for consideration
  - Evidence based
- Enforcement of *Skin Cancer Prevention Act* and *Healthy Menu Choices Act*
  - Implemented by Environmental Health staff

Peterborough Public Health

Change from Previous Standards

- Guidelines vs Guidance Documents
- Inclusion of Well-being
- New topics for consideration e.g. mental health promotion
- Mandate to address protective factors
- Emphasis on priority populations and health equity outcomes
- No longer a mandate to include cancer screening promotion

Peterborough Public Health

Substance Use and Injury Prevention: Requirements

- Monitoring
- Public health interventions
  - Assessment
  - Consultation
  - Assessment of existing programs and services
  - Topics for consideration
  - Evidence based
- Enforcement of *Smoke-Free Ontario Act* and *Electronic Cigarettes Act*
  - Implemented by Environmental Health staff

Peterborough Public Health

Change from Previous Standards

- Guidelines vs Guidance Documents
- Emphasis on health equity and priority populations
- Inclusion of harm reduction approach
- Addition of tobacco as a substance
- New topics for consideration
  - Life promotion
  - Mental health promotion
- Mandate to address protective factors

Peterborough Public Health

Moving Forward

- Our Planning Process
  - High level Intended Impact Statement
    "Enhanced and equitable health outcomes"
  - Emphasizing upstream approaches
- Connection to Foundational Standards and Environmental Health, School Health and Healthy Growth and Development Standards
  - Share some topics for consideration e.g. built environment, healthy sexuality

Peterborough Public Health

Staffing

- Multi-disciplinary
  - Registered Dieticians
  - Health Promoters
  - Public Health Nurses
  - Community Workers
  - Youth Development Worker
  - Peer Leaders
  - Administrative Assistants

Peterborough Public Health

Uncertainty

- How will the renewed Smoke-free Ontario Strategy fit with the standards and guidelines?
- Pending guidelines
  - *Chronic Disease Prevention*
  - *Injury Prevention*
- Indicators

Peterborough Public Health

Questions

To: All Members
Board of Health

From: Dr. Rosana Salvaterra, Medical Officer of Health

Subject: Staff Presentation: Website Redevelopment Project

Date: April 11, 2018

Proposed Recommendation:

That the Board of Health for Peterborough Public Health receive the following for information:
Staff Presentation: Website Redevelopment Project
Presenters: Kerri Tojcic, Computer Technician Analyst; Brittany Cadence, Manager, Communications & I.T.

Attachments:

Attachment A – Website Redevelopment Project Presentation

Website Redevelopment Project

Presenters: Kerri Tojcic and Brittany Cadence
Date: April 11, 2018

Peterborough Public Health

Today's Presentation

Peterborough Public Health

Why a New Website?

- Last redesign in 2012
- Mobile-friendly
- AODA requirements
- Online payments and scheduling

Ontario
ACCESSIBILITY FOR ONTARIANS
WITH DISABILITIES ACT 2005 (AODA)

Peterborough Public Health

Project Overview

- **February 2017** – Submitted one-time funding request to the Ministry for website redevelopment project
- **November 2017** – request approved for $26,500
- **December 2017** – sent out RFPs, selected Addrenaline Media
- **January – March 2018** – finalized project plan, commenced work, including photo shoot and focus groups
- **March 31, 2018** – completed sandbox

Peterborough Public Health

Next Steps

- **April/May 2018** – PPH staff review draft content
- **May 27-June 2, 2018** – Launch new site during National Access Awareness Week
- **June 2018** → implement AODA compliance and website content management systems

Peterborough Public Health

How about a

SNEAK PEEK?

Peterborough Public Health

To: All Members
Board of Health

From: Mayor Rick Woodcock, Chair, Stewardship Committee
Richard Steiginga, Partner, Collins Barrow Kawarthas LLP

Subject: **2017 Draft Audited Financial Statements**

Date: April 11, 2018

Proposed Recommendation:

That the Board of Health for Peterborough Public Health:

- *receive for information, the oral presentation by Richard Steiginga,* Partner, Collins *Barrow Kawarthas LLP, regarding the 2017 Draft Audited Financial Statements; and,*
- *approve the 2017 Draft Audited Financial Statements as circulated.*

Background:

The Stewardship Committee met last on March 20, 2018. At that meeting, the Committee requested that the statements come forward to the Board at their next meeting.

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

Attachments:

Attachment A – 2017 Draft Audited Financial Statements (to be provided)

Staff Report

Summary of Peterborough Public Health's 2018 Annual Service Plan Submission

Date:	April 11, 2018
To:	Board of Health
From:	Dr. Rosana Salvaterra, Medical Officer of Health

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

Proposed Recommendations

That the Board of Health for Peterborough Public Health:

- receive the staff report, *Summary of Peterborough Public Health's 2018 Annual Service Plan (ASP) Submission,* for information;
- approve the 2018 budgets for Ministry of Health and Long-Term Care 100% funded programs in the amount of $2,043,100; and
- approve the 2018 budgets for Ministry of Health and Long-Term Care Additional Base and One-Time programs in the amount of $702,597.

Financial Implications and Impact

This staff report is an update on the new procedure being utilized by the Ministry of Health and Long-Term Care (MOHLTC or Ministry) for budget submission. The Board of Health approved the cost-shared budget at its meeting in November of 2017. With the exception of one-time requests and the additional base enhancement noted above, the Annual Service Plan (ASP) aligns with that approved budget.

As part of the ASP submission, the Ministry provided an opportunity to request Additional Base Funding to address requirements under the new Ontario Public Health Standards (OPHS) or fiscal pressures. Funding of Additional Base programs is to be cost-shared by the Ministry and local partners. Additional Base Funding requests were submitted to the Ministry for Menu Labelling in the amount $111,947 and for Vision Screening in the amount of $108,994. If the budget submissions are approved, additional local funding in the amount of $55,235 will be required to match the Ministry funding of $165,706. These additional funds were not requested from the local partners when the cost-shared budget was approved by the Board, as this opportunity was not known.

Budgets for one-time funding were included in the ASP to fund programs and services not covered through base funding. Budget submissions in excess of $100,000 must be approved by the Board of Health. A funding request of $292,000 was submitted for the acquisition and implementation of an Electronic Medical Record (EMR) system for sexual health services. The funding will help to modernize service delivery, improve transparency and accountability, and support a culture of quality and continuous improvement in the Sexual Health Clinic and other settings in accordance with the OPHS Foundational Standard "Effective Public Health Practice - Quality and Transparency". Approved one-time funding is provided at 100% by the Ministry.

Decision History

The Board of Health approved the 2018 cost-shared budget on November 8, 2017. At that time budget requests for the 100% Funded Programs, Additional Base or One-Time Funding requests had not been submitted to the Board of Health for approval as the Ministry had not provided guidelines to prepare.

In 2017, no funding increases were provided by the Province for 100% funded programs with the exception of the Needle Exchange Initiative and new funding for the Harm Reduction Enhancement Program.

Early communication by the Ministry indicated that no increase in funding should be expected for 100% Funded Programs in 2018. These budgets were prepared and submitted based on the same funding as the prior year. When the Province does not provide adequate funding to cover the costs of 100% programs, the excess costs must be covered through the mandatory cost-shared programs funded 25% by local partners.

Background

In February 2018, the Ministry circulated the new ASP Template for Cost-Shared and 100% Funded Programs to local public health agencies. The Province designed this template to collect information that they feel will help them make better informed decisions about public health funding needs. Using this additional information provided through the template, the M Ministry hopes to demonstrate to the Province the value of money for the investment in public health programs.

The new template itself is over 100 pages in length. This is due, in part, to the addition of narrative components that were previously not required by the Ministry. Current programs were sorted by their relevance to the focus of the new set of Standards (see Appendix A). The template also required the inclusion of program details including: local evidence demonstrating need or priority, key stakeholders, objectives, indicators and descriptions of the included interventions.

The final submission represents a fulsome collaboration between Program Managers and the Finance Manager. It is important to emphasize that the ASP document was written in a context of an incomplete set of Ministry guidelines and protocols. This meant that Managers considered budget needs of programming as it currently is designed instead of budget needs for programming that has been adjusted to meet the new standards. The board-approved 2018 budget set the parameters for the 2018 PPH Annual Service Plan for both Cost-Shared and 100% Funded programs.

Summary tables containing budget information from the ASP are attached (see Appendices B, C & D).

Rationale

The Board of Health is required to approve and submit to the Ministry, an ASP for both cost-shared and 100% funded programs that does not result in a deficit. Specifically, the Public Health Accountability Framework demands the following requirement:

> "The Board of Health shall submit an Annual Service Plan and Budget Submission to include all programs and services delivered by boards of health and program costing for Ministry-funded programs." (MOHLTC OPHS: Requirements for Programs, Services, and Accountability (2018), pg. 70)

Strategic Direction

The 2018 approved budget allows the Board to address all its strategic priorities.

Contact:

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

Attachments:

Appendix A: Summary of PPH's Annual Service Plan Submission – Program List by Standard
Appendix B: Cost-Shared Program by Program Standard – 2018 Budget
Appendix C: 100% Funded Programs – 2018 Budget
Appendix D: Additional Base and One-Time Funding Requests – 2018 Budget

APPENDIX A: Summary of PPH's Annual Service Plan Submission - Program List by 2018 Ontario Public Health Standards (Includes Cost-Shared and 100% Funded Programs)

Chronic Disease Prevention and Well-Being	Food Safety
Physical Activity Promotion	Inspections
Skin Cancer Prevention	Education
Healthy Eating	Menu Labelling
Work and Health	Enhanced Food Safety (100%)
Cancer Screening Promotion – Indigenous Communities	
Health and Housing (Social Determinants – 100%)	

Healthy Environments	Healthy Growth and Development
Surveillance and Monitoring of Health Hazards	Child Health
Inspections	Reproductive Health
Climate Change	Family Health (Social Determinants – 100%)

Infectious and Communicable Diseases Prevention and Control	Safe Water
Reportable Diseases and Outbreak Investigations	Recreational Water (Beaches) Surveillance and Monitoring
Zoonotic Disease Surveillance and Monitoring	Inspections/Investigations
Rabies Prevention and Control	Small Drinking Water
Vector Borne Diseases	Enhanced Safe Water (100%)
Sexual Health Clinics	
Infection Prevention and Control Nurses (100%)	
Infectious Disease Control Initiative (100%)	

Immunization	School Health – Oral Health
Vaccine services	Oral Health Assessment and Surveillance
	Healthy Smiles Ontario (100%)

School Health – Immunization	School Health – Vision
Immunization	Vision Health and Vision Screening

School Health – Other
Comprehensive School Health

Substance Use	Injury Prevention
Tobacco Wise Living	Transportation Safety
Cannabis	Complete Play Spaces
Alcohol	
Harm Reduction – Opioid (100%)	
Needle Exchange Initiative (100%)	
Smoke Free Ontario – Youth Engagement (100%)	
Smoke-Free Ontario – Tobacco Control (100%)	
Smoke-Free Ontario – Enforcement (100%)	
Smoke-Free Ontario – Prosecution (100%)	
Electronic Cigarette Act (100%)	

APPENDIX B: Cost-Shared Program by Program Standard – 2018 Budget

Programs Funded January 1 to December 31, 2018	2018 Budget Request
Foundational Standards	$700,314
Emergency Management	$65,243
Chronic Disease Prevention and Well-Being	$1,133,164
Food Safety	$469,578
Healthy Environments	$186,785
Healthy Growth and Development	$783,803
Immunization	$133,706
Infectious and Communicable Diseases Prevention and Control	$1,542,768
Safe Water	$304,266
School Health – Oral Health	$233,880
School Health – Immunization	$246,331
School Health – Comprehensive	$285,035
Substance Use	$285,622
Injury Prevention	$237,764
Public Health Administration	$1,200,246
Small Drinking Water	$90,800
Vector Borne Diseases	$76,133
Total Cost-Shared Programs	**$7,975,438**

APPENDIX C: 100% Funded Programs – 2018 Budget

Programs Funded January 1 to December 31, 2018	2018 Budget Request
Chief Nursing Officer	$121,500
Infection Prevention and Control Nurses	$90,100
Infectious Diseases Control	$222,300
Social Determinants of Health Nurses	$180,500
Enhanced Safe Water	$15,500
Enhanced Food Safety – Haines	$25,000
Needle Exchange Initiative	$57,000
Electronic Cigarettes Act	$29,300
Smoke-Free Ontario	$388,800
Harm Reduction Enhancement – Opioid	$150,000
Healthy Smiles Ontario	$763,100
Total 100% Funded Programs	**$2,043,100**

APPENDIX D: Additional Base and One-Time Funding Requests – 2018 Budget

Additional Base - January 1 to December 31, 2018	2018 Budget Request
Menu Labelling	$111,947
Vision Screening	$108,994
Total Additional Base Funding Requests	**$220,941**
One-Time Funding (100%)	
Enhanced Cessation	$30,000
Public Health Inspector Practicum	$20,000
Needle Exchange Program Evaluation	$50,000
Vaccine Refrigerators	$45,800
Electronical Medical Record – Sexual Health Services	$292,000
Enhanced Food Safety – Haines	$25,000
Vision Screening Equipment	$13,856
Recreational Water (Beaches) Predictive Modelling Pilot	$30,000
Total One-Time Funding Requests – 100% Funded	**$481,656**
Total Additional Base and One-Time Funding Requests	**$702,597**

To: All Members
Board of Health

From: Dr. Rosana Salvaterra, Medical Officer of Health

Subject: **Presentation: Cancer Care Ontario Report - Prevention System Quality Index: Health Equity**

Date: April 11, 2018

Proposed Recommendation:

That the Board of Health for Peterborough Public Health receive the following for information:
Presentation: Cancer Care Ontario Report - Prevention System Quality Index: Health Equity
Presenter: Dr. Rosana Salvaterra, Medical Officer of Health

Attachments:

Attachment A – Presentation - CCO Report, Prevention System Quality Index: Health Equity
Attachment B – Executive Summary
Attachment C – Full Report **(NOTE: WEB HYPERLINK)**

Web of Being: Social determinants and Indigenous people's health

SOURCE: Dr. Margo Greenwood, National Collaborating Centre for Aboriginal Health (NCCAH) 2009.

