

Meeting Book - Sudbury & District Board of Health - Regular Meeting - September 17, 2015

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Environmental Health

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d) Northern Ontario Evacuations of First Nations Communities

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f) National Alcohol Strategy Advisory Committee (NASAC)

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j) Food Safety Protocol, 2015

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10.0 ADDENDUM

MOTION: Addendum

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11.0 ANNOUNCEMENTS / ENQUIRIES

For completion

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12.0 ADJOURNMENT

MOTION: Adjournment

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The Chair will call the meeting to order and welcome members.

Board of Health attendance is taken and recorded.

**AGENDA – FIFTH MEETING
SUDBURY & DISTRICT BOARD OF HEALTH
BOARDROOM, SECOND FLOOR, SUDBURY & DISTRICT HEALTH UNIT
THURSDAY, SEPTEMBER 17, 2015 - 1:30 P.M.**

- 1. CALL TO ORDER**
- 2. ROLL CALL**
- 3. REVIEW OF AGENDA / DECLARATION OF CONFLICT OF INTEREST**
- 4. DELEGATION / PRESENTATION**

i) Blue-Green Algae

- Stacey Laforest, Director, Environmental Health Division

5. MINUTES OF PREVIOUS MEETING

i) Fourth Meeting – June 18, 2015

APPROVAL OF MINUTES

MOTION: THAT the minutes of the Board of Health meeting of June 18, 2015, be approved as distributed.

6. BUSINESS ARISING FROM MINUTES

7. REPORT OF THE MEDICAL OFFICER OF HEALTH / CHIEF EXECUTIVE OFFICER

i) September 2015 – Medical Officer of Health / Chief Executive Officer Report

ACCEPTANCE OF REPORTS

MOTION: THAT the Report of the Medical Officer of Health / Chief Executive Officer for the month of September 2015 be accepted as distributed.

8. NEW BUSINESS

i) Items for Discussion

a) Alcohol and Substance Misuse

- The Impact of Alcohol Poster
- Briefing Note from the Medical Officer of Health and Chief Executive Officer to the Board Chair dated September 10, 2015
- Report to the Sudbury & District Board of Health: *Addressing substance misuse in Sudbury & District Health Unit service area*, September 10, 2015
- The Sudbury & District Health Unit Alcohol Use and the Health of Our Community Report

b) Expansion of Proactive Disclosure System

- Briefing Note from the Medical Officer of Health and Chief Executive Officer to the Board Chair dated September 10, 2015

EXPANSION OF PROACTIVE DISCLOSURE SYSTEM

MOTION: WHEREAS the Minister of Health and Long-Term Care has requested that each Board of Health and Medical Officer of Health make transparency a priority objective in business plans; and

WHEREAS the Minister of Health and Long-Term Care has requested that each Board of Health and Medical Officer of Health take steps towards developing and establishing new reporting practices to make information readily available to the public; and

WHEREAS the Sudbury & District Health Unit is committed to public transparency;

THEREFORE BE IT RESOLVED THAT the Sudbury & District Board of Health endorse the expansion of the Check Before you Eat! disclosure system to include findings of routine inspection and enforcement-related activities pertaining to public pools, public spas, personal services settings, and tobacco vendors; and

THAT the following be the Board policy on the release of enforcement and inspection information:

1. Charges: Statistical information on charges (i.e. no identifying information) is released to the Sudbury & District Board of Health at its regularly scheduled meetings.

2. Convictions: Convictions related to food premises, public pools, public spas, personal services settings, and tobacco vendor infractions are posted on the Sudbury & District Health Unit website as soon as possible following the conviction and for a period of 12 months from the date on which the conviction was rendered.

3. Orders: Orders pertaining to food premises, public pools, public spas, personal services settings, and tobacco vendors are posted on the Sudbury & District Health Unit website as soon as possible following the issuance of the order and for a period of 12 months from the date on which the order was rescinded.

4. Routine inspection reports related to food premises, public pools, public spas, and personal services settings: Routine inspection and re-inspection reports are posted on the Sudbury & District Health Unit website as soon as possible following the inspection and for a period of 12 months from the date of the inspection.

5. Requests for information not posted on website: Requests for information not posted on the website are considered on an individual basis in accordance with Health Unit policy and the Municipal Freedom of Information and Protection of Privacy Act (MFIPPA) and the Personal Health Information Protection Act (PHIPA); and

FURTHER THAT motion 36-09 is hereby rescinded and Board of Health Disclosure Information Sheet F-IV-10 be correspondingly updated.

c) Provincial Public Health Funding

- Letter from the Minister of Health and Long-Term Care to the Sudbury & District Board of Health Chair dated September 4, 2015, regarding 2015 base and 2015-16 one-time funding
- Public Health Funding Review
 - Memo from the Ministry of Health and Long-Term Care's Executive Director and Assistant Deputy Minister re PH Funding Review Update dated September 4, 2015
 - Final Report of Funding Review Working Group dated December 2013
 - Appendix 1 - Funding Review Working Group Field Input Responses

d) Accessibility for Ontarians with Disabilities Act (AODA) and Human Rights Compliance

- Briefing Note from the Medical Officer of Health and Chief Executive Officer to the Board Chair dated September 10, 2015

e) Board of Health Proceedings

- Briefing Note from the Medical Officer of Health and Chief Executive Officer to the Board Chair dated September 10, 2015

BOARD OF HEALTH PROCEEDINGS – CONSENT AGENDA PROCESS

MOTION: THAT the Sudbury & District Board of Health support in principal a consent agenda process and direct staff to recommend related revisions to the Board of Health Manual for the Board's review and approval.

ii) Correspondence

a) Access to Alcohol

Sudbury & District Board of Health Motion #08-15 Modernization of Beverage Alcohol Regulations in Ontario

- Letter from the Peterborough County-City Health Unit's Board Chair to the Premier of Ontario dated July 6, 2015
- Letter from the Durham Region Public Health's Medical Officer of Health to the Premier of Ontario dated July 7, 2015
- Letter from the Minister of Finance to Dr. Sutcliffe dated July 30, 2015

- Letter from the Township of Nairn and Hyman to the Premier of Ontario dated August 17, 2015

**b) Ontario Grades 1-12 Health and Physical Education Curriculum
“Human Development and Sexual Health” Content**

- Letter from the Perth District Health Unit’s Medical Officer of Health and Board Chair to the Premier of Ontario dated June 19, 2015

c) Healthy Babies Healthy Children (HBHC) Program

Sudbury & District Board of Health Motion #28-15 Healthy Babies Healthy Children (HBHC) Program

- Letter from the Grey Bruce Health Unit’s Medical Officer of Health to the Minister of Children and Youth Services dated August 6, 2015
- Letter from the Minister of Children and Youth Services to Dr. Sutcliffe dated August 10, 2015

d) Northern Ontario Evacuations of First Nations Communities

Sudbury & District Board of Health Motion #32-15 Northern Ontario Evacuations of First Nations Communities

- Letter from the Grey Bruce Health Unit’s Medical Officer of Health to the Premier of Ontario dated August 6, 2015
- Letter from the Township of Nairn and Hyman to the Premier of Ontario dated August 12, 2015

e) Smoke-Free Multi-Unit Housing

- Letter and Resolution from the Grey Bruce Health Unit’s Medical Officer of Health to the Minister of Health and Long-Term Care dated August 6, 2015

f) National Alcohol Strategy Advisory Committee (NASAC)

- Letter from the Durham Region Regional Clerk to the Prime Minister dated June 25, 2015

g) Food Charter

- Letters and Resolution from the Grey Bruce Health Unit’s Medical Officer of Health to the County of Bruce and the Corporation of the County of Grey dated August 11, 2015

**h) Amendment to the Protocol under the Ontario Public Health Standards -
Public Health Emergency Preparedness Protocol, 2015**

- Memo from the Acting Chief Medical Officer of Health to the Board of Health Chairs dated August 19, 2015

i) Basic Income Guarantee

- Letter to the Minister of Health and Long-Term Care from Ontario Physicians dated August 17, 2015

j) Food Safety Protocol, 2015

- Memo from the Acting Chief Medical Officer of Health to the Board of Health Chairs dated August 10, 2015

k) Low Income Dental Integration

- Letter from the Minister of Health and Long-Term Care to Dr. Sutcliffe dated August 10, 2015

ACCEPTANCE OF NEW BUSINESS ITEMS

MOTION: THAT this Board of Health receives New Business items 8 i) to ii).

9. ITEMS OF INFORMATION

- | | |
|---|---|
| i) alPHa Information Break | July 8, 2015
July 21, 2015
August 11, 2015
September 1, 2015
Spring/Summer 2015 |
| ii) SDHU Workplace Health Newsletter
(English and French versions) | |
| iii) 2014 Snapshot of Public Health
(English and French versions) | Chapleau Area |
| iv) 2014 Snapshot of Public Health
(English and French versions) | Lacloche Foothills |
| v) 2014 Snapshot of Public Health
(English and French versions) | Manitoulin Island |
| vi) SDHU Commentary on Health Quality Ontario Report | July 2015 |

10. ADDENDUM

ADDENDUM

MOTION: THAT this Board of Health deals with the items on the Addendum.

11. ANNOUNCEMENTS / ENQUIRIES

Please remember to complete the Board Evaluation following the Board meeting:
<https://fluidsurveys.com/s/sdhuBOHmeeting/>

12. ADJOURNMENT

ADJOURNMENT

MOTION: THAT we do now adjourn. Time: _____ p.m.

The Chair will ask Board members whether there are any conflicts of interest.

This is an opportunity for Board members to announce a conflict which would then eliminate the individual(s) from any discussion on that topic.

This month's presentation is from the Environmental Health Division.

- Stacey Laforest, Director, Environmental Health

**MINUTES – FOURTH MEETING
SUDBURY & DISTRICT BOARD OF HEALTH
SUDBURY & DISTRICT HEALTH UNIT, BOARDROOM
THURSDAY, JUNE 18, 2015, AT 1:30 P.M.**

BOARD MEMBERS PRESENT

Claude Belcourt
René Lapierre
Ken Noland
Mark Signoretti (arrived at 1:40 pm)

Janet Bradley
Stewart Meikleham
Rita Pilon
Carolyn Thain

Robert Kirwan (arrived at 1:50 pm)
Paul Myre
Ursula Sauvé

BOARD MEMBERS REGRETS

Jeffery Huska

Paul Schoppmann

STAFF MEMBERS PRESENT

Shelley Westhaver
Stacey Laforest

Nicole Frappier
Rachel Quesnel

Marc Piquette
Dr. P. Sutcliffe

GUESTS

Dr. X. Wang, NOSM Resident
Dr. J. Jackman, NOSM Resident
Media

R. LAPIERRE PRESIDING

1.0 CALL TO ORDER

The meeting was called to order at 1:30 p.m.

2.0 ROLL CALL

3.0 DECLARATION OF CONFLICT OF INTEREST

None.

4.0 DELEGATION / PRESENTATION

i) New Sudbury & District Health Unit Website

- Jamie Lamothe, Senior Communications Officer, Corporate Services Division
- Cynthia Peacock-Rocca, Manager, Environmental Health Division

J. Lamothe was invited to introduce and demonstrate the *new* SDHU website. The new site has been developed to:

- improve how information is organized on the site and enhance the information that is provided to clients as well as the services offered to them through the site;
- upgrade to a highly functional and easy-to-use open-source software that adapts to future needs and offers the SDHU flexibility of working with various vendors;
- increase the accessibility of the website so that individuals with disabilities are able to better access and use the site.

The SDHU is ensuring it meets specific obligations under the Accessibility for Ontarians with Disabilities Act (AODA) so that its website and its contents are as accessible as possible. For example, it is now possible for people who use assistive technologies to easily navigate the site and the information is offered in different formats such as posted scripts for videos.

The multi-device compatibility includes a responsive design allowing full content to be displayed on various devices such as mobile phones, tablets, and desktops. The navigation meets the user's needs and applies research-based web design principles, based on usability studies and best practices and includes structures that encourage exploring other content. The customer service feature makes it easier for clients to connect with us and request services, e.g. requesting appointments for clinics or using online registration for certain classes.

C. Rocca was welcomed to demonstrate the updated *Check Before You Eat* inspection disclosure website and new public education program. The SDHU has had a proactive food safety inspection results disclosure site in place since 2009. This updated disclosure site has now been rebranded the "Check Before You Eat!" site. The updated site features an interactive map of our service area that illustrates the location of all food premises where the user can access detailed inspection data for each food premises.

In 2014, the BOH passed motion 32-14 directing staff to enhance its promotion of safe food handling and the food safety program, with particular emphasis on the food safety inspection program and how to access inspection information. The Check Before You Eat decal program is being initiated now that the Check Before You Eat feature in on our new website. Owners and operators of food premises will be receiving a package in the mail shortly that contains various information such as the Check Before You Eat decal, a description of the program and the bi-annual Food Watch newsletter. A media release will subsequently be sent to all media outlets advising the public of this new program.

Questions and comments were entertained and Dr. Sutcliffe thanked the teams involved with these collaborative projects that crossed over the whole organization under the leadership of J. Lamothe. We will continue to improve the site and staff are excited regarding its functionalities, accessibility and further potential for the future.

5.0 MINUTES OF PREVIOUS MEETING

i) Third Meeting – May 21, 2015

A question concerning the 100% funded Healthy Communities Partnership Fund was entertained.

23-15 APPROVAL OF MINUTES

Moved by Noland – Myre: THAT the minutes of the Board of Health meeting of May 21, 2015, be approved as distributed.

CARRIED

6.0 BUSINESS ARISING FROM MINUTES

None.

7.0 REPORT OF THE MEDICAL OFFICER OF HEALTH / CHIEF EXECUTIVE OFFICER

i) June 2015 – Medical Officer of Health / Chief Executive Officer Report

Words for thought in this month's report introduces the new Air Quality Health Index (AQHI) that will be launched by the province this month. The AQHI will forecast and report on air quality and educate the public on the health risks associated with air pollution. It will also provide health-based recommendations and offer specific advice for people who are vulnerable to the effects of air pollution. The Sudbury & District Health Unit (SDHU) will be including the AQHI in its public health messaging.

Board members are encouraged to read and provide feedback regarding the SDHU's 2014 annual report titled *Public Health: It's in Your Interest*. The report has been designed for a widespread distribution electronically and is Accessibility for Ontarians with Disabilities Act (AODA) compliant.

The Association of Local Public Health Agencies (alPHA), the Sudbury & District Board of Health and other Ontario boards of health have been advocating to the province to ensure enough time is taken to effectively plan for the integration of the provincial oral health programs to ensure more children and youth have access to free dental care. Board members were informed that the Ministry of Health and Long-Term Care has recently announced that it is extending the August 1, 2015, deadline for this integration to January 2016.

Board members were thanked for attending the SDHU's inaugural Public Health Champion Award ceremony this morning at 10:30 a.m. The first ever recipient is Franco Marriotti, retired Science North biologist, in recognition of his leadership in numerous environmental initiatives.

The May 21 meeting with the LaCloche Foothills Association was deferred by the Association. Dr. Sutcliffe reported on a meeting held on May 21, 2015, with representatives of the Sudbury East Municipal Association (SEMA) where there was good dialogue regarding public health in Ontario, the SDHU as well as local public health programs and services, needs and issues. In response to SEMA's request, the SDHU has prepared a report that is specific to the Sudbury East area summarizing Sudbury East activities for 2014. The report will be shared with the Board with today's addendum and will then be shared with SEMA. It is the SDHU's intention to produce a similar report for each of our district office areas.

Dr. Sutcliffe reported on the Council of Ontario Medical Officers of Health (COMOH) Section meeting on June 9, 2015, following the alPHA AGM and resolution session which she as well as Board members J. Bradley and U. Sauvé attended. Both Board members were invited to provide verbal highlights regarding the alPHA Annual Conference 2015, Rethinking Public Health, held from June 7 to 9 in Ottawa.

U. Sauvé provided an overview of the conference themes and resolutions that were carried during the resolution session. J. Bradley summarized the conference topics and provided highlights from a workshop during the Board section meeting by Valerie Tarasuk from the University of Toronto regarding food insecurity in Canada. The workshop helped Board members gain an understanding of this important public health problem and to discuss possible policy solutions through an interactive learning experience. This workshop summary prompted a discussion among the Sudbury & District Board of Health members regarding contributing factors towards food insecurities confirming this Boards' commitment to addressing health inequities.

J. Bradley displayed a plaque that Dr. Sutcliffe received at the June alPHa meeting in recognition of her work as alPHa President following a two-year term as Chair of COMOH. Board members congratulated Dr. Sutcliffe recognizing her contributions to the public health system at the provincial level.

A postcard regarding sustainable food was distributed to the Board members who were invited to attend a local conference on October 3.

The Senior Management Executive Committee has been carefully monitoring changes in the expectations of local public health and considering the implications for the SDHU structure and initiatives, such as the increased emphasis on community and stakeholder engagement and communications as per the Ontario Public Health Organizational Standards. Recent organizational changes align the SDHU to ensure capacity for strategic leadership. These changes, which are within the board-approved budget parameters, include the creation of the Assistant Director, Strategic Engagement, a change in one position to Senior Communications Officer and elimination of the Manager of Communications position.

With the position being vacant since September 2013, active recruitment for the Associate Medical Officer of Health position will resume shortly.

This monthly report outlines the twice yearly Corporate Services divisional routine updates and items that require mandatory reporting. More timely issues are included in the monthly MOH/CEO reports.

Submissions of eight ticks to the Public Health Ontario lab identified two blacklegged ticks and one testing positive for the bacteria that causes Lyme disease.

The SDHU continues to monitor the Gogama train derailment situation as it relates to water quality and fish consumption.

Questions and comments were entertained. Clarification was provided regarding the types of requests the SDHU receives relating to freedom of information requests.

24-15 ACCEPTANCE OF REPORTS

Moved by Belcourt – Noland: THAT the Report of the Medical Officer of Health and Chief Executive Officer for the month of June 2015 be accepted as distributed.

CARRIED

8.0 NEW BUSINESS

i) Items for Discussion

a) Immunization of School Pupils Act (ISPA) Enforcement

- Briefing Note from the Medical Officer of Health dated June 11, 2015

Beginning in the 2014/15 school year, elementary and secondary school students were required to comply with changes in the *Immunization of School Pupils Act* (ISPA). Health units across the province experienced a significant increase in workload relating to the enforcement of the ISPA which also coincided with the role out of the provincial electronic immunization module of Panorama. Some health

units indicated that they are unable to uphold the ISPA and the Chief Medical Officer of Health subsequently communicated a clear directive to Ontario public health units to ensure that, by September 2015, all school-aged children are compliant with the ISPA provisions.

Dr. Sutcliffe reassured the Board that the SDHU has been responsive to the changes in legislation under the leadership of Shelley Westhaver, Director, Clinical and Family Services. Alignment of resources has allowed us to be compliant with the legislation and ensure a good position with Panorama. However, these efforts have also resulted in challenges for the Health Unit related to duplicate records or unreported immunizations.

The proposed motion today calls for an electronic immunization record and common electronic data base to address the current challenges at the local public health level in collecting immunization data.

25-15 ENFORCEMENT OF THE IMMUNIZATION OF SCHOOL PUPILS ACT (ISPA)

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

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

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

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

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

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

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

CARRIED

b) Board of Health Manual

- Briefing Note to the Board Chair dated June 11, 2015

A review has been undertaken of the Board Manual and revisions are proposed for the Board's approval. Dr. Sutcliffe highlighted significant changes which, if approved, will be posted on Board Effect.

While most changes are housekeeping in nature to reflect the Board's shift from paper to electronic meetings, other updates were required to reflect legislation and the Ontario Public Health Organizational Standard.

A new information sheet recommends the establishment of a Board Finance Standing Committee. Other noteworthy changes include the delegation of authority under the Municipal Freedom of Information and Protection of Privacy Act to the MOH and the requirement for the Board Chair's approval of MOH expenses.

Questions were entertained.

26-15 BOARD OF HEALTH MANUAL

Moved by Signoretti – Belcourt: THAT the Board of Health, having reviewed the Board of Health Policy & Procedure Manual, approves the contents therein.

CARRIED

Discussion ensued regarding terms for the Finance Standing Committee, Board Executive Committee as well as for the elected Chair and Vice-Chair. Pros and cons were shared and it was clarified that the Health Protection and Promotion Act stipulates that the term of for the Chair and Vice-Chair are for the year.

27-15 BOARD OF HEALTH FINANCE STANDING COMMITTEE

Moved by Myre – Meikleham: THAT the Sudbury & District Board of Health appoint the following three Board of Health members to the Board of Health Finance Standing Committee for 2015:

1. ***Carolyn Thain***
2. ***René Lapierre***
3. ***Claude Belcourt***

CARRIED

c) Healthy Babies Healthy Children (HBHC) Program

- Briefing Note from the Medical Officer of Health dated June 11, 2015

The HBHC program is 100% provincial funded where public health nurses and family home visitors provide supportive services to new families. This program has been subject to a funding freeze for several years. This Board previously advocated for adequate funding for the HBHC program twice by board motions in 2010 and 2004, joining other Ontario Boards of Health as this is a well known issue throughout the province. Although some other health units have decided to reduce the HBHC services in their health units, the SDHU is not proposing such action at this time.

28-15 HEALTHY BABIES HEALTHY CHILDREN (HBHC) PROGRAM

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

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

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

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

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

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

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

FURTHER THAT this motion be forwarded to the Ministers of Children and Youth Services and Health and Long-Term Care, the Association of Local Public Health Agencies, Ontario Boards of Health and the Chief Medical Officer of Health.

CARRIED

d) Disclosure and Transparency

- Briefing Note from the Medical Officer of Health dated June 11, 2015
- Memorandum from Ministry of Health and Long-Term Care Executive Director, R. Martino, to Medical Officers of Health and Associate Medical Officers of Health dated June 9, 2015

The briefing note details the province's direction towards transparency in reporting practices such as through revised Ontario Public Health Standards requiring public disclosure of non-routine infection prevention and control lapse investigations.

The Sudbury & District Health Unit will comply with requirements outlined in the revised Ontario Public Health Standards upon their release. We have already

begun to explore the concept of open government and the potential implications for public health work.

The Check Before You Eat campaign is an example of SDHU initiatives moving toward more transparency of non-routine inspections. Dr. Sutcliffe noted that each scenario of reporting has to be assessed for risk and feasibility to ensure nothing is jeopardized and privacy is protected, such as releasing charges and convictions under the Smoke-Free Ontario Act Charges.

The proposed motion is seeking the Board's support for the spirit of the direction for the SDHU to develop detailed reporting practices for disclosure.

Questions were entertained.

29-15 TRANSPARENCY IN REPORTING PRACTICES

Moved by Thain – Meikleham: WHEREAS the Minister of Health and Long-Term Care has requested that each Board of Health and Medical Officer of Health make transparency a priority objective in business plans; and

WHEREAS the Minister of Health and Long-Term Care has requested that each Board of Health and Medical Officer of Health publicly disclose more detailed information with respect to non-routine infection prevention and control lapse investigations in accordance with planned revisions to the Ontario Public Health Standards; and

WHEREAS the Minister of Health and Long-Term Care has requested that each Board of Health and Medical Officer of Health take steps towards developing and establishing new reporting practices to make information readily available to the public; and

WHEREAS the Sudbury & District Health Unit has made a commitment to transparency;

THEREFORE BE IT RESOLVED THAT the Sudbury & District Board of Health direct staff to plan appropriate actions to increase transparency in public reporting practices including expansion of the current proactive disclosure system and revisions to applicable sections of the Board of Health manual.

CARRIED

- e) Sudbury & District Health Unit 2013-2017 Performance Monitoring Plan**
 - Strategic Narrative Report, June 2015

Joint Board/Staff Performance Monitoring Working Group member, R. Pilon, was invited to speak to the summer edition of the Strategic Narrative Report dated June 2015. The Working Group recently reviewed the five key SDHU activities that are included in the report.

R. Pilon reviewed the five strategic priority narratives which are each linked to a strategic priority and represent the broad scope of work across all division and our district offices. The process for collecting and selecting the narratives was also reviewed. Kudos were extended to staff for their work which clearly aligns with the Board's strategic priorities.

ii) Correspondence

a) Access to Alcohol

Sudbury & District Board of Health Motion #08-15 Modernization of Beverage Alcohol Regulations in Ontario

- Letter from the Premier to the Sudbury & District Health Unit Medical Officer of Health dated May 15, 2015

No discussion.

b) Smoke-Free Multi-Unit Housing

- Letter from the Perth District Health Unit Board to the Minister of Health and Long-Term Care dated May 19, 2015

No discussion.

c) Bill 45, Making Healthy Choices Act

- Letter from the Peterborough County-City Health Unit Board Chair to the Premier of Ontario dated May 14, 2015
- Email from M. Greenberg dated May 26, 2015

No discussion.

d) Low Income Dental Integration

- Letter from R. Martino, Executive Director, Public Health Division, and M. Greenberg, Interim ADM, Health Promotion Division, Ministry of Health and Long-Term Care dated June 2, 2015
- Health Bulletin dated May 29, 2015

No discussion.

e) Basic Income Guarantee

- Letter from Simcoe Muskoka District Board of Health to the Federal and Provincial Government dated May 28, 2015

No discussion.

f) Ontario Public Health Standards – Amendments to the Institutional/Facility Outbreak Prevention and Control Protocol

- Memo from Interim Chief Medical Officer of Health to Board Chairs, Associate/Medical Officers of Health dated May 29, 2015

No discussion.

30-15 ACCEPTANCE OF NEW BUSINESS ITEMS

Moved by Meikleham – Myre: THAT this Board of Health receives New Business items 8 i) to ii).

CARRIED

9.0 ITEMS OF INFORMATION

- | | | |
|------|---|--------------|
| i) | SDHU Strategic Plan Newsletter
(English and French versions) | Spring 2015 |
| ii) | Ministry of Health and Long-Term Care
News Release “Joint Statement by Ministerial
Participants of Pharmacare Roundtable” | June 8, 2015 |
| iii) | 2015 Sudbury & District Health Unit’s
Annual Report (English and French versions) | |

A print copy of the annual report is available for the Board; however, the report will be shared with others electronically.

10.0 ADDENDUM

31-15 ADDENDUM

Moved by Meikleham – Myre: THAT this Board of Health deals with the items on the Addendum.

CARRIED

DECLARATION OF CONFLICT OF INTEREST

There were no declarations of conflict of interest.

i) Algoma Public Health

- Assessor’s Report on Algoma Public Health, *April 24, 2015*
- Ministry of Health and Long-Term Care Actions on Assessor’s Report, *June 2015*
- Letter from the District of Algoma Health Unit Board of Health Chair to the Sudbury & District Board of Health Chair dated June 17, 2015

On June 16, 2015, the Minister of Health and Long-Term Care was in Sault Ste. Marie to publicly share the Assessor’s Report on the Algoma Public Health and the MOHLTC’s response and actions to the report which are summarized the MOHLTC Actions on Assessor’s Report, June 2015.

Recommendations in the Assessor’s report were summarized by Dr. Sutcliffe.

The Sudbury & District Board of Health were appreciative of the letter from the Algoma Public Health Board of Health recognizing this Board’s support as well as coverage by Dr. Sutcliffe as Acting MOH and by Sandra Laclé as Acting Chief Executive Officer.

The potential implications from the assessor’s report and Ministry actions were discussed such as the skills based board. One of the recommendations in the Assessor’s report was the possible merger with the Sudbury & District Board of Health; however, the Ministry has

indicated that this will be reviewed in the larger context of public health review as indicated in the Minister's mandate letter.

Questions were entertained.

The situation will be closely monitored as to future direction and the Board will be kept apprised of any actions or new developments. Should actions or discussions take place regarding the merger recommendation, this Board would be convened to discuss implications.

ii) Association of Local Public Health Agencies (aLPHa) Resolutions Session, 2015 Annual General Meeting (AGM)

- Disposition of Resolutions, June 2015

Previously discussed under agenda item 7.0

iii) 2014 Snapshot of Public Health – Sudbury East Report, June 2015

The 2014 Snapshot of Public Health Report provides a summary of public health activities that have taken place in the Sudbury East area in 2014. Board members are encouraged to read the report. The SDHU is exploring the feasibility of developing a similar report for other areas within its catchment area, including Chapleau and municipal associations of Lacloche Foothills and Manitoulin Island.

iv) Northern Ontario Evacuation of First Nation Communities – Resolution 50-2015

- Letter from the Thunder Bay District Health Unit Medical Officer to Dr. Sutcliffe dated April 13, 2015

The Thunder Bay District Board of Health is seeking support from other Boards of Health to encourage the provincial government to review existing protocols and plans for a better and safer First Nation evacuation/relocation process.

The Sudbury & District Board of Health agreed that the correspondence to the provincial government should be shared with local municipalities.

32-15 NORTHERN ONTARIO EVACUATIONS OF FIRST NATIONS COMMUNITIES

Moved by Sauvé – Bradley: WHEREAS the evacuation and relocation of residents of a number of First Nations communities in Northwestern Ontario and along the James Bay Coast, is required on a close to annual basis due to seasonal flooding and risk of forest fires; and

WHEREAS a safe, effective, and efficient temporary community relocation is challenging within the current reactive model; and

WHEREAS a proactive, planned and adequately resourced evacuation system would ensure the maintenance of quality evacuation centers in pre-selected host municipalities, as well as appropriate infrastructure to ensure the health and safety of evacuees in a culturally acceptable manner; and

WHEREAS the Thunder Bay District Board of Health passed a motion on March 18, 2015, and has submitted a letter dated April 10, 2015 to the Honourable Kathleen Wynne requesting that the provincial government address the ongoing lack of resources and infrastructure to ensure the safe, efficient and effective temporary relocation of First Nations communities in Northwestern Ontario and the James Bay coast when they face environmental and weather related threats in the form of seasonal flooding and forest fires;

THEREFORE BE IT RESOLVED THAT the Sudbury and District Board of Health support the Thunder Bay District Board of Health's resolution 50-2015 dated March 18, 2015; and

FURTHER THAT a copy of this motion be forwarded to the Premier of Ontario, Ministers responsible for Health and Long-Term Care, Community Safety and Correctional Services, Aboriginal Affairs, Northern Development and Mines, Natural Resources and Forestry, local area Members of Provincial Parliament and all Ontario Boards of Health.

CARRIED

13.0 ANNOUNCEMENTS / ENQUIRIES

Kudos were extended to the SDHU and staff for its contributions to the most recent Rainbow Routes new trail map project.

Board members were encouraged to completed the Board evaluation regarding today's Board meeting.

14.0 ADJOURNMENT

33-15 ADJOURNMENT

Moved by Bradley – Sauvé: THAT we do now adjourn. Time: 3:56 p.m.

CARRIED

(Chair)

(Secretary)

APPROVAL OF MINUTES

MOTION: THAT the minutes of the Board of Health meeting of June 18, 2015, be approved as distributed.

There are no items coming forward under Business Arising.

Medical Officer of Health/Chief Executive Officer Board Report, September 2015

Words for thought...

In 2010, when CPHA celebrated its centennial, we talked a lot about the [12 great achievements of public health](#). Each of those achievements, in their own way, contributed to increasing the quality of life and the average lifespan of Canadians. Along the way, expectations also grew. Living longer was one thing, but living **healthier, more meaningful lives quickly became just as important. In short, we've helped set a higher standard for Canadians.**

And yet, we live in a country where [1 in 7 \(or 4.8 million\) people](#) live in poverty. Canada is ranked [24th out of 34](#) Organisation for Economic Co-operation and Development (OECD) countries in terms of poverty levels, and UNICEF rated Canada [17th out of 29 wealthy countries](#) due to the number of children living in poverty. In addition, we live in a country that is not meeting its international obligations concerning the environment.

Clearly, there are forces at work that are undermining the values that Canadians have traditionally embraced.

As a proud Canadian, I like to think that, in addition to being polite and saying 'eh?', **we are a people for whom fairness is an important value. It's so important, it is enshrined in the [Canada Health Act](#)** through the principle of universality. Fairness is also a foundational concept for public health. Should we not be looking to continue renewing this commitment to a higher standard?

As we prepare for a general federal election in October, we have an opportunity to challenge all candidates to set a higher standard for Canadians. We should not be satisfied with rehearsed answers that lack depth. We need to hold the candidates themselves to a higher standard and expect more from them.

In early September, CPHA, in collaboration with the Canadian Coalition for Public Health in the 21st Century, will be releasing a pre-election 'playbook' that addresses major issues that the next federal government must be prepared to tackle in a serious manner. A federal election is a prime opportunity to get the public health agenda in front of politicians and the general public.

It's time that politicians and their proposed policies are held to a higher standard.

Source: Ian Culbert, Executive Director, Canadian Public Health Association
<http://www.cpha.ca/en/about/digest/39-2/3.aspx>
Canadian Health Digest
Summer 2015, Volume XXXIX, Number 2

Chair and Members of the Board,

Welcome back to all Board members from a summer hiatus of Board meetings. As you will have witnessed through the SDHU news releases shared with you this summer, the Sudbury & District Health Unit has been busy with a variety of public health activities such as beach monitoring, heat advisories, drinking water advisories, healthy eating and physical activity promotion, injury prevention and education about alcohol intake.

As noted in the CPHA's Executive Director's article, the values we hold and the standards we set for ourselves are critical. At the local level, Sudbury & District Health Unit staff continuously strive to live our values to hold ourselves to high standards as we work to meet our Vision of *Healthier communities for all*. For example, the Board will note in the RRED section of this report, the work that is underway promoting the values of our Strategic Plan. And, concerning high standards, a recently developed SDHU Evidence-Informed Public Health Practice Primer supports staff's use of evidence-based standards in their work. As quoted by Roy E. Disney, "It's not hard to make decisions once you know what your values are."

I am pleased to look forward to a busy fall and to present the September report, which includes program highlights for the past three months following the summer hiatus.

GENERAL REPORT

1. Human Resources Update

Active recruitment is underway for the Associate Medical Officer of Health position and interviews are expected to be conducted this fall.

I am pleased to report that Sandra Laclé has returned to the Sudbury & District Health Unit as the Director of Health Promotion. Algoma Public Health (APH) hired an interim Chief Executive Officer and Sandra's almost six-month term as the Acting Chief Executive Officer ended on August 31. The APH Board and staff have shared their appreciation for the Sudbury & District Board's support as well as that of Dr. Sutcliffe and Sandra.

I continue to provide month-to-month Acting MOH coverage for the Algoma Public Health. I provide MOH support on a consultant basis and participate in person at most Board meetings. I will provide support to their newly appointed CEO through weekly teleconferences.

The SDHU was able to provide support to our APH neighbour due to the SDHU's leadership capacity. I would like to acknowledge Nicole Frappier for her leadership as Interim Director of Health Promotion as well as Martha Andrews for taking on the Interim Manager of Health Promotion position.

Some internal changes have taken place to further build on our organizational priorities such as health equity and strengthen our response to provincial accountabilities. Nicole Frappier is now the Assistant Director of the newly established Strategic Engagement Unit and oversees the Communication team and district offices.

We are pleased to be hosting visiting Public Health Physician from Australia, Dr. Donna Mak, who is working at the SDHU and NOSM from August 19 to September 25, 2015.

2. Local and Provincial Meetings

The funding for the Greater Sudbury's Healthy Kids Community Challenge was recently announced and initial planning has begun to discuss the leadership and governance model for the project and planning next steps in launching and implementing the Healthy Kids Community Challenge project. I had the privilege of speaking at the Sudbury launch, hosted on September 10 by Associate Minister of Health and Long-Term Care, Ms. Damerla.

I was ably supported by SDHU staff in July when I spoke at the public consultation hosted by the Ontario Ministry of Labour. A series of public consultations was held across the province to explore possible changes to the Labour Relations Act and the Employment Standards Act. My comments reflected the public health perspective that workplaces are a critical determinant of individual, community and population health.

I continue to participate in the Association of Local Public Health Agencies (aLPHa) Executive Committee teleconferences.

After a summer break, the Northern Medical Officers of Health will resume their monthly teleconferences on September 16.

The Ministry of Health and Long-Term Care continue to host monthly teleconferences with local public health leadership.

3. SDHU Website

Since being launched on June 15, the Health Unit's new website has been very well received by users. Anecdotal feedback from members of the public, partner agencies, as well as members of the media have focused on the clean design and simple information structure, which makes finding detailed information easy and intuitive. User input has also been used to guide refinements. The fully responsive (mobile compatible) features of the site have also helped to increase the reach of SDHU's content by allowing users on mobile devices and tablets to more easily interact with and share content via the site and social media platforms.

Web analytics [excludes SDHU internal traffic] -- June 15 to September 3, 2015

- Daily session average: 467 (total: 37,806)
- Average pageviews per session: 3 (total: 120,162)
- Mobile vs. non-mobile device users: 49% mobile, 51% non-mobile (mobile includes tablets and smart phones/cellphones)

4. Board Orientation

A complete Board orientation session was held this year and to date, a total of 88% of members participated in the orientation. Those who were not available for the orientation are encouraged to review the orientation materials and contact the Board Secretary if they have any questions.

All Board members are encouraged to review the updated Board of Health E-Learning Module on the Public Health section of the e-Health Ontario portal:

https://www.ehealthontario.ca/portal/server.pt/community/public_health

The Module was first released in 2011 as a learning tool for both new and more seasoned board of health members, to complement and support existing Board orientation resources. It provides an orientation to the public health sector and to specific roles and responsibilities under the Health Protection and Promotion Act with respect to the oversight and delivery of public health programs and services in Ontario. The Module includes overviews of the Ontario Public Health Standards and the Ontario Public Health Organizational Standards using examples of particular relevance to members of boards of health. The updated Module can be accessed in both English and French from the Public Health section of the e-Health Ontario portal.

5. Annual Board Self-Evaluation

As part of the Sudbury & District Board of Health's commitment to good governance and continuous quality improvement and in accordance with Board of Health Manual policy C-I-12 and C-I-14, the Board of Health has committed to carrying out a self-evaluation of its governance practices and outcomes.

In 2013, a Sudbury & District Board of Health Member Self-Evaluation of Performance questionnaire was constructed based on past Sudbury & District Board of Health surveys, with some revisions made to meet the data requirements for the 2013–2017 Performance Monitoring Plan and the Ontario Public Health Organizational Standards.

In addition, the yearly Sudbury & District Board of Health Member Self-Evaluation of Performance is used as a data source for the Sudbury & District Health Unit 2013–2017 Annual Performance

Monitoring Report. The Performance Monitoring Plan was developed in order to provide the Board of Health with accountability measures on a number of key focus areas from the 2013–2017 Strategy Map. Leadership excellence, one of the focus areas, includes Board of Health commitment and satisfaction. The rate of completion of the annual self-evaluation questionnaire is one component of the Board of Health Commitment Index. The Board of Health Members' Satisfaction Index combines information on three aspects of Board of Health members' satisfaction: their individual performance as a Board member; Board processes; and overall Board performance.

The Board of Health members are asked to complete the [online self-evaluation questionnaire](#) by Monday, October 19, 2015. The questionnaire will be used to obtain valuable and comparative data for the 2013–2017 period and identify possible areas for improvement in Board effectiveness and engagement.

Results of the Board of Health member self-evaluation of performance will be presented at the future Board meeting.

6. 2015 Program-Based Grant

This item will be the subject of discussion at the Board meeting and will also be reviewed at the following week's inaugural meeting of the Finance Committee.

7. Financial Report

The positive variance in the cost-shared program is \$330,508 for the period ending July 31, 2015. Gapped salaries and benefits account for \$203,343 or 61.5% with operating expenses and other revenue accounting for \$127,164 or 38.5% of the variance. The operating and revenue variance is attributable to timing and calendarization of revenue and expenses.

A number of one-time operating pressures were identified, approved and processed in the current fiscal year and are reflected on the July 2015 financial reporting in the amount of \$81,465 as follows:

- **Staffing** – Clinical Student Office Assistant to perform Panorama data cleansing and support the fall school consent mail out. (\$5,285)
- **Programming and Research** – Sable-Spanish River Trail assessment (Rural study). (\$10,000)
- **Staff Development** – Cultural Competency Facilitator, Mindfulness Training and Clinical Engagement training and implementation. (\$14,774)
- **Infrastructure** – Carpet replacement and replace payment processing equipment. (\$51,406)

The process of preparing the 2016 cost-shared operating budget has commenced. The budget process timeline and key assumptions will be reviewed at the Finance Standing Committee in September.

8. Environmental Public Health Week

Environmental Public Health Week will be celebrated the week of September 21, 2015. This year's theme is *Looking Back, Moving Forward, Building on 100 years of success*. This initiative was established in 2003 with the aim of recognizing the work of Certified Public Health Inspectors and Environmental Health Officers in Canada, and increasing awareness of the profession with the general public and our private/public sector partners.

The Sudbury & District Health Unit public health inspectors are dedicated professionals who play a vital role in reducing exposure to environmental hazards and providing timely information to protect and promote the health of the public.

9. Quarterly Compliance Report

The SDHU is compliant with the terms and conditions of our Public Health Accountability Agreement. The SDHU has procedures in place to uphold the Ontario Public Health Organization Standards, to provide for the effective management of our funding and to enable the timely identification and management of risks.

The SDHU has paid all payable remittances for employee income tax deductions and Canada Pension Plan and Employment Insurance premiums, as required by law to August 28, 2015, on August 28, 2015. The Employer Health Tax has been paid as required by law, to August 28, 2015, with a cheque dated September 15, 2015. Workplace Safety and Insurance Board premiums have also been paid, as required by law, to August 28, 2015, with a cheque dated September 30, 2015. There are no outstanding issues regarding compliance with the Occupational Health & Safety Act, Ontario Human rights Code, or Employment Standards Act.

10. District Area Snapshot Reports (2014)

As a follow-up to the Sudbury East snapshot report that was prepared in June and shared with the Board of Health and the Sudbury East Municipal Association (SEMA), the SDHU has produced similar reports for each of our other district office areas. Included in today's package are reports for Manitoulin Island, LaCloche Foothills, and the Chapleau area. These reports, which highlight activities for these areas for 2014, will be posted on our website and shared with municipal leaders.

Following are the divisional highlights since the June Board of Health meeting. Board members will note that the report is lengthy due to both the busy summer and the time period covered.

CLINICAL AND FAMILY SERVICES DIVISION

1. Control of Infectious Diseases (CID)

Influenza: There have been no cases of influenza A or B identified during the months of June, July and August. Preparations for the upcoming Universal Influenza Immunization Program are underway.

Respiratory Outbreaks: There has been one identified respiratory outbreak in a long-term care home during the months of June, July and August. Causative organism for this outbreak has been identified as Rhinovirus.

2. Vaccine Preventable Diseases

Grade 7 & 8 Vaccination Program: Preparations are underway to begin the 2014–2015 Grade 7 (hepatitis B & Menactra) and Grade 8 female (Gardasil) vaccination campaign.

Effective September 2015, Ontario public health units will be offering the Gardasil program as a two-dose schedule for most recipients (some will still require a three dose schedule). This program change aligns with current scientific and expert recommendations from the National Advisory Committee on Immunization (NACI) and the Provincial Infectious Disease Advisory Committee on Immunization (PIDAC-I).

Clinics are planned throughout the year within the schools to ensure that all eligible students may receive the vaccine during the school year.

The CID team continues to monitor all reports of respiratory illness.

3. Family Health

Prenatal Education: Between June and August 2015, 173 pregnant women and their support persons attended in-person prenatal classes at SDHU's main site and 24 clients registered for online prenatal learning modules.

Breastfeeding: Over the summer months, 17 participants attended the breastfeeding support group in the Minnow Lake location.

The SDHU will complete its Baby-Friendly Initiative (BFI) pre-assessment site visit on November 3, 2015. Work is underway to prepare all staff in the organization for this visit, which is a mandatory component of the designation process for the BFI accountability indicator. Once the pre-assessment site visit is completed and all recommendations have been implemented, the SDHU will be granted a second and final visit from the Breastfeeding Committee of Canada to attempt to achieve our designation, which we expect will occur in 2016.

Positive Parenting Program (Triple P): Over the summer months, 17* parents of teens took part in one-to-one parenting sessions. Family Health team staff offered a 0–12 years group parenting session to 42* participants at the Aboriginal People's Alliance of Northern Ontario location in downtown Sudbury. Six* parents participated in the new Family Transitions program, which is a Triple P program for parents in the process of separation and divorce.

Note: *Triple P participant totals represent repeat clients.

Child Health Community Events:

Approximately 12 parents from Our Children, Our Future participated in a safe sleep session held at Our Children, Our Future's Capreol location.

Along with the SDHU Dental team and others and with the support of the Health Equity team, Family Health team staff attended the Back to School community event in August that assisted families by providing them with necessary school supplies. The Family Health team had a booth where resources on parenting, breastfeeding, etc., were shared with 106 participants.

Family Health team staff provided assistance at local car seat clinics in Capreol and Garson in July and August where 25 families had their car seats inspected.

Approximately 400 participants attended the Chelmsford Neighbourhood Team Bike Rodeo held on June 6, 2015. This event was coordinated in collaboration with many community partners such as Best Start Hubs, Centre de santé communautaire de Sudbury, Greater Sudbury Police Services, SDHU, etc. Helmets were provided to families and the SDHU shade canopy was installed to promote sun safety.

4. Infection Prevention

We are proud to note that SDHU Infection Control Nurse, Stephanie Hastie, was appointed as a representative for a three-year term to Infection Prevention and Control Canada's (IPAC) Immunize Canada. Immunize Canada is a partnership of national non-governmental, professional, health, consumer, government and private sector organizations with an interest in promoting the understanding and use of vaccines recommended by the National Advisory Committee on Immunization. The goal of Immunize Canada is to contribute to the control, elimination and eradication of vaccine-preventable diseases in Canada by increasing awareness of the benefits and risks of immunization for all ages via education, promotion, advocacy and media relations.

5. Sexual Health / Sexually Transmitted Infections (STI) / Blood-Bourne Infections (BBI) Including Human Immunodeficiency Virus (HIV) Program

In July, the Sexual Health team participated in the Fierté Sudbury Pride Week events. We advertised the Sexual Health Clinic services in the Pride Guide publication. On July 25, the Sexual Health team hosted a display that highlighted the availability of anonymous HIV testing in our community and offered an anonymous HIV testing clinic at the YMCA. Condoms and dental dams were also provided to the organizers of Fierté Pride Week for distribution at their events.

The Sexual Health team responded to four community agency requests providing education to 58 participants. Topics included sexually transmitted infections and the importance of maintaining healthy relationships via safe sex practices. Birth control options were also discussed including the availability of low cost birth control at the SDHU.

ENVIRONMENTAL HEALTH DIVISION

1. Control of Infectious Diseases

During the months of June, July, and August, a total of 31 sporadic enteric cases and 13 infection control complaints were investigated. One enteric outbreak was declared in an institution. No causative organism was identified.

2. Food Safety

During the months of June, July, and August, seven food product recalls prompted public health inspectors to conduct checks of 310 local premises. All affected establishments had been notified, and subsequently had removed the recalled products from sale.

Public health inspectors issued four charges to three food premises for infractions identified under the Food Premises Regulation.

In June, July, and August, staff issued 388 special event food service permits to various organizations for events serving approximately 73 000 attendees.

Through Food Handler Training and Certification Program sessions offered over the summer months, 128 individuals were certified as food handlers.

The updated *Check Before You Eat!* food safety inspection results disclosure website and voluntary decal program were launched and promoted to the public via media release.

3. Health Hazard

In June, July, and August, 81 health hazard complaints were received and investigated. Six of these complaints involved marginalized populations.

In response to high daily temperatures, three press releases were issued to inform the public of the importance of preventing heat-related illness.

4. Ontario Building Code

During the months of June, July, and August, 141 sewage system permits, 73 renovation applications, one minor variance, and 10 consent applications were received.

Sixteen mandatory maintenance inspections of private septic systems were completed for the Source Water Protection program in June, July, and August.

5. Rabies Prevention and Control

One hundred and thirteen rabies-related investigations were carried out in the months of June, July, and August. Eight specimens were submitted to the Canadian Food Inspection Agency Rabies Laboratory for analysis, and were subsequently reported as negative.

Nine individuals received rabies post-exposure prophylaxis due to exposure to wild or stray animals.

6. Safe Water

In June, July, and August, two drinking water advisories were issued for residents of Foleyet who draw their water from the Foleyet Water Treatment Plant, due to a loss of pressure in the drinking water distribution system.

During the summer months, 33 beaches were sampled by Health Unit staff with 2 605 samples taken during 494 visits. In August, three beaches were posted as unsafe for swimming due to elevated levels of E.coli. All beach sample results have since returned to acceptable levels.

In July, one beach was ordered closed as it was deemed unsafe for public use as a result of Eurasian milfoil.

Public health inspectors investigated 16 blue-green algae complaints in the months of June, July, and August, eight of which were subsequently identified as blue-green algae capable of producing toxin.

Three hundred and nineteen residents were contacted regarding adverse private drinking water samples, 57 regulated adverse water sample results were investigated, nine boil water orders, one boil water advisory, four drinking water advisories, one drinking water order, and one health information notice for sodium were issued. Furthermore 12 boil water orders, one boil water advisory, five drinking water advisories, and one drinking water order were rescinded.

The 2015 District Children's Water Festival was held in Espanola in June. Local school children Grades 2 to 5 attended the festival. One hundred and twenty children were provided with education regarding water conservation, water safety and the importance of potable water using a fun, hands-on approach.

7. Vector Borne Diseases

In June, media releases were issued to remind residents of the importance of taking precautions to prevent West Nile virus (WNV) and Lyme disease.

In June, July, and August, 5 592 mosquitoes were trapped and sent for analysis. A total of 134 mosquito pools were tested, 45 for Eastern Equine Encephalitis (EEE) virus, and 89 for West Nile virus (WNV). All pools tested negative for EEE and WNV.

On Wednesday, August 12, 2015, residents were advised that a horse in the city of Greater Sudbury had tested positive for WNV. This is the second reported horse to test positive in the Health Unit's service area. As a result, the SDHU enhanced mosquito trapping in the area where the horse was identified.

On June 12, 2015, residents were informed that a blacklegged tick found locally tested positive for the bacteria that can cause Lyme disease with a subsequent news release issued on August 25, 2015, advising of two additional locally acquired positive blacklegged ticks.

8. Emergency Response

On August 13, 2015, SDHU responded to a nitrogen oxide and nitrogen dioxide release from the Vale Acid Plant in Copper Cliff. The City of Greater Sudbury Emergency Operations Centre was activated in response to the event. The Health Unit worked with other City of Greater Sudbury Community Control Group members, as well as Public Health Ontario, the Ministry of Health and Long-Term Care, and Ministry of the Environment and Climate Change in response to the event.

HEALTH PROMOTION DIVISION

1. Early Detection of Cancer and UVR Exposure

In partnership with the Cancer Prevention and Screening Network (CPSN) – North East, the SDHU along with the other northeastern health units, the North East Cancer Centre, and the Canadian Cancer Society, launched a regional media campaign that reminded community members of the importance of sun safe practices in all aspects of their daily lives. The 30-second information clip was broadcast on CTV Northern Ontario, as well as on social media, from early July through to mid-August.

2. Healthy Eating

In Sudbury, a public health dietitian delivered a three-hour healthy eating education session for 12 staff from the Centre for Addiction and Mental Health (CAMH) and the Northern Initiative for Social Action (NISA) to assist them with helping their clients choose healthier food options. Topics included healthier alternatives, menu planning and reading food labels. This request initially came from NISA staff who serve adults living in group homes.

3. Healthy Weights

The Nutrition Physical Activity Action team (NPAAT) Healthy Weights Working Group and the School team participated in two events. The first event was for students enrolled in the Native Counsellor Training Program at Laurentian University. Individuals enrolled in this program will be working as counsellors in elementary and secondary schools in remote areas. A public health dietitian presented on the Balanced Approach. The second event was for high-risk youth who will be peer mentors at the St. Francis summer camp. A public health dietitian gave a presentation on body image, self-esteem, media literacy and the role of adult influencers, and a public health nurse presented on physical activity.

Health Promotion staff provided concurrent sessions on healthy eating and body image, sun safety and physical literacy to approximately 120 City of Greater Sudbury summer camps and playground junior staff during their training week in early July.

4. Injury Prevention

A Child Passenger Safety Association Car Seat Technician training was held in St. Charles on August 18 and 19, which included Ministry of Transportation Ontario (MTO) and SDHU staff.

SDHU staff attended an information booth about child passenger safety at the Community Store and Magasin-partage in Sudbury on August 18 and 19.

SDHU staff are involved in a Laurentian University research project entitled “Anti-texting and Driving Strategies: Youth Perceptions, Attitudes and Behaviours.” There are two main goals: 1) To examine youth perceptions, attitudes and behavior towards anti-texting and driving campaigns and 2) To determine what health promotion strategies may prevent youth from texting and driving. Funding has been sought through the MTO.

As an active member of the Sudbury East Safety Coalition, the SDHU helped to kick-off the bilingual, Impaired Driving and Distracted Driving campaigns. Newsletters were distributed to local households, flyers were shared throughout the communities and banners were displayed in Hagar and Noëlville throughout June, July and August.

As an active member of the Manitoulin Injury Prevention Coalition, the SDHU once again assisted with the implementation of a water safety awareness campaign on Manitoulin Island throughout the summer. Drowning awareness and water safety presentations were offered by coalition members at municipally-run swimming lessons and promotional materials such as postcards and beach towels were distributed in 5 local communities (Little Current, Mindemoya, Assiginack, Gore Bay and Kagawong). The Municipality of Assiginack also featured images of the event on social media, which were re-tweeted by the Northeastern Ontario branch of the Ontario Provincial Police (OPP) and the Lifesaving Society.

5. Physical Activity

The first of six Skate Exchange events for the 2015–2016 season took place on August 22, 2015, at the Twin Forks Playground. At this event, 37 pairs of previously owned skates were provided to community members.

Skate drop off locations at the Espanola and Sudbury East District Offices will be added. The donated skates will then be distributed to local organizations and arenas who host their own Skate Exchanges.

Since 2002, Skate Exchange Committee partners and volunteers have collected and redistributed gently-used skates, free of charge, to children, youth and adults in order to improve access to the equipment needed to participate in winter activity.

Sudbury Cycles worked collaboratively with the Greater Sudbury Police Services to conduct a Children’s Bicycle Give Away at the Sudbury Housing and New Opportunities and Hope (NOAH) spaces on July 16. A total of 17 children bicycles and helmets were provided to children identified by referral agencies. Safe cycling resources were distributed to the caregivers and instruction on proper helmet fitting was provided. The Police Bicycle Patrol provided incentive coupons, to the children, to promote safe cycling habits.

Additionally, SDHU staff supported the Township of Sables-Spanish with their grant application to the Lawson Foundation for Active Outdoor Play. The Townships applied for \$49,000 to create a "natural playground" at their existing Mouth Park in Massey.

6. Prevention of Substance Misuse

On June 25, 2015, the SDHU hosted the PAIRINGS Event at Laughing Buddha, a local restaurant in Greater Sudbury. The goal of the event was to engage decision makers in conversation about alcohol use. Some local politicians and community members joined Board of Health members and were treated to a mouth-watering three-course light lunch paired with delicious mocktails. The conversation

focused on the Low-risk Alcohol Drinking Guidelines, the impacts of alcohol use on health, as well as the social and environmental effects of alcohol use. Media interviews before, during and after the event, as well as tweets from attendees led to considerable media attention.

The LaCloche Foothills Drug Strategy was presented to the Nairn-Hyman and Baldwin councils in June, and both councils unanimously endorsed the strategy.

7. School Health

The School Health Promotion team has been working closely over the past few years with the École secondaire Hanmer, which has a student population of approximately 120. The school was awarded a \$50,000 healthy eating grant from the Ministry of Education in 2014.

A School Health Promotion team public health nurse and public health dietitian took a lead role in bringing together school staff, students, parents and approximately 12 active community partners in planning and implementing the following projects:

- A community garden “Jardin du Village Garden”. The school will also benefit from their season’s yield by using the produce in their cafeteria and for their Specialist High Skills Major in Hospitality and Tourism program.
- Renovating and improving the cafeteria to ensure a safe and welcoming place for students, school staff and community to come together to enjoy a meal, socialize and host community events.
- Fifty students, parents, seniors and community members also benefited from Food Handler Certification offered by the SDHU Environmental Health Division.
- Education and consultations were offered to school staff to increase their knowledge and skills with regards to healthy eating.
- In partnership with the Centre de santé communautaire du Grand Sudbury, a French cookbook was provided to each student, staff and community member.
- A cooking challenge, in partnership with a chef from Collège Boréal and two of his students, took place in conjunction with the launch of the cafeteria and the community garden. Over 180 community members gathered and feasted on a full course meal prepared and served by students, staff and community members.

8. Tobacco Use Prevention (in district offices)

District office staff in Chapleau, Espanola, Manitoulin and Sudbury East supported the latest Leave the Pack Behind (LTPB) poster campaign in their respective communities. LTPB posters were distributed in time for the holiday weekends (e.g. Victoria Day, Canada Day, Civic Holiday) to all district office areas to encourage cessation throughout the summer.

9. Workplace Health

From mid-June to mid-August, the Workplace Health team provided resources, referrals and knowledge brokering services to 10 workplaces.

Additionally, in June, the Workplace Health team distributed, to approximately 200 workplaces/businesses, 250 hard copies and 185 electronic copies of the Spring/Summer 2015 Workplace Health newsletter entitled “Work Stress”.

RESOURCES, RESEARCH, EVALUATION AND DEVELOPMENT (RRED) DIVISION

1. Population Health Assessment and Surveillance

The Quarterly Reportable Disease Report for April to June 2015 was completed in the summer and circulated to the SDHU Outbreak Team, specialists, program managers, and directors. These snapshots of the quarter's information available through the integrated Public Health Information System (iPHIS) include cases diagnosed in the SDHU area that were reported and confirmed.

The Manager, Population Health Assessment and Surveillance continues to actively participate as the technical lead for the Manitoulin - Sudbury Data Sharing Network (formerly the Sudbury Data Consortium), which is under the leadership of the Social Planning Council. At its last meeting, the group renewed commitment to the Network, including a plan to grow the membership, seek out training opportunities, and demonstrate success through shared projects. In this capacity as technical lead for the Network, the Manager attended the Canadian Council on Social Development's (CCSD) Community Data Program National Leads Meeting in Montreal on May 21, 2015.

2. Health Equity

Dr. Sutcliffe and the Health Equity Foundational Standard Specialist submitted an invited commentary to healthydebates.ca on a 2014 Health Quality Ontario report, which identified a "greater burden of poor health status" in Northern Ontario. The commentary, which was published in July 2015, emphasizes the need for Health Quality Ontario to consider the broader social determinants that underpin health differences as key to understanding the health outcomes in our unique northern context.

The SDHU continues to participate on the Greater Sudbury Community Safety and Well-being Steering Committee, which was recently successful in its application for a second round of funding of \$100,000 through the Ministry of Community Safety and Corrections (MCSC) Proceeds of Crime grant program. Led by the Greater Sudbury Police Services, the Steering Committee also includes representatives from the City of Greater Sudbury, the North East Local Health Integration Network, Community Mobilization Sudbury, the Canadian Mental Health Association, and the Social Planning Council of Sudbury. In this second phase of the project, the Steering Committee will continue to engage with community stakeholders to build a sustainable plan to ensure ongoing safety and well-being planning in the community.

The Health Equity Knowledge Exchange and Resource Team (HEKERT) continues to link with community partners to improve understanding of the social determinants of health and health equity. Team members presented on this topic to students from the School of Nursing (May 25) and the Native Counsellor Training Program (July 17) at Laurentian University. Members of HEKERT also assisted in facilitating a poverty workshop for clinicians led by Dr. Amanda Hey in North Bay on June 15. This workshop was attended by some physicians from the SDHU catchment area, and inspired collaboration with the North Bay Parry Sound District Health Unit around increasing awareness of income supports for individuals and families living in poverty.

On September 15, 2015, the SDHU will host a facilitator from the Wellington-Dufferin Guelph Public Health (WDGPH) to train 80 managers, staff, and community partners on the "Bridges Out of Poverty" framework. This framework is used to foster a greater understanding of what it means for individuals to live in poverty, and how poverty impacts our community as a whole. The facilitator will also lead a discussion about local public health application of the international framework.

3. Research and Evaluation

Staff from the RRED and Health Promotion divisions attended a proposal development workshop for Public Health Ontario Locally Driven Collaborative Projects (LDCP) in July. SDHU staff are collaborating with other Ontario public health units on developing a proposal for the second phase of the Beyond BMI project, which will build on research findings from the first phase. The first phase explored the feasibility of using NutriSTEP®, a nutritional screening tool, in primary care practices. The focus of the next phase of work is to test the implementation of an electronic version of NutriSTEP® in primary care practices, and to assess what processes and structures are needed to support successful sharing of the data.

On June 11, 2015, I. Vettoretti, Foundational Standard Specialist participated in an all-day Public Health Ontario (PHO) Ethics Review Board (ERB) meeting. The ERB membership includes hospital researchers, PHO scientists, university researchers, community partners, lawyers, physicians, ethicists, and public health unit representatives from across Ontario. Key discussions were held around provincial projects related to vaccines and hepatitis C.

4. Student Placement Program

The SDHU, in keeping with its Teaching Health Unit principles, is once again preparing to host students as they embark on a new school year. Students from undergraduate and postgraduate levels from various professions including nursing, dietetics, dental hygiene, medicine, and social work will begin their placements at the SDHU for the upcoming semester. A student orientation session will be provided to students on September 9.

5. Strategic Plan

The Strategic Planning Committee is currently leading an internal campaign geared toward developing meaning to and understanding of the Strategic Plan values. Values are being featured through a number of staff engagement activities which include internal newsletter features and as well as gathering of staff feedback via white boards and online surveys. In order to mark the half-way point of this campaign, four short videos providing an overview of engagement results for the values of accountability, caring leadership, innovation, and excellence have been developed and posted on the SDHU YouTube channel (<https://www.youtube.com/user/TheHealthUnit>). The Strategic Planning Committee looks forward to further engaging with staff on the remaining three values in the latter half of the year.

Respectfully submitted

Original signed by

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

2015 Sudbury & District Board of Health Member Self-Evaluation of Performance

The Board of Health members are asked to complete the online self-evaluation questionnaire by Monday, October 19, 2015:

<https://fluidsurveys.com/surveys/sdhu/boh-self-evaluation-of-performance/>

Your responses will be kept anonymous and all responses will be presented through aggregated results.

Sudbury & District Health Unit
STATEMENT OF REVENUE & EXPENDITURES
For The 7 Periods Ending July 31, 2015

Cost Shared Programs

	Annual Budget	Budget YTD	Current Expenditures YTD	Variance YTD (over)/under	Balance Available
Revenue:					
MOHLTC - General Program	15,190,835	8,861,320	8,861,320	0	6,329,515
MOHLTC - Unorganized Territory	800,980	467,238	467,238	0	333,742
MOHLTC - VBD Education & Surveillance	64,939	37,881	37,881	0	27,058
MOHLTC - VBD Contingency	375,000	0	0	0	375,000
MOHLTC - SDWS	106,000	61,833	61,833	0	44,167
MOHLTC - CINOT Expansion	31,510	18,381	18,381	(0)	13,129
Municipal Levies	6,641,127	3,873,951	3,873,951	(0)	2,767,176
Municipal Levies - Small Drinking Water Syst	47,222	27,546	27,546	0	19,676
Municipal Levies - VBD Education & Surveill	21,646	12,627	12,627	(0)	9,019
Municipal Levies - VBD Contingency	125,000	0	0	0	125,000
Municipal Levies - CINOT Expansion	10,503	6,127	6,127	(0)	4,376
Interest Earned	85,000	40,768	40,768	(0)	44,232
Total Revenues:	\$23,499,762	\$13,407,673	\$13,407,672	\$0	\$10,092,090
Expenditures:					
Corporate Services:					
Corporate Services	4,641,327	2,975,509	2,982,444	(6,935)	1,658,883
Print Shop	262,837	153,273	130,185	23,088	132,652
Espanola	120,927	72,904	73,462	(559)	47,465
Manitoulin	124,866	75,232	71,529	3,702	53,337
Chapleau	98,398	59,631	55,684	3,947	42,714
Sudbury East	16,486	9,678	9,521	157	6,965
Volunteer Services	6,598	2,103	899	1,203	5,699
Total Corporate Services:	\$5,271,439	\$3,348,328	\$3,323,724	\$24,604	\$1,947,715
Clinical and Family Services:					
General	1,043,538	641,560	611,893	29,666	431,644
Clinical Services	1,224,184	766,173	904,871	(138,698)	319,313
Branches	341,475	209,875	164,615	45,260	176,860
Family	639,452	404,283	400,673	3,610	238,779
Risk Reduction	134,516	67,258	62,114	5,144	72,402
Intake	314,165	193,681	197,437	(3,756)	116,728
Clinical Preventative Services - Outreach	140,503	87,806	82,719	5,087	57,784
Sexual Health	940,792	578,010	554,548	23,462	386,244
Influenza	0	0	1,325	(1,325)	(1,325)
Meningitis	0	0	0	(0)	(0)
HPV	0	0	(0)	0	0
Dental - Clinic	773,177	463,610	429,261	34,349	343,916
CINOT Expansion - Clinic	42,013	22,737	21,461	1,276	20,552
Family - Repro/Child Health	1,205,946	729,383	681,268	48,115	524,678
Total Clinical Services:	\$6,799,761	\$4,164,376	\$4,112,186	\$52,190	\$2,687,575
Environmental Health:					
General	785,386	461,149	450,012	11,137	335,374
Environmental	2,598,675	1,592,964	1,537,285	55,678	1,061,390
Vector Borne Disease (VBD)	586,585	37,821	29,319	8,502	557,266
Small Drinking Water System	169,995	99,000	90,694	8,306	79,301
Total Environmental Health:	\$4,140,640	\$2,190,934	\$2,107,310	\$83,624	\$2,033,330
Health Promotion:					
General	1,413,798	891,044	836,917	54,127	576,880
School	1,323,800	792,280	748,274	44,007	575,526
Healthy Communities & Workplaces	287,720	181,887	165,415	16,472	122,305
Branches	540,859	331,364	337,187	(5,823)	203,671
Nutrition & Physical Activity	1,258,571	732,800	702,511	30,290	556,061
Injury Prevention	423,924	240,452	225,851	14,602	198,073
Tobacco By-Law	331,408	189,984	185,246	4,738	146,162
Alcohol and Substance Misuse	287,288	170,089	161,503	8,586	125,785
Total Health Promotion:	\$5,867,367	\$3,529,900	\$3,362,904	\$166,997	\$2,504,464
RRED:					
General	1,405,314	854,392	853,645	747	551,669
Health Equity Office	15,240	5,932	3,586	2,346	11,654
Total RRED:	\$1,420,554	\$860,324	\$857,230	\$3,093	\$563,324
Total Expenditures:	\$23,499,762	\$14,093,863	\$13,763,355	\$330,508	\$9,736,407
Net Surplus/(Deficit)	\$0	\$(686,190)	\$(355,682)	\$330,508	

Sudbury & District Health Unit 2010-2015

Cost Shared Programs

STATEMENT OF REVENUE & EXPENDITURES

Summary By Expenditure Category

For The 7 Periods Ending July 31, 2015

	BOH Annual Budget	Budget YTD	Current Expenditures YTD	Variance YTD (over) /under	Budget Available
Revenues & Expenditure Recoveries:					
Funding	23,614,680	13,522,591	13,541,639	(19,048)	10,073,042
Other Revenue/Transfers	1,031,693	700,348	712,856	(12,508)	318,837
Total Revenues & Expenditure Recoveries:	24,646,373	14,222,939	14,254,495	(31,555)	10,391,879
Expenditures:					
Salaries	15,802,104	9,695,834	9,544,790	151,044	6,257,314
Benefits	4,286,599	2,669,676	2,617,377	52,299	1,669,222
Travel	276,074	142,617	128,212	14,405	147,862
Program Expenses	1,403,211	524,147	491,414	32,733	911,797
Office Supplies	80,420	44,450	42,888	1,562	37,532
Postage & Courier Services	72,230	39,634	30,959	8,675	41,271
Photocopy Expenses	94,512	46,383	32,396	13,987	62,116
Telephone Expenses	59,466	34,750	31,377	3,373	28,089
Building Maintenance	388,161	254,561	266,792	(12,231)	121,369
Utilities	195,265	112,905	110,236	2,668	85,029
Rent	239,198	139,532	134,778	4,754	104,420
Insurance	111,340	106,340	109,390	(3,050)	1,950
Employee Assistance Program (EAP)	34,969	26,226	22,651	3,575	12,318
Memberships	34,120	29,438	30,175	(737)	3,945
Staff Development	239,719	175,563	121,864	53,699	117,855
Books & Subscriptions	17,110	9,879	6,343	3,536	10,767
Media & Advertising	149,077	52,720	36,890	15,830	112,187
Professional Fees	393,406	228,017	249,700	(21,683)	143,706
Translation	54,550	30,761	26,984	3,777	27,566
Furniture & Equipment	17,730	8,679	10,574	(1,895)	7,156
Information Technology	697,114	537,018	564,387	(27,369)	132,727
Total Expenditures	24,646,373	14,909,129	14,610,177	298,952	10,036,197
Net Surplus (Deficit)	0	(686,190)	(355,682)	330,508	

Sudbury & District Health Unit

SUMMARY OF REVENUE & EXPENDITURES

For the Period Ended July 31, 2015

100% Funded Programs

Program	FTE	Annual Budget	Current YTD	Balance Available	% YTD	Program Year End	Expected % YTD
Pre/Postnatal Nurse Practitioner	704	139,000	84,427	54,573	60.7%	Dec 31	58.3%
SFO -TCAN - Prevention	724	97,200	18,707	78,493	19.2%	Dec 31	58.3%
SFO - Tobacco Control Area Network - TCAN	725	285,800	147,232	138,568	51.5%	Dec 31	58.3%
SFO - Local Capacity Building: Prevention & Protection	726	190,500	123,357	67,143	64.8%	Dec 31	58.3%
SFO - Tobacco Control Coordination	730	100,000	63,136	36,864	63.1%	Dec 31	58.3%
SFO - Youth Engagement	732	80,000	40,598	39,402	50.7%	Dec 31	58.3%
Infectious Disease Control	735	478,973	297,881	181,092	62.2%	Dec 31	58.3%
LHIN - Falls Prevention Project & LHIN Screen	736	100,000	26,905	73,095	26.9%	Mar 31/15	33.3%
MOHLTC - Special Nursing Initiative	738	180,448	111,045	69,403	61.5%	Dec 31	58.3%
MOHLTC - Northern Fruit and Vegetable Funding	743	150,100	51,786	98,314	34.5%	Mar 31/15	66.7%
Food Safety - Haines Funding	750	36,435	9,867	26,568	27.1%	Dec 31	58.3%
Triple P Co-Ordination	766	86,807	40,478	46,329	46.6%	Dec 31	58.3%
Healthy Babies Healthy Children	778	1,476,897	874,929	601,968	59.2%	Dec 31	58.3%
Healthy Babies Healthy Children - Screening	779	25,000	25,000	-	100.0%	Mar 31/15	100.0%
Healthy Smiles Ontario (HSO)	787	445,350	240,224	205,126	53.9%	Dec 31	58.3%
Anonymous Testing	788	59,393	17,939	41,454	30.2%	Mar 31/15	33.3%
MHPS- Aboriginal Diabetes	792	175,000	45,432	129,568	26.0%	Mar 31/15	33.3%
Total		4,106,903	2,218,943	1,887,960			

ACCEPTANCE OF REPORTS

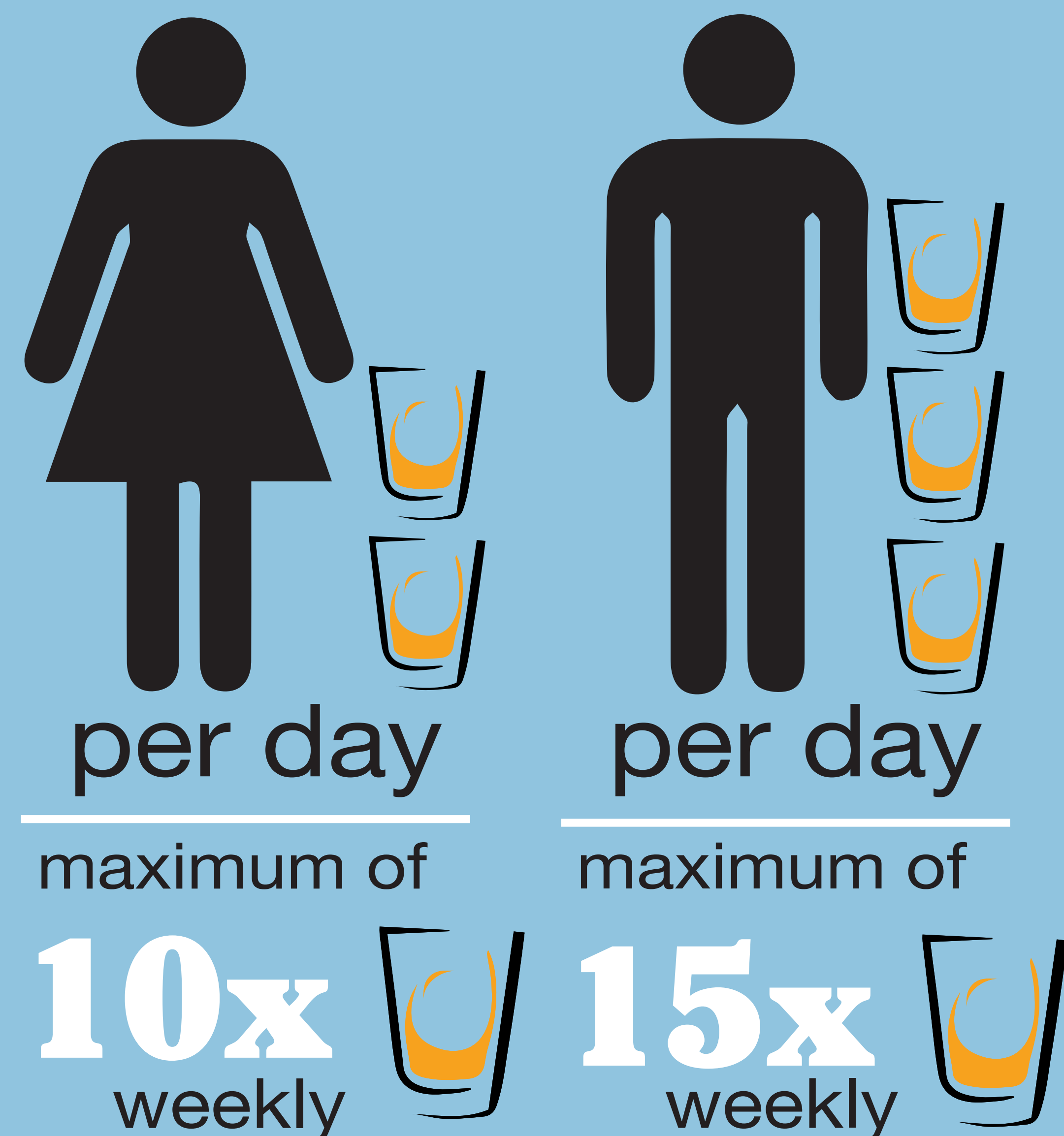
MOTION: THAT the Report of the Medical Officer of Health / Chief Executive Officer for the month of September 2015 be accepted as distributed.

8. NEW BUSINESS

i) Items for Discussion

- a) Alcohol and Substance Misuse**
- b) Expansion of Proactive Disclosure System**
- c) Provincial Public Health Funding**
- d) Accessibility for Ontarians with Disabilities Act (AODA) and Human Rights Compliance**
- e) Board of Health Proceedings**

Canada's Low-Risk
Alcohol Drinking Guidelines (LRADG)



36% of SDHU population
exceed the LRADG

1 drink per day
increases risk of
breast cancer by
13%



22%
of youth aged 12
to 18 reported
heavy drinking in
the past year



49% of adults
reported heavy
drinking

Ontario saw a deficit of
\$456 Million
as a result of alcohol use

The Impact of Alcohol

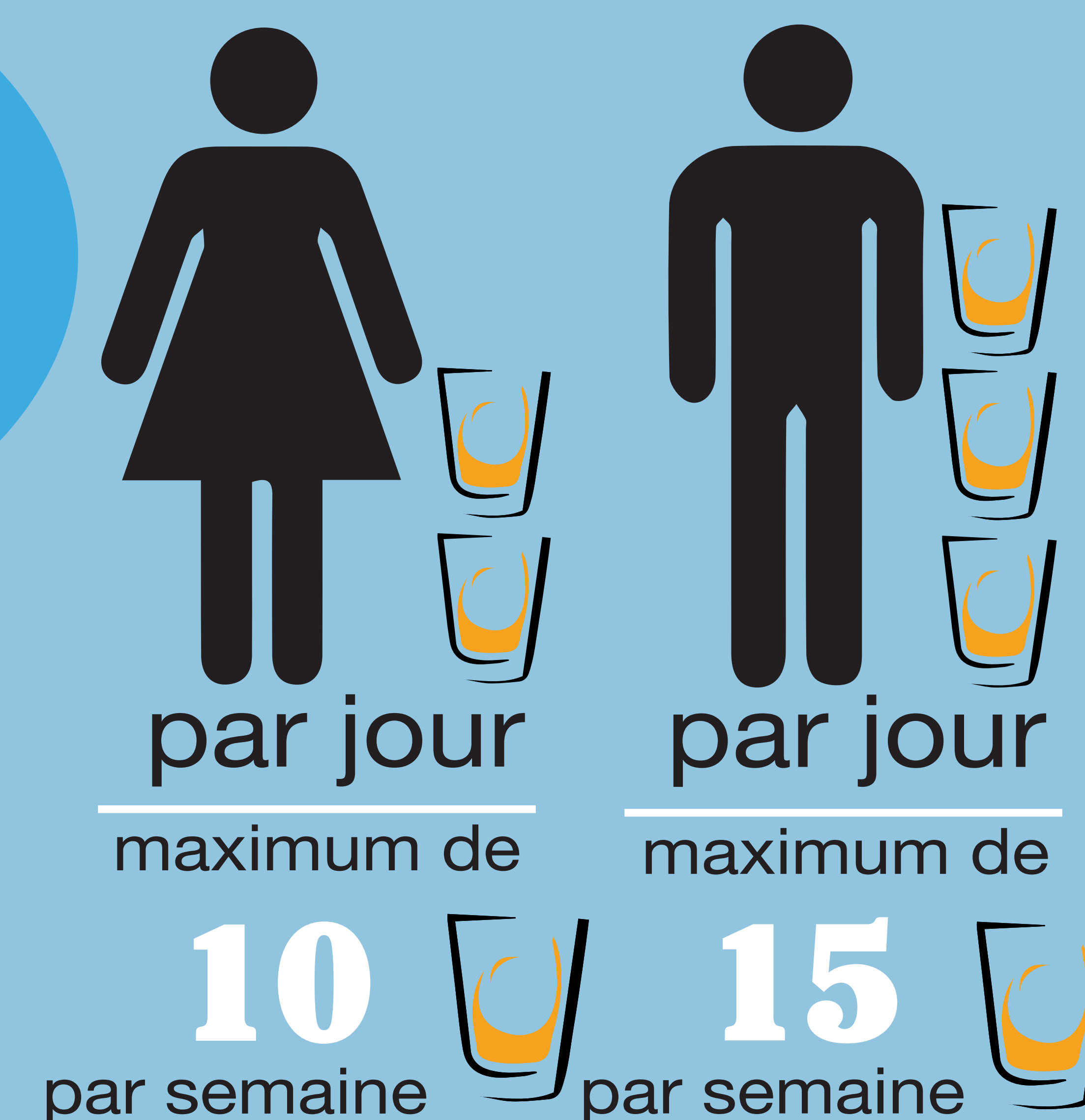
22 %
des jeunes âgés de 12
à 18 ans ont signalé
avoir consommé de
l'alcool de manière
excessive au cours de
la dernière année



49 % des adultes
ont signalé
consommer de
l'alcool de manière
excessive

L'Ontario a connu un déficit de
456 millions de dollars
à cause de la consommation d'alcool

Directives de consommation d'alcool à
faible risque du Canada (DCAFR)



36 % de la population servie
par le SSPSD ne respecte
pas les DCAFR

1 consommation
d'alcool par jour
augmente le risque
de cancer du sein de
13 %



L'incidence de l'alcool

Briefing Note

To: René Lapierre, Chair, Sudbury & District Board of Health

From: Dr. Penny Sutcliffe, Medical Officer of Health and Chief Executive Officer

Date: September 10, 2015

Re: Addressing Substance Misuse in the Sudbury & District Health Unit Service Area

☒ For Information

☐ For a Discussion

☐ For a Decision

Issue:

The Sudbury & District Health Unit, in partnership with police services, municipalities, First Nations and others, has engaged in the development of area drug strategies. These drug strategies seek to reduce the harms associated with substance use and misuse, through interventions based on evidence, trends, resources and existing programs. This briefing note informs the Board of Health of local substance use statistics and alcohol and drug strategies and invites Board members to consider future opportunities to champion this issue.

Recommended Action:

That the Board of Health receive this briefing note for information and consider future opportunities to champion alcohol and drug strategies.

Background:

In an effort to enhance the health and safety of our communities, reduce the harms associated with substance misuse, and to educate and inform the public about low-risk drinking behaviours, the SDHU developed, in collaboration with its partners, alcohol and drug strategies to prevent alcohol and drug misuse and to mitigate the harms of substance misuse. The Alcohol Strategy and Substance Misuse strategies have identified key areas of action for the CGS, LaCloche and Manitoulin Districts. Recently the development of a drug strategy has been requested by some Sudbury East citizens.