Ontario population: Indicators, data sources and socio-demographic factors included in the report

Indicator	Indicator type	Data source(s)	Socio-demographic factors analyzed[1]								
			Sex	Household income	Education	Residence	Geography	Immigration status	Cultural or racial group	Sexual orientation	Occupational group
Commercial tobacco											
Percentage of adults who are current smokers	Prevalence	CCHS	✓	✓	✓	✓	✓	✓	✓	✓	✓
Exposure to second-hand smoke in adults	Policy/program	CCHS	✓	✓	✓	✓	✓	✓		✓	
Exposure to second-hand smoke in adolescents	Policy/program	CCHS	✓	✓	✓	✓	✓				
Smoke-free policies in social housing	Policy/program	Local housing corporations									
Quit attempts	Policy/program	CCHS	✓	✓	✓	✓	✓	✓		✓	✓
Long-term smoking cessation	Policy/program	CCHS	✓	✓	✓	✓	✓	✓	✓	✓	✓
Alcohol											
Percentage of adults who drink alcohol in excess of cancer prevention recommendations	Prevalence	CCHS	✓	✓	✓	✓		✓		✓	
Percentage of adults who binge drink	Prevalence	CCHS	✓	✓	✓	✓		✓		✓	
Frequency of binges for adult binge drinkers	Prevalence	CCHS	✓	✓	✓	✓		✓		✓	
Intensity of binges for adult binge drinkers	Prevalence	CCHS	✓	✓	✓	✓		✓		✓	
Healthy eating											
Percentage of adults with inadequate vegetable and fruit consumption	Prevalence	CCHS	✓	✓	✓	✓	✓	✓	✓		
Percentage of households that are food insecure	Policy/program	CCHS		✓			✓				
Percentage of adults who are food insecure	Policy/program	CCHS	✓								
Physical activity											
Percentage of adults who are physically inactive	Prevalence	CCHS	✓	✓	✓	✓	✓	✓	✓	✓	
Percentage of adolescents who are physically inactive	Prevalence	CCHS	✓	✓	✓	✓			✓		
Enrolment in health and physical education, by school neighbourhood income	Policy/program	Ontario Ministry of Education	✓	✓							

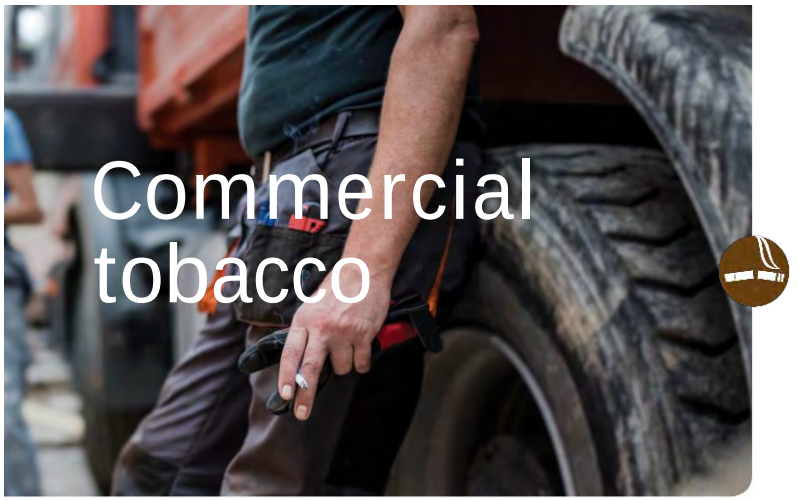
Ontario population: Indicators, data sources and socio-demographic factors included in the report (cont'd)

*Socio-demographic factors analyzed	Definition
Sex	The sex of the respondent: male or female.
Household income	Respondents' derived household income sorted into quintiles based on the ratio of household income to the low-income cut-off for the household size and community. The low-income cut-off is the threshold at which a family would typically spend a larger portion of its income than the average family on the necessities of food, shelter and clothing.
Education (individual)	The highest level of education attained by the respondent: less than secondary school, secondary school graduate, or post-secondary graduate.
Education (household)	The highest level of education attained by any member of a household: less than secondary school, secondary school graduate, or post-secondary graduate.
Residence	Respondents living in any census metropolitan area (CMA) or census agglomeration (CA) are considered urban residents and those living outside of any CMA or CA are classified as rural residents.
Geography	The northern region is defined to include only Algoma, North Bay-Parry Sound, Northwestern, Porcupine, Sudbury, Thunder Bay and Timiskaming public health units. The remaining 29 public health units comprise the southern region.
Immigration status	Distinguishes immigrants, according to time since immigration, from the Canadian-born population based on three categories: less than or equal to 10 years in Canada, more than 10 years in Canada, or Canadian-born.
Cultural or racial group	The cultural or racial group of the respondent: white, Black, East and Southeast Asian (includes Filipino, Japanese, Korean, Chinese and Southeast Asian), West and South Asian or Arab (includes South Asian, Arab and West Asian), or other (includes Latin American, other cultural or racial origin and multiple cultural or racial origins).
Sexual orientation	The sexual orientation of the respondent: heterosexual, or gay, lesbian or bisexual.
Occupational group	The occupational group (based on job type) the respondent belongs to using the National Occupational Classification-Statistics (NOC-S) 2006 at the two-digit level. An occupational group is defined as a collection of jobs, which are grouped by the type of work performed.

First Nations, Inuit and Métis populations: Indicators, data sources and socio-demographic factors included in the report

Indicator	Indicator type	Data source(s)	Socio-demographic factors analyzed
Commercial tobacco			
Percentage of First Nations on- and off-reserve who are current smokers	Prevalence	RHS and CCHS	Age
Percentage of Métis who are current smokers	Prevalence	CCHS	Age, household income, education
Percentage of Inuit who are current smokers	Prevalence	APS	Age
Exposure to second-hand smoke (home, vehicles, public places) in First Nations off-reserve	Policy/program	CCHS	Age
Exposure to second-hand smoke (home, vehicles, public places) in Métis	Policy/program	CCHS	Age
Exposure to second-hand smoke (home) in Inuit	Policy/program	APS	Sex
Alcohol			
Percentage of First Nations adults on- and off-reserve who abstain from drinking alcohol	Prevalence	RHS and CCHS	Sex
Percentage of Métis adults who abstain from drinking alcohol	Prevalence	CCHS	Sex
Percentage of Inuit adults who abstain from drinking alcohol	Prevalence	APS	Sex
Percentage of First Nations adults on- and off-reserve who binge drink	Prevalence	RHS and CCHS	Sex
Percentage of Métis adults who binge drink	Prevalence	CCHS	Sex
Percentage of Inuit adults who binge drink	Prevalence	APS	Sex
Healthy eating			
Percentage of First Nations adults on- and off-reserve with inadequate vegetable and fruit consumption (ate vegetables fewer than 2 times per day and fruit fewer than 2 times per day)	Prevalence	RHS and CCHS	Sex
Percentage of Métis adults with inadequate vegetable and fruit consumption (ate vegetables and fruit fewer than 5 times per day)	Prevalence	CCHS	Sex, household income, education
Percentage of First Nations adults (on- and off-reserve) who live in (moderately or severely) food insecure households	Policy/program	RHS and CCHS	
Percentage of Métis adults who live in (marginally, moderately or severely) food insecure households	Policy/program	CCHS	
Percentage of Inuit adults who live in food secure households	Policy/program	APS	
Physical activity			
Percentage of First Nations adults on- and off-reserve who are physically inactive	Prevalence	RHS and CCHS	Sex
Percentage of Métis adults who are physically inactive in leisure time	Prevalence	APS	Sex, household income, education, geography

RHS: First Nations Regional Health Survey
CCHS: Canadian Community Health Survey
APS: Aboriginal Peoples Survey



Cancer Care Ontario

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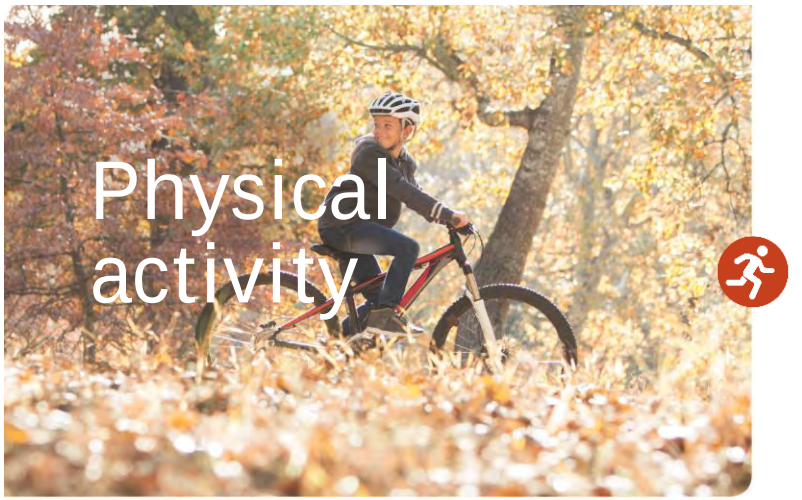

Cancer Care Ontario

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Cancer Care Ontario

Cancer Care Ontario

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Cancer Care Ontario

Sub-populations that were at higher risk related to commercial tobacco, Ontario, 2010–2014

Indicator		Socio-demographic factor								
		Sex	Household income	Education	Residence	Geography	Immigration status	Cultural or racial group	Sexual orientation	Occupational group
Commercial tobacco										
Current smoking		Male	Lower income	Lower education	Rural	Northern	Canadian-born	White	Gay, lesbian or bisexual	Blue collar[3]
Second-hand smoke exposure: Adults	Vehicle	Male	Lower income	Lower education	Rural	Northern	Canadian-born		—	
	Home	—	Lower income	Lower education	Rural	—	Canadian-born		—	
	Public places	—	Lower income	—	—	—	—		—	
Second-hand smoke exposure: Adolescents	Vehicle	—	Lower income	Lower education	—	Northern				
	Home	—	Lower income	Lower education	—	Northern				
	Public places	Female	—	—	Urban	—				
Have not made quit attempt (in past year)[1]		—	—	Lower education	—	Southern	Canadian-born		—	White collar[4]
Have not quit long term (cessation)[1]		—	Lower income	Lower education	—	Northern	Canadian-born	Black	—	Blue collar[3]

Legend

- Significantly higher risk
- Significantly higher risk, with a small effect size (i.e., <5.0% absolute difference)
- — Similar level of risk across categories (i.e., no significant difference)
- Socio-demographic factor not analyzed

Sub-populations that were at higher risk related to alcohol, Ontario, 2010–2014

Indicator	Socio-demographic factor								
	Sex	Household income	Education	Residence	Geography	Immigration status	Cultural or racial group	Sexual orientation	Occupational group
Alcohol									
Exceed recommended limits for cancer prevention	Male	Higher income	—	Rural		Canadian-born		—	
Binge drinking	Male	Higher income	Lower education	Rural		Canadian-born		Gay, lesbian or bisexual	
Frequency of binges for binge drinkers	Male	Lower income	Lower education	—		—		—	
Intensity of binges for binge drinkers	—	Lower income	—	—		Canadian-born		Heterosexual	

Legend

- Significantly higher risk
- Significantly higher risk, with a small effect size (i.e., <5.0% absolute difference)
- — Similar level of risk across categories (i.e., no significant difference)
- Socio-demographic factor not analyzed

Sub-populations that were at higher risk related to healthy eating and physical activity, Ontario, 2010–2014

Indicator		Socio-demographic factor								
		Sex	Household income	Education	Residence	Geography	Immigration status	Cultural or racial group	Sexual orientation	Occupational group
Healthy eating										
Inadequate vegetable and fruit consumption		Male	Lower income	Lower education	Rural	Northern	Canadian-born	—		
Household food insecurity			Lower income			—				
Individual food insecurity		Female								
Physical activity										
Inactive during leisure time	Adults	Female	Lower income	Lower education	Urban	Southern	Immigrants	Non-white	Heterosexual	
	Adolescents	Female	Lower income	Lower education	Urban			Non-white[4]		
Did not enrol in health and physical education beyond 1 compulsory credit[1]		Female	Lower income[3]							

Legend

- Significantly higher risk
- Significantly higher risk, with a small effect size (i.e., <5.0% absolute difference)
- — Similar level of risk across categories (i.e., no significant difference)
- Socio-demographic factor not analyzed

Risk of commercial tobacco use, alcohol consumption, unhealthy eating and physical inactivity in First Nations, Inuit and Métis adults, compared to non-Aboriginal Ontarians, Ontario, 2007–2014

Indicator		Population				
		First Nations on-reserve	First Nations off-reserve	Métis	Inuit living in Nunangat	Inuit living outside Nunangat
Commercial tobacco						
Current smoking		↑	↑	↑	↑	↑
Second-hand smoke exposure	Home and vehicles		—	↑	↑	↑
	Public places		—	—		
Alcohol						
Binge drinking		↑	↑	↑	↑	—
Healthy eating						
Inadequate vegetable and fruit consumption		↑	↑	—		
Household food insecurity		↑	↑	↑	↑[1]	↑[1]
Physical activity						
Physically inactive		↑	—	—		

Legend

↑ Significantly higher risk than non-Aboriginal Ontarians

— Similar level of risk to non-Aboriginal Ontarians (i.e., no significant difference)

Data not available

Cancer Care Ontario

Prevention System Quality Index: Health Equity

A companion to *2016 Prevention System Quality Index: Monitoring Ontario's Efforts in Cancer Prevention*

Prevention System Quality Index: Health Equity reports from a health equity perspective on four risk factors for cancer and other chronic diseases—tobacco use, alcohol consumption, unhealthy eating and physical inactivity.

Many populations in Ontario facing health inequities experience shorter overall life expectancies, and higher incidence and mortality rates for certain cancers.

This report describes the distribution of cancer risk factors in the Ontario population, and how system-level policies and programs with the potential to reduce cancer risk factors can affect groups facing health inequities. It discusses the current status of policies and programs in Ontario, as well as opportunities to reduce cancer risk factors in populations with health inequities.

The main findings show that populations facing health inequities have a higher prevalence of certain cancer risk factors and fare worse on several indicators that measure policy and program effects. Comprehensive strategies implemented across sectors at multiple levels, and include universal and targeted policies and programs are required to reduce risk factor prevalence in the population as a whole and in populations facing health inequities. Better data are needed to understand the cancer risk of populations with health inequities, and to monitor the effects of policies and programs on these populations over time.

What is health equity?

Health equity is achieved when everyone can reach their full health potential no matter where they live, what they have or who they are. Health inequities are differences in health that are systematic, avoidable and unfair. People facing health inequities have greater health risks and poorer health outcomes.

First Nations, Inuit and Métis populations

A major focus of the report is First Nations, Inuit and Métis who face health inequities rooted in colonialism, racism and social exclusion. First Nations, Inuit and Métis populations have a higher prevalence of several cancer risk factors, higher cancer mortality rates, rising rates of cancer incidence and poorer cancer survival than non-Aboriginal Ontarians. This report highlights recommendations for First Nations, Inuit and Métis populations from Cancer Care Ontario's *Path to Prevention —Recommendations for Reducing Chronic Disease in First Nations, Inuit and Métis* report.

The full 2018 PSQI: Health Equity report can be found at cancercareontario.ca/PSQI

Ontario

Cancer Care Ontario

Commercial tobacco

Indicator findings: key differences in tobacco use

More likely to smoke:
- Lower income or education
- Rural or northern areas
- Gay, lesbian or bisexual
- Some blue collar occupations

More likely to be exposed to second-hand smoke in vehicles or homes:
- Adolescents in lower income or education households
- Adolescents in northern areas

Less likely to quit smoking long term:
- Lower income or education
- Some blue collar occupations
- Identify as Black

Ontario has made significant progress in reducing tobacco use through Smoke-Free Ontario, but many groups facing health inequities continue to smoke at much higher rates than the rest of the population. Universal and targeted interventions are needed to further reduce tobacco use.

Highlights of findings, and policy and program opportunities include:

Increase the price of tobacco through taxes

Increasing tobacco prices reduces smoking more than any other policy intervention, especially in groups with low socio-economic status. Ontario has the second-lowest retail price of cigarettes in Canada and its tobacco taxes are only 65 percent of the total retail price; the World Health Organization recommends a minimum of 75 percent.

Develop policies that prohibit smoking in multi-unit housing, with a focus on social housing

Residents of multi-unit housing are more likely to be exposed to second-hand smoke; residents of social housing are particularly vulnerable.

Of the 12 largest local housing corporations (social housing providers), only five have a policy prohibiting smoking in residential units.

Ensure sustained funding for smoking cessation interventions, including pharmacotherapy, for populations facing health inequities

Tailored interventions and free pharmacotherapy, such as nicotine replacement therapy, can increase smoking cessation in populations facing health inequities. The Ontario government currently funds many smoking cessation programs and is planning a coordinated cessation system, with a focus on priority populations.

First Nations, Inuit and Métis populations

First Nations, Inuit and Métis populations have higher smoking rates, and Inuit and Métis people are more likely to be exposed to second-hand smoke than non-Aboriginal Ontarians.

Recommended policies and programs:
- Develop and implement a coordinated plan to prevent commercial tobacco use among First Nations, Inuit and Métis children and youth.
- Establish commercial tobacco cessation programs and services in First Nations, Inuit and Métis communities.
- Support the development of resources to address second- and third-hand smoke.
- Support community-initiated and managed tobacco control measures, while respecting First Nations' rights.

Alcohol

Indicator findings: key differences in alcohol consumption

At similar and lower levels of drinking, groups with low socio-economic status experience more alcohol-related harms than those with high socio-economic status.

Binge drinkers more likely to binge drink frequently (once a week or more):
- Lower income or education

Ontario has many elements of a strong alcohol control system, but there are opportunities to strengthen policies and programs as part of a cross-sectoral, comprehensive provincial alcohol control strategy.

Highlights of findings, and policy and program opportunities include:

Increase the minimum price of alcohol in off-premises outlets

Increasing the price of alcoholic beverages results in lower alcohol consumption in heavy drinkers, especially in low-income populations. In Ontario, current minimum prices are not high enough to appreciably reduce alcohol consumption at the population level.

Reduce alcohol availability by limiting the density of alcohol outlets

An increase in the availability of alcohol outlets in neighbourhoods with lower socio-economic status has been associated with increases in heavy drinking or alcohol-related harms in several jurisdictions. Some municipalities in Ontario have implemented zoning bylaws to reduce clustering of alcohol outlets, but a provincial policy limiting the density of alcohol outlets is not in place.

Increase access to government-funded alcohol treatment services, especially for populations facing health inequities

Many Canadians with at-risk drinking and alcohol use disorders experience barriers accessing appropriate treatment due to limited availability of services, stigma towards alcohol use disorders and financial difficulties.

Ontario has a Mental Health and Addictions Strategy that includes goals to identify mental health and addictions problems, and to provide timely, high-quality, integrated, person-directed health and other human services.

First Nations, Inuit and Métis populations

On-reserve First Nations adults and Inuit adults living in Inuit Nunangat (traditional Inuit homeland) are more likely to abstain from alcohol than non-Aboriginal Ontarians; however, First Nations, Inuit living in Inuit Nunangat and Métis populations have higher rates of binge drinking than non-Aboriginal Ontarians.

Recommended policies and programs:

- Ensure that culturally acceptable and relevant alcohol prevention and treatment programs for First Nations, Inuit and Métis peoples are available.
- Broaden the impact of alcohol intervention strategies.
- Incorporate alcohol interventions into existing tobacco control initiatives.

Healthy eating

Indicator findings: key differences in healthy eating

Less likely to consume vegetables and fruit:

- Lower income or education
- Food insecure

More likely to be food insecure:

- Households with lower income

The high rates of food insecurity in low-income households and high prevalence of inadequate vegetable and fruit consumption in Ontario adults, especially those with low income and education, indicate the need for a provincial strategy, such as the Ontario Food and Nutrition Strategy, which was developed by organizations with a role in food systems and health.

Highlights of findings, and policy and program opportunities include:

Develop and implement the provincial Food Security Strategy

Ontario's Food Security Strategy, which aims to empower communities, integrate food initiatives, address income and drive innovation, is currently being developed. In Ontario, there are several community-based food programs, such as community food centres and the Student Nutrition Program that should also continue to be supported.

Continue to implement poverty reduction policies

Poverty reduction policies, such as raising the minimum wage and social assistance benefits, have been shown to reduce household food insecurity in Canada. Ontario has a Poverty Reduction Strategy (2014–2019) that includes increasing the minimum wage, a basic income pilot project and increasing funding for affordable housing.

Support tailored and economically accessible food literacy programs in communities

Food literacy programs may increase healthy eating in adults and children. In Ontario, there is little provincial coordination of food literacy programs and the school curriculum does not require practical food skills.

Improve the food environment through strategies such as land use planning, tax incentives, re-zoning, taxes on sweetened beverages and food labelling

Changes to the food environment, including the types of foods available from food retailers, the effects of pricing or taxation policies on food purchasing behaviours and environmental cues that prompt food choices, can improve healthy eating. In Ontario, policies and programs to increase the availability of healthy food mainly occur at the local level. Ontario's Healthy Menu Choices Act, 2015 requires menu labelling for restaurants and other food service providers with 20 or more locations.

First Nations, Inuit and Métis populations

First Nations adults on- and off-reserve have higher rates of inadequate vegetable and fruit consumption than non-Aboriginal Ontarians. First Nations adults are more likely to live in a food insecure household than non-Aboriginal Ontarians. Métis households also have higher rates of food insecurity. Inuit have lower rates of food security than non-Aboriginal Ontarians.

Recommended policies and programs:

- Develop an Indigenous food and nutrition strategy.
- Reduce barriers that prevent access to healthy foods for First Nations, Inuit and Métis.
- Address environmental issues for Indigenous foods.
- Develop traditional food and nutrition skills.

Physical activity

Indicator findings: key differences in physical activity

More likely to be inactive during leisure time:

- Adults and adolescents with lower household income or education
- Immigrant adults
- Non-white adults and adolescents
- Adolescent girls

Grade 10 to 12 students less likely to enrol in health and physical education courses:

- Girls
- Boys at schools in lower income neighbourhoods

A comprehensive provincial physical activity strategy is needed to increase physical activity and reduce sedentary behaviour in the Ontario population, including in groups facing health inequities.

Highlights of findings, and policy and program opportunities include:

Develop interventions that increase active transportation, with a focus on health equity

The built environment has an impact on active transportation, which is an important contributor to physical activity. In Ontario, the Provincial Policy Statement does not address equity in active transportation or public transit planning. The province recently announced funding for school-based active transportation initiatives.

Require a health and physical education credit in each year of secondary school and ensure equitable physical activity opportunities

Participation in health and physical education can increase physical activity levels in adolescents. In Ontario, high school students are required to take only one health and physical education course, and boys attending schools in lower income neighbourhoods are less likely to enrol in non-compulsory courses than boys attending schools in higher income neighbourhoods.

Create provincial funding and guidelines to help municipalities make sport and recreation activities accessible to residents with low incomes

Tailored community-based physical activity programs and facilities can increase physical activity levels in populations facing health inequities. In Ontario, some municipalities and organizations offer subsidized or no-cost recreational programming, but this subsidization is not consistently available across the province.

First Nations, Inuit and Métis populations

On-reserve First Nations adults have higher rates of physical inactivity than non-Aboriginal Ontarians.