Financial Implications: Nil

Ontario Public Health Standard: Chronic Disease Prevention and Preventable Injury and Substance Misuse

Strategic Priority: 1, 2, 3, 5

Contact: MaryAnn Diosi, Manager, Health Promotion Division

2013–2017 Strategic Priorities:

1. Champion and lead equitable opportunities for health.
2. Strengthen relationships.
3. Strengthen evidence-informed public health practice.
4. Support community actions promoting health equity.
5. Foster organization-wide excellence in leadership and innovation.

O: October 19, 2001
R: October 2013

Report to: Sudbury & District Health Unit Board of Health

Date: September 10, 2015

Submitted by: Dr. Penny Sutcliffe, Medical Officer of Health

Program Manager: Mary-Ann Diosi, Health Promotion Division, Sudbury & District Health Unit,
705-522-9200 x.341, diosim@sdhu.com

Contact Person(s):

Brenda Stankiewicz, Public Health Nurse, Health Promotion Division
Evan Jolicoeur, Public Health Nurse, Health Promotion Division
Stephanie Bale, Health Promoter, Health Promotion Division

Subject: Addressing substance misuse in Sudbury & District Health Unit service area

Background:

Under Chronic Disease and Injuries Program standards, in the Ontario Public Health Standardsⁱ, the Sudbury and District Health Unit (SDHU) is mandated to reduce the frequency, severity, and impact of chronic disease, preventable injury and substance misuse, through assessment and surveillance, health promotion and policy development, and health protection. Additionally, for health units, the Ministry of Health and Long Term Care Accountability Indicator monitors the percentage of the population that exceeds the low-risk alcohol drinking guidelines (LRADG). The LRADG were established to help Canadians moderate their alcohol consumption in an effort to reduce acute and chronic alcohol-related harms. The guidelines offer gender specific daily and weekly limits for the adult population up to 65 years of age.

Canada's Low-Risk Alcohol Drinking Guidelinesⁱⁱ, Daily and Weekly Limits

Males: Limit alcohol use to **3** beverages per day and **15** per week

Females: Limit alcohol use to **2** beverages per day and **10** per week

*Special Occasions: 3 drinks for females and 4 drinks for males daily

Prevalence of Substance Misuse in the Sudbury and Manitoulin Districts
(including district office areas)

Beverage alcohol use is not uncommon in the Sudbury & District Health Unit service area:

- 84% of adults (19+) reported consuming alcohol in the past 12 months, compared to 78% of Ontario adultsⁱⁱⁱ
- 84% of adults (18+) in the City of Greater Sudbury reported alcohol in the past 12 months^{iv}
 - Espanola district office area (78%¹)
 - Manitoulin district office area (77%¹)
 - Sudbury East district office area (78%)
 - Chapleau district office area (82%)
- 43% of teens (12 to 18 years) reported consuming alcohol in the last 12 months, compared to 37% of Ontario teens^v

Heavy drinking is the consumption of 5 or more alcoholic beverages on at least one occasion in the past year:

- 49% of SDHU adults (19+) reported heavy drinking, which is higher than Ontario (37%), and has risen significantly since 2001 (29%)^{vi}

The health unit monitors adherence to the LRADG (MOHLTC Accountability Agreement):

- 36% reported exceeding the LRADG^{vii}

Illicit drug use remains a concern in this area:

- In 2012, 14% of the population aged 12+ reported illicit drug use in the past year^{viii}
- In 2012, 16% of the population aged 12+ reported using marijuana, cannabis, or hashish in the past year^{ix}
- In 2013, 549 drug offence charges were laid^x
- From 2008-2013, there were 87 in the City of Greater Sudbury opioid toxicity deaths and 11 on Manitoulin Island^{xi}

According to the 2013 Ontario Student and Drug Use and Health Survey^{xii}:

- 34% of youth in the SDHU service area reported using at least one illicit drug in the previous 12 months, this is not significantly different from Ontario or Northern Ontario.
- 9% of students between grades 7 and 12 reported non-medical use of opioid pain relievers in the past year.

¹ Significantly different from the City of Greater Sudbury

These statistics raise considerable concern. The immediate risks for personal injury, violence, death and harm to others increases with each alcoholic beverage or illicit substance consumed. In the long term, alcohol use raises risks for many cancers and other chronic diseases. Marijuana use, prescription drug misuse, and the use of other illegal substances can lead to poor physical and mental health and community safety concerns as a result of break-ins and robberies to obtain their substance of choice. Contaminants in street drugs also put the lives of users at great risk. The social, legal, financial implications of alcohol and substance misuse can have lasting effects on families and communities.

Framework for the Alcohol Strategy and Drug Strategies

In an effort to enhance the health and safety of our communities, reduce the harms associated with substance misuse, and to educate and inform the public about low-risk drinking behaviours, the SDHU developed strategic initiatives to address substance misuse issues.

Alcohol Strategy

The SDHU Alcohol Strategy includes the following components to enhance advocacy and policy initiatives and support awareness raising events and presentations.

1. Surveillance and Stakeholder Engagement: Local alcohol use data and a synthesis of current evidence about the health, social, and environmental effects of alcohol use and misuse is compiled in the *Alcohol Use and the Health of our Community* report that will be used to engage community partners and subject matter experts to help shape recommendations that will be implemented to address alcohol misuse in our communities (see appended full report).
2. Social Marketing Campaign: Delivered through multiple social media platforms, the campaign *Alcohol, Let's Get Real*. creates the conditions for a conversation around alcohol, questioning common beliefs and behaviours and reduce the normalization of alcohol use. The community will be engaged to ask questions, encouraged to dialogue with one another and express opinions through social media.
3. Primary Care Provider Outreach: The new SDHU Academic Detailing Program² pilot is set to launch in early fall 2015. The program's first initiative will encourage clinicians to use the *Screening Brief Intervention and Referral* (SBIR)

² Academic detailing is the process by which a trained academic detailer connects with a primary care provider to deliver topic-based key messages and/or tools the clinicians can incorporate into their practice.

tool to assess their patient's level of risk as it relates to alcohol use, and connect them with appropriate resources and services if required.

SDHU Area Community Drug Strategies

Built in collaboration with community partners and tailored to individual communities, these drug strategies seek to reduce the harms associated with substance (drug) use and misuse, through interventions based on evidence, trends, resources and existing programs.

Community Drug Strategy for the City of Greater Sudbury

The vision of the strategy is to form “a community working together to improve the health, safety and well-being of all individuals, families, neighbourhoods, and communities in the City of Greater Sudbury by reducing the incidence of drug use and creating a society increasingly free of the range of harms associated with substance misuse”. This will be fulfilled through five foundations focusing on Health Promotion and Prevention of Drug Misuse, Treatment, Harm Reduction, Enforcement and Justice and Sustaining Relationships within 9 key priority areas. The nine priorities will guide the work of the drug strategy by focusing on inclusivity, housing, public policy, treatment, harm reduction, enforcement and supportive environments.

LaCloche Foothills Drug Strategy

With a vision of “working together to improve the well-being of all people in the LaCloche Foothills area by building respectful and educated communities increasingly free of the harms caused by substance use” and working in four foundation areas of Education, Services, Enforcement and Relations, the committee will be seeking community input this fall.

Manitoulin Drug Strategy

Currently in development and hoping to gain the support of all 18 municipalities and 6 First Nations communities, this strategy will focus work in four directions: Health Promotion, Community Safety, Collaboration and Services and Support.

Where are we going from here?

These strategies are great examples of community engagement to enhance safety and well-being in the SDHU service area by involving people and agencies from health, treatment, social services, education, housing, enforcement and faith sectors. We will continue to work with existing partners and build new partnerships to facilitate and support the implementation of these drug and alcohol strategies in all district office areas. Community engagement is essential to this process. We will continue our advocacy efforts with decision makers, raise public awareness and actively participate in educational opportunities to increase engagement with the community around alcohol and substance misuse.

A significant component of our Alcohol Strategy involves a community forum to present the results of the *Alcohol Use and the Health of our Community* report. It will be helpful to have leadership support in this work and as such a Board of Health member(s) will be sought in the near future to champion the strategy and support the development of key recommendations to help reduce the burden of alcohol use and misuse on our communities.

ⁱ Ontario Public Health Standards (2008)

ⁱⁱ Canadian Centre on Substance Abuse, 2011

ⁱⁱⁱ Statistics Canada (2011/12)

^{iv} RRFSS (2012)

^v Statistics Canada (2011/12)

^{vi} Statistics Canada (2011/12)

^{vii} Statistics Canada (2011/12)

^{viii} Statistics Canada (2011/12)

^{ix} Statistics Canada (2011/12)

^x GSPS (2013)

^{xi} Office of the Chief Coroner (2014)

^{xii} CAMH (2013)

A decorative graphic featuring a large, dark red, diamond-shaped frame. Inside the frame, there is a close-up photograph of several blueberries. The frame is positioned diagonally across the page, with its top-left corner near the top-left of the page and its bottom-right corner extending towards the bottom-right. The background of the page is white.

The Sudbury & District Health Unit

Alcohol Use

and the Health of Our Community



Sudbury & District Health Unit
Service de santé publique de Sudbury et du district

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Overview

Alcohol. As one of the oldest drugs with a long, deep rooted presence within societies, it is used by diverse cultures and peoples around the globe. In western society, alcohol is consumed and incorporated as a societal norm. The World Health Organization recognizes that “preventing and reducing the harmful use of alcohol is a public health priority”, and as such has committed to reducing the health and social burden of alcohol (World Health Organization, 2014, p. 2). The burden of alcohol-related disease and death around the world is significant (WHO, 1992). Alcohol use is causally linked to over 200 diseases and injuries (WHO, 1992), and the negative health effects far outweigh any potential benefits (Canadian Public Health Association, 2011). Despite the expansive social, health and economic burden of alcohol misuse, the concerns surrounding alcohol use have remained a low priority in the public domain, including public policy and government decision making.

Under the Ontario Public Health Standards (2008), the Sudbury & District Health Unit (SDHU) is mandated to provide current and reliable data and evidence around the health effects of alcohol misuse. This evidence is pivotal to inform the need for and the development of policies, programs, and additional resources and services in our communities.

A snapshot of alcohol use and misuse in our community and of harms related is needed to address issues related to increased alcohol consumption. The data gathered in this report will be used to address these issues in an effort to decrease alcohol-related harms from disease and injury. Using a multi-faceted approach, the SDHU seeks to develop community-based strategies to address alcohol misuse, specifically within the SDHU service area. This report will explore trends in alcohol use in our community in addition to the social, economic, and health impacts of alcohol use and misuse.

Data & Methods

The SDHU monitors alcohol consumption trends, and other alcohol use behaviours in the community through a number of data sources. The data presented within this report were obtained from the following sources:

- Rapid Risk Factor Surveillance System (RRFSS)
- Canadian Community Health Survey (CCHS)
- Ontario Student Drug Use and Health Survey (OSDUHS)
- Statistics Canada, Census & National Household Survey (NHS)



Alcohol is perceived by many to be a relatively safe beverage that is culturally and socially accepted. While, alcohol was once symbolically and culturally significant, it is now used primarily for socialization, celebration, and at times, to cope with internal and external stressors. While many are aware of the effects of impaired driving, less is known and spoken of its short and long-term health effects (Babor et al., 2010). Alcohol is metabolized in the liver and becomes acetaldehyde, a Group 1 carcinogen. Acetaldehyde is known to cause cancer (International Agency for Research on Cancer [IARC], 2015). Other examples of Group 1 carcinogens include: arsenic, asbestos, mustard gas, plutonium, radon and tobacco (IARC, 2015). In addition to its cancer causing properties, alcohol can also lead to numerous other medical and social issues, including motor vehicle collisions, violence, acute organ damage, and dependence (Babor et al., 2010).

In Canada, the majority (76%) of the population have consumed alcohol in the past year (Health Canada, 2011), and Canadians consume 50% more alcohol than the worldwide average (Shield et al., 2013).

Although alcohol can impact health and social well-being negatively, it also has an effect on the economy through the generation of revenue from production and distribution, the creation of employment opportunities, and the generation of significant tax revenue for the government (Babor et al., 2010). Total direct net revenue to provincial and territorial governments from the control and sale of alcohol was \$5.87 billion across Canada in 2010/11 (Statistics Canada, 2012). Although this is a significant amount, the direct and indirect costs of alcohol use far exceed it (Thomas, 2012). The impacts of alcohol use and misuse are costing the government more through enforcement, healthcare, and lost productivity (Thomas, 2012). In Ontario, in 2002, a deficit of over \$456 million was directly related to alcohol use (acute care, enforcement and prevention). The indirect costs of alcohol in Canada in 2002 were estimated at over \$7 billion (Thomas, 2012).

In 2002 Ontario
saw a deficit of over
\$456 Million
as a result of **ALCOHOL** use.

(Thomas 2012)



The Business of Alcohol

In Canada, the provincial governments play a dual role as a distributor and regulator of beverage alcohol. Ontario has a mix of public and private systems, meaning there is involvement of both private and public outlets in the distribution of alcohol. The alcohol distribution landscape is mixed across the country, with some provinces having government monopolies, others having a mixed framework and Alberta is systemically private, (Thomas, 2012).

The alcohol industry worldwide has significant influence on public policy through the lobbying of politicians and government officials, and over the last few years there has been an increasing amount of privatization of the alcohol distribution and retail system (Giesbrecht et al., 2013). The Alcohol and Gaming Commission of Ontario's 2013 Regulatory Modernization of Ontario's Beverage Alcohol Industry, proposed many initiatives that have relaxed government regulations and plan to further liberalize the sale, service and distribution of alcohol in Ontario (AGCO, 2014). Most recently privatization of the beverage alcohol industry in Ontario allows large retail supermarkets to acquire licenses to sell beer in their facilities. In addition, a two year pilot program allows the sale of Vintners Quality Alliance (VQA) products at local Farmer's Markets. This is of concern for public health, as evidence has shown that as availability increases, consumption increases, and with it associated harms (Babor et al., 2010).

In 2012/13, in Ontario, there were 17 118 liquor sales licensed establishments, 577 ferment on premise facilities, 295 liquor delivery services, 358 manufacturers, and 874 manufacturer's representatives, for a total of 19 222. There were also 61 463 special occasion permits issued (AGCO, 2013/14). In the SDHU service area, there are currently 299 sale licenses, 8 ferment on premise facilities, 6 liquor delivery services, 4 manufacturers, and 3 manufacturer's representatives, for a total of 324 licensed establishments. (AGCO, 2015)

The price of alcohol plays a significant role in alcohol use and misuse and pricing policies can contribute to a reduction in consumption. The LCBO pricing policy strives to balance social responsibility, excellent customer service, and profit generation while ensuring it meets the legislated requirements under the Liquor Control Act. The minimum price a product can be sold is in accordance with the three year average Consumer Price Index (Queen's Printer for Ontario, 2012/15), which is not necessarily the practice of private sector retailers (LCBO, 2015). In 2013-14, approximately \$20.5 billion dollars' worth of alcoholic beverages were sold in Canada, a 2.2% increase from the previous years (Statistics Canada, 2014).

In 2015, in **SDHU Area**, there were:

- 324 Licensed establishments.
- 299 Sales licenses.
 - 8 Ferment on premise facilities.
 - 6 Liquor delivery services.
 - 4 Manufacturers.
 - 1 winery & 3 breweries
 - 3 Manufacturer representatives.

Greater Sudbury Area

- 228 licensed establishments.
- 210 sales licenses.
 - 8 ferment on premise facilities.
 - 6 liquor delivery services.
 - 7 manufacturers (1 brewery)
 - 3 manufacturer representatives.

Chapleau Area

- 7 licensed establishments (all sales licenses).

Espanola Area

- 25 licensed establishments.
- 24 sales licenses.
 - 1 ferment on premise establishment.

Manitoulin Area

- 40 licensed establishments.
- 35 sales licenses.
 - 3 ferment on premise establishment.
 - 2 manufacturers.

Sudbury East Area

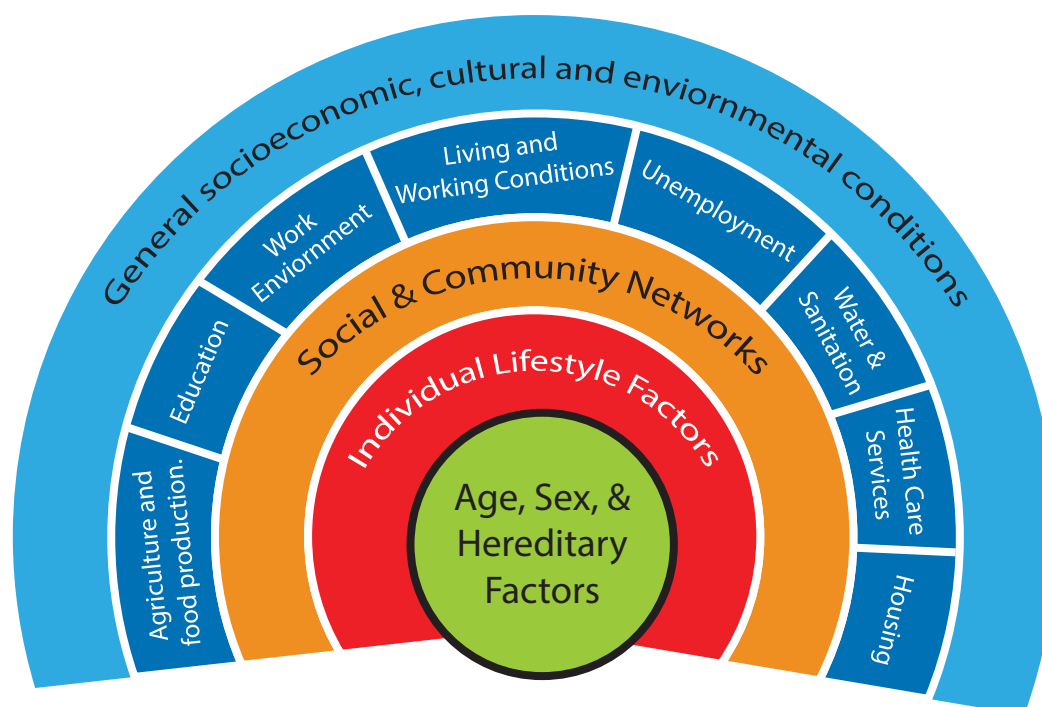
- 17 licensed establishments.
- 16 sales licenses.
 - 1 manufacturer.

Sudbury, Unorganized, North Part

- 7 licensed establishments (all sales licenses).

Alcohol & Income

The social determinants of health, are the social, economic and environmental factors that influence a person's health. These determinants impact an individual's ability to access healthy foods, participate in physical activity, connect with supportive resources or services, and may reduce opportunities for good mental, physical, and spiritual health (SDHU, 2013). The use and misuse of alcohol is important once viewed with a social determinants of health lens.



The Determinants of Health (1992) Dahlgren and Whitehead

A recent report by the SDHU explored the relationship between the social and economic environments and a number of health outcomes and behaviours, most notably heavy alcohol use. The report did not find a statistically significant difference for heavy drinking between the most and least deprived areas in the community, but evidence has shown that a lower socioeconomic status can contribute to increasingly negative impacts of alcohol use (SDHU, 2013, Grittner, Kuntsche, Graham, & Bloomfield, 2012). Individuals and communities with limited access to resources, lack the protective factors needed to manage alcohol misuse or dependence or related stressors (Grittner et al., 2012). The literature suggests that there is no dominant risk factor for alcohol misuse but the likelihood that a person develops an alcohol use disorder increases as the amount of inequities increases (Schmidt et. al. 2010). In addition, individuals within the lower socioeconomic status appear to be at an increased risk of experiencing the consequences of alcohol consumption (Grittner et al., 2012). A low socioeconomic status has been found to lead to a higher burden of disease attributable to alcohol consumption despite lower consumption rates (Schmidt, Makela, Rehn & Room, 2010). Probst, Roerecke, Behrendt, & Rehm (2015) examined alcohol attributable death, and found an increased risk of death among both lower income compared to high income **males** and **females** (4.87 and 4.78 greater risk, respectively).

An increased risk of death attributable to alcohol, amongst both lower income males (4.87 times greater risk) and females (4.78 times greater risk) compared to higher income.



(Probst, C., Roerecke, M., Behrendt, S., Rehm, J. 2015)

This relationship between alcohol and conditions of inequity is complex (CPHA, 2011). Not only can socioeconomic status lead to differences in consumption and burden of disease related to alcohol, but **alcohol-attributable disease can also lead to social and economic consequences** (WHO, 2014). Some of these include **employment related issues such as loss of earnings, increased sick days, unemployment, family and relational issues, interpersonal violence and stigmatization**. The amount of alcohol consumed is not the only factor influencing the health outcomes of the population or the related socioeconomic consequences, but importantly enough so too are the patterns of consumption over time and the quality and type of alcohol consumed (Schmidt et al., 2010).

When considering the impacts of alcohol at the individual, community, and societal levels it is necessary to consider the influence of the social determinants of health. The social determinants provide a common understanding for the development of strategies, policies, programs, services, supports or initiatives aimed at addressing the issue of alcohol misuse across the socioeconomic gradient.

Demographic Data

The SDHU service area includes a population of 192 291 and covers over 46,000 square kilometres. The main office is located in the City of Greater Sudbury (CGS), and four district offices are located in the following communities: Manitoulin (Mindemoya), Espanola, Sudbury East (St. Charles), and Chapleau. Each district office area comprises demographic variances, for example, age distribution, Aboriginal status, and health needs, to which services are tailored to meet the individual needs of the community (see Tables 1 & 2).

Table 1: Population, by Age, Sex, Aboriginal Status, & Census Division, 2011

Geographic Area	Population	Aboriginal Status	Male	Female
City of Greater Sudbury ¹	160 380	13 045 (8.1%)	48.8%	51.2%
Manitoulin District ¹	13 045	5 295 (40.5%)	50.0%	50.0%
Sudbury District ¹	21 200	3 334 (15.7%)	50.8%	49.2%

Source: Statistics Canada, 2011

Table 2: Population, by Age, Sex, & District Office Area, 2011

Geographic Area	Population	Male	Female	0-18 years of age	19-44 years of age	45+ years of age
Chapleau Area	2 503	49.8%	50.2%	23.1%	28.4%	48.6%
Espanola Area	9 467	49.9%	50.1%	21.3%	26.9%	51.7%
Manitoulin Area	13 048	50.0%	50.0%	22.3%	25.4%	52.2%
Sudbury East Area	6 526	52.3%	49.2%	16.2%	24.2%	59.6%

Source: Statistics Canada, 2011

¹The City of Greater Sudbury census division includes the City of Greater Sudbury Census Subdivision and the Wahnapiitae 11 First Nation Subdivision. The Sudbury Census Division comprises 86% of the SDHU land area including but not limited to the Chapleau, Espanola, and Sudbury East area. The Manitoulin Census Division comprises all municipalities, reserves, and townships on the island.



Alcohol Use in Our Communities

Alcohol Use

The majority (84%) of SDHU area adults (aged 19+) reported consuming alcohol in the past 12 months. This is significantly higher than Ontario (78%) (Statistics Canada, 2011/12).

In the City of Greater Sudbury, 84% of adults (18+) reported consuming alcohol in the past year. This is significantly higher than Espanola and Manitoulin areas (RRFSS, 2012). See Table 3 for a full breakdown.

Table 3: Alcohol Use, by District Office Area, 2012.

Geographic Areas	Alcohol Use
City of Greater Sudbury €	84.4%
Espanola Area	77.9%*
Manitoulin Area	77.2%*
Sudbury East Area	77.6%
Chapleau Area	81.5%

*Significantly different from the City of Greater Sudbury.

€ Reference Group

Heavy Drinking

Heavy drinking² is defined as consuming five or more alcoholic beverages on at least one occasion in the past year. In the SDHU area, nearly half (49%) of adults (aged 19+) reported heavy drinking. This is significantly higher than Ontario (37%), and has risen significantly since 2001 (29%) (Statistics Canada, 2011/12)

Nearly half (49%) of adults reported heavy drinking.

²Note: This has since been adapted, heavy drinking for women is now 4 drinks and for men is 5 drinks.

Results will not be comparable for future data collection for the female population.

* Interpret with caution — high sampling variability.

Low-Risk Drinkers

Canada's Low-Risk Alcohol Drinking Guidelines (LRADG) were developed by a group of experts on behalf of the National Alcohol Strategy Advisory Committee (NASAC) and were informed by the report Alcohol and Health in Canada: A Summary of Evidence and Guidelines for Low Risk Drinking (Butt et al., 2011). The guidelines were developed to moderate alcohol consumption and reduce the harms associated with acute and chronic alcohol use. In 2011/12, 36% of the SDHU population (aged 19+) exceeded the LRADG⁴, this is significantly higher than Ontario (29%) (Statistics Canada, 2011/12).

In the SDHU area, only 17% of adults reported awareness of Canada's LRADG. Nearly half (45%) reported they would change or reduce the amount of alcohol they consumed if the LRADG indicated they should drink less (RRFSS, 2013). Similar results were observed in the Campus Alcohol Behaviour Survey conducted in 2013 in the City of Greater Sudbury. These results are further explained in the section Alcohol and Youth.

Canada's Low-Risk Alcohol Drinking Guidelines



per day.

Maximum of


10x 

per week.



per day.

Maximum of

15x 

per week.

36% of the SDHU population exceeded the LRADG.

An extra drink can be consumed on special occasions.

In the City of Greater Sudbury, 20% of adults had seen or heard about Canada's LRADG, and nearly half (46%) reported they would change or reduce the amount of alcohol they consumed as a result of the LRADG (RRFSS, 2001-2010).

When asked to identify the maximum number of alcoholic beverages according to the LRADG, most of SDHU area adult men (66%) and women (75%) underestimated the weekly limits (RRFSS, 2013).

Table 4: Awareness of low-risk alcohol drinking guidelines (LRADG), by District Office Area, 2001-2010.

Indicator	Greater Sudbury €	Sudbury East	Chapleau	Espanola	Manitoulin
Percentage of adults (+18) who have seen or heard about Canada's Low Risk Alcohol Drinking Guidelines (LRADG) ³	19.8%	20.6%†	-	16.4% †	10.0% †*
Percentage of adults (18+) who would change (reduce) the amount of alcohol they consumed because of the LRADG ³	46.0%	66.7%*	-	43.3% †	61.3%*

*Significantly different from the City of Greater Sudbury.

† Interpret with caution — high sampling variability.

€ Reference Group

Young Drinkers

Alcohol use is a common practice among youth and young adults in our communities. Nearly half (43%) of teens between the ages of 12 and 18 reported consuming alcohol in the past 12 months (CCHS, 2011/12). Nearly two-thirds (64%) of youth in the SDHU area initiated drinking between grade 7 and 9; 22% reported heavy drinking in the past month; 19% reported being drunk⁵ in the past month; and 72% reported it was easy to obtain alcohol

64% of youth in the SDHU area, initiated drinking between grade 7 and 9.

³Canada's LRADG were launched in 2011m prior to this each province had a version of LRADG.

Among our post-secondary population, the majority (92%) have used alcohol in the previous 12 months. Students between the ages of 19 and 24 were least likely to abstain from alcohol, whereas those with a high academic average, non-Caucasian, or those who had been pregnant or breastfed were **most** likely to abstain. Of those who reported consumption of alcohol, most (77%) consumed at least monthly, and just over half (53%) reported getting drunk⁴ at least monthly. Forty-one percent of students reported binge drinking⁵ at least once a month in the past year, and **46% reported exceeding at least one of the LRADG measures⁶** in the past year (Charbonneau et al., 2014).

53% reported getting drunk
at least monthly.

Less than a fifth (15%) of the post-secondary students in the City of Greater Sudbury were aware of the LRADG; this did not seem to affect binge drinking or drinking over the daily LRADG. However, awareness of the LRADG contributed to fewer binge drinking episodes, a reduction in the rates of drunkenness and use in excess of the weekly limits (this was diminished by personal characteristics, such as age) (Charbonneau et al., 2014).

46% of youth reported exceeding at
least one of the LRADG measures.

⁴“got intoxicated to the point of impairment of physical and mental faculties”

⁵Binge Drinking: The consumption of five or more alcohol drinks on one occasion in the past year. This has since been changed to four drinks on one occasion for females and five for men.

⁶Exceeding LRADG was categorized as: exceeding weekly or daily LRADG in the past 7 days or binge drank at least once month in the past 12 months (Charbonneau et al., 2014).

Health Impacts of Alcohol Consumption

Worldwide, the use and misuse of alcohol contributes to over 200 acute and chronic illnesses and injuries (WHO, 1992), and is one of the top five risk factors for disease, disability, and death, (Lim et al., 2012). Globally, **alcohol is estimated to cause 3.3 million deaths each year**, which accounts for **6% of all deaths** (WHO, 2015). In Ontario, only tobacco rates higher for substance-attributable morbidity and mortality (Ratnasingham et al., 2013). Alcohol, as a risk factor for health, is linked to many different types of cancer, cardiovascular disease, gastro-intestinal disease, injury, and can impact sexual health, and pre and post-natal health.

Only tobacco rates are higher for substance-attributable morbidity and mortality.

Awareness of the link between daily alcohol consumption and selected chronic disease in the SDHU service area is quite high, with the exception of cancer. Most adults in the SDHU area were aware that alcohol is causally linked to the following diseases: Fetal Alcohol Spectrum Disorder (FASD) (97%), liver or stomach disease (96%), depression (90%), diabetes (80%), heart disease and stroke (79%). Fewer than half (48%) were aware that alcohol can increase a person's risk of developing cancer (RRFSS, 2012).

Most adults in the City of Greater Sudbury area were aware that consumption of alcohol is causally linked to heart disease and stroke (78%), depression (90%), diabetes (80%), liver stomach disease (96%), and FASD (97%). Fewer than half (49%) were aware of the increased risk of cancer with daily consumption of alcohol (RRFSS, 2001-2010). See Table 5 for a full breakdown by district office areas.

Table 5: Awareness of alcohol use and chronic disease incidence, by district office area, 2012.

Indicator	Greater Sudbury €	Sudbury East	Chapleau	Espanola	Manitoulin
Percentage of adults (18+) who have heard that drinking alcohol everyday may increase the risk of cancer.	49.1%	48.6%	-	49.2%	37.5%*
Percentage of adults (18+) who believe that drinking alcohol causes heart disease and stroke.	77.7%	83.3%	86.1%	74.3%	74.7%
Percentage of adults (18+) who believe that drinking alcohol causes depression.	90.0%	94.8%	90.7%	88.7%	91.3%
Percentage of adults (18+) who believe that drinking alcohol causes diabetes.	80.3%	85.4%	69.4%	79.0%	80.0%

Indicator	Greater Sudbury €	Sudbury East	Chapleau	Espanola	Manitoulin
Percentage of adults (18+) who believe that drinking alcohol causes disease of the liver/stomach	95.8%	99.0%*	95.4%	95.7%	96.1%
Percentage of adults (18+) who believe that drinking alcohol causes fetal alcohol spectrum disorder.	97.1%	93.8%	94.9%	97.3%	97.6%

Source: RRFSS, 2001/10

*Significantly different from the City of Greater Sudbury.

€ Reference Group

Alcohol and Cancer

Unlike many other health risks associated with alcohol use and misuse, few recognize the link between alcohol use and cancer. Alcohol, considered a class 1 carcinogen (IARC, 2015), which is an important cause of cancer in humans (Cogliano et al., 2011). The use of beverage alcohol, as little as one drink a day on average, can put an individual at risk of developing breast, colon, rectum, esophagus, larynx, liver, mouth, and pharynx cancer (Rehm et al., 2009). In 2010 in Ontario, **approximately 2% or 1000 new cancer cases can be attributed to alcohol**, and if we adjust that number to account for underestimation of alcohol consumption, **this number could increase to nearly 4% or 3000 cases** (Cancer Care Ontario, 2014). The highest percentage of cases are cancers of the upper digestive tract (e.g., oral, pharyngeal, and laryngeal cancer). **Due to the higher consumption of alcohol among males, a larger proportion of cancer cases in males are attributable to alcohol compared to females** (10-29% vs. 3-8%) (Cancer Care Ontario, 2014). Approximately **2%-7%** of breast cancer cases can be attributed to alcohol use. Colorectal cancer represents close to **40%** of all alcohol-attributable cases (Canadian Cancer Society's Steering Committee on Cancer Statistics, 2013). See table 6 through 8 for additional details.

Colorectal cancer
represents close to
40% of all alcohol-
attributable cases

(Canadian Cancer Society's Steering Committee on Cancer Statistics, 2013).

Alcohol and Chronic Disease

Alcohol use is linked to a number of chronic diseases. Although a moderate amount of alcohol may have some protective effects for type 2 diabetes, cardiovascular disease, and ischaemic heart disease, the many other health effects may in fact negate the positive effects (Baliunas et al., 2009; Roerecke & Rehm, 2012). When interpreting research it is important to remember that people often **underestimate their alcohol consumption by amounts of 30 to 70%** (Babor et al., 2010), which could in turn underestimate the magnitude of risk.

Butt, Beirness, Stockwell, Gliksman, and Paradis (2009) summarized the increased risk of serious medical conditions by average standard drinks per day. For example, consumption of one drink per day can increase an individual's risk of liver cancer by **10%**, death by liver cirrhosis in women by **139%**, and hypertension in men by **13%**. See Table 6 through 8 for a full breakdown for both men and women.

Table 6. Percentage change in long-term relative risk by average standard drinks per day for 5 illnesses that are similar for men and women aged below 70 years.

Type of Illness or Disease	1 Drink	2 Drinks	3-4 Drinks	5-6 Drinks	+6 Drinks
Oral Cavity & Pharynx Cancer	+42%	+96%	+197%	+366%	+697%
Oral Esophagus Cancer	+20%	+43%	+87%	+164%	+367%
Colon Cancer	+3%	+5%	+9%	+15%	+26%
Rectum Cancer	+5%	+10%	+18%	+30%	+53%
Liver Cancer	+10%	+21%	+38%	+60%	+99%

Adapted with permission from Canadian Centre on Substance Abuse, 2011 (See Appendix A for full table)
Source: Butt et al. (2011)

1 drink per day increases one's risk of oral cavity and pharynx cancer by 42% (This increases with each additional drink).

Table 7. Percentage change in long-term relative risk by average standard drinks per day for 5 illnesses for men aged below 70 years (Butt et al., 2011).

Type of Illness or Disease	1 Drink	2 Drinks	3-4 Drinks	5-6 Drinks	+6 Drinks
Hemorrhagic Stroke (morbidity)	+11%	+23%	+44%	+78%	+156%
Hemorrhagic Stroke (mortality)	+20%	+21%	+39%	+68%	+133%
Ischemic Stroke (morbidity)	-13%	0%	0%	+25%	+63%
Ischemic Stroke (mortality)	-13%	0%	+6%	+29%	+70%
Hypertension	+13%	+28%	+54%	+97%	+203%

Males

1 drink per day increases one's risk of hypertension or high blood pressure by 13% (this increases with each additional drink).

Adapted with permission from Canadian Centre on Substance Abuse, 2011 (See Appendix A for full table)
Source: Butt et al. (2011)

Table 8. Percentage change in long-term relative risk by average standard drinks per day for 6 illnesses for women aged below 70 years (Butt et al., 2011).

Type of Illness or Disease	1 Drink	2 Drinks	3-4 Drinks	5-6 Drinks	+6 Drinks
Breast Cancer	+13%	+27%	+52%	+93%	+193%
Hemorrhagic Stroke (morbidity)	-29%	0%	0%	+76%	+249%
Hemorrhagic Stroke (mortality)	+22%	+49%	+101%	199%	+502%
Ischemic Stroke (morbidity)	-18%	-13%	0%	+31%	+121%
Ischemic Stroke (mortality)	-34%	-25%	0	+86%	+297%
Hypertension	0%	+48%	+161%	+417%	+1414%

Females

1 drink per day increases one's risk of breast cancer by 13% (this increases with each additional drink)

Adapted with permission from Canadian Centre on Substance Abuse, 2011 (See Appendix A for full table)
Source: Butt et al. (2011)

Alcohol and Mental Health

Depression, anxiety and other mental illnesses have been linked to alcohol use. In some cases alcohol may contribute to the development and severity of a mental illness, or may cause a mental illness (Boden & Fergusson, 2011). Research suggests that there is a causal linkage between alcohol use disorders and major depression, and that increased use of alcohol increases the risk of depression (Boden & Fergusson, 2011).

In Ontario, mental health and addictions contributed to over 600 000 health adjusted life years⁷ lost, with alcohol use disorders accounting for more than 80 000. Alcohol use disorders contributed to the greatest number of deaths (88%) and highest percentage of years of life lost (91%) compared to other mental illnesses and addictions (Ratnasingham, Cairney, Manson, Rehm, Lin, and Krudyak, 2013).

Substance use disorders were highest among youth (12%) and lowest among adults aged 45+ (2%). Males had higher rates of substance use disorders in the past 12 months (6% vs. 3%). Approximately 5% of males and 2% of females met the criteria for alcohol abuse or dependence in the past year (Statistics Canada, 2012).

Substance use disorders were **highest** among youth and **lowest** among adults aged 45+.



Heavy drinking

has been causally linked to suicide and violence.
(Cherpitel, 2013; Macdonald et al., 2013)

⁷Health adjusted life year: Measure of future years of life lost and year-equivalent of reduced functioning owing to incident cases of disease in an average year.

Alcohol and Injury

Impaired Driving

Alcohol use affects reasoning and perception, and decreases reaction time, therefore as alcohol consumption increases, the risk of alcohol-related injuries increases (Blomberg, Peck, Moskowitz, Burns & Fiorentino, 2009).

Although impaired driving fatalities have declined since 1993, in 2012, there were 143 fatalities on Ontario roads, 25% of which were due to impaired driving (Ministry of Transportation, 2012). In 2014, in the City of Greater Sudbury, there were 164 impaired driving offences, 33 of which were female. Also in 2014, 16 132 vehicles were checked by the R.I.D.E. Program, and of those 28 received suspensions and 20 were charged with a blood alcohol concentration abuse 0.08 (Greater Sudbury Police Service, 2014).

In 2012, 143 fatalities on Ontario roads, 25% of which were due to impaired driving.

Novice drivers and those 21 years of age and under, cannot have any alcohol in their bloodstream while driving. In the City of Greater Sudbury, 15 drivers under that age of 21 were charged with impaired driving. (Greater Sudbury Police Service, 2014).

In the SDHU area, 6%⁸ of drivers (aged 16+) reported having driven a motor vehicle after 2 or more drinks the hour before they drove, and a slightly higher percentage (9%) of SDHU area respondents (aged 12+) reported being a passenger in a motor vehicle where the driver had consumed alcohol. Similar results were observed provincially (6% & 9% respectively) (Statistics Canada, 2009/10).

Eleven percent (11%⁸) of SDHU area respondents (aged 12+) reported driving a recreational vehicle (ATV, snowmobile, boat etc.) after consuming 2 or more alcoholic drinks. Similar results were observed provincially (7%). A significantly higher proportion (10%⁸) of SDHU area respondents (aged 12+) reported being a passenger of a recreational vehicle where the driver had consumed alcohol compared to the province (5%) (Statistics Canada, 2009-10).

⁸Interpret with caution — high sampling variability.

Alcohol and Other Injuries

Injuries can be divided into two categories: unintentional and intentional. Unintentional injuries include road traffic injuries, drownings, burns, poisoning and falls. Intentional injuries are those that result from deliberate acts of violence against oneself or others (WHO, 2007). In Ontario, **alcohol and drugs were found to be involved in nearly a quarter (23%) of motor vehicle collisions, 25% of homicides, 14% of suicides, and 7% of unintentional falls with a BAC greater than or equal to 0.08% (CIHI, 2007).** In 2009-10, there were **142** unintentional falls with a blood alcohol concentration greater than or equal to 0.08% (CIHI, 2009-10), and in Ontario in 2010, there were **89** drownings, **44%** of which were related to alcohol use (Ontario Ministry of Community Safety & Correctional Services, 2010).

Alcohol, Pregnancy & Breastfeeding

Alcohol use during pregnancy should be avoided. The fetus becomes exposed to alcohol through the mother's bloodstream, and can result in a variety of physical and developmental impairments (Public Health Agency of Canada, 2012). The most common diagnosis is Fetal Alcohol Spectrum Disorder (FASD), which refers to physical, mental and psychological deficits that can occur with an individual if their mother consumed alcohol during her pregnancy. These deficits can have both acute and chronic implications (Chudley, Conry, Cook, Loock, Rosales, & LeBlanc, 2005). Although there is limited evidence to confirm the quantity of alcohol that may contribute to FASD or other birth defects, alcohol use during pregnancy can contribute negatively to the health of a newborn (Foltran, Gregori, Franchin, Verduci, Giovanni, 2011). Research has found that heavy alcohol use prenatally increases risk of behavioural problems, anxiety and depression (O'Leary, Nassar, Zubrick, Kruinczuk, Stanley & Bower, 2010). It is recommended to completely abstain as no amount can be considered safe (CDC, 2005). The same advice can be made for alcohol consumption and breastfeeding due to potential impacts to infant sleeping patterns and behaviour with presence of alcohol in breast milk. When breastfeeding, it is recommended to store breast milk in advance to avoid the presence of alcohol in breast milk (Giglia & Binns, 2006).

It is recommended to completely abstain from alcohol during pregnancy, as no amount can be considered safe.

SDHU area adults were asked to respond to a number of questions related to their beliefs and knowledge of the harmful effects of alcohol use during pregnancy. Most adults (82%) in the City of Greater Sudbury reported believing that drinking alcohol during pregnancy is harmful to an unborn baby (RRFSS, 2001-2010). Similar results were observed for all four district office areas (see Table 10 for details).

Table 10: Percentage Of Adults (18+) who Believe Drinking Alcohol during Pregnancy is Harmful to an Unborn Baby, SDHU, 2001-2010

Geographic Areas	Percentage (%)
Greater Sudbury €	81.6%
Sudbury East Area	76.6%
Chapleau Area	80.0%
Espanola Area	78.7%

Source: RRFSS (2001-2010)

Youth, Young Adults and Alcohol

Youth and young adults are at risk of alcohol-related harm and in particular at risk for more short-term impacts such as falls, date rape, and other assaults as well as an increased risk of injuries and deaths caused by impaired driving (CPHA, 2011). This is an increasingly vulnerable time for the developing brain. The regions of the brain responsible for various actions, such as: judgement, planning and impulse control; new learning; information transmission; rewards systems, can all be affected by the consumption of alcohol (Clark, Thatcher, & Tapert, 2008). Due to the rapid changes occurring in the brain, youth and young adults are more impacted by marketing and advertising, are more likely to expose themselves to risk taking behaviours including alcohol use, and are at an increased risk of addiction compared to adults (Pechmann, Levine, Loughlin & Leslie, 2005). Exposure to alcohol marketing has shown to effect the perceptions of drinking, specifically around promoting and reinforces alcohol as a seemingly positive, glamorous, and portrayed as relatively low-risk (Babor, 2010). While this type of marketing can lead to more favorable attitudes it also increases the normalization of acceptance towards heavy drinking (Babor, 2010; Heipel-Fortin, 2007).

It is increasingly important to reduce and limit the amount of alcohol consumption in youth.

Changes to the physical and social environment also strongly impact alcohol use rates. These changes include increased accessibility to alcohol, on campus versus off campus housing, the demographics of the college or university, on campus policies and enforcement of policies, the “social norm” of alcohol use, and many other activities aligned with alcohol use (Wechsler & Nelson, 2008). All of these factors contribute to binge drinking, which can in turn lead to social, environmental and physical harms (Wechsler & Nelson, 2008).

It is increasingly important to reduce and limit the amount of alcohol consumed in youth. Developmental assets, for example, family support, school engagement, and adult relationships play an important role in reducing substance use among youth and young adults, and consideration and preventive efforts should include the development of these assets.

Conclusions and Implications for Practice

Alcohol use is a normalized common practice undertaken by the majority of the SDHU service area, which is inclusive of our district office areas. Alcohol use and misuse also has significant social, environmental, and health impacts and as part of our mandate it is important to inform the community of these factors to make informed choices when it comes to their alcohol use. The Canadian Centre on Substance Abuse conducted extensive research in the development of Canada's Low-risk Alcohol Drinking Guidelines, and part of our mandate includes informing the public of the guidelines. Most (83%) of the SDHU area are still unaware of the guidelines and just over a third (36%) exceed the guidelines, which indicates there is a need for additional dissemination. The findings support the need for SDHU to work with the community and community organizations to inform and develop strategies to reduce alcohol use and the harms associated with alcohol misuse.

Next Steps

In order to reduce the burden of alcohol use and misuse in our community, we must continue to work comprehensively on programs that address alcohol misuse but more importantly engage and commit to addressing key strategies around alcohol use and misuse with our partners and external stakeholders. Alcohol prevention strategies are complex and multi-faceted and should include dissemination of evidence-informed practice and skills training, advocacy for policy change, and partnership development. This report highlights and supports the need to develop and deliver evidence-informed research (e.g., LRADG) in innovative and engaging ways, to advocate for review and update to current bylaws and policies, and advocacy for new bylaws and policies. In order to disseminate quality information, we must continue to monitor alcohol use trends in the community and keep apprised of new, emerging and innovative research. The alcohol report to the community captures all of this and will be used to guide the steps below:

Community Discussions:

The SDHU will conduct a number of discussions in a variety of settings with communities in our services area (including district office areas) to determine community readiness, capture lived experience as they related to alcohol, and gain support in the development of key strategies around alcohol use and misuse.

Expert Panel:

The SDHU will gather a group of leading local experts with experience in the area of alcohol. This would include experts in addiction, mental health, academia, housing, enforcement, law, and municipal sectors. The report results will be presented to the panel, and discussion will ensue around the results, next steps, and recommendations to reduce the harms associated with alcohol use and misuse.

Report Update:

The report will be updated every 3 years and shared with the community as well as internal and external stakeholders and partners. This will act as a report for future years to monitor alcohol use trends, emerging research, and policy change.



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Sudbury & District Health Unit
Service de santé publique de Sudbury et du district

Table 6. Percentage change in long-term relative risk by average standard drinks per day for 12 illnesses that are similar for men and women aged below 70 years (Butt et al., 2011).

Type of Illness or Disease	Proportion of All Deaths, 2002-2005	Percentage Increase/ Decrease in Risk						
		Zero or Decreased Risk						
		Increased Risk						
		0%	-1 to -24%	-25 to -60%	Up to +24%	+60 to 80%	+100 to 180	Over +200%
		1 Drink	2 Drinks	3-4 Drinks	5-6 Drinks	+6 Drinks		
Tuberculosis	1 in 2500	0	0	+194	+194	+194		
Oral cavity & pharynx cancer	1 in 200	+42	+96	+197	+366	+697		
Oral esophagus cancer	1 in 150	+20	+43	+87	+164	+367		
Colon Cancer	1 in 40	+3	+5	+9	+15	+26		
Rectum Cancer	1 in 200	+5	+10	+18	+30	+53		
Liver Cancer	1 in 200	+10	+21	+38	+60	+99		
Larynx Cancer	1 in 500	+21	+47	+95	+181	+399		
Ischemic heart disease	1 in 13	-19	-19	-14	0	+31		
Epilepsy	1 in 1000	+19	+41	+81	+152	+353		
Dysrhythmias	1 in 250	+6	+17	+32	+54	+102		
Pancreatitis	1 in 750	+3	+12	+41	+133	+651		
Low Birth Weight	1 in 1000	0	+29	+84	+207	+685		

Table 7. Percentage change in long-term relative risk by average standard drinks per day for 5 illnesses for men aged below 70 years (Butt et al., 2011).

Type of Illness or Disease	Proportion of All Deaths, 2002-2005	Percentage Increase/ Decrease in Risk				
		Zero or Decreased Risk				
		Increased Risk				
		<div></div> 0%	<div></div> -1 to -24%	<div></div> -25 to -60%		
		<div></div> Up to +24%	<div></div> +60 to 80%	<div></div> +100 to 180	<div></div> Over +200%	
		1 Drink	2 Drinks	3-4 Drinks	5-6 Drinks	+6 Drinks
Hemorrhagic Stroke (morbidity)	-	+11	+23	+44	+78	+156
Hemorrhagic Stroke (mortality)	1 in 30	+20	+21	+39	+68	+133
Ischemic Stroke (morbidity)	-	-13	0	0	+25	+63
Ischemic Stroke (mortality)	1 in 80	-13	0	+6	+29	+70
Diabetes Mellitus	1 in 30	-12	0	0	0	+72
Hypertension	1 in 150	+13	+28	+54	+97	+203
Liver Cirrhosis (morbidity)*	-	0	0	+33	+109	+242
Liver Cirrhosis (mortality)	1 in 90	+26	+59	+124	+254	+691

Table 8. Percentage change in long-term relative risk by average standard drinks per day for 5 illnesses for women aged below 70 years (Butt et al., 2011).

Type of Illness or Disease	Proportion of All Deaths, 2002-2005	Percentage Increase/ Decrease in Risk				
		Zero or Decreased Risk 0% -1 to -24% -25 to -60% Increased Risk Up to +24% +60 to 80% +100 to 180 Over +200%				
		1 Drink	2 Drinks	3-4 Drinks	5-6 Drinks	+6 Drinks
Breast Cancer	1 in 45	+13	+27	+52	+93	+193
Hemorrhagic Stroke (morbidity)	-	-29	0	0	+78	+249
Hemorrhagic Stroke (mortality)	1 in 20	+22	+49	+101	+199	+502
Ischemic Stroke (morbidity)	-	-18	-13	0	+31	+121
Ischemic Stroke (mortality)	1 in 65	-34	-25	0	+86	+297
Diabetes Mellitus	1 in 30	-36	-40	0	+739	+1560
Hypertension	1 in 85	0	+48	+161	+417	+1414
Liver Cirrhosis (morbidity)*	-	+21	+70	+125	+182	+260
Liver Cirrhosis (mortality)	1 in 160	+139	+242	+408	+666	+1251

BRIEFING NOTE

To: R. Lapierre, Chair, Sudbury & District Board of Health
From: Dr. P. Sutcliffe, Medical Officer of Health
Re: Expansion of Proactive Disclosure System
Date: September 10, 2015

☐ For Information

☐ For Discussion

☒ For a Decision

Issue:

At its meeting on June 18, 2015, the Sudbury & District Board of Health carried Motion #29-15, directing staff to plan appropriate actions to increase transparency in public reporting practices including expansion of the current proactive disclosure system and revisions to applicable sections of the Board of Health manual.

Recommended Action:

THAT the Sudbury & District Board of Health endorse the expansion of the *Check Before you Eat!* disclosure system to include findings of routine inspection and enforcement-related activities pertaining to public pools, public spas, personal services settings, and tobacco vendors; and

THAT the following be the Board policy on the release of enforcement and inspection information:

- 1. Charges:** Statistical information on charges (i.e. no identifying information) is released to the Sudbury & District Board of Health at its regularly scheduled meetings.
- 2. Convictions:** Convictions related to food premises, public pools, public spas, personal services settings, and tobacco vendor infractions are posted on the Sudbury & District Health Unit website as soon as possible following the conviction and for a period of 12 months from the date on which the conviction was rendered.
- 3. Orders:** Orders pertaining to food premises, public pools, public spas, personal services settings, and tobacco vendors are posted on the Sudbury & District Health Unit website as soon as possible following the issuance of the order and for a period of 12 months from the date on which the order was rescinded.
- 4. Routine inspection reports related to food premises, public pools, public spas, and personal services settings:** Routine inspection and re-inspection reports are posted on the Sudbury & District Health Unit website as soon as possible following the inspection and for a period of 12 months from the date of the inspection.
- 5. Requests for information not posted on website:** Requests for information not posted on the website are considered on an individual basis in accordance with Health Unit policy and the Municipal Freedom of Information and Protection of Privacy Act (MFIPPA) and the Personal Health Information Protection Act (PHIPA).

Background:

The Ministry of Health and Long-Term Care has signaled its intent to increase transparency overall (i.e. Open Government initiative), and specifically to enhance disclosure of inspection findings from settings routinely inspected by public health.

Correspondence dated October 4, 2014 from the Minister, MOHLTC, requested Boards of Health and Medical Officers of Health to make transparency a priority objective in all reporting practices and to take steps towards developing and establishing new reporting practices to make information readily available to the public. We were specifically requested to ensure that detailed information with respect to *non-routine infection prevention and control lapse investigations be publicly disclosed and to make a commitment to incorporate transparency into business and operational plans.*

The MOHLTC is revising the *Ontario Public Health Standards* to require public disclosure of non-routine infection prevention and control lapse investigations. The Sudbury & District Health Unit (SDHU) will comply with requirements outlined in the revised *Ontario Public Health Standards* upon their release.

Correspondence dated June 9, 2015 from the MOHLTC informed health units that the Ministry is exploring the feasibility of adopting provincially an existing disclosure program for routinely inspected settings such as food premises, public pools and spas, personal services settings, etc. It is not anticipated that a provincial disclosure system would be established in the immediate future and the Sudbury & District Board of Health at its June meeting directed staff to move forward on this initiative locally.

Since 2009, the SDHU has exceeded the disclosure requirements outlined within the *Food Safety Protocol* under the *Ontario Public Health Standards*, by proactively disclosing food premises inspection results via the SDHU website. The website provides public access to inspection results of all routine compliance inspections and re-inspections completed within the past 12 months, as well as a list of establishments that have been convicted of offences under the *Food Premises Regulation*, and food premises that have been issued a closure order under the *Health Protection and Promotion Act*. This disclosure website has been recently updated and rebranded as *Check Before You Eat!*. The disclosure website was intentionally built on a platform that could be easily expanded to other program areas.

Financial Implications:

The costs associated with the recommended action will need to be further explored and quantified. Open data projects can be complex and costs can be difficult to determine at the commencement of exploratory work. While the exact costs associated with the recommended action are not yet known, they are not expected to be substantial and are anticipated to be one time and managed from within budget or related reserves. Costs will be reviewed to ensure value for money prior to proceeding with implementation.

Timeframe:

With the support of the Sudbury & District Board of Health for the new policy on the release of enforcement and inspection information, it is expected that the changes in the recommended action will be implemented by June 2016.

Strategic Priority:

1. Champion and lead equitable opportunities for health

Contacts:

Stacey Laforest, Director, Environmental Health Division

2013–2017 Strategic Priorities:

1. Champion and lead equitable opportunities for health.
2. Strengthen relationships.
3. Strengthen evidence-informed public health practice.
4. Support community actions promoting health equity.
5. Foster organization-wide excellence in leadership and innovation.

O: October 19, 2001
R: October 2013

EXPANSION OF PROACTIVE DISCLOSURE SYSTEM

MOTION: WHEREAS the Minister of Health and Long-Term Care has requested that each Board of Health and Medical Officer of Health make transparency a priority objective in business plans; and

WHEREAS the Minister of Health and Long-Term Care has requested that each Board of Health and Medical Officer of Health take steps towards developing and establishing new reporting practices to make information readily available to the public; and

WHEREAS the Sudbury & District Health Unit is committed to public transparency;

THEREFORE BE IT RESOLVED THAT the Sudbury & District Board of Health endorse the expansion of the Check Before you Eat! disclosure system to include findings of routine inspection and enforcement-related activities pertaining to public pools, public spas, personal services settings, and tobacco vendors; and

THAT the following be the Board policy on the release of enforcement and inspection information:

1. **Charges:** Statistical information on charges (i.e. no identifying information) is released to the Sudbury & District Board of Health at its regularly scheduled meetings.

2. **Convictions:** Convictions related to food premises, public pools, public spas, personal services settings, and tobacco vendor infractions are posted on the Sudbury & District Health Unit website as soon as possible following the conviction and for a period of 12 months from the date on which the conviction was rendered.

3. **Orders:** Orders pertaining to food premises, public pools, public spas, personal services settings, and tobacco vendors are posted on the Sudbury & District Health Unit website as soon as possible following the issuance of the order and for a period of 12 months from the date on which the order was rescinded.

4. **Routine inspection reports related to food premises, public pools, public spas, and personal services settings:** Routine inspection and re-inspection reports are posted on the Sudbury & District Health Unit website as soon as possible following the inspection and for a period of 12 months from the date of the inspection.

5. **Requests for information not posted on website:** Requests for information not posted on the website are considered on an individual basis in accordance with Health Unit policy and the Municipal Freedom of Information and Protection of Privacy Act (MFIPPA) and the Personal Health Information Protection Act (PHIPA); and

FURTHER THAT motion 36-09 is hereby rescinded and Board of Health Disclosure Information Sheet F-IV-10 be correspondingly updated.

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iApprove-2015-00949

SEP 04 2015

Mr. René Lapierre
Chair, Board of Health
Sudbury and District Health Unit
1300 Paris Street
Sudbury ON P3E 3A3

Dear Mr. Lapierre:

I am pleased to advise you that the Ministry of Health and Long-Term Care will provide the Board of Health for the Sudbury and District Health Unit up to \$156,177 in additional base funding and up to \$94,600 in one-time funding for the 2015-16 funding year to support the provision of mandatory and related public health programs and services in your community.

The Executive Director of the Public Health Division and Assistant Deputy Minister (A) of the Health Promotion Division will write to the Sudbury and District Health Unit shortly concerning the terms and conditions governing this funding.

Thank you for your dedication and commitment to Ontario's public health system.

Yours sincerely,

Dr. Eric Hoskins
Minister

c: Michael Mantha, MPP, Algoma-Manitoulin
France Gélinas, MPP, Nickel Belt
Glenn Thibeault, MPP, Sudbury
Dr. Penny Sutcliffe, Medical Officer of Health, Sudbury and District Health Unit

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September 4, 2015

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

RE: Update on Public Health Funding Review

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

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

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

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

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

.../2

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

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

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

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

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

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

Yours truly,

Original signed by

Roselle Martino
Executive Director

Original signed by

Martha Greenberg
Assistant Deputy Minister (A)

Enclosure

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

PUBLIC HEALTH FUNDING MODEL FOR MANDATORY PROGRAMS

The Final Report of the Funding Review Working Group

December 2013

Letter of Transmittal

December 2013

Dr. Arlene King
Chief Medical Officer of Health, Public Health Division

Roselle Martino
Executive Director, Public Health Division and
Office of the Chief Medical Officer of Health

Kate Manson-Smith
Assistant Deputy Minister, Health Promotion Division

Dear Dr. King, Ms. Martino, and Ms. Manson-Smith:

On behalf of the Funding Review Working Group, we are pleased to present you with our final report *Public Health Funding Model for Mandatory Programs: The Final Report of the Funding Review Working Group*. This report provides advice and recommendations on a model for the allocation of provincial funding to public health units for the delivery of mandatory public health programs and services in both organized and unorganized areas.

The recommendations in this report support the creation of a public health funding model with an “upstream” approach incorporating socio-economic determinants of health. This funding model was developed with the intention of identifying an appropriate funding share for each public health unit that reflects its needs in relation to all other public health units. The report also provides advice to the Ministry on implementation principles.

The Funding Review Working Group would like to thank the Ministry of Health and Long-Term Care for its dedication to the development of a fair, transparent, and consistent method of funding for public health units. We would also like to thank former members of the Funding Review Working Group who contributed to the findings and recommendations of this report and our sector colleagues for their invaluable input to the development of this funding model. Dedicated staff from the Public Health Division, Health Promotion Division, and Health System Information and Investment Division also provided adept and diligent secretariat support.

This funding model represents not only an opportunity to improve upon the accountability and transparency of provincial funding of public health services but, more importantly, marks an opportunity for the Province of Ontario to implement an equitable way of funding public health services.

Sincerely,

Original Signed By

Dr. David L. Mowat
Chair, Funding Review Working Group

c: Members, Funding Review Working Group

Sylvia Shedden, Director, Public Health Standards, Practice & Accountability Branch
Laura Pisko, Director, Health Promotion Implementation Branch
Brent Feeney, Manager, Public Health Standards, Practice & Accountability Branch

Members of the Funding Review Working Group

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Medical Officer of Health, Peel Public Health

Jackie Boufford

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Jack Butt

Chair, Leeds, Grenville & Lanark District Board of Health

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Chief Administrative Officer, Porcupine Health Unit

Past Members of the Funding Review Working Group:

Vance Blackmore (*April 2010 – January 2011*)

Former Member, Board of Health Section, Association of Local Public Health Agencies

Dale Jackson (*April 2010 – June 2011*)

Former Director of Administration, Hastings & Prince Edward Counties Health Unit

Dr. Christopher Mackie (*April 2010 – June 2011*)

Former Associate Medical Officer of Health, City of Hamilton, Public Health Services

Dr. Allan Northan (*April 2010 – July 2011*)

Former Medical Officer of Health, District of Algoma Health Unit

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Public Health Standards, Practice & Accountability Branch, Public Health Division

Health Promotion Implementation Branch, Health Promotion Division

Health System Funding Policy Branch, Health System Information Management and Investment Division

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Executive Summary

Why is a funding review necessary?

Over the past few years, the Ministry of Health and Long-Term Care (the “Ministry”) has been faced with increased scrutiny and accountability requirements for the provision of transfer payments to health sector organizations, such as public health units.

Public health is one of the few areas where provincial funding is not governed by a formula for its distribution. As a result, the Ministry cannot explain or justify the variation in per capita funding levels among public health units. Public health funding also does not currently align with the underlying principles of Health System Funding Reform. In addition, a number of reports and stakeholders have recommended that the Ministry allocate provincial funding for public health units more equitably, using indicators that reflect service costs and the relative health needs of communities.

It was within this context that the Ministry initiated a process to review the provincial funding provided to public health units for mandatory programs in both organized and unorganized areas. The Funding Review Working Group, made up of public health sector representatives, was established in 2010 with a mandate to investigate the current status of public health funding, provide advice to the Ministry on a future public health funding model, and advise the Ministry on principles for implementing the funding model.

What guided the Funding Review Working Group’s deliberations?

A great deal of research, analysis, and thoughtful discussion has taken place over almost three (3) years to develop the funding model recommended in this report. Representatives from across the public health sector, including boards of health, public health units, the Association of Local Public Health Agencies (alPHA), and the Association of Municipalities of Ontario (AMO), have worked to develop a model we believe best represents the costs of the provision of mandatory program services in public health units using the best available data.

Over the past few years, the Funding Review Working Group has reviewed and analyzed current and historical funding levels, sources of funding, expenses, and cost pressures of public health units; examined prior reviews/reports and information from other jurisdictions; established sub-committees to conduct research and make recommendations on key issues/areas; established characteristics and criteria for the funding model; reviewed potential components and indicators for inclusion in a funding model and developed the respective scaling and weighting of the various components; and, formulated implementation principles. Over the course of our deliberations, input was sought from the field on the proposed elements of the public health funding model.

Public Health Funding Model Recommendations

The Funding Review Working Group considered three (3) potential components for the public health funding model: population, infrastructure/administration, and an equity-adjusted population model.

Population was considered by the Funding Review Working Group, where funding would be allocated to each public health unit in proportion to its population. While public health units with a higher population likely require more funding, this approach alone would not reflect the drivers of need and/or service cost drivers that differ from public health unit to public health unit. For these reasons population was not recommended as a separate model component.

Costs associated with **infrastructure/administration** were also considered by the working group for which funding would be allocated to each public health unit based, in part, on these costs. Upon further examination, it was determined that the key factor affecting infrastructure/administration was geography, which is recommended in the final model as a service cost driver indicator. Other costs, such as those associated with board of health governance, were found to be relatively consistent across public health units. Based on this, the Funding Review Working Group determined that infrastructure/administration would not be recommended as a separate model component.

The Funding Review Working Group is recommending that **an equity-adjusted population model** be used that takes into account population as well as equity measures. Six (6) groups of equity factors and associated indicators were considered for inclusion:

1. Health Risks (e.g., Daily Smoking, Obesity, Physical Inactivity)
2. Health Outcomes (e.g., Low Birth Rate, Preventable Mortality Rate)
3. Service Cost Drivers (e.g., Cost of Living, Geography, Language)
4. Drivers of Need (e.g., Aboriginal, Recent Immigrants, Visible Minorities)
5. Socio-Economic Characteristics (e.g., Deprivation Indices, Education)
6. Replacement Services (e.g., Pharmacies, Physicians)

The Funding Review Working Group also reviewed each of the potential indicators against characteristics and criteria established at the outset of the review. Indicators must be resistant to manipulation, reliable, independent, based on available data, easily explained, and unlikely to change over time. In many cases, data were not available at the public health unit level, resulting in the exclusion of those indicators or the use of proxy indicators.

The public health funding model recommended in this report uses an “upstream” approach focusing on socio-economic determinants of health. The resulting model has two (2) groups of equity factors (and associated indicators) as follows:

1. **Service Cost Drivers** that reflect the variable cost of delivering public health services. **Geography** and **Language** are being recommended to reflect service cost drivers.
2. **Drivers of Need** that address demand and reflect the utilization of public health services. **Aboriginal, Ontario Marginalization Index (ON-Marg)**, and **Preventable Mortality Rate** are being recommended to reflect drivers of need. It is important to note that ON-Marg contains four (4)

dimensions (i.e. Residential Instability, Material Deprivation, Dependency, and Ethnic Concentration), which are used in the model to reflect the socio-economic determinants of health.

The intention of this funding model is to identify an appropriate funding share for each public health unit that reflects its needs in relation to all other public health units. The model can work with any size of funding allocation.

In calculating the share for each public health unit, the actual values for each indicator have been rescaled to a common range to allow them to be combined. Percentage weights are then assigned to each of the indicators based on relative valuing. If a certain indicator is felt to account for a higher degree of need/cost, it is assigned a higher weight.

For the **mandatory programs funding model**, the Funding Review Working Group is recommending that Service Cost Drivers reflect 35% of the overall weight and Drivers of Need reflect 65% of the overall weight of the model. The Funding Review Working Group is also recommending that these two (2) Drivers be broken down as follows:

- Service Cost Drivers (35%): Geography at 25% and Language at 10%.
- Drivers of Need (65%): Aboriginal at 12.5%, ON-Marg at 42.5%, and Preventable Mortality Rate at 10%.

An adjustment to the weighting was required for the unorganized territories funding model to adequately reflect the demands and cost of service delivery in remote areas. The Funding Review Working Group, based on advice from the Unorganized Territories Sub-Committee, is recommending that the two (2) Drivers be broken down as follows:

- Service Cost Drivers (45%): Geography at 35% and Language at 10%.
- Drivers of Need (55%): Aboriginal at 20%, ON-Marg at 25%, and Preventable Mortality Rate at 10%.

The indicators are combined to create a unique Equity Adjustment Factor (EAF) for each public health unit. Each public health unit's population is then multiplied by its calculated EAF to arrive at its equity-adjusted population.

To determine the proportional share for each public health unit, its equity-adjusted population is divided by the sum of the equity-adjusted population for all public health units.

The Funding Review Working Group is recommending that the most recent Statistics Canada Population Estimates be used for the purposes of the funding model. It is also recommended that population statistics be updated annually in order to acknowledge the high growth experienced in certain public health unit regions.

The Funding Review Working Group recognizes that the implementation method to be chosen for the funding model is a government policy decision and will be dependent on available funding. To guide the

Ministry in its decisions on implementation, the Funding Review Working Group is proposing the following principles for the Ministry's consideration:

- The timing to reach equity/model-based share must be balanced with maintaining system stability but should not further exacerbate current funding disparities.
- The Ministry should use incremental funding to the greatest extent possible in the application of the new funding model in order to minimize the disruption to existing service provision.
- Public health units should be provided with sufficient notice regarding the implementation of the funding model for planning purposes. A transition period (e.g., at least 3 years) is necessary to implement changes to funding. The Ministry should work with boards of health and public health units to mitigate the impact on service provision during the transition period.
- The impact of funding changes should be monitored by the Ministry to ensure that service provision is not being unduly impacted.
- The impact of funding changes should be taken into consideration in the setting of targets for Public Health Accountability Agreement indicators.
- The model is not intended to affect the municipal cost-share formula (75% provincial/25% municipal) although there may be impacts on municipal funding contributions resulting from the implementation of the model.
- The impact of funding changes to the municipal cost-share formula (i.e., decreases or increases in provincial funding affecting municipal contribution levels) should be taken into consideration when determining an implementation method.
- The most current data should be used for the public health funding model.

The funding model was developed by the Funding Review Working Group as an Ontario model balancing the needs of all 36 public health units. However, the funding model recommended in this report is sufficiently flexible to allow the Ministry to develop implementation strategies that reflect other factors that contribute to the unique funding needs of each public health unit in Ontario.

Developing a funding model for public health services proved to be an exercise in uncharted waters with members having to rely on their professional judgment and experience in the field of public health. It was exciting and interesting work aimed at supporting the strategic vision of strengthening public health in Ontario in the coming years.

1.0 Public Health Funding in Ontario

1.1 Introduction

In Ontario, public health programs and services are delivered by 36 public health units which are established under the *Health Protection and Promotion Act* (HPPA) and aligned with municipal boundaries. Each public health unit is governed by a board of health, whose duty it is to provide or ensure the provision of public health programs and services as required by the HPPA, Ontario Public Health Standards (OPHS), and Ontario Public Health Organizational Standards (Organizational Standards). Part of this responsibility includes the establishment of the operating budget for the public health unit.

Under section 72 of the HPPA, obligated municipalities (single and upper-tier) are required to pay the expenses of boards of health and medical officers of health. The legislative authority for provincial funding to public health units can be found in section 76 of the HPPA, which specifically states that the Minister may make grants for the purposes of the HPPA on such conditions as he or she considers appropriate. This funding is discretionary.

The Ministry currently provides ongoing funding to public health units for the provision of mandatory programs in both organized and unorganized (without municipal organization) areas. Mandatory programs refer to the public health programs and services that public health units must provide to their local communities in accordance with the HPPA, OPHS, and Organizational Standards. Mandatory programs are currently funded at 75% of the Ministry approved allocation in organized areas and 100% in unorganized areas.

When funds are available, the Ministry approves an annual increase over the prior year's base budget for mandatory programs. Over the past 10 years, the increase has ranged between 1.5% to 9.5% for mandatory programs in organized areas and 2% to 15% for mandatory programs in unorganized areas. Over and above the funding for mandatory programs, the Ministry also provides funding to public health units for a number of related programs and initiatives.

Ministry funding to public health units for mandatory and related programs is typically based on a calendar year. Funding decisions are made upon Ministry review of budget submissions from public health units and Minister's approval. If a public health unit's total approved budget exceeds the Ministry's approved funding, then obligated municipalities are solely responsible for those excess costs (as per section 72 of the HPPA).

Funding for mandatory programs is currently governed by the Public Health Accountability Agreement ("Accountability Agreement"), which sets out the obligations of the Ministry and public health units. The Accountability Agreement incorporates financial and performance indicators, and continuous quality improvement tools. Indicators are program-based and focus on board of health outcomes and performance based on identified targets. Targets are negotiated between individual public health units and the Ministry. Performance expectations and financial data are refreshed annually and additional measures may be incorporated in agreements to address issues specific to certain public health units.

1.2 Historical Funding for Mandatory Programs

Over the course of the last century, public health in Ontario has progressed from a very large number of small municipal health departments to the current number of thirty-six (36) public health units. As amalgamations occurred, largely with the encouragement of the Province, existing budgets, which were based upon the ability and willingness of municipalities to pay, were combined. Over time, provincial priorities for program expansion were implemented, sometimes with 100% provincial funding. In the late 1980s, after the introduction of mandatory programs, public health units could apply for additional funding in order to meet the requirements; however, this was at the discretion of boards of health.

Across-the-board increases in provincial funding have served to perpetuate historical anomalies in funding. In addition, the need to secure approval from both municipal and provincial sources has hampered efforts of some public health units to catch up. If a board of health budgets for less than the increase offered, then the provincial funding is reduced accordingly (i.e. the budget is always the lesser of what the province is able to fund or the board of health is prepared to request). Should the board of health wish to recoup funding that had been available in earlier years in a future funding year, the matching provincial funding may not be available.

Perhaps the most important factor affecting per capita funding is differential growth. The population of some public health units has grown at a rate many times faster than others. Over time, across-the-board increases have resulted in large disparities in funding on a per capita basis. Provincial across-the-board allocations for new related initiatives (e.g., Chief Nursing Officer Initiative, Public Health Nurses Initiative, etc) continue to occur.

For the period up to 1997, the Ministry provided grants at 75% of the approved public health unit budgets with the exception of the municipalities in Metropolitan Toronto (Toronto, East York, North York, York, Scarborough and Etobicoke), which received grants at 40% of their approved budgets. Up to 1995, provincial funding was provided at the cost-shared amount based upon the funding available from the province.

In 1996, public health units and the Ministry were facing cuts to provincial transfer payments which necessitated a review of the current funding patterns. At that time, there was agreement between the Ministry and external stakeholders that the impending cuts should not be applied equally (i.e. across-the-board percentage reduction) to all public health units. A stakeholder committee, the Equitable Funding for Public Health Working Group, was established to review factors to rationalize public health funding and propose acceptable modifiers that could be included in the funding model (such as indicators of health needs and service costs). The working group recommended four (4) indicators for use in the model: standardized potential years of life lost ratio, incidence of low income, home language not English, and geographic dispersion. An EAF, which summarized each public health unit's relative position in the provincial distribution, was calculated as a product of the modifiers. There was no attempt to assign relative weights to the modifiers.

The recommended funding model was implemented by the Ministry in 1996 and 1997 and resulted in a reduction of cost-shared mandatory programs totaling \$8.3 million in 1996 and \$3.7 million in 1997.

Funding reductions were made in such a way that there was a 2.6-fold difference in per capita funding between the public health unit with the highest per capita funding and the public health unit with the lowest per capita funding.

In 1998, a review of public health funding was part of the Local Services Realignment (LSR) process that involved numerous changes in provincial/municipal transfers. The transfers between the Province and municipalities were very broad in scope and included airports, roads, bridges, gross receipt taxes, social services, education, public health, etc. For one year (1998), as a result of LSR, the Ministry provided no grants to public health units for mandatory programs in municipally incorporated areas.

Between 1999 and 2004 the Ministry provided 50% of board of health approved public health unit costs for the provision of mandatory programs. During this time, the Ministry placed no caps on public health unit budget requests, i.e. the Ministry funded 50% of what was requested by any public health unit.

In 2001, the Funding Allocation Formula Working Group, a stakeholder committee, was established to determine a methodology for allocating provincial grants to public health units for the delivery of mandatory programs. Despite changes made as a result of the 1996 funding review, there still existed a 3.0-fold difference in per capita funding between the highest and lowest funded public health units, which could not be explained or justified.

The Funding Allocation Formula Working Group recommended five (5) modifiers for inclusion in the funding model, including: low income, low education (less than grade 9), standardized potential years of life lost ratio, geographic dispersion, and home language (not English). The working group recommended that 5% of the total funding available be allocated for core funding (i.e. administration and overhead costs), two-thirds of the funding available after the core amount was removed be allocated on a per capita basis using permanent resident populations, and one-third of the funding available after the core amount was removed be allocated based on a needs-adjusted per capita allocation. The 2001 funding model developed by the working group was not implemented as consensus was not reached by the working group on many issues (e.g., the inclusion of modifiers such as the absence of general practitioners and transitory populations).

In the 2004 Ontario Budget (and committed to in *Operation Health Protection – An Action Plan to Prevent Threats to our Health and to Promote a Healthy Ontario*), the Ministry announced that it would increase its share of mandatory programs funding from 50% in 2004 to 75% by 2007 to strengthen the resource base of public health. Subsequently, the provincial share for mandatory programs was increased from 50% in 2004 to: 55% in 2005, 65% in 2006, and 75% in 2007.

In 2005, no caps were placed on public health unit budget requests by the Ministry (i.e. the Ministry funded 55% of what was requested by public health units). In 2005, provincial funding for public health units increased by 9.5% over the prior year's Ministry approved allocation.

Due to the provincial need for constraint, in both 2006 and 2007 the Ministry allocated 5% growth above the prior year's Ministry approved allocation to each public health unit, or less if requested, for

the provision of mandatory programs. In 2007, public health units started to report that obligated municipalities were contributing more than 25% of the mandatory programs funding.

In an effort to be more responsive to local needs, elements of the prior funding reviews were implemented in 2008 and 2009 through incremental funding. In both years, the 5% growth in mandatory programs was apportioned based on a 3% across-the-board increase to all public health units for common cost drivers, 1% based on population growth, and 1% based on low income populations. Stabilization funding was provided in the 2008 transition year to ensure that no public health unit received less than a 5% increase.

In 2010, as part of a government-wide commitment to reduce expenditures, the growth funding for mandatory programs was reduced. In 2010 and 2011, the Ministry allocated a 3% across-the-board increase to all public health units, or less if requested, over the prior year's Ministry approved allocation. In 2012 and 2013, the Ministry allocated a 2% across-the-board increase to all public health units, or less if requested.

The 2013 per capita funding for mandatory programs ranged from \$29.83 to \$83.97 – a 2.8 fold difference. In addition, approximately 50% of public health units are now reporting that obligated municipalities are contributing more than 25% of the mandatory programs funding.

Appendix 1 provides a graph of provincial funding to public health units for mandatory programs from 1995 to 2013.

Appendix 2 provides the 2013 per capita funding for public health units for mandatory programs.

1.3 Historical Funding for Unorganized Territories

Until the late 1970s, the Northern Ontario Public Health Services (provincially funded at 100%) provided public health services to individuals in unorganized northern territories. In 1983, section 6 of Ontario Regulation 382/84 under the HPPA made provision for the Minister to provide grants (100% of board of health approved costs) to a public health unit that has an unorganized territory within its area. About that time, the Ministry began transferring responsibility for these services to public health units (District of Algoma, Muskoka-Parry Sound, North Bay District, Northwestern, Porcupine, Renfrew County & District, Sudbury & District, Thunder Bay, and Timiskaming).

Initial base budgets for unorganized territories were negotiated public health unit by public health unit and the methodology for calculating the grant varied. This ad hoc approach to calculating grants resulted in wide variances in funding among public health units delivering services to unorganized territories. Once a base amount was established for each public health unit, funding was increased by inflationary adjustments until 1991 when the provincial base funding totalled \$2.9 million. In 1991/92, funding for unorganized territories was essentially flat-lined for most public health units.

In 2001, a stakeholder committee, the Funding Allocation Formula Working Group, was established to determine a methodology for allocating provincial grants to public health units for the delivery of

mandatory programs in both organized and unorganized areas. Several broad based funding models for unorganized territories were proposed, including:

1. Increase unorganized territories funding levels by the same percentage amount that organized area budgets had increased from 1991 to 2001.
2. Set the per capita grant for unorganized territories equal to the per-capita rate for organized areas.
3. Set the unorganized territories grant as per the per-capita rate of the organized area plus 20%.
4. Poll representatives from each of the public health units and ask them what they required to adequately provide services to their unorganized territory.

While options were developed and recommendations were proposed, none were implemented.

By 2003, total funding had increased to \$3.3 million, a cumulative increase of 11% or approximately 1% per year. In 2004, the Ministry recognized the need for additional funding for unorganized territories and from 2004 to 2007 provided an annual increase of 5% for these services.

While funding for unorganized territories increased by 5% annually between 2004 and 2007, some northern public health units continued to maintain that the amount of provincial funding provided for unorganized territories did not cover the true cost of the programs delivered in those territories. In an effort to address this concern, in 2008, the eight (8) public health units receiving funding for unorganized territories were asked to identify as part of their annual budget submission actual staffing costs and other expenditures relating to providing services in unorganized territories. In total, these 8 public health units requested a total of \$7.9 million, an increase of 99% over the 2007 Ministry approved allocation.

It was difficult for the Ministry to make comparisons or conduct a detailed analysis as data and methodologies used to calculate the amount needed for service provision in unorganized territories varied with each public health unit. As a funding approach could not be developed from the data, the Ministry committed to conducting a review of the funding provided for unorganized territories.

In the interim, a 15% across-the-board increase was allocated in 2008 in an effort to recognize the increased costs associated with the delivery of services in remote areas. In each of 2009, 2010, and 2011, funding for unorganized territories increased by 5%, exceeding the increase provided for mandatory programs in 2010 and 2011. In 2012 and 2013, funding for unorganized territories increased by 2% consistent with the growth approved for mandatory programs.

Appendix 3 provides a table of provincial funding to public health units for unorganized territories from 1991 to 2013.

2.0 Public Health Funding Review

2.1 Need For a Funding Review

A number of recommendations, reports and other factors have informed the Ministry's decision to initiate a review of the way provincial funding is provided to public health units.

Over the past few years, the Ministry has faced increased scrutiny and accountability requirements in the provision of transfer payments to health sector organizations such as public health units. Most recently the government introduced Ontario's Action Plan for Health Care, which includes a vision to make Ontario the healthiest place in North America to grow up and grow old. The Ministry aims to accomplish this by getting better value for its health care dollars.

Health System Funding Reform is moving Ontario's health care system away from a global funding system towards what is known as Patient-Based Funding. Under this reform, health care organizations are compensated based on how many patients they look after, the services they deliver, the evidence-based quality of those services, and the specific needs of the broader population they serve. Several other Ministries have used funding formulas for some time (e.g., Education), or have recently introduced them (e.g., child care, children's mental health). Patient-based funding is inappropriate for a public health system focused primarily on population health. However, there is an opportunity to align provincial public health funding with the principles that underline this reform, particularly the alignment of funding to reflect the needs of the population of each public health unit.

Public health is one of the few areas where the distribution of provincial funding is not governed by a formula. As a result, the Ministry cannot explain or justify the variation in per capita funding levels between public health units. The Ministry also often receives letters from boards of health, public health units, and other stakeholders (e.g., municipalities) requesting changes to the funding methodology and increased allocations for mandatory programs.