Recommended policies and programs:

- Work with First Nations, Inuit and Métis to create safe places for physical activity.
- Develop a strategy to promote equity in physical activity infrastructure for First Nations, Inuit and Métis.
- Address the socio-economic barriers to physical activity for First Nations, Inuit and Métis.
- Build and disseminate a knowledge base around physical activity interventions in First Nations, Inuit and Métis communities.

Cancer Care Ontario

The full 2018 Prevention System Quality Index: Health Equity report can be found at cancercareontario.ca/PSQI.

Need this information in an accessible format?
1-855-460-2647 / TTY (416) 217-1815
publicaffairs@cancercare.on.ca

620 University Avenue
Toronto, ON M5G 2L7
416.971.9800
publicaffairs@cancercare.on.ca
cancercareontario.ca

Ontario
Cancer Care Ontario

To: All Members
Board of Health

From: Dr. Rosana Salvaterra, Medical Officer of Health

Subject: Correspondence for Information

Date: April 11, 2018

Proposed Recommendation:

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

a. Letter dated March 19, 2018 from Ministers Coteau and Milczyn regarding the Nutritious Food Basket and the 'Income Security – A Roadmap for Change' report.

b. Summary from the Association of Local Public Health Agencies regarding the 2018 Provincial Budget.

Minister Responsible for the Poverty Reduction Strategy

Office of the Minister

777 Bay Street, 17th Floor
Toronto ON M5G 2E5
Tel.: 416 585-6500
Fax: 416 585-4035

Ministry of Community and Social Services

Minister's Office

Hepburn Block
Queen's Park
Toronto ON M7A 1E9
Tel.: (416) 325-5225
Fax: (416) 325-3347

Ontario

Ministre responsable de la Stratégie de réduction de la pauvreté

Bureau du ministre

777, rue Bay, 17e étage
Toronto ON M5G 2E5
Tél. : 416 585-6500
Téléc. : 416 585-4035

Ministère des Services sociaux et communautaires

Bureau du Ministre

Édifice Hepburn
Queen's Park
Toronto (Ontario) M7A 1E9
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Téléc. : 416 325-3347

MAR 1 9 2018

Ms. Rosanna Salvaterra, Medical Officer of Health
Peterborough Public Health
Jackson Square, 185 King Street
Peterborough, Ontario
K9J 2R8

Dear Ms. Salvaterra:

Thank you for your letter concerning the Nutritious Food Basket, the "Income Security: A Roadmap for Change" report, and the Basic Income Pilot. We appreciate being made aware of Peterborough Public Health's perspective on food security in Ontario, and we thank you for your work in this important area.

As you may know, in 2017, our Poverty Reduction Strategy Office (PRSO) held consultations on food security via an online survey, and hosted in-person meetings to give Ontarians a chance to provide early feedback and help us develop a food security strategy. Outreach included an Indigenous-specific food security questionnaire to help gather input information on key issues, barriers and challenges to food security, as well as to better understand Indigenous perspectives on promising practices and community-led solutions. All of the feedback we received will help develop Ontario's first food security strategy. For more information, please visit www.ontario.ca/page/food-security-consultation.

We acknowledge that, while progress is being made on improving food security in the province, further work is required to close the gap for the many food insecure households in Ontario. Recently, the government invested $5 million in funding for 14 Local Poverty Reduction Fund projects that will increase food security across the province and include a third-party evaluation component. This is important because better data will help communities develop better solutions to increase food security.

.../cont'd

As you know, the Basic Income Pilot is a research study intended to explore a new way of helping people living on low incomes, and evaluate how receiving a basic income might affect the well-being of low-income people who live in different parts of Ontario and in different life situations. We want to see whether it helps people better meet their basic needs while improving their education, employment and health outcomes. Over the three years of the study, we will measure outcomes in areas such as:

- food security;
- stress and anxiety;
- mental health;
- health and health care usage;
- housing stability;
- education and training; and
- employment and labour market participation.

What we learn from this pilot will help inform the government's longer-term plans for income security reform.

Your comments about the "Income Security: A Roadmap for Change" report is much appreciated. All of the feedback we received will be valuable for informing future improvements, and will be taken into account for further decision-making.

As your letter would also interest our colleague the Honourable Dr. Helena Jaczek, Minister of Health and Long-Term Care, we have shared a copy of your letter with Minister Jaczek for her information.

Once again, thank you for writing.

Sincerely,

Hon. Michael Coteau
Minister of Community and Social Services

Hon. Peter Milczyn
Minister of Housing
Minister Responsible for the Poverty Reduction Strategy

c: Honourable Dr. Helena Jaczek, Minister of Health and Long-Term Care

alPHa Summary
Budget 2018:
A Plan for Care and Opportunity

This year's Ontario budget will return to running modest deficits in the coming years to allow for additional investments in a number of significant and long-awaited social programs as well as further investments in health care to ensure that hospitals can continue to meet growing needs. Confidence remains in continued growth and successful management measures, but the aim now is to improve growth and ensure fair distribution of its benefits.

Some of the significant measures in this budget have already been announced or at least reported in the media, such as the provision of free pre-school child care for kids between 2.5 years old and kindergarten entry, expanded pharmacare for seniors, mental health and addictions services and enhancements to the post-secondary tuition coverage.

The focus is to allow Ontarians to better manage the pressures of everyday life thereby boosting economic growth through job creation and opening up access to economic opportunities. Significant attention is of course paid to health, as spending in this area still accounts for over 40% of overall program spending.

There is no specific mention of Ontario's public health system (though public health units are mentioned in a couple of places as recipients of special-purpose funding), but there are as always a number of items of interest that have some bearing on its mandate, as well as priorities that have been identified by alPHa members through its resolutions, Board positions and other activities.

The following summarizes the items that are likely of most interest to alPHa's members, whether they directly affect their business, are related to resolutions and positions that alPHa and its members have taken or are items in which our members have demonstrated a keen interest.

It is worth noting that there is a strong focus on priority / vulnerable populations (seniors, Indigenous, homeless, children with developmental disabilities) in many of the sections that have not been included in this summary (such as affordable housing, justice reforms, gender-based violence). There are also sections on climate change, public transit, community hubs and more that may be of interest. Links to all of the documentation are included below for those who wish to have a closer look and / or examine the sections not captured here.

alPHa will continue its strategy of using the language and commitments found in these documents to advance our own advocacy efforts by underscoring that the work of public health is well-aligned with Government priorities.

- Headings and page numbers refer to the 2018 Budget Papers document, which you can download by clicking this link.
- The Minister's speech is here.
- Online Index to the 2018 Budget is here.

CHAPTER 1: A PLAN FOR CARE

This chapter covers the theme of the budget, which is to alleviate economic pressures on families to help Ontarians "get ahead today and prepare for tomorrow". Following references to the implementation of full-day kindergarten, tuition grants, coverage for prescriptions for Ontarians under 25 and hiking the minimum wage, the chapter outlines investments and pledges in the following areas:

Better Health Care for Everyone in Ontario

The Government will be investing an additional $5 Billion over three years into health care. This includes

- $822M in new money to the Hospital sector, bringing the total to $19B (P5).
- Building on the existing OHIP+ investment ($465M / yr.) for Ontarians under 25, the Province will expand it to include seniors starting in August 2019. This is expected to cost $575M / yr. by the time it is fully implemented in 2020-21 (P11).
- Extended health benefits for the 1 in 4 working-age Ontarians (and 60% of seniors) who do not have access through employers or government programs. A new Ontario Drug and Dental Program will be launched in the summer of 2019 and is expected to cost $800M over the first two years (P12).
- A three-year, $5M investment in the implementation of Rowan's Law, which will establish requirements for concussion management for amateur competitive athletes (P14).

Expanding Access to Mental Health and Addictions Services

Recognizing that there is "no health without mental health", the Province is committed to ensuring access to care and supports for people living with mental illness and / or substance abuse disorders. This will include:

- A new investment of $2.1B over four years to support an integrated, high quality mental health and addictions system (P15).
- $570M over four years for community programs focused on children and youth, including provision of community-designed and -delivered programs for First Nation, Inuit, Métis and urban Indigenous communities (P16).
- $175M over four years to support school-based mental health services (P17).
- $222M investment to continue implementation of the Strategy to Prevent Opioid Addiction and Overdose. This bit includes a reference to the additional staff that have been added to Public Health Units to support local responses (P19).
- $425M for expanding supportive housing for homeless, with a focus on people with complex mental health and addictions needs (P20)
- There is a table on Page 20 that states the following: "Up to five Public Health Units will receive one-time funding (total investment of $1M in 2018-19) for initiatives that promote mental health, including assistance for those who are underhoused and living in rural and remote regions".

Making Child Care More Accessible and Affordable

This initiative is introduced as an investment in the future through provision of a best start in life as well as a means for increasing women's economic empowerment. Reference is made to an estimate that

every dollar spent on child care yields a $2.47 return to the Ontario economy. The Province has already announced that it will be spending $2.2B over 3 years to increase access to affordable child care. This includes

- $1B over 3 years to support reduced fees and subsidized spaces for infants and toddlers (P21).
- Free licensed child-care for pre-schoolers starting at age 2.5 until kindergarten entry.
- $534M over six years to build 10,000 new preschool care spaces and an additional 4,000 community-based ones (P22).
- Increasing subsidies available to low- and middle-income Ontarians to access spaces (P23).

Strengthening Income Security

Government commitments to a social assistance system are informed by the Income Security Reform Working Group's report (Income Security: a Roadmap for Change). The investment here amounts to $2.3B over three years, and includes:

- Simplification of social assistance programs
- Increasing Ontario Works and Ontario Disability Support Program rates by 3% annually for the next three years (previous annual increases were 1%) (P40).
- Increasing amounts of income that can be earned from other sources without impacting benefits (P41).
- Development of a made-in-Ontario Market Basket Measure to inform future rates (P41).
- Commitment to evaluating the existing Basic Income pilot project (P42).
- Launching a Food Security and Climate Change Impact Fund to support existing community-based initiatives (P43).

CHAPTER II: GROWING THE ECONOMY AND CREATING GOOD JOBS

This chapter's focus is on job creation and skills development to service a strong economy. Items of interest to alPHa members include:

- Focus on Well-Being, Equity and New Approaches to Learning (P77), which promises to strengthen programs that improve students' cognitive, emotional, social and physical development.
- Development of a new multi-year strategy for beverage alcohol industry growth (P95).
- Reiteration of the commitment to raise the Ontario minimum wage to $15 on January 1 2019.

CHAPTER III: ONTARIO'S ECONOMIC AND FISCAL STRENGTH

This chapter provides further detail on Ontario's finances, economic performance and plans for future management and spending. The budget will be balanced for 2017-18, but will return to modest deficits to allow new investments totaling $20.3B to focus on priority areas such as education, child care, health care, seniors, social services and so on. There is a good summary of the new program spending announcements on Pages 218-219. There is also a chart (Chart 3.13) on page 226 that breaks down sector expenses. The health sector is divided into six component parts, one of which is "Other Health". This is, presumably where public health funding is captured.

CHAPTER IV: FAIRNESS AND OPPORTUNITY THROUGH PARTNERSHIPS

This chapter outlines the partnerships that are essential to reaching the goals and objectives that the Ontario Government is aiming to achieve. They include:

Working with Indigenous Partners

- Reiteration of commitment to reconciliation and creating socioeconomic opportunities for First Nation, Inuit, Métis and urban Indigenous peoples (P251).
- Reference to the Indigenous Youth and Community Wellness Secrretariat (P252).
- Reference to community-based regulation of tobacco in return for a share of provincial tobacco tax revenues (P260).

Working with Federal, Provincial, Territorial and Municipal Partners

- Reference to Ontario's leadership in paving the way toward a National Pharmacare Program (P268-9).
- Reference to the implementation of cannabis legalization, including a pledge to "provide public health units with support and resources to help address local needs related to cannabis legalization" (P270).
- There is a list of provincial supports for municipalities on pages 278-279 that omits reference to the program-based grants for public health.

CHAPTER V: Taxation

This chapter includes references to addressing unregulated tobacco (P302-303) and supporting Smoke-Free Ontario through an immediate tax increase on tobacco amounting to $4 per carton of cigarettes.

We hope that you find this information useful.

To: All Members
Board of Health

From: Councillor Kathryn Wilson, Vice Chair, First Nations Committee

Subject: **Committee Report: First Nations**

Date: April 11, 2018

Proposed Recommendations:

a. *That the Board of Health for Peterborough Public Health receive meeting minutes of the First Nations Committee from September 6, 2017, for information.*

b. *That the Board of Health for Peterborough Public Health receive meeting minutes of the First Nations Committee from January 13, 2018, for information.*

c. *That the Board of Health for Peterborough Public Health send a letter to Ministers Bennet and Philpott, copied to MP Monsef, regarding the Truth and Reconciliation Commission's Call to Action #8.*

Background:

The First Nations Committee met last on March 15, 2018. At that meeting, the Committee requested that these items come forward to the Board of Health.