In January 2005, the Ministry announced the creation of the Local Public Health Capacity Review Committee to oversee a review of local public health capacity and to provide guidance and advice to the Ontario Government with respect to the optimal configuration of the delivery of public health programs and services by local public health units. The Final Report of the Capacity Review Committee was transmitted to the Ministry in May 2006 and contained several recommendations for substantial transformation of the current system, including funding. The Capacity Review Committee recommended that the Ministry establish a collaborative process with municipalities, boards of health, public health professionals and academic partners to continue to refine the budgetary allocation mechanism, to achieve greater equity in public health system funding over time.

In addition, two (2) Provincial Auditor Reports (1997 and 2003) recommended that public health funding be allocated more equitably and that the Ministry should use indicators reflecting service costs and relative health needs of communities. In 1997, the Office of the Provincial Auditor of Ontario noted that "in many cases the variations (in funding) appear to be based solely on historical patterns" and recommended that, "to ensure that funding for all mandatory public health programs is allocated

equitably, the Ministry should expand the use of indicators of service costs and of the relative health needs of communities.” In 2003, the Office of the Provincial Auditor of Ontario expanded on its 1997 Report stating that “to help meet its objective for Public Health Activity, the Ministry should ensure that individuals with similar needs and risks receive a similar level of service regardless of where in the province they live.”

Two previous funding reviews have been conducted since the mid-nineties. These reviews met with limited success in achieving a more equitable approach to public health funding.

The finite resources available from provincial sources should be allocated among the public health units so as to produce the maximum benefit for Ontarians. The most practical approximation of this would be an allocation based upon relative need so that all residents of Ontario with similar needs receive the same level of services. Lastly, there is an imperative to be able to explain to the Legislature and to the public the basis upon which public funds are distributed.

2.2 Approach and Objectives

In 2009/10, the Ministry initiated a process to review provincial funding provided to public health units in an effort to ensure a fair, transparent, and consistent method of funding. The funding review is examining the funding for the delivery of **mandatory programs** in organized and unorganized areas. Funding for other related programs and services, such as the Healthy Smiles Ontario Program, Infectious Diseases Control Initiative, and other nursing initiatives were not included as part of the review as they were already based on explicit funding criteria and/or formulas.

The objectives of the review are to develop a needs-based approach to public health funding, improve funding responsiveness to service needs through the inclusion of equity and population adjustment factors, and reduce funding inequities among public health units over time. The review is not intended to affect the current provincial/municipal cost-sharing formula of 75%/25%, and concerns provincial funding only.

In April 2010, the Funding Review Working Group was struck with a mandate to investigate the current status of public health funding, provide advice to the Ministry on a future public health funding model, and advise the Ministry on implementation principles. Specifically, the Funding Review Working Group was responsible for:

- Reviewing and determining the factors to be used in developing the funding model.
- Providing advice and recommending a model for the allocation of provincial transfer payments to public health units for the provision of mandatory programs in both organized and unorganized territories.
- Providing input into the method of conducting field consultation and determining which model(s) to present for consultation.
- Reviewing the comments of stakeholders following the consultation process.

- Reviewing the draft report.
- Providing advice with respect to the evaluation process of any implemented funding model.

Membership consisted of representatives from boards of health, public health unit staff (medical officers of health, associate medical officers of health, executive directors, business administrators and program staff), alPHA, and AMO.

2.3 Funding Assumptions Underlying the Review

The public health funding review took place during a fiscally challenging time. When the Funding Review Working Group was established, its Terms of Reference recognized that no new significant funding would be available to implement a new funding model, and that any funding adjustments would be implemented on an incremental basis, using any future increases to the overall provincial funding envelope.

Since this time, overall growth for mandatory programs was reduced from 5% in 2009 to 2% in 2013. Accordingly, the Funding Review Working Group was informed by the Ministry that application of a new funding model using only incremental funding may no longer be possible given the current fiscal environment. Regardless, the Funding Review Working Group believed it was important to finalize the work of the funding review in an effort to address funding inequities and to align public health funding with the Health System Funding Reform.

Appendix 4 provides the original Terms of Reference for the Funding Review Working Group. It is important to note that the Terms of Reference were not updated throughout the process of developing the model; however, revisions to the timelines and changes to membership were discussed with the Funding Review Working Group throughout the process.

3.0 Public Health Funding Model

3.1 Development of the Model

A great deal of research, analysis, and thoughtful discussion took place over almost three (3) years to develop the funding model recommended in this report.

Since April 2010, the Funding Review Working Group has held 14 meetings, the majority of which took place in person. Members agreed that decisions would be made by consensus with any disagreements noted in the minutes and Final Report. Members were advised by the Ministry that deliberations and discussions of the Funding Review Working Group were confidential - confidentiality agreements were signed by each of the members. For this reason, no substitutes were allowed in situations where members were unavailable to attend a meeting. It was noted that the timelines at the outset of the working group were aggressive and might change as the process continued (this was ultimately the case).

The Funding Review Working Group reviewed and analyzed historical and current funding levels, sources of funding, current expenses, and cost pressures of public health units. This review found that during the past 15 years, each board of health made decisions and choices based upon its local environment; these choices affected public health unit budgets and public health services delivered in the community, thereby contributing to the disparities in funding. There were many variables affecting local decisions including: increased service demands due to population growth and/or health status; a shortage of health care professionals (e.g., physicians, nurses, etc.); municipal government support and priorities; public health unit capacity; and/or other socio-economic and environmental factors.

To assist with the public health allocation model development, the Funding Review Working Group reviewed the findings of the prior funding reviews conducted since the mid-nineties. The 1996 and 2001 funding reviews looked at a two (2) and three (3) component funding formula respectively. Base funding to support public health unit infrastructure/administration was included in the 2001 review; both reviews included an adjustment for service cost variables (e.g., geographic dispersion to reflect costs of travel/multiple offices, home language to reflect costs of serving multicultural populations) and equity factors such as socio-economic determinants of health (e.g., education, low income), population health status (e.g., premature deaths), and health behaviors (e.g., smoking, physical inactivity, obesity, heavy drinking).

A review of academic literature and an inter-jurisdictional survey of public health allocation methods and methodologies were also conducted. In 2009, a comprehensive literature review revealed very little on funding approaches related specifically to public health. Instead, research findings related primarily to general allocation methods and methodologies. The only literature deemed relevant to public health funding model development was a paper published by the Department of Health, United Kingdom, Resource Allocation: Weighted Capitation Formula. Three (3) provinces (Alberta, Manitoba, and Nova Scotia) provided information about their public health funding methodologies and processes.

Key findings were the presence of largely regionalized approaches, in which the government allocated funds to local authorities. Only a few allocation models dealt exclusively with public health funding. In addition, several jurisdictions made adjustments for social equity factors (e.g., socio-economic status).

Two sub-committees, accountable to the Funding Review Working Group, were established over the course of the review; an Unorganized Territories Sub-Committee and an Infrastructure Sub-Committee.

The Unorganized Territories Sub-Committee was convened to make recommendations to the Funding Review Working Group regarding the potential adaptation of the funding model for the funding of unorganized areas. This sub-committee was composed of representatives from the eight (8) public health units that deliver public health programs and services for unorganized territories.

The Infrastructure Sub-Committee was convened to make recommendations to the Funding Review Working Group respecting public health infrastructure costs and their potential inclusion in the funding model. This sub-committee examined other funding models; reviewed and analyzed infrastructure costs of public health units, including variable and non-variable costs; and, discussed options related to incorporating infrastructure costs as a separate component.

Appendix 5 provides the membership of both sub-committees.

Field input sessions were led by members of the Funding Review Working Group on January 14, 2013 with public health unit Medical Officers of Health and Chief Executive Officers, and again on January 16, 2013 with public health unit business administrators. The purpose of the field input sessions was to seek input on the proposed elements of the public health funding model. The sessions were well attended and a total of 28 public health units and the Council of Ontario Medical Officers of Health provided feedback during the sessions, in writing, or both.

3.2 Characteristics and Criteria

After reviewing the objectives of the current and prior funding reviews, the Funding Review Working Group agreed that the funding model must be based on the following characteristics:

- **Equitable:** Funding model must increase equity in funding among public health units over time.
- **Transparent:** Model must be simple to administer and communicate to the field.
- **Stable:** Model must allow for multi-year planning.
- **Needs-Based:** Model must reflect needs based on provider and community characteristics.
- **Evidence-Based:** Model must be based on measurable demand for and the cost of providing public health services.

Based on these characteristics, the Funding Review Working Group determined that the funding model indicators must also meet certain criteria to be included in the model. The indicators should be:

- Resistant to manipulation (to avoid “gaming” by interested parties);

- Reliable (reproducible over time);
- Largely independent of each other to avoid double counting unless there is a specific rationale to do so;
- Based on available data with proxy validity when direct measurement of a variable is not possible;
- Easily explained; and,
- Unlikely to change over time. (i.e., consistently measured with any change reflective of changes in measured variable only).

3.3 Structure of the Model

The Funding Review Working Group considered the means by which changes to the funding of public health units might be affected. One option, for example, used by Nova Scotia, would be to develop a formula which would be applied to the amount of additional funding only, to guide its distribution. Although this may work well when there is a specific amount of additional funding immediately available, it would be difficult to maintain this system over time. It also does little to address the equity of base funding, and thus lacks transparency. The Funding Review Working Group rejected this approach in favour of one which applies a formula or “model” (based upon relative need) for each public health unit within the mandatory programs provincial funding envelope/budget. The result is expressed as a “share” (percentage) of the funding for each public health unit.

The intent is for funding to be adjusted over time (see section 4.0 Implementation) so as to move all public health units towards their model share. The model share may be easily converted to the amount of the public health unit grant by multiplying the proportion of the share by the total provincial funding for mandatory programs.

3.4 Components of the Model

The Funding Review Working Group is recommending an equity-adjusted population model, meaning that funding is based on population size adjusted for equity factors.

The Funding Review Working Group investigated three (3) possible components to be included in the funding model as described below: population, infrastructure/administration, and equity.

3.4.1 Population

The Funding Review Working Group considered the inclusion of population as a separate component in the funding model. A population component would allocate funding to each public health unit in direct proportion to its population size. Following much discussion, it was determined that population would not be included as a stand-alone component in the funding model.

The Working Group determined that the optimal approach is to use population as the basis for the model, but only after the population number has been modified by the application of “equity-adjustment factors” to produce an “equity-adjusted population”.

3.4.2 Infrastructure/Administration

The Funding Review Working Group also extensively considered the inclusion of infrastructure/administration as a separate component in the funding model.

Infrastructure/administration costs were defined as those costs associated with the organizational functions of each public health unit. Organizational infrastructure costs, while necessary, are generally not viewed as contributing directly to service delivery. It is not uncommon for funding models to include a separate infrastructure/administration component as the perception is that it provides some assurance of stability for the organization.

Funding Review Working Group members were unable to come to a consensus on the inclusion of infrastructure/administration costs as a separate component in the funding model. Accordingly, an Infrastructure Sub-Committee was established to develop recommendations to the Funding Review Working Group respecting infrastructure/administration costs.

The Infrastructure Sub-Committee met on December 8, 2010 to consider whether or not infrastructure/administration costs should be included as a separate component in the funding model and make recommendations to the Funding Review Working Group regarding the inclusion of infrastructure/administration in the funding model. The Sub-Committee examined other funding models, reviewed and analyzed infrastructure/administration costs of public health units, including variable and non-variable costs, reviewed the factors that affect infrastructure/administration costs, and discussed the reasons for incorporating infrastructure/administration costs as a separate component.

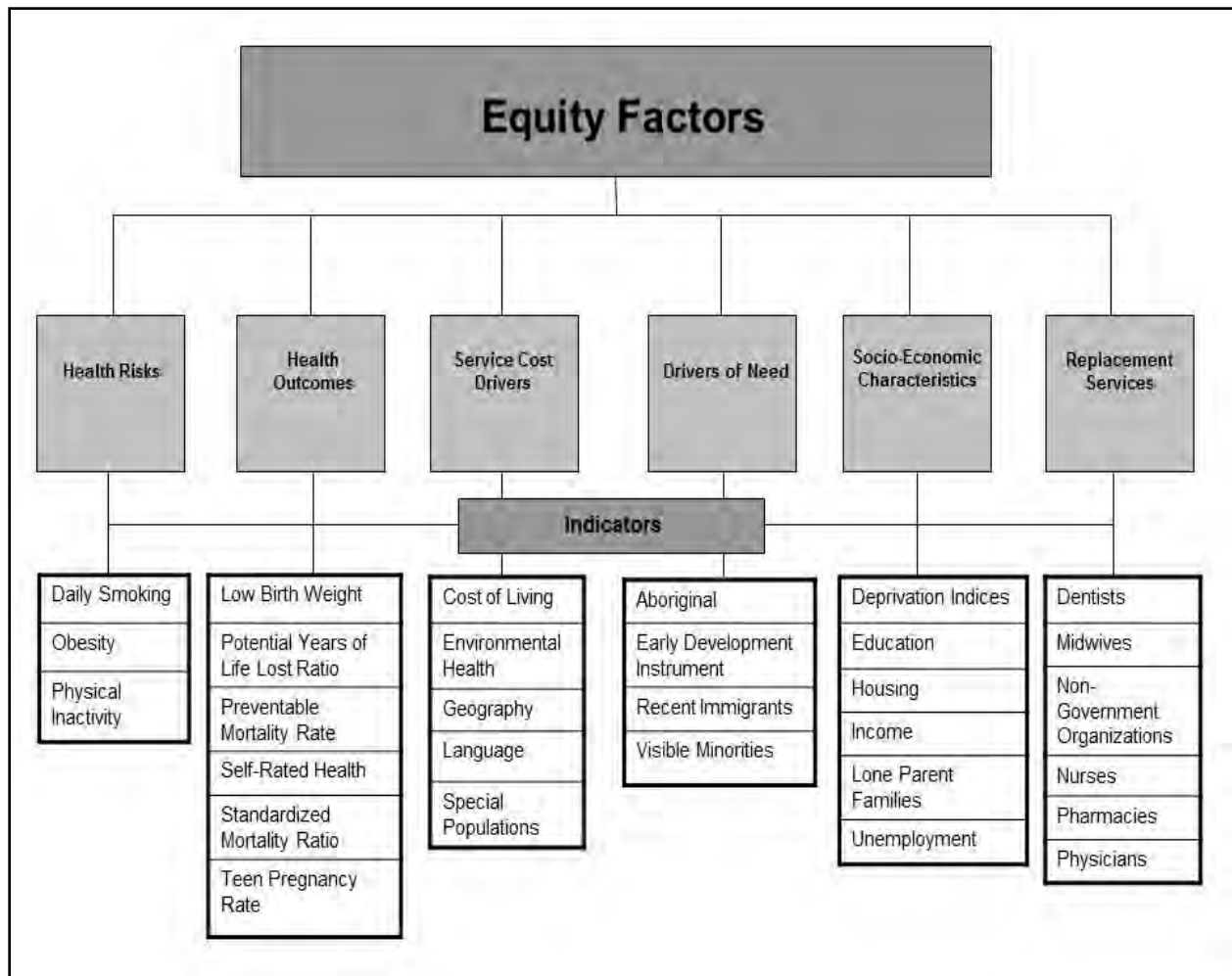
The review noted that, at a provincial level, the average per cent of funding spent by all public health units on infrastructure/administration costs between 2007 and 2009 was consistent at approximately 21%. When the information was viewed on a public health unit by public health unit basis, the percentage of total expenditures spent on infrastructure/administration costs had a significant but fairly consistent range in each of the three (3) years; 11.3% to 29.9% in 2007; 11.8% to 30.4% in 2008; and 11.7% to 33.4% in 2009. The proportion and the dollar per capita spent on infrastructure/administration costs generally tended to decrease as the population increased up to 1 million. The 23 public health units with smaller populations (less than 200,000) spent a higher percentage on infrastructure/administration costs than their larger counterparts.

Upon further examination, it was determined that the key factor affecting infrastructure/administration was geography which is included in the funding model as a service cost driver. Other costs, such as those associated with board of health governance costs, were found to be relatively consistent across all public health units. Based on this, it was determined that infrastructure/administration would not be included as a separate model component.

3.5 Equity Factors Considered

The Funding Review Working Group considered six (6) groups of equity factors and associated indicators as shown below.

Equity Factors Considered



The Funding Review Working Group reviewed each of the above potential indicators against the characteristics and criteria that had been established for the public health funding model (see Section 3.2). In many cases, data was not available at the public health unit level (e.g., Cost of Living) and therefore could not be included or a proxy indicator was selected in its place.

Appendix 6 provides a list of indicators considered but not included, their descriptions, and the rationale for non-inclusion.

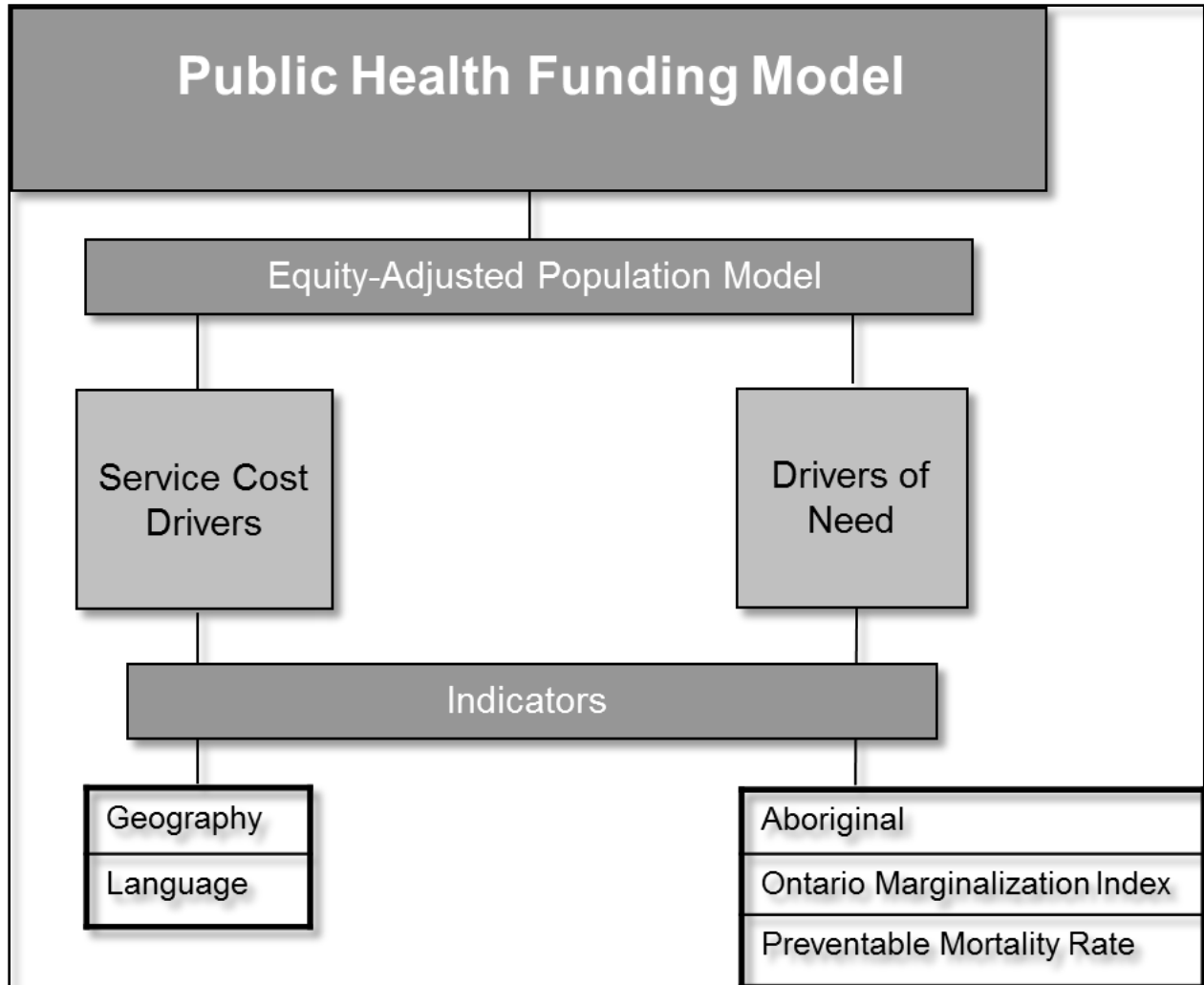
3.6 Recommended Model

The Funding Review Working Group determined that an “upstream” approach focusing on socio-economic determinants of health, rather than the “downstream” health outcomes (e.g., low birth weight), would be used in the development of the funding model. Disease incidence and prevalence indicators, which are available, are limited in range and quality; data on risk factors rely very heavily on self-reported population surveys. The problem of mortality data, which are available and of reasonable quality, lies in their relevance. The reduction of mortality is not the best measure of the impact of public

health programs. Most of the funding for public health is spent on programs (e.g., family health, environmental health, oral health, communicable disease control) which are only weakly related to mortality. Nevertheless, in order to provide a balanced model, a health status indicator (preventable mortality rate) was incorporated in the model.

The resulting model has two (2) groups of equity factors (and associated indicators) as follows:

1. **Service Cost Drivers** that reflect the variable cost of delivering public health services. **Geography** and **Language** are recommended to reflect service cost drivers.
2. **Drivers of Need** that address demand and reflect the utilization of public health services. **Aboriginal, ON-Marg,** and **Preventable Mortality Rate** are recommended to reflect drivers of need. It is important to note that ON-Marg contains four (4) dimensions (i.e. Residential Instability, Material Deprivation, Dependency, and Ethnic Concentration), which are used in the model to reflect the socio-economic determinants of health.



It is also recommended that the funding model be adopted for unorganized territories. The funding model components and indicators address the significant factors affecting demand/utilization and service delivery in the north and key issues identified for unorganized territories funding.

3.6.1 Service Cost Drivers: Geography

A measure of geography is recommended for inclusion in the funding model as geographic characteristics affect costs related to delivering public health programs and services (e.g., transportation costs, travel time).

Consistent with the 1996 and 2001 funding models/reviews, the **Adapted Concentric Circle Model** was chosen to represent these costs. This model takes the population in a defined area (census subdivision (CSD) or dissemination area (DA)) and weights it according to how far it is from the largest office of the public health unit (the site with the greatest number of staff). This definition was chosen as it provided

the best data available to represent where the most staff would be travelling from to deliver programs and services.

Appendix 7 provides the largest office for each public health unit.

A high value would indicate that a public health unit has a substantial proportion of its population living far away from the largest public health unit office. This would represent additional cost pressures associated with providing services due to travel time and transportation costs.

The distance between a public health unit's largest office and the population served is determined using census boundaries and Geographic Information System (GIS) software. It is calculated as the straight-line distance between the largest public health unit office and the centroid of the CSD or DA. Then the population in the CSD or DA is weighted according to how far it is from the head office according to following scheme:

CSD or DA distance (KM) from largest public health unit office	Weight
0-29	1
30-59	1.2
60-89	1.4
...	...
360-389	3.4
>=390	3.6

The weighted CSD or DA population is calculated as the distance weight multiplied by the population of the CSD or DA. The weighted population of the public health unit is the sum of the weighted populations of all its CSDs or DAs. The geography score of each public health unit is calculated by dividing its weighted population by its population.

The Funding Review Working Group is recommending that the Ministry use CSD level data when calculating the Adapted Concentric Circle Model after reviewing a comparison analysis of CSD level (larger geographic areas) and DA level (smaller geographic areas) data. The result does not differ substantially between the two (2) levels of data. However, the DA level data is only available based on census population counts whereas the CSD population can be based on either census population counts or population estimates. The population estimates take into account net under-coverage from the post-censal coverage study and therefore provide a more accurate measure of population counts. **Appendix 8** provides a comparison of CSD to DA scores.

Adapted Concentric Circle Model (Geography) scores ranged from a low of 1.00 to a high of 2.01 across public health units with an average (mean) score of 1.12. **Appendix 9** provides a table of Adapted Concentric Circle Model (Geography) scores by public health unit.

Additional modifications to the methodology were considered but not adopted, as they were either unfeasible or did not add to the validity of the measure. For example, an adaptation for road density, to account for the fact that some areas are difficult to travel to, was considered. However, updated road

density data is not available. Road density is generally highly correlated with population density and thus may not adequately measure the remoteness of the population. Other Geography indicators considered but not selected included: Population per Km Road, Rural Index of Ontario, Rural and Small Community Measure, and Population Density. See **Appendix 6** for a list of indicators considered but not included, their descriptions, and the rationales for non-inclusion.

3.6.2 Service Cost Drivers: Language

Language is being recommended for inclusion in the model as language spoken can impact the costs of service delivery since certain populations may require linguistically and/or culturally adapted services. A measure of the proportion of the population whose Home Language is not English was chosen to represent these costs. This indicator was also recommended in the 1996 and 2001 funding models/reviews. Although this service cost driver is named “Language”, it is recognized that there are also costs related to cultural adaptation of materials and programs.

The proportion of population whose Home Language was not English ranged from a low of 1.4% to a high of 38.9% across public health units, with an average (mean) proportion of 10.6%. **Appendix 10** provides a table of Home Language not English values for each public health unit.

Several other ways of measuring language were reviewed, including measures of the Francophone population and the population that speaks neither English nor French. In addition, the impact of the number of different languages was considered. The Funding Review Working Group decided that the population whose Home Language is not English was the most appropriate way to represent the costs of translation and culturally specific programming at public health units.

It is recognized that there are unique obligations regarding the provision of services in French; however, the indicator is intended to reflect the costs for translation and cultural adaptation of materials and programs, which are expected to be similar regardless of language.

3.6.3 Drivers of Need: Aboriginal

A measure of Aboriginal status is being recommended for inclusion in the model to reflect the established disparity in health status between Aboriginal and non-Aboriginal populations. The Aboriginal population refers to those persons who report: identifying with at least one Aboriginal group, that is, North American Indian, Métis or Inuit, and/or being a Treaty Indian or a Registered Indian, as defined by the *Indian Act* of Canada, and/or they were members of an Indian band or First Nation (Statistics Canada, 2006 Census of Population). The known under reporting of Aboriginal populations in the Census supports the importance of using population estimates that adjust for this, for example, in the geography indicator and for the overall funding model. In addition, using the same source of data for all public health units should capture the relative impact of need in public health units related to Aboriginal population.

Aboriginal people experience the lowest health status of any identifiable population in Ontario. Indicators of lower health status include: shorter life expectancy; higher infant mortality; elevated rates of obesity; greater prevalence of chronic diseases (including diabetes and mental health and addictions); higher hospitalization rates, longer length of hospital stays, fewer visits to specialists, and, poor

outcomes regarding socio-economic determinants of health (e.g., greater burden of poverty, unemployment, and lower educational attainment). The average income for First Nations people in Ontario is \$24,000, compared to \$38,000 for non-aboriginal people (Statistics Canada, 2006 Census).

In the 2006 Canada Census, 242,495 people self-identified as Aboriginal persons in Ontario (2% of the province's total population). The majority of Ontario's Aboriginal population (estimates range from 62% to 78%) live in urban/rural areas; 72% of Métis and 57% of First Nations people are urban, primarily city dwellers. Aboriginal urban dwellers have higher labour force participation, employment rates, higher education levels and higher incomes than those Aboriginal people living on-reserve, but all rates are significantly lower than the urban non-Aboriginal population. Approximately 1 in 10 Aboriginal people (26,575) in Ontario live in the Toronto Census Metropolitan Area (CMA), representing 0.5% of the total population of the CMA. In Northern Ontario, Aboriginal people comprise about 10% of the total population.

The proportion of Aboriginal population per public health unit ranges from a low of 0.4% to a high of 32.0% with an average (mean) proportion of 4.1%. **Appendix 11** provides a table of the Aboriginal population percentage by public health unit.

Health Canada's First Nations and Inuit Health Branch (FNIHB) has a role with respect to on-reserve public health given the history and mandate of the Branch, funding and governance relationships with First Nations, and the extent of programming and expertise currently deployed for on-reserve First Nations peoples. Notwithstanding FNIHB's responsibility, the province has primary responsibility for the provision of health care services to all residents of Ontario, including First Nations people living on-and-off-reserve. Public health units are defined based on their geographic boundaries; therefore, every part of Ontario is covered by a public health unit and subject to the HPPA, including First Nation communities and reserves. The Ministry's position is that provincial funding for public health units for mandatory and related programs is for the entire population within the public health units - with the actual program and service delivery being determined between the public health units and First Nations communities. Under section 50 of the HPPA, a board of health and a band council may enter into an agreement under which: the board agrees to provide health programs and services to members of the band; the band council agrees to accept the responsibilities of a municipality within the public health unit; and, the band council may appoint a member of the band to sit on the board of health.

The Aboriginal indicator has a moderate correlation with some of the other indicators. This means that needs related to some of the issues faced by this population are addressed by other indicators, not this one. However, as these other indicators alone do not fully reflect the needs of the Aboriginal population, the Aboriginal indicator is also necessary to recognize this residual disadvantage.

3.6.4 Drivers of Need: Ontario Marginalization Index

In line with the Funding Review Working Group's decision to use an upstream approach for the development of the funding model, several deprivation and marginalization indices were considered for inclusion in the model. Relative deprivation is a comparative measure, referring to a state of disadvantage experienced by communities relative to the surrounding population. These indices are

typically divided into two (2) primary constructs – social position (e.g., marital status, family structure, number of individuals living alone, etc.) and material access (e.g., income, education, employment, etc.). **Appendix 12** provides a comparison of deprivation/marginalization indices considered.

The Funding Review Working Group was able to locate only one example of the use of deprivation indices for resource allocation purposes (Department of Health, United Kingdom, [Resource Allocation: Weighted Capitation Formula](#)). Deprivation indices have primarily been used to assess disparities between communities/populations. However, the Funding Review Working Group felt that the use of a deprivation index was an important component of an upstream-based funding model to represent costs associated with the prevention services provided by public health units to improve future health outcomes of public health unit populations.

ON-Marg was chosen by the Funding Review Working Group as it demonstrates the difference in marginalization between areas and describes the inequalities in various health and social wellbeing measures. ON-Marg is a census- and geographically-based index that can be used for planning and needs assessment, resource allocation, monitoring of inequities, and research. ON-Marg is an Ontario-specific version of the Canadian Marginalization Index (CAN-Marg, www.canmarg.ca), which has been in use since 2006.

ON-Marg is multifaceted, allowing researchers and policy and program analysts to explore multiple dimensions of marginalization in urban and rural Ontario. The four (4) dimensions are: Residential Instability, Material Deprivation, Dependency, and Ethnic Concentration.

On-Marg Deprivation Dimensions
(Ontario Marginalization Index: User Guide Version 1.0)

	Dimensions			
	Residential Instability	Material Deprivation	Dependency	Ethnic Concentration
	<ul style="list-style-type: none"> - Proportion of the population living alone - Proportion of the population who are not youth (age 16+) - Average number of persons per dwelling - Proportion of dwellings that are apartment buildings - Proportion of the population who are single / divorced / widowed - Proportion of dwellings that are not owned - Proportion of the population who moved during the past 5 years 	<ul style="list-style-type: none"> - Proportion of the population aged 20+ without a high-school diploma - Proportion of families who are lone parent families - Proportion of the population receiving government transfer payments - Proportion of the population aged 15+ who are unemployed - Proportion of the population considered low-income - Proportion of households living in dwellings that are in need of major repair 	<ul style="list-style-type: none"> - Proportion of the population who are aged 65 and older - Dependency ratio (total population 15 to 64/total population 0-14 and 65+) - Proportion of the population not participating in labour force (aged 15+) 	<ul style="list-style-type: none"> - Proportion of the population who are recent immigrants (arrived in the 5 years prior to census) - Proportion of the population who self-identify as a visible minority

The index was developed using a theoretical framework based on previous work on deprivation and marginalization. It was then empirically derived using principal components factor analysis on data from across Ontario including all geographic areas. It has been demonstrated to be stable across time periods and across different geographic areas (e.g., cities and rural areas). It has also been demonstrated to be associated with health outcomes including hypertension, depression, youth smoking, alcohol consumption, injuries, body mass index and infant birth weight.

3.6.4.1 ON-Marg Dimensions

Each of the four (4) ON-Marg dimensions can be used separately or combined into a composite index. Dimensions may be chosen by comparing correlations between each dimension and a given outcome, as a way of testing appropriateness for inclusion. Each dimension may not be related to the chosen outcome in the same direction. The Funding Review Working Group analyzed each dimension's relationship to two (2) Health Status indicators to support the choice of dimensions to be incorporated in the model. Two (2) measures of mortality, Preventable Mortality Rate and Potential Years of Life Lost Ratio, were used in the analysis. Although it is recognized that mortality rates are not an ideal measure of outcome for public health programs, the data for these indicators are available and of reasonable quality. These two (2) measures are also focused on the causes of death that are most likely to be influenced through public health activities.

There was a positive relationship with the **Residential Instability** dimension. Variables in the Residential Instability dimension include: proportion of the population living alone, proportion of the population who are not youth (age 16+), average number of persons per dwelling, proportion of dwellings that are apartment buildings, proportion of the population who are single/divorced/widowed, proportion of dwellings that are not owned, and proportion of the population who moved during the past 5 years.

There was a positive association with the **Material Deprivation** dimension. Variables in the Material Deprivation dimension include: proportion of the population age 20+ without a high-school diploma, proportion of families who are lone parent families, proportion of the population receiving government transfer payments, proportion of the population aged 15+ who are unemployed, proportion of the population considered low-income, and proportion of households living in dwellings that are in need of major repair.

There was a positive correlation with the **Dependency** dimension. Variables in the Dependency dimension include: proportion of the population who are aged 65 and older, dependency ratio (total population 15 to 64/total population 0-14 and 65+), and proportion of the population not participating in the labor force (aged 15+).

In contrast to the other dimensions, there was a negative correlation with the **Ethnic Concentration** dimension. Variables in the Ethnic Concentration dimension include: proportion of the population who are recent immigrants arrived in 5 years prior to census, and proportion of the population who self-identify as a visible minority.

The Ethnic Concentration dimension is likely correlated negatively with the mortality-based Health Status indicators used for the correlation analysis due to the 'healthy immigrant effect'. Mortality and health care utilization rates have been observed to be lower for recent immigrants as compared to Canadian-born comparison populations. However, the health advantages seen in the data diminish with time, with mortality rates among more established immigrants approaching those of the Canadian-born population. Furthermore, mortality alone is an inadequate measure of the health status and public health needs of immigrant populations, particularly with respect to a number of important conditions that may require substantial public health resources but are generally not reflected in mortality rates in Ontario. Recent immigrants have a manyfold excess of numerous infectious diseases (e.g., tuberculosis, enterics) which require intensive follow up by public health. Many immigrant groups have poor oral health and/or greatly increased risks of chronic conditions such as diabetes and cardiovascular disease. Refugee populations in particular tend to have multiple health problems and worse health status than other immigrant populations. **Appendix 13** provides a list of references regarding the healthy immigrant effect.

The Funding Review Working Group is recommending the inclusion of an indicator that represents the health needs of immigrants, and that each of the four (4) dimensions of ON-Marg be included in the model. The Funding Review Working Group is also recommending that each of the four (4) dimensions be used separately so that each can be individually weighted to reflect its impact as a public health driver of need.

3.6.4.2 ON-Marg Construction

Each ON-Marg dimension is provided in two (2) forms at the DA level (i.e., factor scores and quintiles). Factor scores are developed from the principal component analysis and represent a standardized scale with a mean of 0 and a standard deviation of 1. Quintiles are created by sorting the factor scores into five (5) groups, ranked from 1 (least marginalized) to 5 (most marginalized). Each group contains one-

fifth of the geographic units. For instance, an area with a value of 5 means it is in the most marginalized 20 percent of areas in the province.

In constructing scores of a public health unit for each ON-Marg dimension, quintile scales (1 – 5) of the dimensions were multiplied by the DA level population to obtain the weighted population. The weighted population of a public health unit was the sum of the weighted population of its all DA levels. The score of the public health unit for each dimension was calculated by dividing its weighted population by its population.

The score for Residential Instability ranged from a low of 1.80 to a high of 3.65 across public health units with an average (mean) score of 2.77. The score for Material Deprivation ranged from a low of 1.67 to a high of 3.91 across public health units with an average (mean) score of 2.89. The score for Dependency ranged from a low of 2.02 to a high of 4.31 across public health units with an average (mean) score of 3.23. The score for Ethnic Concentration ranged from a low of 1.54 to a high of 4.63 across public health units with an average (mean) score of 2.63. **Appendix 14** provides a table of scores for each ON-Marg dimension by public health unit.

3.6.5 Drivers of Need: Preventable Mortality Rate

The Funding Review Working Group considered many health status indicators for inclusion in the model. In keeping with the decision to develop a funding model using an upstream approach focusing on socio-economic determinants of health rather than on health outcomes, the majority of indicators recommended for the model are drivers of need. However, it was also recognized that certain aspects of need not fully captured by these other indicators could be incorporated by including a health status indicator. Health status indicators considered by the Funding Review Working Group include: Obesity, Daily Smoking, Physical Inactivity, Self-Rated Health, Low Birth Weight, Potential Years of Life Lost Ratio, Standardized Mortality Ratio, and Preventable Mortality Rate.

Most of the funding for public health is spent on programs only weakly related to mortality, and where better measures of outcome might include disease incidence and prevalence indicators, or data on risk factors. However, there are significant limitations in the range, quality and availability of risk factor and morbidity data. Therefore, although risk factor and morbidity rates most appropriately reflect issues related to the mandate of public health, the Funding Review Working Group does not recommend the inclusion of any health status indicators based on morbidity or risk factor data in the model.

The Funding Review Working Group conducted an analysis of the correlations of two (2) mortality-based health status indicators with the other indicators recommended for the model. This analysis was intended to determine if the need for prevention programs or services that could potentially reduce premature mortality were already represented by other indicators of the funding model. A high correlation would indicate that health status was already represented in the model. Conversely, a low correlation would indicate that health status was not already represented in the model by one of the other indicators.

The health status indicators analyzed were: (1) Preventable Mortality Rate (under age 75) which is defined as premature mortality per number of population from preventable causes that could be

potentially avoided through primary prevention efforts; and, (2) Potential Years of Life Lost Ratio (under age 75) which is defined as potential years of life lost per number of population from premature mortality due to a particular cause that could be potentially prevented. Both health status indicators measure the relative impact of preventable diseases and lethal forces on population.

There was a very high correlation between the two (2) health status indicators which indicated that they represented similar aspects of health. Both indicators were moderately positively correlated with Geography which indicated that the higher the proportion of a population living at a distance from the main public health unit office in their area the greater the likelihood that they would have a lower health status. The Preventable Mortality Rate was moderately positively correlated with the Aboriginal indicator while the Potential Years of Life Lost Ratio had a high positive correlation with the Aboriginal indicator. This reflects the fact that the Aboriginal population experiences more potential years of life lost and lower health status than the non-Aboriginal population.

The Preventable Mortality Rate and the Potential Years of Life Lost Ratio were the same indicators used in considering the four (4) dimensions of ON-Marg for inclusion in the model. Both were moderately positively correlated with the Deprivation dimension of ON-Marg which indicated that a higher degree of material deprivation is likely related to lower health status. Both were moderately positively correlated with the Dependency dimension, reflecting that higher dependency is a relative factor that contributes to lower health status. Finally, both were moderately negatively correlated with Ethnic Concentration which indicated that higher ethnically concentrated populations tend to have lower mortality rates.

Appendix 15 provides a table of funding model indicator to health status indicator correlations.

The Funding Review Working Group recommends the inclusion of the Preventable Mortality Rate in the model to reflect unrecognized aspects (i.e., not included in the other model indicators) of the health profile of public health unit populations and the services they provide. The Preventable Mortality Rate was considered the most appropriate proxy indicator of health status for the purposes of the funding model.

The Preventable Mortality Rate (per 100,000 population) ranged from a low of 62.9 to a high of 192.1 across public health units with an average (mean) rate of 125.7. **Appendix 16** provides a table of Preventable Mortality Rates by public health unit.

3.7 Model Construction

The public health funding model was constructed with the intention of identifying an appropriate funding share for each public health unit that reflects its needs in relation to all other public health units.

There are a number of steps that were undertaken to calculate each public health unit's equity-adjusted funding share.

3.7.1 Scaling

The actual values of each indicator need to be scaled to a common range in order to allow them to be combined. After consideration of options of a scale of 1-2, 1-4, and 1-8, the Funding Review Working Group recommends a scale of 1-8, meaning that the lowest possible value for each indicator will be one (1), and the highest possible value will be eight (8). This approach was felt to provide the best recognition of the base needs for a public health unit and reflection of the difference in resource intensity between the public health units with the lowest and highest need.

The first step in this scaling is to establish theoretical maximums of indicator values. These theoretical maximums are considered as the “highest achievable” values, and are assigned a value of eight (8). The theoretical maximums are determined by “stretching” the highest current value of each indicator by 15% to recognize that there will be changes to the highest values over time and thus allows for increases in them while providing consistency and stability to the calculations over time by avoiding the need to change the highest values annually.

The next step is to transform the raw indicator values to the 1-8 scale. This is done by determining the exponent required to transform the theoretical maximum to a value of 8. The raw value of the indicator for each public health unit is then exponentiated with the indicator exponent to provide an indicator value between 1 and 8.

Example:

1. The raw value range of Language is from 1% to 38%. The theoretical maximum is 44% ($38\% \times 1.15$).
2. The exponent required to transform 44% to a scaling unit of 8 is 5.63, i.e. $[(1+44\%)^{5.63}=8]$.
3. The scaled value of Language for each public health unit is therefore calculated using the formula $(1+xi)^{5.63}$, where xi is the raw value of Language (%) of the public health unit (i).

3.7.2 Weighting

Percentage weights are then assigned to each indicator based on relative valuing. If a certain indicator is felt to account for a higher degree of need/cost, it is assigned a higher weight.

Very little research was available on funding model development for the public health sector. As such, Funding Review Working Group members relied on their public health expertise and judgment when considering recommendations for the weighting of each indicator. Through a scenario analysis tool, which included the interaction between weight and scale, a variety of weighting scenarios were considered by the Funding Review Working Group.

The Funding Review Working Group recommends the following weights for the funding model for mandatory programs.

Mandatory Programs Indicators Weighting	
Service Cost Drivers (35%)	Weight
Geography	25%
Language	10%
Drivers of Need (65%)	Weight
Aboriginal	12.5%
ON-Marg Dependency	10%
ON-Marg Ethnic Concentration	10%
ON-Marg Material Deprivation	15%
ON-Marg Residential Instability	7.5%
Preventable Mortality	10%
Total	100%

The Funding Review Working Group recommends the following weights, based on recommendations from the Unorganized Territories Sub-Committee recommendations, for the unorganized territories funding model so that it reflects the differences in demands and cost of service delivery in remote areas.

Unorganized Territories Indicators Weighting	
Service Cost Drivers (45%)	Weight
Geography	35%
Language	10%
Drivers of Need (55%)	Weight
Aboriginal	20%
ON-Marg Dependency	5%
ON-Marg Ethnic Concentration	5%
ON-Marg Material Deprivation	10%
ON-Marg Residential Instability	5%
Preventable Mortality	10%
Total	100%

It is important to note that the indicator weights in the funding model do not translate or equate to a percentage of total public health unit funding (e.g., a relative weighting of 10% for Language \neq 10% of public health mandatory program funding to be allocated based on the value of this indicator). Rather, the weighting of an indicator is only used to determine the EAF.

3.7.3 Calculating the EAF (Equity Adjustment Factor)

An EAF summarizes each public health unit's relative position in the provincial distribution. Indicators are combined (added) to create a unique EAF for each public health unit.

Two (2) possible approaches were considered – additive or multiplicative. In the additive approach (e.g., used in the Nova Scotia formula) each scaled indicator is multiplied by a weight, then all the indicators are added together to create an index. In the multiplicative approach (e.g., used in the 1996 and 2001 formulas) the scaled indicators are multiplied by one another to create an index. Under the multiplicative approach, extreme values have more influence on the formula. Under the additive

approach, there is more explicit control over how much a particular indicator contributes to the index. Therefore, the Funding Review Working Group recommends the model employ the additive approach to combining the indicators.

Note: EAF scores, models share values and variances between current public health unit share and funding model share, reviewed by the Funding Review Working Group were anonymized by the Secretariat. This allowed working group members to make recommendations on a system level in a fair and unbiased way.

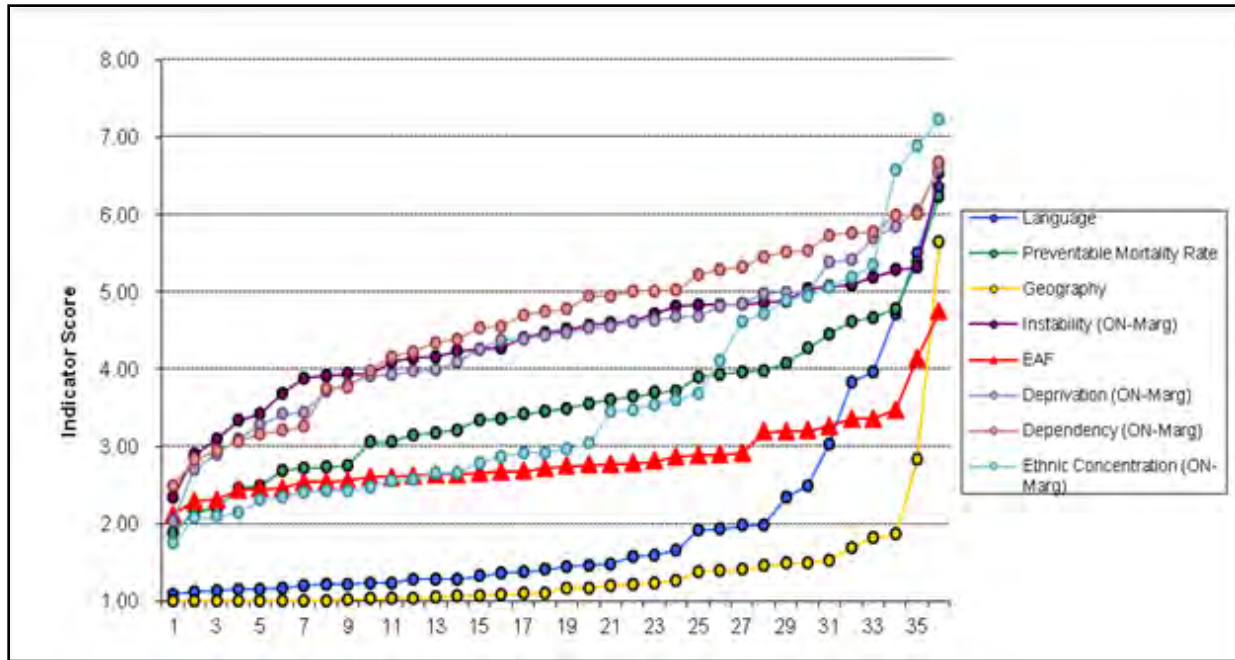
These scores, values, and variances are also presented here anonymously although the Ministry has indicated it may share this information, identified by public health unit, when consulting on implementation methods with the public health sector.

EAF for public health unit #1 (Mandatory Programs)	=	[0.25*Geography] + [0.10*Language] + [0.125* Aboriginal] + [0.075*Residential Stability] + [0.15*Material Deprivation] + [0.10*Ethnic Concentration] + [0.10*Dependency] + [0.10*Preventable Mortality]
EAF for public health unit #1 (Unorganized Territories)	=	[0.35*Geography] + [0.10*Language] + [0.20 Aboriginal] + [0.05*Residential Stability] + [0.10*Material Deprivation] + [0.05*Ethnic Concentration] + [0.05*Dependency] + [0.10*Preventable Mortality]

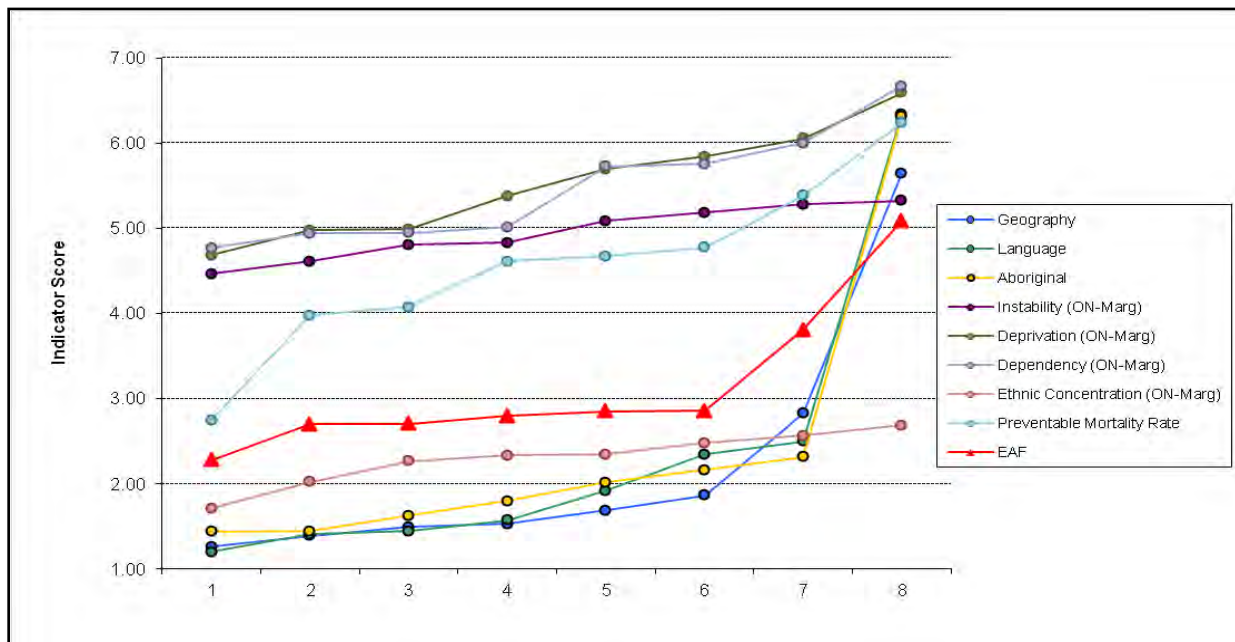
The EAF scores for mandatory programs ranged from 2.14-low to 4.75-high with an average (mean) score of 2.88. The EAF scores for unorganized territories ranged from 2.28-low to 5.09-high with an average (mean) score of 3.14

Appendix 17 provides a table of EAF scores by public health unit (anonymized).

Indicator & EAF Scores for Mandatory Program



Indicator & EAF Scores for Unorganized Territories



Note: Each indicator and EAF was sorted independently (i.e. no single public health unit received the highest or lowest score for all indicators).

3.7.4 Population

The Funding Review Working Group recommends that the most recent Statistics Canada Population Estimates be used for the purposes of the funding model for both mandatory programs and unorganized territories funding as these statistics represent populations in both organized and unorganized areas. Population statistics will be updated annually in order to acknowledge the high growth experienced in certain regions. **Appendix 18** provides a table of population estimates (2011) by public health unit.

Statistics Canada Estimates were deemed to provide the most accurate Aboriginal population numbers as Statistics Canada Post-Censal Estimates include adjustments for incompletely enumerated First Nation Reserves.

It is also recommended that the population data used for the unorganized territories funding model calculations only reflect Statistics Canada Population Estimates for unorganized territories. Any reserves/settlements contained within the boundaries of the unorganized territory will be included in this population count.

The Funding Review Working Group extensively reviewed the possibility for the inclusion of special populations (e.g., corrections, students, seasonal, migrant workers, homeless, commuters, etc.) not captured by the Statistics Canada Population Estimates. However, what few data were available on these populations were not captured consistently across all public health units. Therefore, there are no adjustments included in the model to account for these factors. Correctional facility populations are included in the Statistics Canada census if they have resided in the facility for longer than 6 months. Students who return home to live with their parents during the summer are enumerated at their parents' place of residence.

Ministry of Finance population statistics projections were considered for inclusion in the model, however, it was determined that, due to several issues that would require adjustment to the data (e.g., geographic boundary differences), Statistics Canada's most recent population estimates should be used.

Concerns have been expressed by both the field and more broadly (e.g., in the media) regarding changes to the Census data collection process. In 2011, the federal government announced that the long-form questionnaire would no longer be mandatory and introduced the voluntary National Household Survey. Critics of the change have expressed concerns that the data collected would be less accurate and results skewed as some population groups may be less likely to respond than others. The Funding Review Working Group recommends that the government consider how changes to the Census data collection process will affect the funding model put forward in this report and pursue the most appropriate and accurate data sources, if they become available, in its implementation.

3.7.5 Calculating Model Shares

Each public health unit's equity-adjusted population is computed by multiplying its EAF by its population.

Equity-Adjusted Population (Mandatory Programs)	=	(EAF for public health unit _{#1}) x (Population for public health unit _{#1})
Equity-Adjusted Population (Unorganized Territories)	=	(EAF for public health unit _{#1}) x (UT Population for public health unit _{#1})

To determine a public health unit's proportional share of the equity-adjusted population, its equity-adjusted population is divided by the total weighted population for all public health units.

Proportional Share for public health unit _{#1} (Mandatory Programs)	=	$\frac{\text{Equity-Adjusted Population for public health unit}_{\#1}}{\text{Sum of Equity-Adjusted Populations for all 36 public health units}}$
Proportional Share for public health unit _{#1} (Unorganized Territories)	=	$\frac{\text{Equity-Adjusted Population for public health unit}_{\#1}}{\text{Sum of Equity-Adjusted UT Populations for all 8 public health units}}$

The model shares for mandatory programs ranged from a low of 0.32% to a high of 24.66% with an average (mean) share of 2.78%. The model shares for unorganized territories ranged from a low of 0.07% to a high of 49.84% with an average (mean) share of 12.5%. **Appendix 19** provides a table of all calculated model shares (anonymized).

In comparison, the 2013 actual allocated share for mandatory programs ranged from a low of 0.52% to a high of 22.39% with an average (mean) share of 2.78%. The 2013 actual allocated share for unorganized territories ranged from a low of 0.93% to a high of 32.69% with an average (mean) share of 12.5%.

Appendix 20 provides a comparison of 2013 shares to model calculated shares (anonymized).

4.0 Implementation

Throughout the development of the funding model, the Funding Review Working Group was cognizant of the fact that the funding model's implementation would ultimately be a government policy decision dependent on available funding and approvals. The Funding Review Working Group understood that the model must be cost neutral and/or within the Ministry's approved funding allocation.

In its simplest application, the amount of provincial public health funding available could be divided based strictly on the calculated model share for each public health unit. However, the Funding Review Working Group does not recommend this approach as resulting changes to funding levels would have a significant impact on public health units that would either benefit from (i.e., receive an increase in funding) or be disadvantaged (i.e., receive a decrease in funding) as a result of this method of application.

The Funding Review Working Group is, therefore, recommending that the Province use the following implementation principles when developing its method for implementing the above recommended funding model:

- The timing to reach equity/model-based share must be balanced with maintaining system stability but should not further exacerbate current funding disparities.
- The Ministry should use incremental funding to the greatest extent possible in the application of the new funding model in order to minimize the disruption to existing service provision.
- Public health units should be provided with sufficient notice regarding the implementation of the funding model for planning purposes. A transition period (e.g., at least 3 years) is necessary to implement changes to funding. The Ministry should work with boards of health and public health units to mitigate the impact on service provision during the transition period.
- The impact of funding changes should be monitored by the Ministry to ensure that service provision is not being unduly impacted.
- The impact of funding changes should be taken into consideration in the setting of targets for Public Health Accountability Agreement indicators.
- The model is not intended to affect the municipal cost-share formula (75% provincial/25% municipal) although there may be impacts on municipal funding contributions resulting from the implementation of the model.
- The impact of funding changes to the municipal cost-share formula (i.e., decreases or increases in provincial funding affecting municipal contribution levels) should be taken into consideration when determining an implementation method.
- The most current data should be used for the public health funding model.

5.0 Next Steps

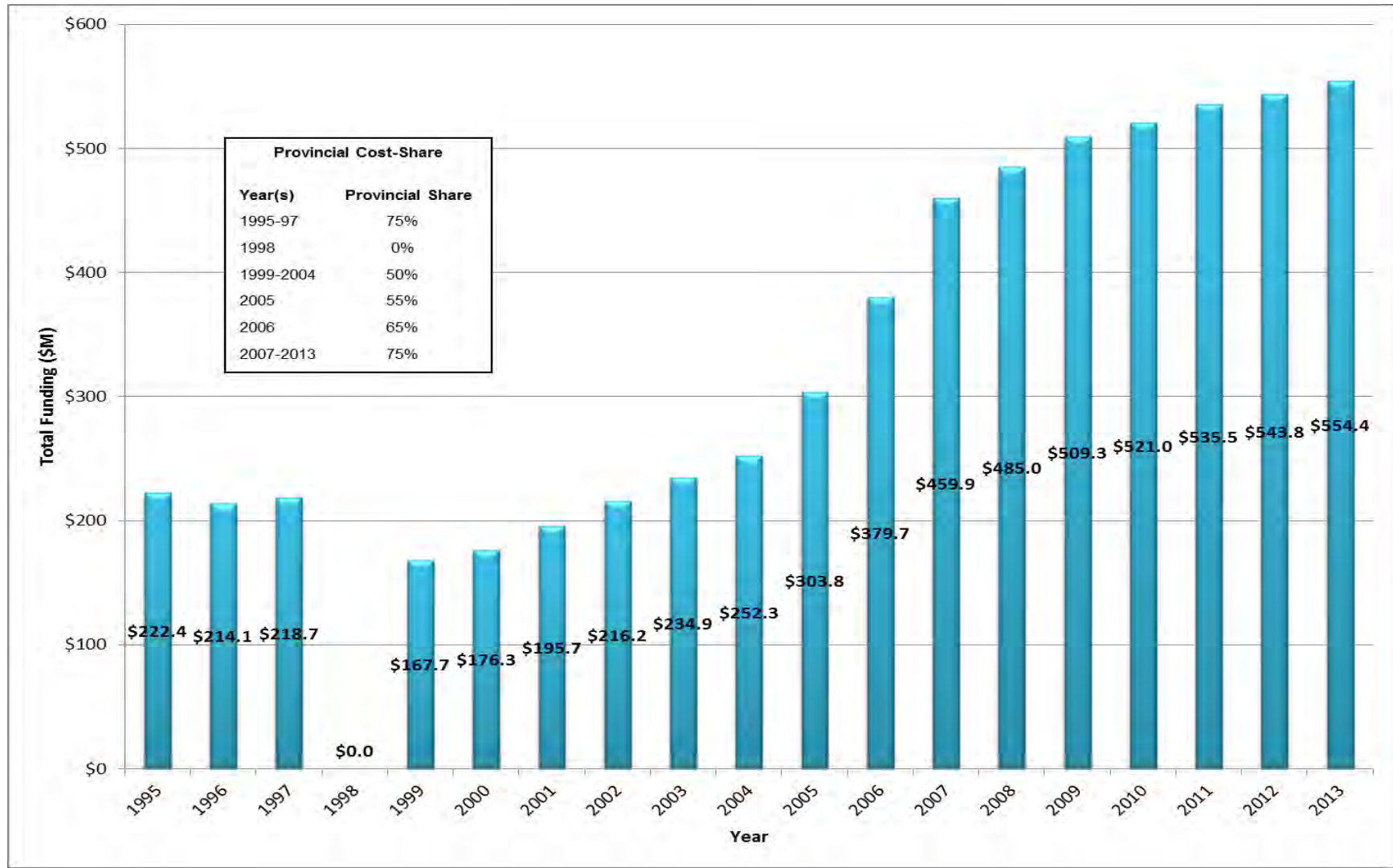
We submit this report and its recommendations to the Ministry with the assumption it will take action to resolve the current inequities in funding across public health units in Ontario. These actions will be important in the creation of a more accountable funding model. More important, however, is the implementation of an equitable funding model that supports the long-term sustainability of public health services in Ontario.

The Ministry, upon receipt of the report, has committed to consider the recommendations made here and conduct its own impact assessment. We strongly encourage the Ministry to develop implementation strategies that are in line with the implementation principles recommended here. In particular, we stress the need for an implementation strategy that achieves a more equitable funding model in a timely way while also maintaining system stability.

Finally, we encourage the Ministry to consult the public health sector on any implementation strategy the Ministry develops prior to implementation. We encourage the Ministry to communicate regularly with the sector throughout its impact assessment of the recommendations made here as well as the development and implementation of a new funding model to mitigate any unforeseen disruptions to the delivery of public health services by public health units.

6.0 Appendices

Appendix 1 – Mandatory Programs Funding 1995-2013

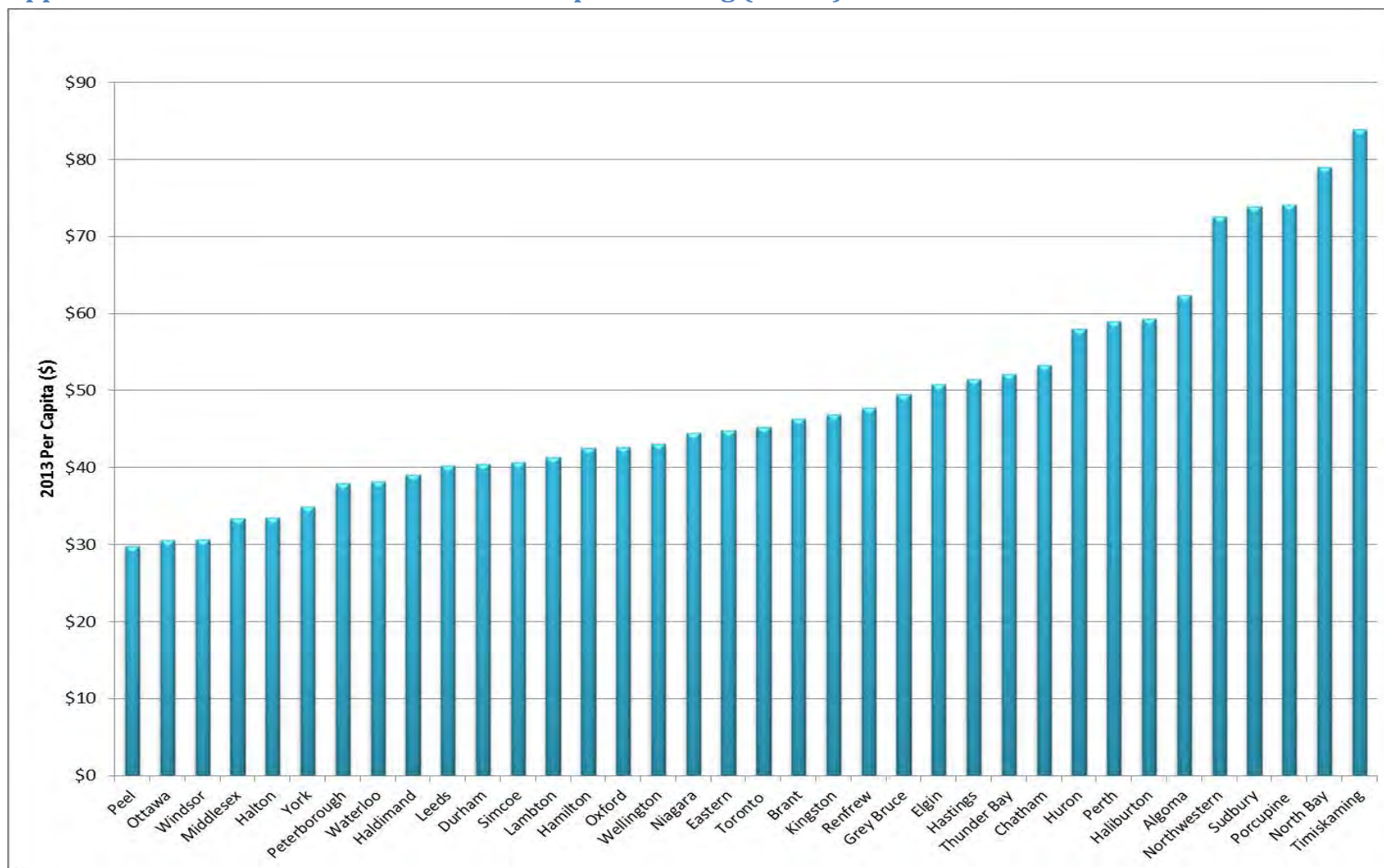


Appendix 2 – 2013 Public Health Unit Per Capita Funding

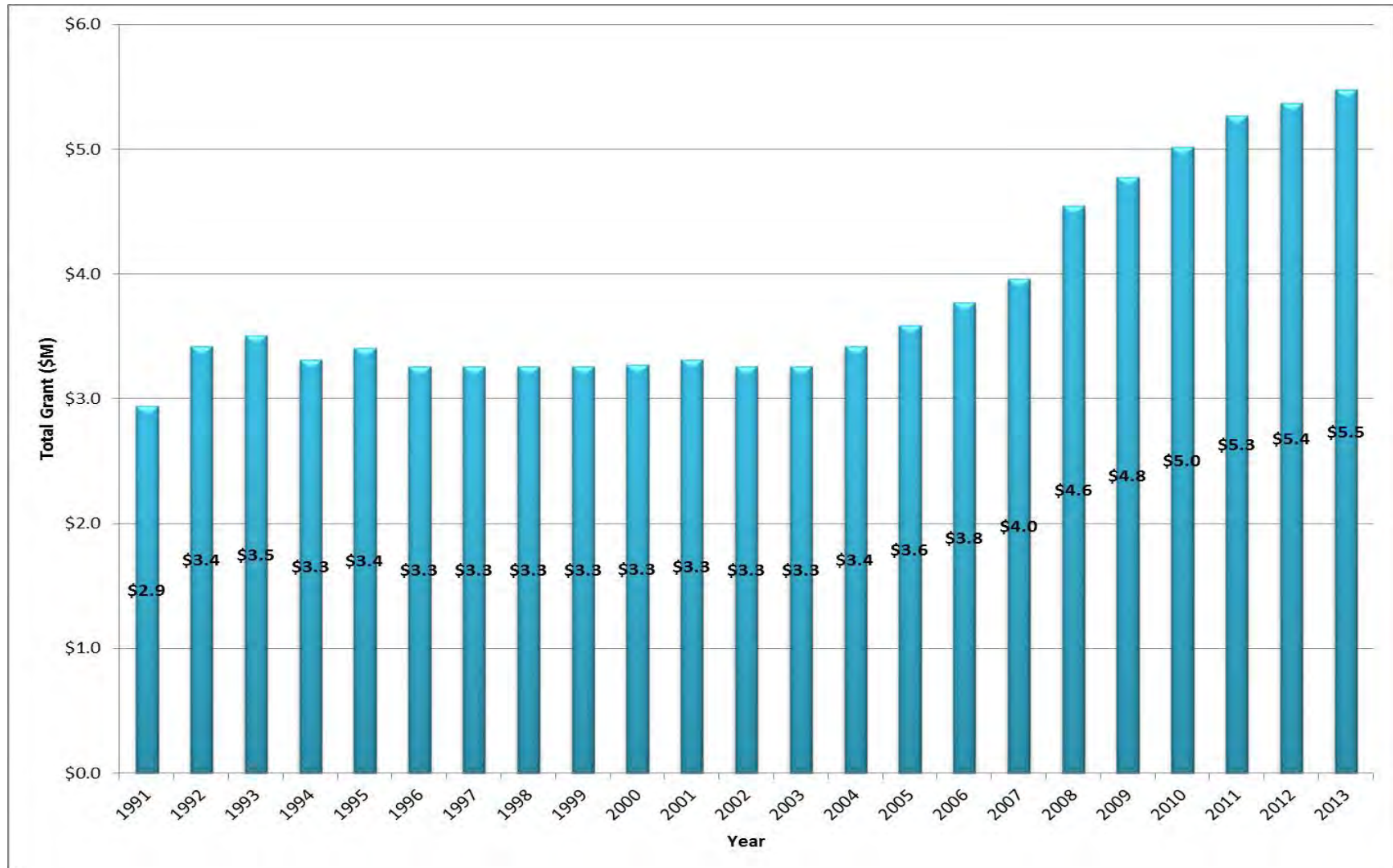
Public Health Unit	2013 Per Capita
Algoma	62.39
Brant County	46.33
Chatham-Kent	53.28
Durham Region	40.44
Eastern Ontario	44.85
Elgin-St. Thomas	50.78
Grey Bruce	49.56
Haldimand-Norfolk	39.05
Haliburton, Kawartha, Pine Ridge District	59.30
Halton Region	33.48
Hamilton	42.57
Hastings & Prince Edward Counties	51.47
Huron County	58.02
Kingston, Frontenac and Lennox & Addington	46.88
Lambton	41.31
Leeds, Grenville & Lanark District	40.27
Middlesex-London	33.42
Niagara Region	44.45
North Bay Parry Sound District	78.98
Northwestern	72.56
Ottawa	30.57
Oxford County	42.65
Peel Region	29.83
Perth District	58.95
Peterborough County-City	37.92
Porcupine	74.16
Renfrew County & District	47.75
Simcoe Muskoka District	40.66
Sudbury and District	73.85
Thunder Bay District	52.12
Timiskaming	83.97
Toronto	45.25
Waterloo Region	38.16
Wellington-Dufferin-Guelph	43.13
Windsor-Essex County	30.66
York Region	34.91

Note: Per capita information calculated using 2013 mandatory programs funding approved for public health units (provincial share) and the most recent Statistics Canada Population Estimates (2011).

Appendix 2 – 2013 Public Health Unit Per Capita Funding (cont'd)



Appendix 3 – Unorganized Territories Funding 1991-2013



Appendix 4 – Funding Review Working Group

Terms of Reference (2010)

BACKGROUND

In Ontario, public health services are delivered by 36 boards of health as mandated by the Health Protection and Promotion Act (HPPA). Each board of health is responsible for programs and services in a defined geographic area known as a public health unit. The Ontario Public Health Standards and Protocols set out the minimum requirements for fundamental public health programs and services (mandatory programs).

Under the HPPA, the legal obligation for board of health funding resides with the municipalities. The province is not legally obliged to provide funding but may make grants under section 76 of the HPPA. In practice, the province has historically shared with municipalities in the funding of mandatory programs. The funding is currently cost-shared with local municipalities at a ratio of 75% provincial funding and 25% municipal funding for approved costs of mandatory programs. In areas without municipal organization, the provincial government currently provides a 100% grant to boards of health for the delivery of mandatory programs.

Despite the significant increases in provincial funding for boards of health since 2004, funding inequities currently exist due to historical funding patterns that have been maintained for a number of years through across-the-board increases. In addition, budget requests were influenced by the capacity of local municipalities to support public health funding.

PURPOSE

The purpose of the Funding Review Working Group is to provide advice to the Ministry of Health and Long-Term Care (MOHLTC) and the Ministry of Health Promotion (MHP) on the development and implementation of a needs based methodology for allocating funds from the provincial envelope to boards of health for the provision of mandatory programs, in both organized and unorganized areas.

CONTEXT

The public health funding review is taking place during a fiscally challenging time. No new funding is currently available to implement review recommendations related to funding levels. Neither will existing base funding be reallocated or redistributed to address the review's recommendations regarding funding. Therefore, any funding adjustments will be implemented on an incremental basis using future increases to the overall provincial funding envelope for public health.

RESPONSIBILITIES

The Funding Review Working Group is charged with the task of providing advice and recommendations on funding models and options, equity factors used in the funding models, risk management and implementation issues. Specifically, the Funding Review Working Group will:

- Review and determine the factors to be used in developing the funding models.

- Provide advice and recommend a model for the allocation of provincial transfer payments to boards of health for the provision of mandatory programs in both organized and unorganized territories for the year 2011 and beyond.
- Provide input into the method of conducting field consultation and determine which model(s) to present for consultation.
- Review the comments of stakeholders following the consultation process.
- Review the draft report once it has been circulated.
- Provide advice with respect to the evaluation process.

MEMBERSHIP

[Notation: See current membership list on pages 2 and 3 of this report.]

ACCOUNTABILITY

Through the co-Chairs, the Funding Review Working Group will be accountable to the Chief Medical Officer of Health, Assistant Deputy Minister, Public Health Division, MOHLTC, and Assistant Deputy Minister, Sport, Public Health and Community Programs, MHP.

TIME FRAME

The funding review will be conducted from March to December 2010 with the implementation of a new funding methodology planned for 2011.

It is anticipated that the Funding Review Working Group will meet primarily from April 2010 to October 2010, in person in Toronto. These meetings will be followed by field consultations which are expected to take place in fall 2010. Further meetings of the Working Group will take place in late fall following the consultation phase and as the final report is being written. Please note that the ministry will cover all travel expenses to Toronto.

Appendix 5 – Sub-Committees’ Membership

Unorganized Territories Sub-Committee

- Don West, Chief Administrative Officer, Porcupine Health Unit (Chair)
- Dr. Kim Barker, Medical Officer of Health, The District of Algoma Health Unit
- Colette Barrette, Manager, Accounting Services, Sudbury & District Health Unit
- Catherine Bloskie, Director, Corporate Services, Renfrew County & District Health Unit
- Isabel Churcher, Manager of Finance, North Bay Parry Sound District Health Unit
- Doug Heath, Chief Executive Officer, Thunder Bay District Health Unit
- Mark Perrault, Chief Executive Officer, Northwestern Health Unit
- Randy Winters, Manager of Administration & Finance, Timiskaming Health Unit

Past Members of the Unorganized Territories Sub-Committee:

- Dr. Allan Northan, Former Medical Officer of Health, District of Algoma Health Unit

Infrastructure Sub-Committee

- Patricia Hewitt, Manager, Public Health Administration, Halton Region Health Department
- Anne-Marie Holt, Manager, Epidemiology and Evaluation Services, Haliburton, Kawartha, Pine Ridge District Health Unit
- Dale Jackson, Former Director of Administration, Hastings and Prince Edward Counties Health Unit
- Shirley MacPherson, Director, Finance & Administration, Toronto Public Health
- Dr. David L. Mowat, Medical Officer of Health, Peel Public Health
- Dr. Andrew Pinto, Public Health & Preventative Medicine Specialist, St. Michael's Hospital

Appendix 6 – Indicators Considered But Not Selected

Category	Model Components/Indicators	Definition	Reason for Exclusion
Drivers of Need	Early Development Instrument	The Early Development Instrument is a teacher-completed checklist that assesses children's readiness to learn at school in five domains: physical health and well-being, social competence, emotional maturity, language and cognitive development, and communication skills and general knowledge. It also includes two additional scales indicating the child's special skills and problems.	At the time of indicator review (2009) data was not available for use in resource allocation.
Drivers of Need	Recent Immigrants	The proportion of the population with immigrant status, with period of immigration 2001 – 2006, to represent increased risk factors.	Recent Immigrants was originally chosen for inclusion in the funding model. However, upon review of the 'healthy immigrant effect' which determined that morbidity issues may present an increased need, it was decided the Ethnic Concentration dimension of ON-Marg would be used to represent these costs.
Drivers of Need	Visible Minorities	Visible minority refers to whether a person belongs to a visible minority group as defined by the Employment Equity Act and, if so, the visible minority group to which the person belongs. The Employment Equity Act defines visible minorities as 'persons, other than Aboriginal peoples, who are non-Caucasian in race or non-white in colour.' The visible minority population consists mainly of the following groups: South Asian, Chinese, Black, Filipino, Latin American, Arab, Southeast Asian, West Asian, Korean and Japanese.	Some minority groups do display risk factors for certain health issues; however, it was felt that the inclusion of the Ethnic Concentration dimension of ON-Marg would pick up the bulk of the issues related to health in these groups.
Health Outcomes	Low Birth Weight	Infants weighing less than 2,500 grams at birth.	The Working Group decided to go with an "up stream" approach which would focus on determinants of health such as education, income, etc. which are related to health outcomes such as low birth weight.
Health Outcomes	Potential Years of Life Lost Ratio	A measure of the relative impact of premature mortality.	The Working Group decided to go with an "up stream" approach which would focus on determinants of health such as education, income, etc. which are related to health outcomes such as potential years of life lost. However, ultimately the Working Group chose to include the Preventable Mortality Rate.
Health Outcomes	Self-Rated Health	Population (aged 12 and over from the Canadian Community Health Survey and National Population Health Survey) who reported perceiving their own health status as being either excellent, very good, good, fair or poor.	The Working Group decided to go with an "up stream" approach which would focus on determinants of health such as education, income, etc. which are related to health outcomes such as self-rated health.
Health Outcomes	Standardized Mortality Ratio	This ratio compares the mortality experience of a sub-population to that of a standard reference population. A higher mortality rate indicates greater	The Working Group decided to go with an "up stream" approach which would focus on determinants of health such as education, income, etc. which are related to health

Category	Model Components/Indicators	Definition	Reason for Exclusion
		demand for health services as it indicates a greater incidence of disease or risks.	outcomes such as standardized morality ratio.
Health Outcomes	Teen Pregnancy Rate	The number of pregnancies (resulting in live births, stillbirths, and therapeutic abortions) per 1,000 females age 15 -19 years.	The Working Group decided to go with an "up stream" approach which would focus on determinants of health such as education, income, etc. which are related to health outcomes such as teen pregnancy rate.
Health Risks	Daily Smoking	Population aged 12 and over who reported being a daily smoker. Does not take into account the number of cigarettes smoked. Studies suggest that this factor is associated with diseases affecting heart and lungs, and has a strong negative correlation with lifespan.	The Working Group decided to go with an "up stream" approach which would focus on determinants of health such as education, income, etc. which are related to risk factors such as smoking.
Health Risks	Obesity - Body Mass Index	Body Mass Index is a method of classifying body weight according to health risk.	The Working Group decided to go with an "up stream" approach which would focus on determinants of health such as education, income, etc. which are related to risk factors such as obesity.
Health Risks	Physical Inactivity	Respondents are classified as active, moderately active or inactive based on an index of average daily physical activity over a 3 month period.	The Working Group decided to go with an "up stream" approach which would focus on determinants of health such as education, income, etc. which are related to risk factors such as physical inactivity.
Replacement Services	Replacement Services and Other Key Community Services	Number of physicians, general practitioners, dentists, Midwives Nurses, pharmacies, Health Non-Governmental Organizations and other community services in a given region.	No comprehensive measure of replacement services in a public health unit exists and attempts to construct an adequate measure were unsuccessful due to lack of data or poor data quality. Finding evidence that any constructed measure correlated with the perceived effects of replacements services was unsuccessful.
Service Cost Drivers	Cost of Living	The level of prices relating to a range of everyday items.	Consideration was given to a cost of living adjustment to account for the varying costs faced by public health units associated with labour, building occupancy, and services. It was decided that the Cost of Living indicator should not be included due to data quality issues. The indicators considered were not sufficiently representative of the costs.
Service Cost Drivers	Cost of Living: Average Dwelling Cost	Average dwelling cost refers to the total monthly shelter cost paid by the household for their dwelling. Shelter costs include the following: For renters: rent and any payments for electricity, fuel, water and other municipal services; For owners: mortgage payments (principal and interest), property taxes, and any condominium fees, along with payments for electricity, fuel, water and other municipal services.	This variable measures the values of residential, not commercial spaces and thus is not an appropriate proxy for public health unit building occupancy costs. It also does not account for costs associated with labour and services.
Service Cost Drivers	Cost of Living: Average Salary per FTE for Public Health Nurses	Average Salary per FTE for Public Health Nurses and Public Health Inspectors at public health units.	This measure is not resistant to manipulation as it is collected from the public health units.