Attachments:

Attachment A – First Nations Committee Minutes, September 6, 2017
Attachment B - First Nations Committee Minutes, January 13, 2018
Attachment C – Draft Letter re: TRC #8

Board of Health for
Peterborough Public Health
MINUTES
First Nations Committee Meeting
Wednesday, September 6, 2017 – 5:00 – 6:30 p.m.
Dr. J. K. Edwards Board Room, 3rd Floor
Peterborough Public Health
Jackson Square, 185 King Street, Peterborough

Present:	**Chief Phyllis Williams** **Deputy Mayor John Fallis** **Mayor Mary Smith** **Councillor Kathryn Wilson** **Ms. Lori Flynn, Chair**
Regrets:	**Ms. Liz Stone** **Ms. Kerri Davies**
Guests:	**Ms. Linda Mitchelson, Division Manager of Social Services, City of Peterborough** **Nancy Fisher, Social Services, City of Peterborough**
Staff:	**Dr. Rosana Salvaterra, Medical Officer of Health** **Ms. Patti Fitzgerald, Assistant Director, Chief Nursing and Privacy Officer** **Ms. Alida Gorizzan, Executive Assistant, Recorder**

1. Call to Order

Ms. Lori Flynn, Chair, called the First Nations Committee meeting to order at 5:02 p.m.

2. Confirmation of the Agenda

MOTION:
That the agenda be approved as circulated.
Moved: Deputy Mayor Fallis
Seconded: Mayor Smith
Motion carried. (M-2017-011-FN)

3. Declaration of Pecuniary Interest

4. Delegations and Presentations

4.1. Community Wellbeing Plan

Ms. Linda Mitchelson and Ms. Nancy Fisher presented the City of Peterborough's Community Wellbeing Plan and sought guidance and feedback on how to best engage and involve Indigenous communities in this initiative.

The following recommendations were made:

- presentations should be sought with local First Nations Councils; general managers should also be included in these presentation requests;
- Indigenous representation on the Community Advisory Network and changes to the plan's objectives to include Indigenous Councils and communities would be beneficial; and,
- incorporating an Indigenous perspective on well being would ensure the plan is inclusive.

MOTION
That the First Nations Committee receive the following for information:
Presentation: Community Wellbeing Plan
Presenters:
Linda Mitchelson, Division Manager of Social Services, City of Peterborough
Nancy Fisher, Social Services, City of Peterborough
Moved: Chief Williams
Seconded: Mayor Smith
Motion carried. (M-2017-012-FN)

5. Confirmation of the Minutes of the Previous Meeting

5.1. April 25, 2017

MOTION:
That the minutes of the First Nations Committee Meeting held February 22, 2017, be approved as amended and provided to the Board of Health at its next meeting for information.
Moved: Deputy Mayor Fallis
Seconded: Mayor Smith
Motion carried. (M-2017-013-FN)

6. Business Arising From the Minutes

6.1. Indigenous Health Strategy – Next Steps

Dr. Salvaterra noted that the follow up on this item was that various plans were going to be shared amongst Committee members (i.e., Curve Lake, Friendship

Centre, LHIN First Nations Advisory Circle*, Indigenous Metis Advisory Circle*).
**LHIN Advisory Circles*
Plans will be independent of one another but will be shared for reference and to identify commonalities. **ACTION: Chief Williams and Ms. Flynn will share these plans.**

6.2. PPH Meeting with Hiawatha L.I.F.E. Services

Ms. Fitzgerald reported that this meeting took place on May 5th with five members of the Hiawatha L.I.F.E. Services staff. Since then, subsequent meetings have taken place. Dr. Salvaterra noted that Peterborough Public Health (PPH) has offered assistance to Hiawatha to complete a community needs assessment survey. **ACTION: Councillor Wilson will follow up with the Hiawatha Health Services Manager on this item.**

6.3. Cultural Safety Overview Update

This internal document was finalized and shared with PPH staff.

It was suggested that perhaps this document could be provided to the County of Peterborough and Townships to provide guidance on cultural safety. Mayor Smith requested that the City of Peterborough's plan to improve relations with local First Nations communities (June 2017) be shared with the Committee.

ACTION: The internal staff document, as well as the City plan will be shared with the Committee at its next meeting.

6.4. Youth Trend and Growing Concern – Cutting

Dr. Salvaterra noted that she raised this in a recent discussion with Dr. Alan White, Chief of Paediatrics at PRHC. In addition to a quick literature search, no new strategies have emerged.

6.5. Association of Local Public Health Agencies (alPHa) Resolution

Dr. Salvaterra shared that the resolution relating to the Truth and Reconciliation Calls to Action (resolution A17-2) was passed at the June 2017 Annual General Meeting. The alPHa board meets next on September 29th and next steps may be identified at that meeting. **ACTION: Dr. Salvaterra will update the Committee on any further activities/updates relating this resolution.**

6.6. 2017 Committee Work Plan - Progress Update

The Committee members reviewed the Work Plan for 2017 and updates were provided for various items.

- TRC #5 – Ms. Flynn noted that she found a Parenting Bundle developed by the Wabano Centre for Aboriginal Health that would be appropriate, it is a train the trainer initiative. Chief Williams advised that Curve Lake was rekindling its positive parenting program. **ACTION: When the programming for the culture-based parenting course is completed, Chief Williams will share it with the Committee.**
- TRC #8 – **ACTION: Chief Williams will follow up with Louise Musgrave on this item as a letter was to be drafted.**
- TRC #18 – A presentation by Chief Madahbee has been confirmed for September 26. **ACTION: Councillor Wilson, Chief Williams and Ms. Flynn will confirm whether staff from Hiawatha, Curve Lake and Niijkiwendidaa can provide assistance in planning this event.**
- TRC #19 – **ACTION: Given the change in ministerial mandates, Dr. Salvaterra will extend an invitation to Minister Philpott.**
- TRC #22 – Dr. Salvaterra shared that the Peterborough Family Health Team (PFHT) is looking for topic suggestions for a one-hour session related to Indigenous Healing Practices. One suggestion for a topic was 'How to Connect Patients with a Healer'. Another was to contact Chris Pike from Anishinabek Health Services as a potential speaker. **ACTION: Councillor Wilson will provide contact information to share with the PFHT.**
- TRC #23 – Dr. Salvaterra noted that the Chiefs of Ontario has been provided with funding to hire a facilitator for the modules; she will be involved in the recruitment process, interviews are scheduled for September 14. Once the modules are near completion, there are plans for Curve Lake and Hiawatha to pilot these.
- TRC #24 – Ms. Fitzgerald has followed up with the Canadian Association of Schools of Nursing given that her previous contact has left the organization.
- TRC #33 – Dr. Salvaterra is awaiting details from Linda Ogilvie at Chiefs of Ontario.
- TRC #55 – Mayor Smith noted a recent research study on the health effects from calorie deprivation of residential schools on later generations. **ACTION: This item will be circulated to Committee members and discussed at the next meeting.**
- TRC #56 - No update.
- TRC #57 – Members discussed promotion efforts to encourage attendance at the blanket exercise by municipal council members and staff.
- TRC #93 – Feedback on this item was recently received from Ms. Flynn. The document was also vetted by Chiefs Williams and Carr. **ACTION: This document for new immigrants will be finalized and provided to the New**

Canadians Centre.

- FNC #1 – Curve Lake recently met with Minister Bennett, it was recommended that a follow up letter should be sent on behalf of the Board. **ACTION: Chief Williams will provide a draft letter for consideration and submission.**

7. Staff Reports

8. Consent Items

MOTION: That the following item be passed as part of the Consent Agenda: 8.1, Correspondence for Information.
Moved: Deputy Mayor Fallis
Seconded: Mayor Smith
Motion carried. (M-2017-014-FN)

MOTION:
That the First Nations Committee receive the following for information:
a. Statement dated May 26, 2017 from the Canadian Human Rights Tribunal regarding Jordan's Principle (forwarded by Chief Williams).
b. Letter dated August 14, 2017 from the Hon. Minister Qualtrough, in response to the Board Chair's initial letter dated May 30, 2017, regarding T.R.C. Call to Action #89.
c. Letter dated August 23, 2017, from the Hon. Carolyn Bennett, copied to Dr. Salvaterra, regarding the County of Peterborough and Jordan's Principle.
Moved: Deputy Mayor Fallis
Seconded: Mayor Smith
Motion carried. (M-2017-014-FN)

9. New Business

10. In Camera to Discuss Confidential Matters

11. Motions for Open Session

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

It was noted that several members would be unable to attend the next meeting scheduled for October 24. **ACTION: Alida will poll members to reschedule this meeting date.**

13. Adjournment

MOTION:
That the meeting be adjourned.
Moved: Councillor Wilson
Seconded: Deputy Mayor Fallis
Motion carried. (M-2017-015-FN)

The meeting was adjourned at 6:35 p.m.

Chairperson

Medical Officer of Health

Board of Health for
Peterborough Public Health
MINUTES
First Nations Committee Meeting
Saturday, January 13, 2018 – 10:00 – 10:30 a.m.
Dr. J. K. Edwards Board Room, 3rd Floor
Jackson Square, 185 King Street, Peterborough

Present:	**Councillor Henry Clarke** **Ms. Kerri Davies** **Deputy Mayor John Fallis** **Councillor Kathryn Wilson** **Ms. Lori Flynn, Chair**
Regrets:	**Chief Phyllis Williams**
Staff:	**Ms. Patti Fitzgerald, Assistant Director, Chief Nursing and Privacy Officer** **Ms. Alida Gorizzan, Executive Assistant, Recorder**

1. Call to Order

As a designate to the Medical Officer of Health, Ms. Fitzgerald called the meeting to order at 10:10 a.m.

2. Elections

2.1. Chairperson

Ms. Fitzgerald called for nominations for the position of Chairperson for the First Nations Committee of the Board of Health for Peterborough Public Health for the year 2018.

MOTION:
That Ms. Lori Flynn be appointed Chair of the First Nations Committee for 2018.
Moved: Councillor Wilson
Seconded: Ms. Davies
Motion carried. (M-2018-001-FN)

Ms. Flynn assumed the Chair.

2.2. Vice-Chairperson

Ms. Flynn called for nominations for the position of Vice Chair for the First Nations

Committee of the Board of Health for Peterborough Public Health for the year 2018.

MOTION:
That Councillor Kathryn Wilson be appointed Vice-Chair for the First Nations Committee for 2018.
Moved: Deputy Mayor Fallis
Seconded: Ms. Davies
Motion carried. (M-2018-002-FN)

3. Confirmation of the Agenda

Ms. Davies requested that the item, Ontario Public Health Standards, be added under new business.

MOTION:
That the agenda be approved as amended
Moved: Councillor Wilson
Seconded: Deputy Mayor Fallis
Motion carried. (M-2018-003-FN)

4. Declaration of Pecuniary Interest

5. Delegations and Presentations

6. Confirmation of the Minutes of the Previous Meeting

6.1. Minutes, September 6, 2017

MOTION:
That the First Nations Committee meeting held September 6, 2017, be approved as circulated and provided to the Board of Health at its next meeting for information.
Moved: Deputy Mayor Fallis
Seconded: Councillor Wilson
Motion carried. (M-2018-004-FN)

7. Business Arising From the Minutes

8. Staff Reports

9. Consent Items

10. New Business

10.1. **Review Committee Terms of Reference**

The Committee reviewed the Terms of Reference and identified no further changes.

10.2. **Establish Date and Time of 2018 Meetings**

The Committee identified the following meeting dates for 2018: February 21, May 16, September 19 and November 21. All meetings will take place from 5:00 p.m. – 6:30 p.m. at Peterborough Public Health.

10.3. **Ontario Public Health Standards**

Ms. Davies noted that with the recent release of the revised Ontario Public Health Standards, the Committee's work plan for 2018 should reflect any new requirements within the standards.

She specifically noted Requirement 10 within the Good Governance and Management Practices Domain which states: *"The board of health shall engage in relationships with Indigenous communities in a way that is meaningful for them."*

11. In Camera to Discuss Confidential Matters

12. Motions for Open Session

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

The next meeting will be held on February 21, 2018, at 5:00 p.m., at 185 King St.

14. Adjournment

MOTION:
That the meeting be adjourned.
Moved: Councillor Kathryn Wilson
Seconded: Deputy Mayor Fallis
Motion Carried. (M-2018-005-FN)

The meeting was adjourned at 10:34 a.m.