Category	Model Components/Indicators	Definition	Reason for Exclusion
	and Public Health Inspectors		
Service Cost Drivers	Cost of Living: Consumer Price Index	The Consumer Price Index is an indicator of changes in consumer prices experienced by Canadians. It is obtained by comparing, over time, the cost of a fixed basket of goods and services purchased by consumers.	The Consumer Price Index is measured for only three municipalities in Ontario and thus does not provide enough variation across public health units.
Service Cost Drivers	Cost of Living: Income for Health Occupations	This variable measures the average salary for all Health Occupations in an Economic Region of Ontario.	It was decided that this measure was not as good at indicating overall cost of living for a public health unit as it was very specific to certain types of professions.
Service Cost Drivers	Cost of Living: Nutritious Food Basket	The National Nutritious Food Basket monitors the cost and affordability of healthy eating. The Nutritious Food Basket describes the quantity (and purchase units) of approximately 60 foods that represent a nutritious diet for individuals in various age and gender groups.	The Nutritious Food Basket was thought to not capture all of the effects desired in a cost of living variable. Furthermore, there was very little variation between the highest and lowest public health unit values.
Service Cost Drivers	Environmental Health	The number of food premises, pools, and personal services settings rates per population.	Analysis suggested a fairly even distribution of premises per population across the province in the majority of cases. Given this even distribution, the Working Group determined that the exclusion of environmental health indicators was appropriate.
Service Cost Drivers	Geography: Rural and Small Community Measure	The Rural and Small Community Measure represents the proportion of a municipality's population residing in rural areas or small communities. This approach recognizes that some municipalities include a mix of rural and non-rural areas.	As a measure of geography the Rural and Small Community Measure does not account for the dispersion of the population which is a factor the Working group wished to capture to reflect the costs of providing services. The Adapted Concentric Circle model was chosen to represent service costs related to geography.
Service Cost Drivers	Geography: Population Density	Measure of the intensity of land use, expressed as number of people per square kilometer or square mile.	As a measure of geography, population density does not account for the dispersion of the population, which is a factor the Working Group wished to capture to reflect the costs of providing services. The Adapted Concentric Circle model was chosen to represent service costs related to geography.
Service Cost Drivers	Geography: Population Per Km Road	Number of population per kilometer of road for a given area.	As a measure of geography, population per km of road does not account for the dispersion of the population which is a factor the Working Group wished to capture to reflect the costs of providing services. Furthermore, this measure was only used in the Nova Scotia model due to lack of data available to run the concentric circle model. The Adapted Concentric Circle model was chosen to represent service costs related to geography.
Service Cost Drivers	Geography: Rurality Index of Ontario	The Rurality Index of Ontario is a methodology used to identify communities that are underserved with respect to physician services. The Rurality Index of Ontario methodology establishes an index score for	As a measure of geography, Rurality Index of Ontario did account for distance from health services to the population but this was based on geographic areas that were less relevant to public health units than in the concentric circle

Category	Model Components/Indicators	Definition	Reason for Exclusion
		each community, which is used to help define which communities require additional funding support for accessing physician services. The Rurality Index of Ontario scoring methodology uses a weighted formula which considers three key elements: population size and density, travel time to nearest basic referral centre, and travel time to nearest advanced referral centre.	model. For example, the measure of the rurality of some communities in Northwestern discussed their distance to Winnipeg and not the distance to public health offices in Ontario.
Service Cost Drivers	Language - Francophone, First Language Neither English Nor French.	Francophone: People with French as their mother tongue. Mother tongue refers to the first language learned at home in childhood and still understood by the individual at the time of the census. First Language Neither English nor French: Individuals who cannot conduct a conversation in either of the official languages of Canada (in English only, in French only, in both English and French).	Home Language Not English is used in the model to represent the costs of translation and culturally specific programming at public health units.
Service Cost Drivers	Special Populations	Short-term corrections, student, seasonal, migrant workers, homeless, commuters, etc. populations.	There are no data sources that accurately and/or consistently record these populations.
Socio-Economic Characteristics	Deprivation Index - Institut national de santé publique du Québec (INSPQ)	A measure of social and material deprivation at the neighbourhood level.	Originally chosen as the deprivation index for the model. Once the ON-Marg was brought to the Committee's attention it was decided to use the ON-Marg rather than the Deprivation Index (INSPQ) as ON-Marg considers a much larger list of indicators, including variables similar to those in the INSPQ.
Socio-Economic Characteristics	Education	The proportion of the population who did not complete High School. Areas that have a higher proportion of people with low education may experience greater demand for services. People with more education are more likely to be able to access safe environments, tend to smoke less, to be more physically active and to eat healthier foods.	Since ON-Marg is to be used an education measure is not needed as this is included in the index.
Socio-Economic Characteristics	Housing Quality: Owner's versus Renters	The number of home owners versus renters in a given region.	Since ON-Marg is to be used this variable, considered as a measure of relative wealth, is not needed as this is included in the index.
Socio-Economic Characteristics	Lone Parent Families	The proportion of families headed by a single parent.	Since ON-Marg is to be used a lone parent family measure is not needed as this is included in the index.
Socio-Economic Characteristics	Low Income Population	The proportion of the population for which the income level at which a family may be in straitened circumstances because it has to spend a greater proportion of its income on necessities than the average family of similar size.	Since ON-Marg is to be used a low income measure is not needed as this is included in the index.
Socio-Economic Characteristics	Median Income	Median income is the amount which divides the income distribution into two equal groups, half having incomes above the median, half having	Since ON-Marg is to be used an income measure is not needed as this is included in the index.

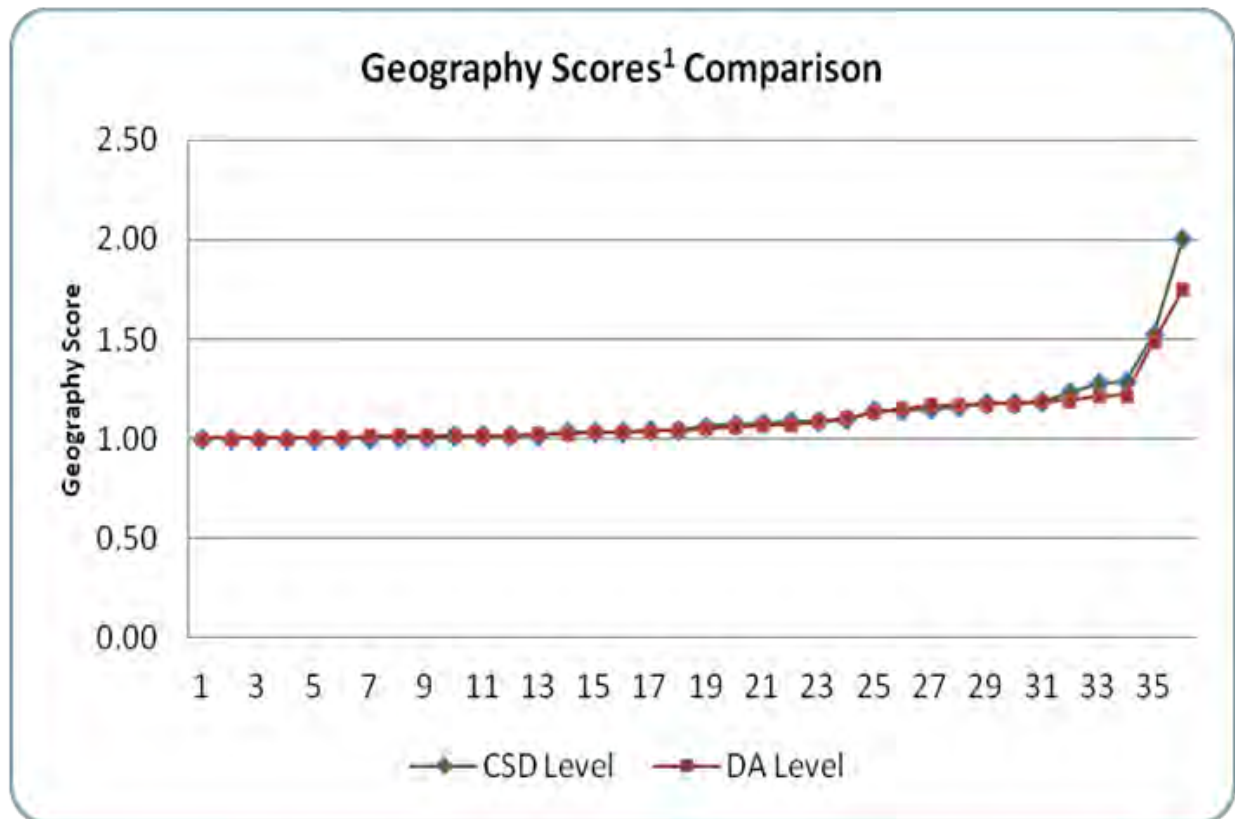
Category	Model Components/Indicators	Definition	Reason for Exclusion
		incomes below the median.	
Socio-Economic Characteristics	Unemployment	Unemployment occurs when people are without work and actively seeking work.	Since ON-Marg is to be used an unemployment measure is not needed as this is included in the index.

Appendix 7 – Public Health Unit Largest Office

Public Health Unit	Largest Office Address
Algoma	294 Willow Ave., Sault Ste. Marie
Brant County	194 Terrace Hill St., Brantford
Chatham-Kent	325 Grand Ave W, Chatham
Durham Region	605 Rossland Rd E, Whitby
Eastern Ontario	1000 Pitt St., Cornwall
Elgin-St. Thomas	99 Edward St., St. Thomas
Grey Bruce	101 17th St. E, Owen Sound
Haldimand-Norfolk	12 Gilbertson Drive, Simcoe
Haliburton, Kawartha, Pine Ridge District	200 Rose Glen Rd., Port Hope
Halton Region	1151 Bronte Rd, Oakville
Hamilton	35 King St E., Hamilton
Hastings & Prince Edward Counties	179 North Park St., Belleville
Huron County	77722B London Rd., Clinton
Kingston, Frontenac and Lennox & Addington	221 Portsmouth Ave., Kingston
Lambton	160 Exmouth St., Point Edward
Leeds, Grenville & Lanark District	458 Laurier Blvd., Brockville
Middlesex-London	50 King St., London
Niagara Region	2201 St. David's Road Campbell E, Thorold
North Bay Parry Sound District	681 Commercial St., North Bay
Northwestern	210 First St. N, Kenora
Ottawa	100 Constellation Cresc., Ottawa
Oxford County	410 Buller St., Woodstock
Peel Region	7120 Hurontario St., Mississauga
Perth District	653 West Gore St., Stratford
Peterborough County-City	10 Hospital Dr., Peterborough
Porcupine	169 Pine St. S, Timmins
Renfrew County & District	7 International Dr., Pembroke
Simcoe Muskoka District	15 Sperling Dr., Barrie
Sudbury and District	1300 Paris St., Sudbury
Thunder Bay District	999 Balmoral St., Thunder Bay
Timiskaming	247 Whitewood Ave., New Liskeard
Toronto	277 Victoria St., Toronto
Waterloo Region	99 Regina St. S, Waterloo
Wellington-Dufferin-Guelph	503 Imperial Rd. N., Guelph
Windsor-Essex County	1005 Ouellette Ave., Windsor
York Region	50 High Tech Rd., Richmond Hill

Note: The largest office represents the office for which the greatest number of staff were reported on the 2013 Program-Based Grants Occupancy Report.

Appendix 8 – Census Subdivision (CSD) and Dissemination Area (DA) Comparison



Note¹:

- (i) Geography Score = Weighted population / Un-weighted population.
- (ii) Caveat – CSD level geography score is calculated based on the 2011 population estimates while DA level geography score is based on the 2011 census population counts.
- (iii) Each geography score line is sorted independently.

Appendix 9 – Adapted Concentric Circle Model Scores (Geography)

Public Health Unit	Adapted Concentric Circle Model Score
BRANT COUNTY	1.00
HALTON REGION	1.00
HAMILTON	1.00
OTTAWA	1.00
PEEL REGION	1.00
TORONTO	1.00
WATERLOO REGION	1.00
CHATHAM-KENT	1.00
MIDDLESEX-LONDON	1.01
DURHAM REGION	1.01
YORK REGION	1.01
NIAGARA REGION	1.02
PETERBOROUGH COUNTY-CITY	1.02
ELGIN-ST. THOMAS	1.03
OXFORD COUNTY	1.03
PERTH DISTRICT	1.03
LAMBTON	1.04
WINDSOR-ESSEX COUNTY	1.04
KINGSTON, FRONTENAC AND LENNOX & ADDINGTON	1.06
HASTINGS & PRINCE EDWARD COUNTIES	1.06
HURON COUNTY	1.08
HALDIMAND-NORFOLK	1.08
WELLINGTON-DUFFERIN-GUELPH	1.09
SUDBURY AND DISTRICT	1.10
SIMCOE MUSKOKA DISTRICT	1.14
RENFREW COUNTY & DISTRICT	1.14
GREY BRUCE	1.15
EASTERN ONTARIO	1.16
LEEDS,GRENVILLE & LANARK DISTRICT	1.17
NORTH BAY PARRY SOUND DISTRICT	1.17
TIMISKAMING	1.19
ALGOMA	1.24
HALIBURTON, KAWARTHA, PINE RIDGE DISTRICT	1.27
THUNDER BAY DISTRICT	1.28
PORCUPINE	1.52
NORTHWESTERN	2.01

Source: Health Analytics Branch, Ministry Health and Long-Term Care (Population estimates July 1, 2011, Census Subdivisions, Ontario; Source: Statistics Canada, Demography Division, customized data and Ministry of Health and Long-Term Care Geographic Conversion File, consgc11.xls).

Appendix 10 – Percentage of Home Language not English Population

Public Health Unit	Home Language not English Population %
HALIBURTON, KAWARTHA, PINE RIDGE DISTRICT	1.4%
LEEDS,GRENVILLE & LANARK DISTRICT	2.1%
PETERBOROUGH COUNTY-CITY	2.2%
HASTINGS & PRINCE EDWARD COUNTIES	2.5%
GREY BRUCE	2.6%
LAMBTON	2.9%
RENFREW COUNTY & DISTRICT	3.3%
SIMCOE MUSKOKA DISTRICT	3.5%
OXFORD COUNTY	3.5%
HURON COUNTY	3.8%
HALDIMAND-NORFOLK	3.8%
KINGSTON, FRONTENAC AND LENNOX & ADDINGTON	4.5%
PERTH DISTRICT	4.5%
BRANT COUNTY	4.5%
CHATHAM-KENT	5.1%
DURHAM REGION	5.6%
ELGIN-ST. THOMAS	5.8%
ALGOMA	6.3%
THUNDER BAY DISTRICT	6.8%
WELLINGTON-DUFFERIN-GUELPH	7.0%
NIAGARA REGION	7.2%
NORTHWESTERN	8.4%
HALTON REGION	8.7%
MIDDLESEX-LONDON	9.4%
NORTH BAY PARRY SOUND DISTRICT	12.2%
WATERLOO REGION	12.4%
WINDSOR-ESSEX COUNTY	12.9%
HAMILTON	12.9%
TIMISKAMING	16.4%
SUDBURY AND DISTRICT	17.7%
OTTAWA	21.8%
YORK REGION	27.0%
PEEL REGION	27.7%
TORONTO	31.7%
EASTERN ONTARIO	35.4%
PORCUPINE	38.9%

Source: Statistics Canada. 2007. 2006 Community Profiles. 2006 Census. The latest data was not available at the time of writing this report.

Appendix 11 – Percentage of Aboriginal Population

Public Health Unit	Aboriginal Status Population %
YORK REGION	0.4%
PEEL REGION	0.5%
HURON COUNTY	0.5%
TORONTO	0.5%
HALTON REGION	0.6%
PERTH DISTRICT	0.7%
WELLINGTON-DUFFERIN-GUELPH	0.9%
OXFORD COUNTY	0.9%
WATERLOO REGION	1.0%
ELGIN-ST. THOMAS	1.1%
DURHAM REGION	1.2%
OTTAWA	1.5%
HAMILTON	1.5%
MIDDLESEX-LONDON	1.6%
WINDSOR-ESSEX COUNTY	1.6%
NIAGARA REGION	1.6%
HALDIMAND-NORFOLK	1.9%
HALIBURTON, KAWARTHA, PINE RIDGE DISTRICT	2.0%
EASTERN ONTARIO	2.0%
LEEDS, GRENVILLE & LANARK DISTRICT	2.1%
GREY BRUCE	2.4%
CHATHAM-KENT	2.5%
KINGSTON, FRONTENAC AND LENNOX & ADDINGTON	2.6%
SIMCOE MUSKOKA DISTRICT	3.1%
PETERBOROUGH COUNTY-CITY	3.2%
BRANT COUNTY	3.5%
HASTINGS & PRINCE EDWARD COUNTIES	3.5%
LAMBTON	4.6%
TIMISKAMING	5.6%
RENFREW COUNTY & DISTRICT	5.7%
NORTH BAY PARRY SOUND DISTRICT	7.6%
SUDBURY AND DISTRICT	9.2%
ALGOMA	11.1%
PORCUPINE	12.3%
THUNDER BAY DISTRICT	13.5%
NORTHWESTERN	32.0%

Source: Statistics Canada. 2007. 2006 Community Profiles. 2006 Census. The latest data was not available at the time of writing this report.

Appendix 12 – Deprivation Indices Considered

Measure	Jarman	Carstairs	Townsend	SEFI	INSPQ	GDI	Matheson, Moineddin, Glazier	ON-Marg
Type of index								
Material Deprivation	X	X	X	X	X	X	X	X
Social Deprivation	X	X		X	X	X		X
Variables used								
Income		X		X	X	X	X	X
Housing	X	X	X			X	X	X
Demographic	X			X	X	X		X
Mobility	X	X	X					
Education				X	X	X	X	X
Employment	X	X	X	X	X	X	X	X
Social class	X	X					X	X
Weighting method								
Principal component analysis				X	X	X		X
Log transformations			X					
Expert weighting	X							
Multiple linear regression				X			X	

Note: See section 7.0 for references.

Appendix 13 – Healthy Immigrant Effect Review

References to publications from which data was extracted and presented to the Funding Review Working Group in support of discussion:

Adhiraki R & Sanou D. 2012. Risk factors of diabetes in Canadian immigrants: a synthesis of recent literature. *Canadian Journal of Diabetes*, vol. 36: 142-150.

Belanger A & Gilbert S. 2003. The fertility of immigrant women and their Canadian-born daughters. In: Report on the demographic situation in Canada. Current demographic analysis. Ottawa: Alain Belanger Ministry of Industry. p. 127-51.

Creatore MI, Moineddin R, Booth G, et al. 2010. Age- and sex-related prevalence of diabetes mellitus among immigrants to Ontario, Canada. *CMAJ*, vol. 182(8): 781-789.

Collins CH, Zimmerman C & Howard LM. 2011. Refugee, asylum seeker, immigrant women and postnatal depression: rates and risk factors. *Arch Womens Ment Health*, vol. 14: 3-11.

Dassanayake J, Gurrin L, Payne WR, et al. 2010. Cardiovascular disease risk in immigrants: what is the evidence and where are the gaps? *Asian-Pacific Journal of Public Health*, vol. 23(6): 882-895.

Gagnon AJ, Zimbeck M, Zeitlin J, et al. 2009. Migration to western industrialised countries and perinatal health: A systematic review. *Social Science & Medicine*, vol. 69:934-946.

Gagnon AJ, McDermott S, Rigol-Chachamovich J, et al. 2011. International migration and gestational diabetes mellitus: a systematic review of the literature and meta-analysis. *Paediatric and Perinatal Epidemiology*, vol. 25:575-592.

Greenaway C, Sandoe A, Vissandjee B, et al. 2011. Tuberculosis: evidence review for newly arriving immigrants and refugees. *CMAJ*, vol. 183(12): E939-E951. MacPherson DW, Gushulak BD. 2008. Syphilis in immigrants and the Canadian immigration medical examination. *J Immigrant Minority Health*, vol. 10: 1-6.

McElroy R, Laskin M, Jiang D, et al. 2009. Rates of rubella immunity among immigrant and non-immigrant pregnant women. *J Obstet Gynaecol Can*, vol. 31(5): 409-413.

Minuk GY & Uhanova J. 2001. Chronic hepatitis B infection in Canada. *Can J Infect Dis*, vol. 12(6): 351-356.

Ng, E. 2011. The healthy immigrant effect and mortality rates. *Health Reports*, vol 22(4):25-29. Statistics Canada Catalogue no. 82-003-XPE

Ravel A, Nesbitt A, Marshall B, et al. 2011. Description and burden of travel-related cases caused by enteropathogens reported in a Canadian community. *Journal of Travel Medicine*, vol. 18(1): 8-19.

Appendix 14 – ON-Marg Dimensions Scores

Public Health Unit	Residential Instability Score	Material Deprivation Score	Dependency Score	Ethnic Concentration Score
ALGOMA	3.15	3.52	3.97	1.93
BRANT COUNTY	2.78	2.94	3.00	2.74
CHATHAM-KENT	2.87	3.39	3.60	2.32
DURHAM REGION	2.18	2.36	2.22	3.58
EASTERN ONTARIO	2.67	3.05	3.31	2.26
ELGIN-ST. THOMAS	2.58	3.03	3.20	2.61
GREY BRUCE	2.83	2.85	3.85	1.77
HALDIMAND-NORFOLK	2.34	3.03	3.57	2.02
HALIBURTON, KAWARTHA, PINE RIDGE DISTRICT	2.73	2.91	3.96	1.91
HALTON REGION	2.30	1.67	2.45	3.51
HAMILTON	2.91	3.11	3.03	3.42
HASTINGS & PRINCE EDWARD COUNTIES	2.96	3.13	3.73	2.29
HURON COUNTY	2.55	2.99	3.69	1.80
KINGSTON, FRONTENAC AND LENNOX & ADDINGTON	2.99	2.63	3.29	2.62
LAMBTON	2.85	2.69	3.46	2.07
LEEDS, GRENVILLE & LANARK DISTRICT	2.72	2.77	3.62	1.98
MIDDLESEX-LONDON	3.07	2.69	2.77	3.27
NIAGARA REGION	2.98	2.91	3.46	2.70
NORTH BAY PARRY SOUND DISTRICT	3.17	3.59	3.85	2.08
NORTHWESTERN	2.81	3.20	3.33	1.76
OTTAWA	2.97	2.16	2.37	3.66
OXFORD COUNTY	2.58	2.71	3.21	2.36
PEEL REGION	2.08	2.43	2.02	4.63
PERTH DISTRICT	2.65	2.72	3.12	2.13
PETERBOROUGH COUNTY-CITY	3.06	2.98	3.73	2.29
PORCUPINE	2.97	3.68	3.42	1.97
RENFREW COUNTY & DISTRICT	2.87	3.06	3.83	1.98
SIMCOE MUSKOKA DISTRICT	2.57	2.58	2.89	2.66
SUDBURY AND DISTRICT	2.96	3.38	3.46	2.21
THUNDER BAY DISTRICT	3.07	3.19	3.42	2.13
TIMISKAMING	3.11	3.91	4.31	1.54
TORONTO	3.65	3.20	2.78	4.45
WATERLOO REGION	2.71	2.45	2.42	3.44
WELLINGTON-DUFFERIN-GUELPH	2.46	2.26	2.48	2.99
WINDSOR-ESSEX COUNTY	2.68	2.96	3.09	3.33
YORK REGION	1.80	2.06	2.30	4.30

Notes:

- Source: Ontario Marginalization Index (ON-Marg_2006_updated_May_2012.xls).
- ON-Marg data will only be refreshed when its updates become available.

Appendix 15 – Health Status Indicator Correlations

		Health Status Indicators	
		Age Std. Preventable Mortality Rate	Age Std. Preventable PYLL Rate
Service Cost Drivers	Language	-0.14005	-0.16732
	Geography	0.58977	0.65436
Drivers of Need	Recent Immigrants	-0.64667	-0.56995
	Aboriginal	0.67509	0.82904
	ON-Marg		
	Instability	0.32285	0.32039
	Deprivation	0.73253	0.63506
	Ethnic Concentration	-0.68300	-0.60255
	Dependency	0.62069	0.56068
	Age Std. Preventable Mortality Rate	1.00000	0.92232
	Age Std. Preventable PYLL Rate		1.00000

The correlation analysis above discusses indicators that have moderate to high correlations.

- Moderate correlation is from 0.5 to 0.79
- High correlation is from 0.8 to 1

Note: * Highlights in blue indicate moderate correlations (positive or negative)

* Highlights in green indicate strong correlations (positive or negative)

Appendix 16 – Preventable Mortality Rate

Public Health Unit	Age Standardized Preventable Mortality Rate (per 100,000 population)
YORK REGION	62.9
PEEL REGION	76.3
HALTON REGION	78.4
OTTAWA	90.4
TORONTO	91.6
WELLINGTON-DUFFERIN-GUELPH	99.3
WATERLOO REGION	101.1
DURHAM REGION	101.2
RENFREW COUNTY & DISTRICT	102
GREY BRUCE	113.3
PERTH DISTRICT	113.7
MIDDLESEX-LONDON	116.1
KINGSTON, FRONTENAC AND LENNOX & ADDINGTON	117.3
HALDIMAND-NORFOLK	118.5
SIMCOE MUSKOKA DISTRICT	122.8
WINDSOR-ESSEX COUNTY	123.1
HAMILTON	125.1
NIAGARA REGION	126.5
PETERBOROUGH COUNTY-CITY	127.3
HURON COUNTY	129.6
HALIBURTON, KAWARTHA, PINE RIDGE DISTRICT	130.9
LAMBTON	132.2
ELGIN-ST. THOMAS	133.6
EASTERN ONTARIO	134.5
LEEDS,GRENVILLE & LANARK DISTRICT	139.4
CHATHAM-KENT	140.3
OXFORD COUNTY	141.3
NORTH BAY PARRY SOUND DISTRICT	141.8
THUNDER BAY DISTRICT	144.4
HASTINGS & PRINCE EDWARD COUNTIES	149.4
BRANT COUNTY	154
TIMISKAMING	158.1
ALGOMA	159.4
SUDBURY AND DISTRICT	161.9
PORCUPINE	175.4
NORTHWESTERN	192.1

Source: Public Health Ontario. Snapshots: Windsor-Essex County Health Unit: Mortality from preventable causes - age standardized rate (both sexes combined) 2009. Toronto, ON: Ontario Agency for Health Protection and Promotion; 2013 Mar 12 [cited 2013 Apr 30]. Available from:

<http://www.publichealthontario.ca/en/DataAndAnalytics/Snapshots/Pages/Mortality-from-Preventable-Causes.aspx>.

Appendix 17 – Equity Adjustment Factor Scores

PHU	Mandatory Programs
1	3.37
2	2.76
3	2.91
4	2.33
5	3.20
6	2.70
7	2.68
8	2.61
9	2.87
10	2.14
11	2.92
12	2.92
13	2.64
14	2.64
15	2.61
16	2.73
17	2.68
18	2.78
19	3.27
20	4.75
21	2.58
22	2.57
23	2.69
24	2.45
25	2.78
26	4.16
27	2.79
28	2.56
29	3.22
30	3.20
31	3.48
32	3.41
33	2.49
34	2.33
35	2.84
36	2.50

PHU	Unorganized Territories
1	2.85
2	2.70
3	5.09
4	3.81
5	2.28
6	2.70
7	2.80
8	2.86

Note: Public health units were randomized independently in the tables.

Appendix 18 – Public Health Unit Population Estimates (2011)

Public Health Unit	Population
TIMISKAMING	34,449
HURON COUNTY	60,339
PERTH DISTRICT	77,130
NORTHWESTERN	81,942
PORCUPINE	86,701
ELGIN-ST. THOMAS	91,418
RENFREW COUNTY & DISTRICT	102,960
OXFORD COUNTY	108,226
CHATHAM-KENT	108,580
HALDIMAND-NORFOLK	110,709
ALGOMA	117,812
NORTH BAY PARRY SOUND DISTRICT	127,320
LAMBTON	131,415
PETERBOROUGH COUNTY-CITY	140,545
BRANT COUNTY	140,816
THUNDER BAY DISTRICT	156,550
HASTINGS & PRINCE EDWARD COUNTIES	162,713
GREY BRUCE	164,837
LEEDS,GRENVILLE & LANARK DISTRICT	170,163
HALIBURTON, KAWARTHA, PINE RIDGE DISTRICT	179,006
KINGSTON, FRONTENAC AND LENNOX & ADDINGTON	197,335
SUDBURY AND DISTRICT	197,707
EASTERN ONTARIO	201,119
WELLINGTON-DUFFERIN-GUELPH	278,462
WINDSOR-ESSEX COUNTY	403,396
NIAGARA REGION	445,363
MIDDLESEX-LONDON	460,850
HALTON REGION	518,660
SIMCOE MUSKOKA DISTRICT	525,492
WATERLOO REGION	530,248
HAMILTON	540,234
DURHAM REGION	631,270
OTTAWA	909,862
YORK REGION	1,069,780
PEEL REGION	1,365,849
TORONTO	2,743,738

Public Health Unit	Unorganized Territory Population
RENFREW COUNTY & DISTRICT	77
SUDBURY AND DISTRICT	3,196
TIMISKAMING	3,372
NORTH BAY PARRY SOUND DISTRICT	4,965
ALGOMA	6,791
PORCUPINE	8,375
THUNDER BAY DISTRICT	13,809
NORTHWESTERN	23,803

Source: Statistics Canada, Demography Division, customized data and Ministry of Health and Long-Term Care Geographic Conversion File, consgc11.xls.

Appendix 19 – Public Health Funding Model Shares

PHU	Mandatory Programs
1	4.16%
2	0.95%
3	1.10%
4	3.27%
5	1.22%
6	1.68%
7	1.71%
8	24.66%
9	0.91%
10	3.02%
11	0.76%
12	2.93%
13	1.17%
14	3.88%
15	3.26%
16	1.03%
17	0.83%
18	3.54%
19	1.32%
20	7.04%
21	0.73%
22	1.37%
23	0.50%
24	1.26%
25	1.03%
26	1.70%
27	1.36%
28	3.49%
29	9.71%
30	6.19%
31	0.32%
32	1.05%
33	0.65%
34	0.42%
35	1.03%
36	0.76%
Total	100%

PHU	Unorganized Territories
1	7.98%
2	5.53%
3	49.84%
4	13.14%
5	0.07%
6	3.55%
7	15.92%
8	3.97%
Total	100%

Note: Public health units were randomized independently in the tables.

Appendix 20 – Public Health Funding Model Share Differences (Model Share - 2013 Current Share)

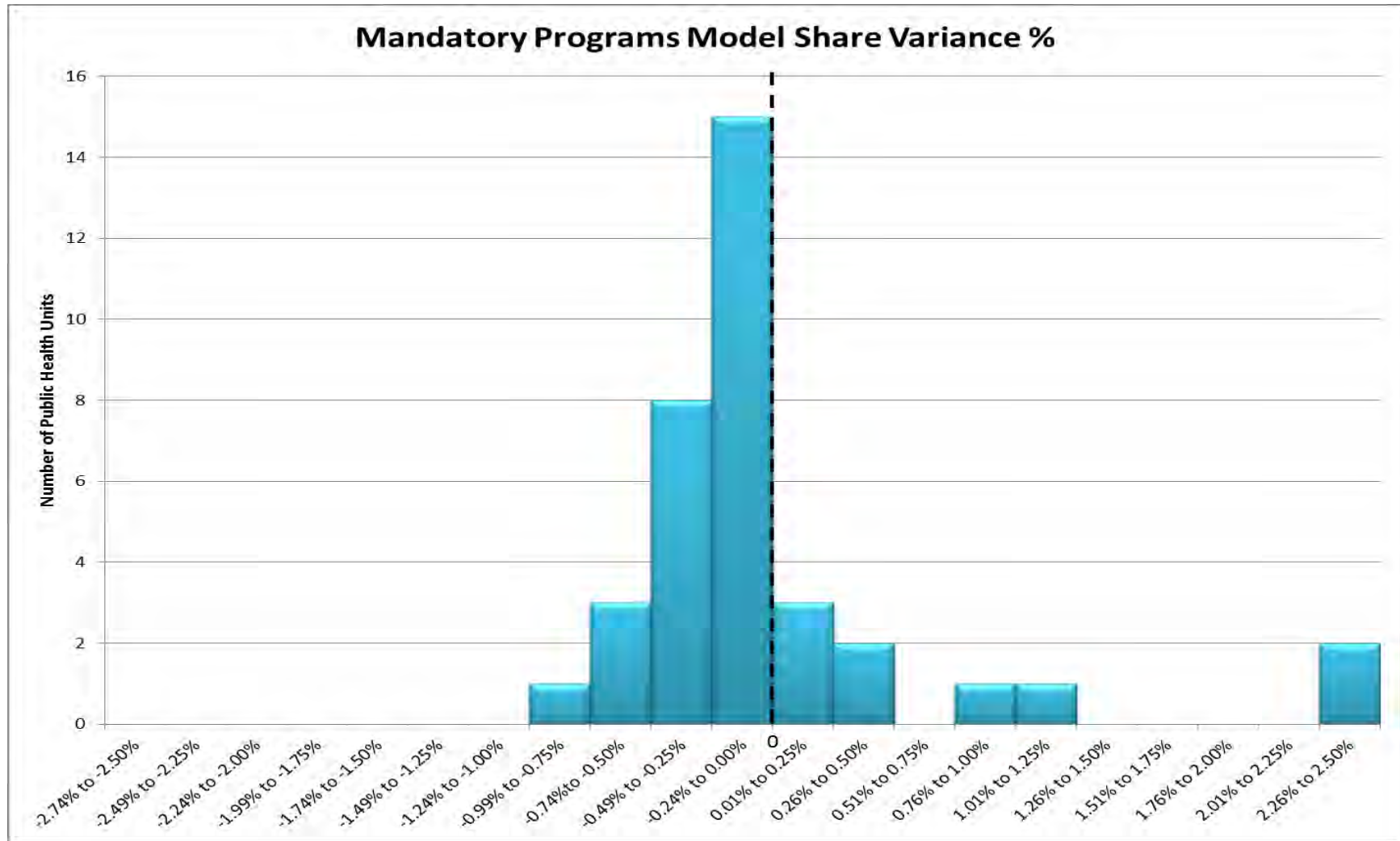
Mandatory Programs		
PHU	Model Share Variance %	Model Share Variance \$
1	-0.19%	-\$ 1,033,872
2	0.31%	\$ 1,704,295
3	-0.31%	-\$ 1,720,128
4	-0.15%	-\$ 832,860
5	-0.21%	-\$ 1,169,028
6	-0.16%	-\$ 882,734
7	2.36%	\$ 13,067,975
8	-0.71%	-\$ 3,954,668
9	-0.10%	-\$ 545,603
10	-0.04%	-\$ 249,019
11	0.07%	\$ 386,235
12	0.01%	\$ 50,132
13	0.07%	\$ 403,027
14	-0.14%	-\$ 717,908
15	-0.30%	-\$ 1,680,994
16	-0.21%	-\$ 1,167,233
17	-0.31%	-\$ 1,702,881
18	-0.21%	-\$ 1,156,071
19	2.28%	\$ 12,590,007
20	-0.02%	-\$ 91,446
21	-0.20%	-\$ 1,111,189
22	-0.21%	-\$ 1,138,990
23	-0.25%	-\$ 1,414,627
24	-0.56%	-\$ 3,086,920
25	1.18%	\$ 6,509,864
26	-0.73%	-\$ 4,042,022
27	-0.16%	-\$ 837,492
28	-0.32%	-\$ 1,784,895
29	0.48%	\$ 2,677,298
30	-0.95%	-\$ 5,296,283
31	0.79%	\$ 4,390,166
32	-0.01%	-\$ 67,683
33	-0.29%	-\$ 1,630,126
34	-0.28%	-\$ 1,545,725
35	-0.07%	-\$ 409,230
36	-0.45%	-\$ 2,509,373

Unorganized Territories		
PHU	Model Share Variance %	Model Share Variance \$
1	-0.86%	-\$ 47,113
2	-10.50%	-\$ 575,350
3	2.52%	\$ 138,336
4	-12.20%	-\$ 668,596
5	0.18%	\$ 9,853
6	2.65%	\$ 145,298
7	1.05%	\$ 57,506
8	17.15%	\$ 940,065

Note: The Funding Review Working Group is not recommending that budgets be changed by the amounts calculated here. Rather, the tables represent the dollar difference between the provincial grant under the full implementation of the funding model and the current grant. It is recommended that, over time the grant move towards the amount represented by the model share. The model share amount will be adjusted annually based on population changes and EAFs for each public health unit.

Public health units were randomized independently in the tables.

Appendix 20 – Public Health Funding Model Share Differences (Model Share - 2013 Current Share) (cont'd)



7.0 References and Resources

Funding Model Indicators

Variable	Data Source
Geography	Health Analytics Branch, Ministry Health and Long-Term Care (Population estimates July 1, 2011, Census Subdivisions, Ontario; Source: Statistics Canada, Demography Division, customized data and Ministry of Health and Long-Term Care Geographic Conversion File, consgc11.xls)
Language	Statistics Canada. 2007. 2006 Community Profiles. 2006 Census.
Aboriginal	Statistics Canada. 2007. 2006 Community Profiles. 2006 Census.
ON-Marg (Instability)	Ontario Marginalization Index (ON-Marg_2006_updated_May_2012.xls)
ON-Marg (Deprivation)	Ontario Marginalization Index (ON-Marg_2006_updated_May_2012.xls)
ON-Marg (Dependency)	Ontario Marginalization Index (ON-Marg_2006_updated_May_2012.xls)
ON-Marg (Ethnic Concentration)	Ontario Marginalization Index (ON-Marg_2006_updated_May_2012.xls)
Age Standardized Preventable Mortality Rate	Public Health Ontario. Snapshots: Windsor-Essex County Health Unit: Mortality from preventable causes - age standardized rate (both sexes combined) 2009. Toronto, ON: Ontario Agency for Health Protection and Promotion; 2013 Mar 12 [cited 2013 Apr 30]. Available from: http://www.publichealthontario.ca/en/DataAndAnalytics/Snapshots/Pages/Mortality-from-Preventable-Causes.aspx

Deprivation Indices Considered

Indices	Reference
Jarman	JARMAN B. Identification of underprivileged areas. BMJ 1983; 286: 1705-09.
Carstairs	CARSTAIRS V, MORRIS R. Deprivation and Health in Scotland. 1991 Aberdeen University Press.
Townsend	TOWNSEND P. Deprivation. Journal of Social Policy 1987; 16, 2, 125-146
Socio-economic Factor Index (SEFI)	http://mchp-appserv.cpe.umanitoba.ca/viewDefinition.php?definitionID=103587
Deprivation Index, INSPQ	http://www.inspq.qc.ca/santescope/indexeddefavoeng.asp?NoIndD=9&Lg=en
General Deprivation Index (GDI)	Langlois, A. and Kitchen, P. (2001) Identifying and measuring dimensions of urban deprivation in Montreal: An analysis of the 1996 census data, Urban Studies, 38(1), pp. 119-139.
Matheson, Moineddin, Glazier	Matheson, F.I., Moineddin, R., & Glazier, R.H. (2008). The weight of place: A multilevel analysis of gender, neighborhood material deprivation, and body mass index among Canadian adults. Social Science and Medicine, 66 (3), 675-690.
ON-Marg g	Overview http://www.torontohealthprofiles.ca/onmarg/additionalResources/OverviewOfONMarg06July2012.pdf User Guide http://www.crunch.mcmaster.ca/documents/ON-Marg_user_guide_1.0_FINAL_MAY2012.pdf FAQ http://www.torontohealthprofiles.ca/onmarg_faq.php#faq6

Indices	Reference
	http://www.health.gov.on.ca/en/pro/programs/publichealth/oph_standards/

Report References & Resources

Report	Reference
Health Protection and Promotion Act	http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_90h07_e.htm
Health System Funding Reform	http://health.gov.on.ca/en/pro/programs/ecfa/funding/hs_funding.aspx
Ontario Public Health Standards	http://www.health.gov.on.ca/en/pro/programs/publichealth/oph_standards/
Operation Health Protection	http://www.health.gov.on.ca/en/common/ministry/publications/reports/consumer_04/oper_healthprotection.aspx
Provincial Auditors Reports	2003: http://www.auditor.on.ca/en/reports_en/en03/309en03.pdf 1997: http://www.auditor.on.ca/en/reports_en/en97/310en97.pdf
Resource Allocation: Weighted Capitation Formula, 6th Edition (United Kingdom)	http://www.traffordccg.nhs.uk/Library/Board_Papers/Items_for_Discussion/2009/01_JAN/Item%206.9%20Resource%20Allocation%20-%20Weighted%20Capitation%20Formula.pdf
Revitalizing Ontario's Public Health Capacity: The Final Report of the Capacity Review Committee (May 2006)	http://www.health.gov.on.ca/en/common/ministry/publications/reports/capacity_review06/capacity_review06.pdf

8.0 Acronyms

Acronym	Term
alPHa	Association of Local Public Health Agencies
AMO	Association of Municipalities of Ontario
CAN-Marg	Canadian Marginalization Index
CMA	Census Metropolitan Area
CSD	Census Subdivision
DA	Dissemination Area
EAF	Equity Adjustment Factor
FNIHB	First Nations Inuit Health Branch (Health Canada)
GIS	Geographic Information System
HPPA	Health Protection and Promotion Act
INSPQ	Institut national de santé publique du Québec (INSPQ)
LSR	Local Services Realignment
MOHLTC (or Ministry)	Ministry of Health and Long-Term Care
ON-Marg	Ontario Marginalization Index
OPHS	Ontario Public Health Standards
PHU	Public Health Unit
PYLL	Potential Years of Life Lost
UT	Unorganized Territory(ies)

Funding Review Working Group Field Input Response

Field input sessions were led by members of the Funding Review Working Group on January 14, 2013 with public health unit Medical Officers of Health and Chief Executive Officers, and again on January 16, 2013 with public health unit Business Administrators.

The purpose of the field input sessions was to seek input on the proposed elements of the public health funding model. The sessions were well attended and a total of 28 public health units and the Council of Ontario Medical Officers of Health provided feedback during the sessions, in writing, or both.

The following represents the response by the Funding Review Working Group to the field input received from Medical Officers of Health, Chief Executive Officers, and Business Administrators. A summary of the input received from the field is first provided (including the number of public health units that provided the comments), followed by a response from the Funding Review Working Group. Much of the language included in this document reflects content included in the Final Report.

1. Service Cost Drivers: Geography

Field Input Summary:

The Adapted Concentric Circle Model is not an appropriate measure of geography for the funding model.

- Further information requested regarding how the largest public health unit office was chosen/measured (2).
- Recommendation that both monetary and distance implications be considered for this indicator (3).
- Assertion that census subdivision (CSD) is too large a measure of geography for a population-weighted approach (1).
- Assertion that this indicator is not resistant to manipulation since office locations and sizes change over time (3).