Chairperson

Medical Officer of Health

Date

Minister Bennett
Minister Philpott

RE: Truth and Reconciliation Call to Action #8 - We call upon the federal government to eliminate the discrepancy in federal education funding for First Nations children being educated on reserves and those First Nations children being educated off reserves.

Our board is writing to you because of ongoing concerns that this call to action has not been addressed in our local First Nation. Curve Lake FN has a school which provides instruction to children from Junior Kindergarten to Grade 3. In the current school year, there are 48 students enrolled and a total of 14 staff employed. In addition to these children, in the 2015/16 school year, Curve Lake FN had a total of 102 students enrolled in 10 elementary and secondary schools in surrounding communities.

Education is a powerful determinant of health and wellness. These children are the future for this community. For this reason, our board is advocating that the federal government ensure that their education needs are addressed to levels comparable to non-Indigenous children in Ontario.

The Office of the Parliamentary Budget Officer's Federal Spending on Primary and Secondary Education on First Nations Reserves states that federal funding for on reserve schools does not adequately take into account the important cost drivers for band-operated schools.[1] Curve Lake First Nation School faces ongoing challenges in teacher recruitment and retention because of the differential in compensation that exists between the band school and the provincial system.

For this reason, our board is asking that your government take the following actions:

- Investigate how Band operated Schools can be funded in an equitable manner that reflects the uniqueness of each First Nation.
- Increase funding for Capital projects such as new schools and addition to schools.
- Increase in dollars to support salaries for teachers that are equal to their provincial colleagues.

All of the TRC Calls to Action addressing the legacy of education are components of a strategy that would strengthen the culture, educational performance and resiliency of Indigenous children. We look to you for your leadership in ensuring that the reforms and investments to education be given the priority and urgency that our children deserve.

Sincerely,

cc: MP Maryam Monsef

[1] The Office of the Parliamentary Budger Office, report "Federal Spending on Primary and Secondary Education on First Nation Reserves. 6 December 2016.

To: All Members
Board of Health

From: Mayor Mary Smith, Chair, Governance Committee

Subject: **Committee Report: Governance**

Date: April 11, 2018

Proposed Recommendations:

a. *That the Board of Health for Peterborough Public Health receive meeting minutes of the Governance Committee from February 6, 2018, for information.*

b. *That the Board of Health for Peterborough Public Health approve policy 2-80 Accessibility (new);*

c. *That the Board of Health for Peterborough Public Health appoint Kerri Davies to the Stewardship Committee.*

Background:

The Governance Committee met last on February 6, 2018. At that meeting, the Committee requested that these items come forward to the Board of Health.

Attachments:

Attachment A - Governance Committee Minutes, February 6, 2018
Attachment B - 2-80 Accessibility

Board of Health for
Peterborough Public Health
MINUTES
Governance Committee Meeting
Tuesday, February 6, 2018 – 5:00 p.m.
Dr. J. K. Edwards Board Room, 185 King Street, Peterborough

Present:	**Mr. Greg Connolley**
	Councillor Lesley Parnell
	Mr. Andy Sharpe
	Mayor Mary Smith, Chair
	Mr. Michael Williams
	Councillor Henry Clarke
Staff:	**Dr. Rosana Salvaterra, Medical Officer of Health**
	Larry Stinson, Director of Operations
	Ms. Natalie Garnett, Recorder

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1. Call to Order

Mayor Smith called the Governance Committee meeting to order at 5:03 p.m.

2. Confirmation of the Agenda

MOTION:
That the Agenda be amended by adding item 9.2 Policy - Cannabis use by Staff.
Moved: Mr. Connolley
Seconded: Mr. Sharpe
Motion carried. (M-2018-008-GV)

3. Declaration of Pecuniary Interest

4. Delegations and Presentations

5. Confirmation of the Minutes of the Previous Meeting

MOTION:
That the minutes of the Governance Meeting held January 13, 2018 be approved as circulated and provided to the Board of Health at its next meeting for information.
Moved: Councillor Parnell
Seconded: Mr. Williams

Motion carried. (M-2018-009-GV)

6. Business Arising from the Minutes

7. Staff Reports

7.1 By-Laws, Policies and Procedures for Review

MOTION:
That the Governance Committee recommend to the Board of Health for Peterborough Public that policy 2-60 – Accommodation, be retired.
Moved: Mr. Sharpe
Seconded: Mr. Williams
Motion carried. (M-2018-010-GV)

MOTION:
That the Governance Committee recommend to the Board of Health for Peterborough Public approve policy 2-190 – Sponsorship, as revised.
Moved: Mr. Connolley
Seconded: Councillor Parnell
Motion carried. (M-2018-011-GV)

MOTION:
That the Governance Committee recommend to the Board of Health for Peterborough Public approve policy 2-191 – Sponsorship, EthicScan as revised.
Moved: Mr. Connolley
Seconded: Mr. Williams
Motion carried. (M-2018-012-GV)

MOTION:
That the Governance Committee recommend to the Board of Health for Peterborough Public approve policy 2-403 – Ethics Reporting Policy.
Moved: Councillor Clarke
Seconded: Councillor Parnell
Motion carried. (M-2018-013-GV)

8. Consent Items

9. New Business

9.1 2018 Work Plan Review

MOTION:
That the Governance Committee adopt the 2018 Work Plan
Moved: Mr. Connolley
Seconded: Mr. Williams
Motion carried. (M-2018-014-GV)

9.2 **Policy - Cannabis Use by Staff**

MOTION:
That staff be directed to review the operational organizational policies to ensure cannabis usage by staff is addressed when cannabis is legalized; and,

That an update be provided to the Governance Committee at a future meeting.
Moved: Mr. Connolley
Seconded: Mr. Williams
Motion carried. (M-2018-15-GV)

10. In Camera to Discuss Confidential Matters

11. Motions from In Camera for Open Session

12. Date, Time and Place of Next Meeting

The next Governance Committee meeting will be held on April 3, 2018.

13. Adjournment

MOTION:
That the Governance Committee meeting be adjourned.
Moved by: Mr. Sharpe
Seconded by: Councillor Parnell
Motion carried. (M-2018-016-GV)

The meeting was adjourned at 5:32 p.m.

Chairperson

Medical Officer of Health

Board of Health
POLICY

Section: Board of Health	**Number:** 2-80	**Title:** Accessibility
Approved by: Board of Health		**Original Approved by Board of Health On** (YYYY-MM-DD)**:**
Signature:		**Author:**
Date (YYYY-MM-DD)**:**		
Accessibility for Ontarians with Disability Act, 2005		

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

SCOPE

This policy applies to all employees, students, volunteers, Board of Health members and any others acting on behalf of Peterborough Public Health (PPH).

ACCESSIBILITY PRINCIPLES

Dignity: provide service in a way that allows a person with a disability to maintain self-respect and the respect of other people.

Independence: allow a person with a disability the freedom to make their own choices, communicate for themselves, and not feel rushed when completing a task, or complete a task on their own without unnecessary help or interference from others.

Integration: provide service in a way that allows the person with a disability to benefit from the same services and programs, in the same place, and in the same or similar way as other customers and clients, unless a different way is necessary to enable them to access the services and programs.

Equal Opportunity: provide service to a person with a disability in such a way that they have an equal opportunity to access services and programs as what is given to others.

DEFINITIONS

Accessible:
Individuals are provided service or care in a manner that is capable of being easily understood and accessed.

Assistive Devices:
Assistive Devices are intended to enable people with physical disabilities to increase their independence. There are more than 8000 types of assistive devices such as equipment or supplies in the following categories:

- Prostheses
- Wheelchairs/mobility aids and specialized seating systems
- Enteral feeding supplies
- Monitors and test strips for those with insulin dependent diabetes
- Insulin pumps and supplies
- Hearing Aids
- Respiratory Equipment
- Orthoses (braces, garments and pumps)
- Visual communication aids
- Oxygen and oxygen delivery equipment such as concentrators, cylinders, liquid systems and related supplies, such as masks and tubing

Barriers:
A barrier is anything that prevents a person with a disability from fully participating in all aspects of society because of his or her disability, including a physical barrier, architectural barrier, information or communication barrier, attitudinal barrier, technological barrier, a policy or practice.

Disability:

- Any degree of physical disability, malformation or disfigurement that is caused by bodily injury, birth defect or illness, and without limiting the generality of the foregoing, includes diabetes mellitus, epilepsy, brain injury, and degree of paralysis, amputation, lack of physical co-ordination, blindness or visual impediment, deafness or hearing impediment, muteness or speech impediment, or physical reliance of a guide dog or other animal or on a wheelchair or other remedial appliance or device,
- A condition of mental impairment or a developmental disability,
- A learning disability, or a dysfunction in one or more of the processes involved in understanding or using symbols or spoken language
- A mental disorder, or
- An injury or disability for which benefits were claimed or received und the insurance plan established under the Workplace and Insurance Act, 1997.

The foregoing definition includes disabilities of differing severity, whether visible or non-visible and whether temporary or permanent in nature.

Service Animal:
Service animals are used by people with many different kinds of disabilities. Examples of service animals include dogs used by people that are blind, hearing alert animals for people who are deaf or hard of hearing; and animals trained to alert individuals to oncoming seizures and lead them to safety.

Support Person:
Support persons are used by people with many different kinds of disabilities. Some people with disabilities rely on support persons for certain services or assistance, such as using the washroom or facilitating communication. A support person may be a paid professional, a volunteer, a family member of friend of the person with a disability.

POLICY STATEMENT

Peterborough Public Health is committed to providing accessible programs and services to all clients. Under the Accessibility for Ontarians with Disabilities Act (2005), Peterborough Public Health strives to meet the requirements of the following applicable accessibility regulations - Customer Service Standard, Employment Standard, Information and Communication Standard and Design of Public Spaces Standard. (Note: the fifth accessibility regulation is the Transportation Standard and is not applicable to PPH).

1. Peterborough Public Health will make all reasonable efforts to provide a barrier-free environment for its clients, customers, students, employees, job applicants, suppliers, visitors and other stakeholders who enter the premises and access programs and services.
2. Peterborough Public Health will:
    a. Welcome people with disabilities who are accompanied by a service animal or support person, or who use assistive devices to our workplaces that are open to the public;
    b. Provide a notice of temporary disruption in the event of a planned or unexpected disruption in services;
    c. Welcome feedback from all customers, including those with disabilities, and respond to any complaints about service in a timely manner;
    d. Train all staff to consider people with disabilities in their day-to-day work and to take their disabilities into account when communicating and interacting with them;
    e. Establish barrier-free recruitment processes, including a supporting policy;
    f. Make accessibility documents available in an accessible format; and
    g. Upon request, provide emergency and public safety information accessible to people with disabilities, in accessible format or with communication supports.

Review/Revisions
On (YYYY-MM-DD)**:**
On (YYYY-MM-DD)**:**
On (YYYY-MM-DD)**:**
On (YYYY-MM-DD)**:**

To: All Members
Board of Health

From: Mayor Rick Woodcock, Chair, Stewardship Committee

Subject: **Committee Report: Stewardship**

Date: April 11, 2018

Proposed Recommendations:

a. *That the Board of Health for Peterborough Public Health receive meeting minutes of the Stewardship Committee from March 8, 2018, for information.*

b. *That the Board of Health for Peterborough Public Health approve By-Law Number 2, Banking and Finance (revised);*

c. *That the Board of Health for Peterborough Public Health approve By-Law Number 9, Banking and Finance (revised);*

Background:

The Stewardship Committee met last on March 20, 2018. At that meeting, the Committee requested that these items come forward to the Board of Health.

Attachments:

Attachment A - Stewardship Committee Minutes, March 8, 2018
Attachment B - By-Law Number 2, Banking and Finance
Attachment C - By-Law Number 9, Procurement of Goods and Services

Board of Health for the
Peterborough County-City Health Unit
MINUTES
Stewardship Committee Meeting
Thursday, March 8, 2018 – 4:30 p.m.
Dr. J.K. Edwards Board Room, 185 King Street, Peterborough

Present:	**Councillor Henry Clarke** **Chief Phillis Williams** **Mayor Rick Woodcock, Chair** **Councillor Gary Baldwin**
Regrets:	**Ms. Catherine Praamsma**
Staff:	**Dr. Rosana Salvaterra, Medical Officer of Health** **Ms. Alida Gorizzan, Executive Assistant** **Ms. Dale Bolton, Manager, Finance and Property** **Ms. Natalie Garnett, Recorder (4:40 p.m.)**

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1. Call to Order

Mayor Woodcock called the Stewardship Committee meeting to order at 4:37 p.m.

2. Confirmation of the Agenda

MOTION:
That the agenda be approved as circulated.
Moved: Councillor Baldwin
Seconded: Councillor Clarke
Motion carried. (M-2018-006-SC)

3. Declaration of Pecuniary Interest

4. Delegations and Presentations

5. Confirmation of the Minutes of the Previous Meeting

5.1 **January 13, 2018**

MOTION:
That the minutes of the Meeting of January 13, 2018 be approved as circulated.
Moved: Councillor Baldwin
Seconded: Chief Williams
Motion carried. (M-2018-007-SC)

6. Business Arising from the Minutes

6.1 **Revisions to Committee Terms of Reference**

MOTION:
That the Stewardship Committee recommend that the Board of Health for Peterborough Public Health approve 2-354, Stewardship Committee Terms of Reference, as revised, and,

That an additional member be added to the Stewardship Committee to increase the number of members to five.
Moved: Councillor Baldwin
Seconded: Councillor Clarke
Motion carried. (M-2018-008-SC)

6.2 **2018 Stewardship Committee Work Plan**

MOTION:
That the Stewardship Committee:
- *Receive the 2018 Work Plan for information; and ,*
- *Schedule Committee dates for the remainder of 2018.*

Moved: Chief Williams
Seconded: Councillor Baldwin
Motion carried. (M-2018-009-SC)

7. Staff Reports

7.1 **Staff Report: Future Funding of Public Health**

Stewardship Committee members reviewed the staff report "Future Funding of Public Health" and ended following discussion of the 'Second Approach'. The balance of the report will be deferred to a future Committee meeting.

MOTION:
That the Stewardship Committee for the Board of Health for Peterborough Public Health receive the staff report, "Future Funding of Public Health" for information.
Moved: Councillor Baldwin
Seconded: Councillor Clarke
Motion carried. (M-2018-010-SC)

8. Consent Items

9. New Business

10. In Camera to Discuss Confidential Matters

11. Motions for Open Session

12. Date, Time and Place of Next Meeting

The next meeting of the Stewardship Committee will be held on Tuesday, March 20, 2018 at 5:00 p.m., in the Dr. J.K. Edwards Board Room, Jackson Square, 185 King Street, Peterborough.

13. Adjournment

MOTION:
That the meeting be adjourned.
Moved: Councillor Baldwin
Seconded: Councillor Clarke
Motion carried. (M-2018-011-SC)

The meeting was adjourned at 5:53 p.m.

Chairperson

Medical Officer of Health

Board of Health

POLICY AND PROCEDURE

Section: Board of Health	**Number:** 2-110	**Title:** By-Law Number 2 – Banking and Finance
Approved by: Board of Health		**Original Approved by Board of Health On** (YYYY-MM-DD)**: 1989-10-11**
Signature:		**Author:** Director of Operations~~, Corporate Services~~
Date (YYYY-MM-DD)**:** 2017-08-~~14-11-12~~		
Reference:		

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

By-Law Number 2
Banking and Finance

1. In this By-law:
   1) "Act" means the Health Protection and Promotion Act;
   2) "Board" means the Board of Health for ~~the~~ Peterborough Public ~~County City~~ Health ~~Unit~~;
   3) "Chairperson of the Board" means the Chairperson elected under the Act;
   4) "Vice-Chairperson of the Board" means the Vice-Chairperson elected under the Act;
   5) "Medical Officer of Health" means the Medical Officer of Health of the Board as defined under the Act and Regulations; and
   6) "Director of Operations" ~~, Corporate Services"~~means the business adminstrator of the organization as defined in the Regulations under the Act.

2. The Medical Officer of Health and Director of Operations, shall be authorized to ~~Board shall~~ enter into an agreement with a recognized chartered bank or trust company which will provide the following services:
   1) a current account;
   2) the provision of cancelled cheques on a regular basis together with a statement showing all debits and credits;
   3) the payment of interest at a rate to be negotiated between the Board and the bank or trust company for all surplus funds held in each account;
   ~~4) payroll services;~~
   ~~5)~~4) the lending of money to the Board as required; and
   5) advice and other banking services as required.

3. The Medical Officer of Health and Director of Operations shall be authorized to enter into an agreement with a recognized company to provide additional financial services including but not limited to:
   1) payroll services;
   2) debit card processing; and
   3) corporate credit card for procurement of goods and services.

~~3.~~4. Once every five years a Request for Proposal or tenders shall be called by the Director of Operations~~, Corporate Services~~ for banking services.

5. The Chairperson and Vice-Chairperson of the Board, the Medical Officer of Health, ~~Director~~Director of Operations or Director of Public Health Programs~~,~~, shall be authorized to sign cheques drawn on a current account.

6. The Chairperson and Vice-Chairperson of the Board, the Medical Officer of Health, Director of Operations and Director of Public Health Programs, shall be authorized to borrow money from a recognized chartered bank or trust company on behalf of the organization not exceeding $100,000. If greater than $100,000, Board approval is required whereby; one of the authorizing signatures must be the Chairperson or Vice-Chairperson of the Board.

7. All cheques shall require two signatures and the Chairperson and Vice-Chairperson of the Board shall not sign the same cheque.

8. No person may approve a payment to themselves.

~~4.~~7. 9. The Medical Officer of Health and the Director of Operations~~, Public Health Programs and Director, Corporate Services~~ shall be authorized:
   1) to deposit with or negotiate or transfer to a bank or trust company (but only for the credit of the Board) any and all cheques, promissory notes, bills of exchange or orders for payment of monies;
   2) to receive all paid cheques and vouchers and to arrange, settle, balance and certify all books and accounts between the Board and the bank or trust company;
   3) to sign the form of settlement of balances and releases of the bank or trust company;
   4) to receive all monies and to give acquittance for the same; and
   5) to invest excess or surplus funds in interest-bearing accounts or short-term deposits.

This By-law shall be deemed to have come in to force on the 11th date of October, 1989.

Dated at the City of Peterborough the 25th date of October, 1989.

Review/Revisions

On (YYYY-MM-DD)**:** 2014-11-12
On (YYYY-MM-DD)**:** 2012-09-12
On (YYYY-MM-DD)**:** 2010-07-07
On (YYYY-MM-DD)**:** 2006-04-12
On (YYYY-MM-DD)**:** 2005-01-12
On (YYYY-MM-DD)**:** 1998-10-28

Board of Health

POLICY AND PROCEDURE

Section: Board of Health	**Number:** 2-180	**Title:** By-Law Number 9 – Procurement of Goods and Services
Approved by: Board of Health		**Original Approved by Board of Health On** (YYYY-MM-DD)**: 2007-10-10**
Signature:		**Author:** Director~~, Corporate Services~~ of Operations
Date (YYYY-MM-DD)**:** ~~2012-12-12~~		Last Review Date: 2014-09-03
Reference:		

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By-Law Number 9
A By-Law to Provide for the Procurement of Goods and Services

1. In this By-law:
   (1) "Act" means the Health Protection and Promotion Act.
   (2) "Board" means the Board of Health for the Peterborough Public Health~~County City Health Unit~~; and
   (3) "Medical Officer of Health" means the Medical Officer of Health of the Board as defined under the Act and Regulations.
   (4) "Director of Operations~~, Corporate Services~~" means the business administrator of the Board as defined in the Regulations under the Act.

2. Peterborough Public Health ~~The Board~~ shall utilize fair, responsible, and efficient methods to secure the supplies, equipment, accommodation, and services needed to implement the Board's programs and services.

3. Board and organizational policies and procedures shall ensure that purchasing decisions are based on price, suitability, availability, impact o~~f~~ employee health and safety and the environment, and stability and integrity of, and previous experience with, the vendor.

4. The following procurement process shall apply depending upon the value of the goods or services. The procurement process undertaken assumes the purchase has been pre-approved within the annual program operational budget. All purchases in excess of $5,000, not included in the program operational plan, must be approved by the Director of Operations or delegate.

   Appendix "A" to this by-law provides a summary of the Types of Procurement Processes set out in~~.~~

4. a) For purchases~~items~~ having an estimated cost of less than $1,000 excluding taxes, no formal quotation process is necessary. The acquisition of goods or services should be through open, fair and competitive pricing in the best interests of the organization. ~~competitive quotations will be obtained where feasible~~. ~~In some circumstances, non-competitive pricing may occur to allow for the procurement of goods and services in an efficient and timely manner.~~

For purchases ~~items costing~~ greater than $1,000 but not exceeding ~~,~~$5,000 excluding taxes, a minimum of two ~~three~~ verbal quotations are obtained and documented. ~~written quotations will be obtained~~. The Program Manager ~~Director, Corporate Services~~ or designate will determine the successful quotation in consultation with the requisitioner. In some circumstances, non-competitive pricing may occur to allow for the procurement of goods and services in an efficient and timely manner.

For purchases ~~items costing~~ greater than $5,000 but not exceeding $30,000 excluding taxes, and as approved within applicable budget, ~~,~~ three documented written quotes shall be obtained. ~~competitive quotes will be called by the Director~~. The Program Manager or designate will determine the successful quotation in consultation with the Director of Operations or delegate.

For purchases greater than $30,000 but not exceeding $100,000, a Request for Proposal or Tender shall be called by the Director of Operations. The Director will determine the successful bidder in consultation with the Medical Officer of Health. Following the awarding of a tender, significant changes to prices or terms previously approved must be submitted to the Director of Operations for approval.

~~-~~For purchases greater than $100,000, a Request for Proposal or Tender shall be called by the Director of Operations ~~Corporate Services or designate~~, for review by the Medical Officer of Health. Recommendations shall be presented to the Board, or designated committee of the Board ~~-~~for consideration and decision. Following the awarding of a tender, significant changes to prices or terms previously approved by the Board must be submitted to the Board for approval.

Calling for quotations and tendering may be waived in emergency and extraordinary circumstances approved by the Medical Officer of Health and the Chairperson of the Board.

Non-competitive procurement through sole or single sourcing may be approved whereby goods and services are unique to a specific vendor and/or can not be obtained through another supplier with a procurement value upto a total purchase value of $ 5,000 by the Program Manager. For goods and services exceeding $5,000 and upto $100,000, approval must be provided by the Director of Operations or delegate.

For capital projects in excess of $100,000, approval from the Board is required.

The use of credit cards to purchase goods and services, and designation of cardholders, shall be approved by the Director of Operations or designate~~Medical Officer of Health~~. The credit card (s) will have an approved set limit whereby one individual card shall not have a credit limit in excess of $25,000.~~Each credit card shall have a set limit as established by the Board from time to time~~. Increases to the credit card limit must be approved by the Director of Operations. All purchases shall be within the established monthly limit. Credit cards shall only be used by the designated cardholder.

The use of debit cards to purchase goods and services, and designation of cardholders, shall be approved by the Director of Operations. Each debit card account has a maximum of $1,500 of available funds. All purchases shall be within the established available funds. Debit cards shall only be used by the designated cardholder.

To ensure that the Board is receiving the best value and to encourage competition, the Director of Operations~~Board~~ shall review ~~during the annual budget approval process~~:

- ~~audit and~~ banking services in accordance with governing legislation and relevant Board By-laws every five years;
- insurance, audit and legal services at least every three years; and
- ~~laboratory, legal services~~, communications services at least every three years or sooner if deemed necessary. ~~telephone, and utilities~~.

This By-law shall be deemed to have come in to force on the 11th day of October, 2007.

Dated at the City of Peterborough the 10th day of October, 2007.

Review/Revisions

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

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

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

Appendix "A" TO BY LAW 9 – PROCUREMENT OF GOODS AND SERVICES

Total Procurement Value	Method of Procurement	Authorization
Upto $1,000	No formal quotation	Program Manager
$1,001 - $5,000	Minimum of two verbal quotes obtained and documented	Program Manager
$5,001 - $30,000	Three written quotes obtained	Director of Operations in consultation with the Program Manger
$30,001 - $100,000	Request for Proposal or Tender	Director of Operations in consulatation with Medical Officer of Health
$100,000 and above	Request for Proposal or Tender	Board of Health or Designated Committee

To: All Members
Board of Health

From: Dr. Rosana Salvaterra, Medical Officer of Health

Subject: **alPHa Resolutions for Submission**

Date: April 11, 2018

Proposed Recommendation:

That the Board of Health for Peterborough Public Health approve the submission of the following draft resolution for the Association for Local Public Health Agencies (alPHa) Resolution Session (2018): Public Health Support for a Minimum Wage that is a Living Wage.

Background:

The 2018 Annual General Meeting (AGM) of the Association of Local Public Health Agencies will be held at the Novotel Toronto Centre Hotel, Toronto, Ontario on Monday, June 11, 2018 at 8:00 a.m. at the 2018 Annual Conference.

Resolutions to be tabled at the AGM must be submitted to alPHa before Friday, April 27, 2018, at 4:30 p.m.

A call out for expressions of interest will be sent to Board Members following this meeting to determine/ensure Board representation at this meeting.

Attachments:

Attachment A – Public Health Support for a Minimum Wage that is a Living Wage

TITLE: Public Health Support for a Minimum Wage that is a Living Wage

SPONSOR: Peterborough Public Health

WHEREAS low income Ontarians are at higher risk of premature death and more likely to suffer more illnesses, even after controlling for factors including age, sex, race, smoking status, and place of residence; and

WHEREAS high income inequality leads to increased social problems, and poorer health of the population as a whole; and

WHEREAS based on the Canadian census Low-Income Measure, after tax (LIM-AT), the low-income rate in Ontario grew from 12.9% to 14.4% from 2005 to 2015, totalling 1,898,975 Ontarians living on low income; and

WHEREAS in contrast with other provinces where recent economic growth and average income increases grossly translated to gains for most families, income inequality in Ontario continues to grow; and

WHEREAS approximately one-third of Ontario workers earned less than $15 an hour in 2016, a rate lower than the calculated living wage in 2016 for the majority of communities throughout the province; and

WHEREAS nearly two-thirds of minimum wage workers in Ontario are adults supporting themselves and their families; and

WHEREAS there is an increasing trend for workers to be employed in precarious jobs with low wages, no benefits, and uncertainty in hours (scheduling) and tenure (longevity in position); and

WHEREAS recent legislative changes to minimum wage in Ontario (Bill 148) present a step in the right direction, current wage adjustments will not reach a level required to meet basic living needs in most Ontario communities; and

WHEREAS a living wage outlines the hourly rate at which a household, based on a family of four, can meet its basic needs based on the actual costs of living in a community, after factoring in both government transfers to families and deductions; and

WHEREAS a living wage affords individuals and families the opportunity to lift themselves out of poverty and provides a basic level of economic security; and

WHEREAS a living wage not only promotes a reduction in poverty, decreased income insecurity and improved health at individual and family levels, evidence also supports fiscal benefits to government and the economy; and

WHEREAS the Universal Declaration of Human Rights, Article 23, Section 3 states: "Everyone who works has the right to just and favourable remuneration ensuring for himself and his family an existence worthy of human dignity…", a living wage transcends simple public policy and addresses principles of justice and basic human rights;

NOW THEREFORE BE IT RESOLVED THAT the Association of Local Public Health Agencies (alPHa) endorse the principles encompassed in a living wage;

AND FURTHER that alPHa request that the provincial Government consider adopting a living wage perspective when setting future minimum wage rates to ensure that it covers the actual costs of living in most Ontario communities, as a way to reduce poverty and income insecurity and promote the health of Ontarians;

AND FURTHER that the Premier of Ontario, the Chief Medical Officer of Health for Ontario, the Ontario Public Health Association, the Association of Municipalities of Ontario, the Ontario Living Wage Network and Living Wage Canada be so advised.

Select References

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Report from Stewardship Committee

Future Funding of Public Health

Date:	April 11, 2018
To:	Board of Health
From:	Rick Woodcock, Chair, Stewardship Committee

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

Proposed Recommendations

That the Board of Health for Peterborough Public Health adopt a "Three over Three" approach to address its funding shortfall. Essentially, this means a three pronged approach over the next three years and consists of the following three elements:

1. **Provincial Advocacy for sustainable public health funding.**
   This first element is directed to our provincial association and allies in order to address the long term funding for local public health. It consists of at least four actions:
   a. An urgent teleconference with Association of Local Public Health Agencies (alPHa) Board President and Executive calling for immediate action.
   b. A motion for the 2018 alPHa AGM directing the provincial association to advocate for sustainable provincial funding for local public health.
   c. A letter to OPHA requesting provincial and federal advocacy for funding for local public health.
   d. A request to the City of Peterborough, the County of Peterborough and Curve Lake and Hiawatha FNs, as well as all boards of health, to request AMO's support in advocacy for sustainable provincial funding for local public health.

2. **Judicious use of reserves to meet deficits.**
   This second element addresses the Board's current reserves and consists of three potential actions:

a. Identify the minimum amounts to be retained in both capital and operating reserves by developing appropriate policies to guide the accrual, retainment and utilization of these funds.
b. Negotiate with Infrastructure Ontario to eliminate the current barrier to using reserves.
c. Identify how reserves can be utilized to reduce anticipated deficits over the next three years as outlined in #3.

3. **Move to 30% local funding over the next three years.**
   Approach all four local funders to map out a 5% increase in their portion of cost-shared local public health funding to be gradually introduced over the next 3 years.

Financial Implications and Impact

The level of funding provided to Peterborough Public Health for its core services has been identified as inadequate. This has resulted from a sustained short fall in provincial funding. The impact, in terms of reduced service levels and unmet Public Health Standards Requirements, has been reported to the Board for many years. During the 2017 budget approval process, the Board was informed of the potential impact on operations should the Board of Health continue to receive 0% annual increases from all funders for the coming five-year period. In 2018, a budget was approved by the Board of Health that reflected a $340,000 shortfall if sustained levels of service are desired.

Decision History

The Board of Health approves an annual budget for cost-shared (Ontario Public Health Standards) and all 100% funded programs over $100,000. These budgets are required to be balanced budgets. The Board has communicated through letters and face to face meetings with government representatives to voice concern regarding inadequate funding, the inequitable allocation of funding across public health agencies and the funding approval process. At its January meeting, the Stewardship Committee gave direction to staff to prepare a report outlining background information and options for ensuring sustainable funding for public health in 2019 and beyond. The Stewardship Committee has met three times to study the funding situation and explore options for the Board. One meeting included discussions with the Auditor. On April 10th, the Stewardship Committee identified the recommended "Three over three" approach and is seeking Board approval.

Background

Funding for public health in Ontario is achieved through a combination of cost-shared (MOHLTC Grants and Municipal and First Nations contributions) and 100% Ministry (MOHLTC, MCYS, MCSS) programs. The cost-shared budget comprises approximately two-thirds of the overall budget. The operation of boards of health (or public health agencies) is governed by the Health Protection and Promotion Act (HPPA). Under the Act, the obligated municipalities shall pay,

(a) the expenses incurred by or on behalf of the board of health of the health unit in the performance of its functions and duties under this or any other Act; and

(b) the expenses incurred by or on behalf of the medical officer of health of the board of health in the performance of his or her functions and duties under this or any other Act. 1997, c. 30, Sched. D, s. 8.

(2) In discharging their obligations under subsection (1), the obligated municipalities in a health unit shall ensure that the amount paid is sufficient to enable the board of health,

(a) to provide or ensure the provision of health programs and services in accordance with sections 5, 6 and 7, the regulations and the public health standards; and

(b) to comply in all other respects with this Act and the regulations. 1997, c. 30, Sched. D, s. 8.

Under section 76 of the HPPA, the Ministry may "make grants for the purposes of this Act on such conditions as he or she considers appropriate". Since 2007, the provincial to local ratio for funding determined by the Ministry of Health for grant purposes has been 75:25.

The challenges with funding for public health in recent years is related to three areas:

a) the long-standing lack of adequate funding to meet minimum standards as established under the HPPA;
b) lack of annual increases to offset growing costs of program delivery; and
c) funding approval process; including both late-in-budget-year approvals and application of funding formulas that don't reflect true need.

The pervasive funding challenges faced by public health has resulted in both legacy and potential future impacts. In an effort to maintain optimal levels of service delivery during periods of funding shortfalls, areas of operation not directly related to service delivery have suffered. Until recently, facilities and equipment remained outdated and inadequate due to years of neglect. The ability to sustain fair compensation rates across the organization has been challenged. The management team has been under-resourced and often short-staffed. Investments in professional development and support program areas such as population health assessment have been severely restricted. A concern that has been raised provincially and has played out locally is that as funding shortfalls grow, programs with immediate impact (e.g. clinic, health protection) will be sustained while programs with longer-term impact (e.g. chronic disease prevention, healthy growth and development) will be compromised. Compliance reports for Ontario Public Health Standards since 2008 reflect this at Peterborough Public Health.

The following table outlines the length of time that provincial funding for public health programs has been frozen:

Program	Funding	Last Increase
Mandatory Programs Grant	Cost-shared	2015
Small Drinking Water (SDW)	Cost-shared	2012
Vector Borne Diseases (VBD)	Cost-shared	2014
Electronic Cigarettes Act (ECA)	100% Ministry	2015
Enhanced Food Safety (FS)	100% Ministry	2012
Enhanced Safe Water (SW)	100% Ministry	2012
Harm Reduction Enhancement (HR) – new 2017	100% Ministry	2017
Healthy Smiles Ontario (HSO)	100% Ministry	2016
Infection Prevention and Control Nurses (IPC)	100% Ministry	2015
Infectious Diseases Control (CID)	100% Ministry	2015
Needle Exchange Initiative (NE)	100% Ministry	2017
Smoke Free Ontario Programs (SFO)	100% Ministry	2012
Social Determinants of Health Nurses (NC)	100% Ministry	2015
Healthy Babies Healthy Children (HBHC)	100% Ministry	2012
Infant Toddler Development Program (ITDP)	100% Ministry	2002

Rationale

To truly address the funding challenges faced by public health agencies across the province, changes are required in both *how* public health funding is provided and *how much* funding is provided for the operational and program delivery needs. Given the fact that Peterborough Public Health is not the only board facing a funding crisis, it was determined that advocacy for sustainable public health funding is best done at the provincial level for all boards of health.

This justifies the first prong of our three-prong approach: **Provincial Advocacy for sustainable public health funding.** This must begin with our own provincial association, alPHa and for this reason, an urgent teleconference is being requested with the alPHa Board Chair and Executive Director to request a meeting with the current Minister of Health and to plan for an election advocacy campaign. This will be followed with a resolution to be brought to the alPHa AGM in June requesting a longer term advocacy strategy to secure more provincial funding for local boards of health. In addition, the committee has identified both OPHA and AMO as other provincial allies that should be approached on this issue and on our behalf.

The second prong being recommended focuses on our existing reserves. The 2018 budget shortfall is being addressed through the use of reserves and other short-term solutions ($90,000 from Program Reserves, $70,000 from Property Reserves, $100,000 from Deferred Revenue, $80,000 from Staff Gapping). After 2018, the Program Reserve Balance will be approximately $90,000 and the Property Reserve will be approximate $500,000 (but has restricted applications).

The second prong of **judicious use of reserves to meet deficits** would require the Board to adopt new policies for management of reserves. It would also require the Board to negotiate a

change in its current agreement with Infrastructure Ontario to address the annual debt-service ratio requirement, which currently prevents us from using our reserves to balance our budget. Once we have been able to determine a reserve management plan a proposal for use of reserves to support a phased increase to local funding will be developed.

Despite the provincial allocation for local public health, the responsibility to ensure public health agencies are adequately funded falls to its obligated municipalities, hence we are recommending a third prong to our funding strategy. Peterborough Public Health has four obligated municipalities: the City, the County and through Section 50 agreements, Curve Lake and Hiawatha First Nations.

For many other boards of health, a shift in the ratio of provincial to local funding for public health from the standard 75:25 has already occurred. In 2016, an alPHa survey indicated the following distribution for municipal contributions for cost-shared programs:

Municipal/Regional Funding %	Public Health Units	
	Number	%
25% to 26%	8	27%
26% to 30%	9	30%
31% to 35%	7	23%
36% to 40%	4	13%
41% to 45%	2	7%
Totals	30	100%

The Board of Health for Peterborough Public Health has traditionally given direction to staff to present budget that align with the 75:25 ratio. Due to increases approved municipally and denied provincially in 2016, for PPH local funders currently pay 25.8% of the cost-shared budget so are among the 8 identified in the chart above for 25 to 26%. **The third approach of our recommended strategy would be to increase this ratio to 30% over the next three years.** This gradual approach would decrease the financial burden but shift a greater share of the long term funding needs to our local governments.

It is important to point out that this would only address the cost-shared budget, and not 100% funded programs.

It is also important to point out that the projected expenditures are based on historical staffing and operating costs, and not based on an assessment of what is required to be fully compliant with expectations set out in the Ontario Public Health Standards 2018. Since there are protocols and guidance documents still to be released and indicators of performance have not been set by the Ministry, it is impossible to fully assess whether the proposed funding level is adequate. Although the intent of the new Standards was that they be developed as revenue neutral, PPH was not fully compliant with Requirements prior to the modernized standard development. Any funding strategy undertaken by the Board will need to be continuously

reviewed and updated over time, and especially following the results of the next provincial election.

Strategic Direction

All areas of our strategic plan:

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

are threatened when funding is reduced or provided at inadequate levels to meet minimum standards.