Funding Review Working Group Response:

A measure of geography is recommended for inclusion in the funding model as geographic characteristics affect costs related to delivering public health programs and services (e.g., transportation costs, travel time).

Consistent with the 1996 and 2001 funding models/reviews, the Adapted Concentric Circle Model was chosen to represent these costs. This model takes the population in a defined area (CSD or dissemination area (DA)) and weights it according to how far it is from the largest office of the public health unit (the site with the greatest number of staff). This definition was chosen as it provided the best data available to represent where the most staff would be travelling from to deliver programs and services. This measure can represent both the direct costs of travel and the costs associated with travel time. The largest public health unit office was identified based on the office for which the greatest number of staff was reported on the 2013 Program-Based Grants Occupancy Report.

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The Funding Review Working Group is recommending that the Ministry use CSD level data when calculating the Adapted Concentric Circle Model after reviewing a comparison analysis of CSD level (larger geographic areas) and DA level (smaller geographic areas) data. The result does not differ substantially between the two (2) levels of data. However, the DA level data is only available based on census population counts whereas the CSD population can be based on either census population counts or population estimates. The population estimates take into account net under-coverage from the post-censal coverage study and therefore provide a more accurate measure of population counts.

Additional modifications to the methodology were considered but not adopted, as they were either unfeasible or did not add to the validity of the measure. For example, an adaptation for road density, to account for the fact that some areas are difficult to travel to, was considered. However, updated road density data is not available. Road density is generally highly correlated with population density and thus may not adequately measure the remoteness of the population. Other Geography indicators considered but not selected included: Population per Km Road, Rural Index of Ontario, Rural and Small Community Measure, and Population Density.

Given the complexities and costs of moving office locations, and the unlikelihood of a public health unit choosing to locate an office further away from the population it serves, the Funding Review Working Group did not believe that this indicator would, in practice, be subject to significant manipulation.

2. Service Cost Drivers: Language

Field Input Summary:

The Language indicator should be measured differently or possibly removed.

- A distinction should be made between French as a first language and other first languages that are not English (2).
- Recommendation that linguistic diversity (communities with different languages) should be taken into consideration (2).
- Assertion that the inclusion of both the Language and Recent Immigrant indicators results in 'double counting' (4).

Funding Review Working Group Response:

Language is being recommended for inclusion in the model as language spoken can impact the costs of service delivery since certain populations may require linguistically and/or culturally adapted services. A measure of the proportion of the population whose Home Language is not English was chosen to represent these costs. This indicator was also recommended in the 1996 and 2001 funding models/reviews. Although this service cost driver is named "Language", it is recognized that there are also costs related to cultural adaption of materials and programs.

Several other ways of measuring language were reviewed, including measures of the Francophone population and the population that speaks neither English nor French. In addition, the impact of the number of different languages was considered. The Funding Review Working Group decided that the population whose Home Language is not English was the most appropriate way to represent the costs of translation and culturally specific programming at public health units.

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It is recognized that there are unique obligations regarding the provision of services in French; however, the indicator is intended to reflect the costs for translation and cultural adaptation of materials and programs, which are expected to be similar regardless of language.

The Funding Review Working Group recognizes that there is some double counting (as there will be with many indicators) if both Language and Recent Immigrant indicators are included in the model. However, the former is included as a service cost driver, with the weighting assigned to reflect the costs of translation and culturally specific programming, while the Recent Immigrants indicator was included as a driver of need with weighting assigned to reflect areas of increased need for public health services among immigrant populations. As noted below, the Recent Immigrants indicator has now been replaced with the Ethnic Concentration dimension within the Ontario Marginalization Index (ON-Marg).

3. Drivers of Need: Aboriginal Population

Field Input Summary:

Greater clarity sought regarding whether the Aboriginal indicator reflects on-reserve aboriginal populations, off-reserve aboriginal populations, or both.

- Assertion that the Aboriginal population is under reported (2).
- Assertion that on-reserve services are funded and provided by the Federal Government not public health units and therefore should be given a lower weight or not be included in the funding model (5).
- Assertion that the Aboriginal indicator does not reflect all the issues that this population faces (2).
- Assertion that the inclusion of both the Aboriginal and ON-Marg indicators results in 'double counting' (2).

Funding Review Working Group Response:

A measure of Aboriginal status is being recommended for inclusion in the model to reflect the established disparity in health status between Aboriginal and non-Aboriginal populations. The Aboriginal population refers to those persons who report: identifying with at least one Aboriginal group, that is, North American Indian, Métis or Inuit, and/or being a Treaty Indian or a Registered Indian, as defined by the *Indian Act* of Canada, and/or they were members of an Indian band or First Nation (Statistics Canada, 2006 Census of Population). Aboriginal status includes both on- and off-reserve populations. The known under reporting of Aboriginal populations in the Census supports the importance of using population estimates that adjust for this, for example, in the geography indicator and for the overall funding model. In addition, using the same source of data for all public health units should capture the relative impact of need in public health units related to Aboriginal population.

Aboriginal people experience the lowest health status of any identifiable population in Ontario. Indicators of lower health status include: shorter life expectancy; higher infant mortality; elevated rates of obesity; greater prevalence of chronic diseases (including diabetes and mental health and addictions); higher hospitalization rates, longer length of hospital stays, fewer visits to specialists, and, poor outcomes regarding socio-economic determinants of health (e.g., greater burden of poverty, unemployment, and lower educational attainment).

Appendix 1

Health Canada's First Nations and Inuit Health Branch (FNIHB) has a role with respect to on-reserve public health given the history and mandate of the Branch, funding and governance relationships with First Nations, and the extent of programming and expertise currently deployed for on-reserve First Nations peoples. Notwithstanding FNIHB's responsibility, the province has primary responsibility for the provision of health care services to all residents of Ontario, including First Nations people living on-and-off-reserve. Public health units are defined based on their geographic boundaries; therefore, every part of Ontario is covered by a public health unit and subject to the HPPA, including First Nation communities and reserves. The Ministry's position is that provincial funding for public health units for mandatory and related programs is for the entire population within the public health units - with the actual program and service delivery being determined between the public health units and First Nations communities. Under section 50 of the HPPA, a board of health and a band council may enter into an agreement under which: the board agrees to provide health programs and services to members of the band; the band council agrees to accept the responsibilities of a municipality within the public health unit; and, the band council may appoint a member of the band to sit on the board of health.

The Aboriginal indicator has a moderate correlation with some of the other indicators. This means that needs related to some of the issues faced by this population are addressed by other indicators, not this one. However, as these other indicators alone do not fully reflect the needs of the Aboriginal population, the Aboriginal indicator is also necessary to recognize this residual disadvantage.

4. Drivers of Need: Ontario Marginalization Index

Field Input Summary:

ON-Marg is an inappropriate measure of deprivation for the funding model.

- Concerns expressed regarding 'double counting' with other drivers of need (7).
- Assertion that ON-Marg is an inner city/urban centric measure of deprivation (6).
- Clarification sought regarding which ON-Marg variables and/or dimensions are used and how the ON-Marg score is used in the model calculation (3).
- Assertion that ON-Marg is an inconsistent predictor of actual health outcomes (1).

Funding Review Working Group Response:

In line with the Funding Review Working Group's decision to use an upstream approach for the development of the funding model, several deprivation and marginalization indices were considered for inclusion in the model.

ON-Marg was chosen by the Funding Review Working Group as it demonstrates the difference in marginalization between areas and describes the inequalities in various health and social wellbeing measures. ON-Marg is a census- and geographically-based index that can be used for planning and needs assessment, resource allocation, monitoring of inequities, and research. ON-Marg is an Ontario-specific version of the Canadian Marginalization Index (CAN-Marg, www.canmarg.ca), which has been in use since 2006.

Appendix 1

ON-Marg is multifaceted, allowing researchers and policy and program analysts to explore multiple dimensions of marginalization in urban and rural Ontario. The four (4) dimensions are: Residential Instability, Material Deprivation, Dependency, and Ethnic Concentration.

The index was developed using a theoretical framework based on previous work on deprivation and marginalization. It was then empirically derived using principal components factor analysis on data from across Ontario including all geographic areas. It has been demonstrated to be stable across time periods and across different geographic areas (e.g., cities and rural areas). It has also been demonstrated to be associated with health outcomes including hypertension, depression, youth smoking, alcohol consumption, injuries, body mass index and infant birth weight.

Each of the four (4) ON-Marg dimensions can be used separately or combined into a composite index. Dimensions may be chosen by comparing correlations between each dimension and a given outcome, as a way of testing appropriateness for inclusion. Each dimension may not be related to the chosen outcome in the same direction. The Funding Review Working Group analyzed each dimension's relationship to two (2) Health Status indicators – Preventable Mortality Rate and Potential Years of Life Lost Ratio – to determine how the dimensions should be incorporated in the model.

There was a positive relationship with the Residential Instability dimension. Variables in this dimension include: proportion of the population living alone, proportion of the population who are not youth (age 16+), average number of persons per dwelling, proportion of dwellings that are apartment buildings, proportion of the population who are single/divorced/widowed, proportion of dwellings that are not owned, and proportion of the population who moved during the past 5 years.

There was a positive association with the Material Deprivation dimension. Variables in this dimension include: proportion of the population age 20+ without a high-school diploma, proportion of families who are lone parent families, proportion of the population receiving government transfer payments, proportion of the population aged 15+ who are unemployed, proportion of the population considered low-income, and proportion of households living in dwellings that are in need of major repair.

There was a positive correlation with the Dependency dimension. Variables in the Dependency dimension include: proportion of the population who are aged 65 and older, dependency ratio (total population 15 to 64/total population 0-14 and 65+), and proportion of the population not participating in the labor force (aged 15+).

In contrast to the other dimensions, there was a negative correlation with the Ethnic Concentration dimension. Variables in this dimension include: proportion of the population who are recent immigrants arrived in 5 years prior to census, and proportion of the population who self-identify as a visible minority.

The Ethnic Concentration dimension was originally removed for the purpose of the funding model because it was negatively correlated with other indicators and a Recent Immigrant indicator was already being considered for inclusion in the model. However, a high level of feedback from the field regarding the appropriateness of the Recent Immigrant indicator led to the review and consideration of the meaning of the 'healthy immigrant effect' in identifying drivers of need in a public health context (see following section regarding "Recent Immigrants").

Appendix 1

The Funding Review Working Group concluded that the inclusion of an indicator that represents the health needs of immigrants was appropriate for the model. However, in deciding how to best represent the immigrant population in the model, that is, whether to include the Recent Immigrant indicator or the Ethnic Concentration dimension of ON-Marg, the Funding Review Working Group decided that the inclusion of the latter indicator would better facilitate interpretation of the model, as the three (3) remaining components of the ON-Marg were already included. Therefore, the Ethnic Concentration dimension was included in the model and the Recent Immigrant indicator was removed.

The Funding Review Working Group is also recommending that each of the four (4) ON-Marg dimensions be used separately so that each can be individually weighted to reflect its impact as a public health driver of need.

For more information on the ON-Marg go to <http://www.crunch.mcmaster.ca/ontario-marginalization-index>.

5. Drivers of Need: Recent Immigrants

Field Input Summary:

The Recent Immigrants indicator should be removed from the model given evidence of the 'healthy immigrant' effect (8).

Funding Review Working Group Response:

The Funding Review Working Group reviewed evidence related to the 'healthy immigrant effect' to better understand the Recent Immigrants indicator as a potential driver of need in this public health context.

The review determined that although new immigrant mortality and health care utilization rates are lower for recent immigrants upon arrival, as compared to the Canadian-born comparison population, the health advantages seen in the data diminished with time, with the health status of more established immigrants approaching that of the Canadian-born population. Furthermore, mortality alone is an inadequate measure of the health impact of immigration. Recent immigrants have a many fold excess of numerous infectious diseases (e.g., tuberculosis, enterics) which require intensive follow up by public health. Many immigrant groups have poor oral health, and many have greatly increased risks of diabetes and cardiovascular disease. Refugees tend to have multiple health problems.

The Funding Review Working Group concluded that the inclusion of an indicator that represents the health needs of immigrants was appropriate for the model. However, in deciding how to best represent the immigrant population in the model, that is, whether to include the Recent Immigrant indicator or the Ethnic Concentration dimension of ON-Marg, the Funding Review Working Group decided that the inclusion of the latter indicator would better facilitate interpretation of the model, as the three (3) remaining components of the ON-Marg were already included. Therefore, the Ethnic Concentration dimension was included in the model and the Recent Immigrant indicator was removed (see also previous section regarding ON-Marg).

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6. Excluded Indicators

Field Input Summary:

The field recommended a number of additional indicators for inclusion in the model including health status (11), cost of living (4), environmental health (11), special populations (8), and infrastructure/administration (10).

Funding Review Working Group Response – Health Status:

The Funding Review Working Group considered many health status indicators but originally chose not to recommend them in the model in keeping with the decision to develop a funding model using an upstream approach focusing on socio-economic determinants of health rather than on health outcomes. Health status indicators originally considered by the Funding Review Working Group included: Obesity, Daily Smoking, Physical Inactivity, Self-Rated Health, Low Birth Weight, Potential Years of Life Lost Ratio, and Standardized Mortality Ratio.

Most of the funding for public health is spent on programs only weakly related to mortality, and where better measures of outcome might include disease incidence and prevalence indicators, or data on risk factors. However, there are significant limitations in the range, quality and availability of risk factor and morbidity data. Therefore, although risk factor and morbidity rates most appropriately reflect issues related to the mandate of public health, the Funding Review Working Group does not recommend the inclusion of any health status indicators based on morbidity or risk factor data in the model.

After a high level of input received from the field recommending the inclusion of a health status indicator in the funding model, the Funding Review Working Group re-examined the issue of a health status indicator, and conducted an analysis of the correlations of two (2) mortality-based health status indicators with other indicators in the model. The health status indicators considered were: (1) Preventable Mortality Rate (under age 75) which is defined as premature mortality per number of population from preventable causes that could be potentially avoided through primary prevention efforts; and, (2) Potential Years of Life Lost Ratio (under age 75) which is defined as potential years of life lost per number of population from premature mortality due to a particular cause that could be potentially prevented. Both health status indicators measure the relative impact of preventable diseases and lethal forces on population. This analysis was intended to determine if the need for prevention programs or services that could potentially reduce premature mortality were already represented by other indicators of the funding model.

The Funding Review Working Group recommends the inclusion of the Preventable Mortality Rate in the model to reflect unrecognized aspects (i.e., not included in the other model indicators) of the health profile of public health unit populations and the services they provide. The Preventable Mortality Rate was considered the most appropriate proxy indicator of health status for the purposes of the funding model.

Funding Review Working Group Response – Cost of Living:

The Funding Review Working Group considered many Cost of Living indicators for inclusion in the funding model. However, due to data quality issues (cost of living, average dwelling cost, income per health occupation), inconsistent availability (consumer price index), little

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demonstrated variation between highest and lowest public health unit values (nutritious food basket), or inclusion in ON-Marg (unemployment), none were included in the model.

Funding Review Working Group Response – Environmental Health:

Environmental health indicators were not originally considered for inclusion in the model. In response to feedback received from the field, an analysis of the number of food premises, pools, and personal service settings per population was reviewed by the group. The analysis suggested a fairly even distribution of these premises per population across the province in most cases. Given the even distribution, the Funding Review Working Group determined that the exclusion of environmental health indicators was appropriate, as it would not add significant differentiation beyond the population distribution.

Funding Review Working Group Response – Special Populations:

The Funding Review Working Group extensively reviewed the possibility for the inclusion of special populations (e.g., corrections, students, seasonal, migrant workers, homeless, commuters, etc.) not captured by the Statistics Canada Population Estimates. However, what few data were available on these populations were not captured consistently across all public health units. Therefore, there are no adjustments included in the model to account for these factors. Correctional facility populations are included in the Statistics Canada census if they have resided in the facility for longer than 6 months. Students who return home to live with their parents during the summer are enumerated at their parents' place of residence.

Funding Review Working Group Response – Infrastructure:

The Funding Review Working Group also extensively considered the inclusion of infrastructure/administration as a separate component in the funding model. Infrastructure/administration costs were defined as those costs associated with the organizational functions of each public health unit. Organizational infrastructure costs, while necessary, are generally not viewed as contributing directly to service delivery. It is not uncommon for funding models to include a separate infrastructure/administration component as the perception is that it provides some assurance of stability for the organization.

Upon further examination, it was determined that the key factor affecting infrastructure/administration was geography, which is recommended in the final model as a service cost driver indicator. Other costs, such as those associated with board of health governance, were found to be relatively consistent across public health units. Based on this, the Funding Review Working Group determined that infrastructure/administration would not be recommended as a separate model component.

7. Model Construction: Weighting

Field Input Summary:

The field felt that the indicator weightings did not represent the work of public health units.

- There were conflicting assertions that the same indicators were weighted either too heavily or not heavily enough (14).
- Questions were raised regarding what evidence was used to support the weighting of the indicators (4).

Appendix 1

Funding Review Working Group Response:

The funding model was developed by the Funding Review Working Group as an Ontario model balancing the needs of all 36 public health units, and this is reflected in the weighting of the indicators. However, the funding model recommended is sufficiently flexible to allow the Ministry to develop implementation strategies that reflect other factors that contribute to the unique funding needs of each public health unit in Ontario.

Very little research was available on funding model development for the public health sector. As such, Funding Review Working Group members relied on their public health expertise and judgment when considering recommendations for the weighting of each indicator. Through a scenario analysis tool, which included the interaction between weight and scale, a variety of weighting scenarios were considered by the Funding Review Working Group.

It is important to note that the indicator weights in the funding model do not translate or equate to a percentage of total public health unit funding. Rather, they are used to determine an equity adjustment factor score for each public health unit that is applied to its population.

8. Model Construction: Population

Field Input Summary:

The field had a number of questions regarding which population data would be used and how it would be used in the model (7). Concerns were also expressed regarding changes to the census process with the move to the National Household Survey.

Funding Review Working Group Response:

The Funding Review Working Group is recommending that the most recent Statistics Canada Population Estimates be used for the purposes of the funding model for both mandatory programs and unorganized territories funding. Population statistics will be updated annually in order to acknowledge the high growth experienced in certain regions.

Statistics Canada Estimates were deemed to provide the most accurate Aboriginal population numbers as Statistics Canada Post-Censal Estimates include adjustments for incompletely enumerated First Nation Reserves.

It is also recommended that the population data used for the unorganized territories funding model calculations only reflect Statistics Canada Population Estimates for unorganized territories. Any reserves/settlements contained within the boundaries of the unorganized territory will be included in this population count.

Ministry of Finance population statistics projections were considered for inclusion in the model, however, it was determined that, due to several issues that would require adjustment to the data (e.g., geographic boundary differences), Statistics Canada's most recent population estimates should be used.

In 2011, the federal government announced that the long-form census questionnaire would no longer be mandatory and introduced the voluntary National Household Survey. Critics of the change have expressed concerns that the data collected is less accurate and results skewed as some population groups may be less likely to respond than others (particularly low-income

Appendix 1

populations and those whose home language is neither official language). The Funding Review Working Group has recommended in its report that the Ministry consider how changes to the Census data collection process will affect the funding model put forward in this report and pursue the most appropriate and accurate data sources, if/as they become available, in its implementation.

9. Model Implementation

Field Input Summary:

The field expressed a number of concerns regarding the implementation of the model.

- Questions were raised regarding the funding impact on each public health unit (14).
- Concerns expressed regarding the impact changes to provincial funding will have on service provision and municipal funding (14).
- Concerns expressed regarding the perceived shift from the model applied to only incremental, versus base funding, as outlined in the original Funding Review Working Group Terms of Reference (4).
- Concerns expressed regarding the timing for implementation (14).
- Assertion that smaller/less populated public health units will be impacted negatively by the model, while other large public health units with larger populations will benefit (2).
- Recommendation that amalgamation be considered as part of the implementation process (3).

Funding Review Working Group Response:

Throughout the development of the funding model, the Funding Review Working Group was cognizant of the fact that the funding model's implementation would ultimately be a government policy decision dependent on available funding and approvals. The Funding Review Working Group understood that the model must be cost neutral and/or within the Ministry's approved funding allocation.

The Funding Review Working Group has recommended that the Province use the following implementation principles when developing its method for implementing the above recommended funding model:

- The timing to reach equity/model-based share must be balanced with maintaining system stability but should not further exacerbate current funding disparities.
- The Ministry should use incremental funding to the greatest extent possible in the application of the new funding model in order to minimize the disruption to existing service provision.
- Public health units should be provided with sufficient notice regarding the implementation of the funding model for planning purposes. A transition period (e.g., at least 3 years) is necessary to implement changes to funding. The Ministry should work with boards of health and public health units to mitigate the impact on service provision during the transition period.

Appendix 1

- The impact of funding changes should be monitored by the Ministry to ensure that service provision is not being unduly impacted.
- The impact of funding changes should be taken into consideration in the setting of targets for Public Health Accountability Agreement indicators.
- The model is not intended to affect the municipal cost-share formula (75% provincial/25% municipal) although there may be impacts on municipal funding contributions resulting from the implementation of the model.
- The impact of funding changes to the municipal cost-share formula (i.e., decreases or increases in provincial funding affecting municipal contribution levels) should be taken into consideration when determining an implementation method.
- The most current data should be used for the public health funding model.

Briefing Note

To: René Lapierre, Chair, Sudbury & District Board of Health

From: Dr. Penny Sutcliffe, Medical Officer of Health and Chief Executive Officer

Date: September 10, 2015

Re: Accessibility for Ontarians with Disabilities Act (AODA) and Human Rights Compliance

☒ For Information

☐ For Discussion

☐ For a Decision

Issue:

The Accessibility for Ontarians with Disabilities Act (AODA) was passed in 2005 with the goal of making Ontario accessible for people with disabilities by 2025. The SDHU has requirements under this Act. This informational briefing note highlights for the Board the organizational actions taken pursuant to the AODA standards and our current state of compliance with the Act.

Recommended Action:

That the Board receive this briefing note for information.

Background:

The *Accessibility for Ontarians with Disabilities Act* was passed in 2005. The goal of the Act is to make Ontario accessible for people with disabilities by 2025. The law sets the following AODA standards applicable to the SDHU:

Customer service includes accessible customer service policies, practices and procedures to address service animals, support persons, customer feedback and staff training. In order to provide accessible customer service, service providers must be able to interact and communicate with a person who has a disability. Every person in the organization has to be trained.

The Employment standard requires organizations to:

- inform job applicants that recruitment and hiring processes will be modified to accommodate their disabilities
- build the accessibility needs of employees into their human resources practices
- create a written process for developing and documenting individual accommodation plans
- provide employees in need with individualized emergency response information;

2013–2017 Strategic Priorities:

1. Champion and lead equitable opportunities for health.
2. Strengthen relationships.
3. Strengthen evidence-informed public health practice.
4. Support community actions promoting health equity.
5. Foster organization-wide excellence in leadership and innovation.

Information and Communications requires organizations to:

- make their websites and web content accessible according to the World Wide Web Consortiums (Web Content Accessibility Guidelines (WCAG) 2.0.)
- provide accessible formats and communications supports as quickly as possible and at no additional cost when a person with a disability asks for them
- make feedback processes accessible by providing accessible formats and communications supports when requested
- make public emergency information accessible when requested

Built Environment focuses on removing barriers in two areas: buildings and public spaces.

The SDHU is required to comply with all the above. It is worth noting that the Built Environment standard would only apply to us in the event that we undertake major changes to existing features of our buildings or construct new locations.

SDHU Accessibility Plan:

Since the Act was passed, we have created and implemented the SDHU Accessibility Plan which is a requirement under AODA.

Within the timelines under the law, we have met the requirements of the Customer Service standard, have made necessary assessments under the Built Environment standard and have been implementing Employment and Information and Communications standards requirements.

To date, the SDHU has successfully completed and filed two reports required by the ministry to demonstrate compliance.

AODA Standards and the Human Rights Code:

One of the requirements under the AODA standards is to educate everybody in the organization about the interplay between the Human Rights Code and the AODA as organizations must comply with both laws.

The Human Rights Code is a provincial law that gives everybody equal rights and opportunities without discrimination based on 17 prohibited grounds of discrimination including disability (The other areas are: Age, ancestry, colour, race, citizenship, ethnic origin, place of origin, creed, disability, family status, marital status (including single status), gender identity, gender expression, receipt of public assistance (in housing only), record of offences (in employment only), sex (including pregnancy and breastfeeding) and sexual orientation).

The Code has primacy over the AODA, and other provincial laws, when there is a conflict. The AODA states that in the event of a conflict between it and any other Act or regulation, the law offering the higher level of accessibility has primacy.

2013–2017 Strategic Priorities:

1. Champion and lead equitable opportunities for health.
2. Strengthen relationships.
3. Strengthen evidence-informed public health practice.
4. Support community actions promoting health equity.
5. Foster organization-wide excellence in leadership and innovation.

The Code and the AODA work together to promote equality and accessibility, but have some important differences:

- The Code says people with disabilities must be free from discrimination where they work, live, and receive services, and their needs must be accommodated. Under the Code, when a person with a disability needs accommodation, there is a duty to accommodate. This means organizations may need to provide an individualized response to an accommodation request.
- The goal of the AODA is for Ontario to be accessible by 2025, by removing and preventing barriers so that people with disabilities can participate more fully in communities. The AODA sets accessibility standards that organizations must meet. The human rights principles of the Code help inform and guide how AODA standards are to be met.

The AODA standards don't limit or replace the requirements of the Code or any other law. Meeting AODA standards doesn't guarantee that an organization has met Code requirements or that the organization won't receive a human rights complaint.

The SDHU is committed to compliance with both laws.

Under the Code, the SDHU has administrative policies that promote human rights, support equity and personal dignity and prohibit behaviours that result in discrimination or harassment.

The same approach was taken in regards to AODA which included the development and implementation of administrative policies regarding accessible SDHU customer service, information and communication, employment and built environment focusing on the rights of people with disabilities.

Furthermore, the SDHU provides ongoing education to service providers and works to create a positive organizational culture that is an inclusive and welcoming place for people with different needs and backgrounds. Examples include a variety of AODA and Human Rights training sessions, the Elephant in the Room campaign and the involvement of community resources like the Canadian Hearing Society in site assessments to guide improvement.

Board of Health Members Role:

Given the governance responsibilities, it is important that Board members have awareness of the AODA law and Human Rights principles. This will assist Board members in applying them to governance decisions and activities to support the health unit's commitment to these laws.

Contact: Marc Piquette, Director, Corporate Services, ext. 356

2013–2017 Strategic Priorities:

1. Champion and lead equitable opportunities for health.
2. Strengthen relationships.
3. Strengthen evidence-informed public health practice.
4. Support community actions promoting health equity.
5. Foster organization-wide excellence in leadership and innovation.

Briefing Note

To: René Lapierre, Chair, Sudbury & District Board of Health
From: Dr. Penny Sutcliffe, Medical Officer of Health and Chief Executive Officer
Date: September 10, 2015
Re: Board of Health Proceedings

☐ For Information

☐ For Discussion

☒ For a Decision

Issue:

The Sudbury & District Board of Health meeting proceedings provide for an orderly process for members to work through Board of Health business. However, agendas are not necessarily structured to prioritize the items that would benefit the most from the Board's discussion. It is proposed that the Board of Health adopt a *consent agenda* process to increase board meeting efficiency and effectiveness.

Recommended Action:

That the Sudbury & District Board of Health support in principal a consent agenda process and direct staff to recommend related revisions to the Board of Health Manual for the Board's review and approval.

Background:

Lessons from elsewhere

The recent assessment of Algoma Public Health (<http://www.algomapublichealth.com/UserFiles/File/Media/Corporate/3129.pdf>) shone a light on board of health functioning and the increasing government and public expectations of governance and board accountability. As noted in the April 2015 report:

The essential linchpin in the effectiveness of the public health unit rests in having an effective board of health. The board must recognize its responsibility for the quality and success of the operations of the health unit and be particularly aware of its accountabilities and responsibilities flowing from the Public Health Funding and Accountability Agreement.

2013–2017 Strategic Priorities:

1. Champion and lead equitable opportunities for health.
2. Strengthen relationships.
3. Strengthen evidence-informed public health practice.
4. Support community actions promoting health equity.
5. Foster organization-wide excellence in leadership and innovation.

O: October 19, 2001
R: October 2013

Significant findings of the Assessor's Report included "that the Algoma Public Health Board failed to ensure adequacy of the quality of administration and management of its affairs and has not met the requirements of the Health Protection and Promotion Act and the Public Health Funding and Accountability Agreement nor the governance expectations under the Ontario Public Health Organizational Standards."

While as yet unknown, it is expected that the Ministry of Health and Long-Term Care response to the Assessor's recommendations will have implications for all Ontario boards of health. The Sudbury & District Board of Health is well placed to review its own processes to ensure it has appropriate time at its regularly scheduled board meetings for board member education, dialogue and decision making.

What is a consent agenda

Consent agendas are used to expedite the approval of non-controversial business that comes to a board. For the Sudbury & District Board these are items such as minutes, MOH/CEO and routine financial reports, correspondence, and information items. Some of these items require formal Board approval but are routine or they may have been previously thoroughly discussed by the Board. For a consent agenda to be effective, board members must be prepared and have had sufficient time to review materials in advance of meetings. A single motion to approve the consent agenda is tabled at the meeting.

- Items for clarification or for which a board member has a question, must be requested before the meeting. Substantive questions and responses are shared in advance with all board members.
- Items for which a board member believes requires discussion or with which the member disagrees are noted at the meeting and the Board Chair moves this item to Items for Discussion.

Benefits and evaluation

Adopting a consent agenda will allow the Board of Health time during meetings for more detailed education, dialogue and decision making on matters of importance to the Board and its governance role. A consent agenda will assist the Board to focus on operational and strategic issues of importance to the organization and also to engage in continuous improvement regarding governance processes and board accountabilities.

It is proposed that the Board of Health self-assessment tool include a question about the consent agenda to ensure the revised process is meeting the Board's needs.

Strategic Priority: 5

2013–2017 Strategic Priorities:

1. Champion and lead equitable opportunities for health.
2. Strengthen relationships.
3. Strengthen evidence-informed public health practice.
4. Support community actions promoting health equity.
5. Foster organization-wide excellence in leadership and innovation.

O: October 19, 2001
R: October 2013

BOARD OF HEALTH PROCEEDINGS – CONSENT AGENDA PROCESS

MOTION: THAT the Sudbury & District Board of Health support in principal a consent agenda process and direct staff to recommend related revisions to the Board of Health Manual for the Board's review and approval.

8.0 NEW BUSINESS

ii) Correspondence

- a) Access to Alcohol**
- b) Ontario Grades 1-12 Health and Physical Education Curriculum
“Human Development and Sexual Health” Content**
- c) Healthy Babies Healthy Children (HBHC) Program**
- d) Northern Ontario Evacuations of First Nations Communities**
- e) Smoke-Free Multi-Unit Housing**
- f) National Alcohol Strategy Advisory Committee (NASAC)**
- g) Food Charter**
- h) Amendment to the Protocol under the Ontario Public Health Standards
- Public Health Emergency Preparedness Protocol, 2015**
- i) Basic Income Guarantee**
- j) Food Safety Protocol, 2015**
- k) Low Income Dental Integration**



July 6, 2015

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

Dear Premier Wynne:

Re: Increasing Alcohol Availability in Ontario

At its meeting held on June 10, 2015, the Board of Health for the Peterborough County-City Health Unit considered correspondence from the Sudbury & District Health Unit regarding increasing alcohol availability in Ontario.

Local boards of health are required under the Ontario Public Health Standards to develop health promotion and protection strategies to mitigate against the risks of alcohol consumption. They are held accountable for reporting on local alcohol consumption rates under the Ministry of Health and Long-Term Care's Accountability Agreements.

The proposed plan to increase alcohol availability to Ontarians in local supermarkets through the Liquor Modernization Project are concerning to our local board of health. The Peterborough County-City Board of Health believes that government decisions regarding alcohol should be made within the broader context of its known and measurable societal harms, negative economic impacts, and risks to the public's health and community safety.

The Regulatory Modernization in Ontario's Beverage Alcohol Industry initiative (2014), through the Ministry of Finance and the Alcohol Gaming Commission of Ontario, has increased alcohol availability in Ontario through initiatives including VQA wine in Farmers' Markets, LCBO Express Kiosks, support to industry, increased hours of sale and removal of special event and festival restrictions. The Government's currently proposed expansion of beverage alcohol in local supermarkets is yet another initiative that will increase access to alcohol and will set a dangerous precedent for further expansion and privatization across multiple venues throughout Ontario.

It is well established that increased access to alcohol increases consumption. According to the most recent Canadian Community Health Survey, 78% of adults in Peterborough city and county (76.2% Ontario-wide) and 35.6% of teens aged 12-18 in Peterborough city and county reported consuming alcohol in the last 12 months¹. In addition, 26.2% of Peterborough city and county residents aged 12 years and older reported episodes of heavy drinking (five or more drinks on one occasion at least once monthly)¹. We are therefore concerned that further increase in the availability of alcohol will negatively impact our communities.

¹ Canadian Community Health Survey 2011-2012, Statistics Canada, Share File, MOHLTC

The current healthcare costs, enforcement, and other social costs related to alcohol misuse are estimated to be over \$5 billion a year². However, in 2013–14, the beverage alcohol sector only contributed approximately \$3 billion to the Ontario government. The proposed private models of delivery and sales must include significant management and control from the LCBO, including training and responsible sale practices. We encourage your government to include best practices such as training staff, setting limits to hours of sale, product marketing and advertising, and ensuring separate retail and cash register areas.

We also strongly recommend the province undertake a detailed analysis of the health and social impacts, including direct and indirect costs related to the proposed changes to Ontario's beverage alcohol retailing system. The Board of Health continues to welcome the opportunity to collaborate with you on these important health concerns.

Sincerely,

Original signed by

Councillor Lesley Parnell
Chair, Board of Health

/at
Encl.

cc: Hon. Charles Sousa, Minister of Finance
Hon. Dr. Eric Hoskins, Minister, Health and Long-Term Care
Hon. Dipika Damerla, Associate Minister, Health and Long-Term Care
Hon. Brad Duguid, Minister, Economic Development, Employment and Infrastructure
Hon. Jeff Leal, Minister, Agriculture, Food and Rural Affairs
Hon. Madeleine Meilleur, Attorney General
Laurie Scott, MPP, Haliburton-Kawartha Lakes-Brock
Dr. David Williams, Chief Medical Officer of Health (Acting)
Dr. Bob Bell, Deputy Minister, Health and Long-Term Care
Martha Greenberg, Assistant Deputy Minister (A), Health and Long-Term Care
Roselle Martino, Executive Director, Public Health, Health and Long-Term Care
Sharon Lee Smith, Associate Deputy Minister, Policy and Transformation
Linda Stewart, Executive Director Association of Local Public Health Agencies
Pegeen Walsh, Executive Director, Ontario Public Health Association
Ontario Boards of Health

² Rehm, J., et al. (2006). *The Cost of Substance Abuse in Canada 2002 – Highlights*. Canadian Centre on Substance Abuse



The Regional
Municipality
of Durham

HEALTH
DEPARTMENT

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Fax: 905-666-6214
1-800-841-2729

www.durham.ca

An Accredited
Public Health Agency

July 7, 2015

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

Dear Premier Wynne:

Re: Increasing Alcohol Availability in Ontario

I am pleased to support the correspondence you have already received from the Sudbury & District and Peterborough County-City Boards of Health regarding this matter (attached).

As was noted by Sudbury, "alcohol is no ordinary commodity and decisions about its promotion and availability should be made within the broader context of alcohol's known negative societal, economic and health risks." As well, as was stated by Peterborough, "increasing the availability of alcohol increases its consumption" and by Sudbury, "alcohol is the second leading cause of death, disease, and disability in Canada and causally linked to over 60 diseases and injuries."

Accordingly, I echo Sudbury's and Peterborough's recommendations regarding the adoption of best practices and the need for a detailed health and social impacts analysis respecting the alcohol retailing system.

Yours sincerely,

A handwritten signature in black ink, appearing to read 'R. Kyle'.

Robert Kyle, BSc, MD, MHSc, CCFP, FRCPC, FACPM
Commissioner & Medical Officer of Health

cc. Dr. Rosana Pellizzari
Dr. Penny Sutcliffe

"Service Excellence
for our Communities"



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Téléphone : 416 325-0400
Télécopieur : 416 325-0374

JUL 30 2015

Dr. Penny Sutcliffe
Medical Officer of Health and Chief Executive Officer
Sudbury and District Health Unit
1300 Paris Street
Sudbury, Ontario
P3E 3A3

Dear Dr. Sutcliffe:

SUDBURY & DISTRICT HEALTH UNIT			
Medical Officer of Health and CEO			
AUG 06 2015			
Environ. Health			
Clinical Services			
Corporate Services			
Health Promotion			
RRCD			
Board			
Committee			
File	()	Circulate	()
Return	()	P.Y.L.	()

Thank you for your letter outlining your concerns about increasing alcohol availability in Ontario. As the Minister responsible for alcohol policy, I am pleased to respond.

Selling alcohol responsibly is a public trust the government takes very seriously. We are aware of the tragic toll that alcohol abuse takes on individuals, families, communities, and society as a whole. The province is continuously building on its efforts to raise awareness of the risks associated with the misuse of alcohol, and to provide Ontarians with information to make informed choices when it comes to alcohol consumption.

On April 16, 2015, the Premier's Advisory Council on Government Assets released *Striking the Right Balance: Modernizing Beer Retailing and Distribution in Ontario*. This report represents the Council's final set of recommendations on the future direction for beer retailing and distribution in Ontario. The government accepted the Council's recommendations and has announced that it will authorize the sale of beer in up to 450 grocery stores to enhance consumer convenience in a socially responsible manner.

The province will establish and enforce social responsibility standards for any new retailers of beverage alcohol. The government will also mandate in law that the sale of alcohol be restricted to set hours, that alcohol be placed in a designated section of each store, and that grocers implement the necessary staff training for the sale of alcohol to the public. Furthermore, the Ministry of Finance will work with the Ministry of Health and Long-Term Care to continue to develop initiatives to support safe consumption of alcohol, in light of the expansion of alcohol sales in Ontario.

.../cont'd

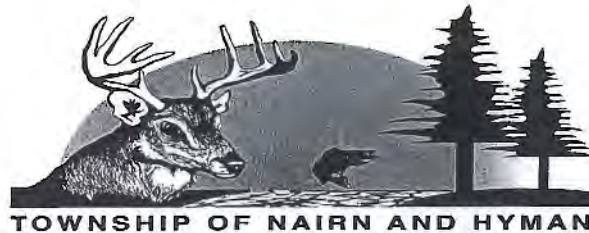
Thank you again for writing.

Sincerely,

A handwritten signature in blue ink, appearing to read 'Charles Sousa', with a stylized, cursive script.

Charles Sousa
Minister

c: The Honourable Kathleen Wynne, Premier of Ontario



TOWNSHIP OF NAIRN AND HYMAN

64 McIntyre Street • Nairn Centre, Ontario • P0M 2L0 • (705) 869-4232 • Fax: (705) 869-5248
 Established: March 7, 1896 Office of the Clerk Treasurer, CAO E-mail: nairncentre@personainternet.com
 web page: www.nairncentre.ca

August 17th, 2015

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

Re: Increasing Alcohol Availability in Ontario

SUDBURY & DISTRICT HEALTH UNIT			
Medical Officer of Health and CEO			
AUG 19 2015			
Environ. Health			
Clinical Services			
Corporate Services			
Health Promotion			
RRRD			
Board			
Committee			
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Dear Premier Wynne:

Please be advised that our Council adopted the following motion at their meeting of June 1, 2015:

RESOLUTION #2015-7-122

MOVED BY: Charlene Y. Martel

SECONDED BY: Riet Wigzell

RESOLVED: that Council supports the motion adopted by the Sudbury and District Health Unit (motion 08-15) regarding the grave concerns for the proposed measures to increase alcohol availability to Ontarians in local supermarkets through the Liquor Modernization Project.

CARRIED

"Home of the Whispering Pines"

Premier of Ontario
Aug 17, 2015
Page 2

Sincerely Yours,

Sylvie Walsh per
Robert Deschene, CAO

A handwritten signature in black ink, appearing to read 'Sylvie Walsh', with a long horizontal flourish extending to the right.

cc: Sudbury & District Health Unit ✓
Michael Mantha, MPP, Algoma-Manitoulin

"Home of the Whispering Pines"



Hon. Kathleen O. Wynne, Premier
Legislative Bldg Rm 281
Queen's Park
Toronto, ON
M7A 1A1

June 19, 2015

Dear Premier Wynne,

RE: Ontario Grades 1-12 Health and Physical Education Curriculum "Human Development and Sexual Health" Content

On behalf of the Board of Health of the Perth District Health Unit, I am writing this letter to congratulate your government for releasing the new Ontario Grades 1-12 Health and Physical Education Curriculum, including the updated "Human Development and Sexual Health" content.

The proposed curriculum changes primarily relate to creating awareness and a culture of respect regarding diversity, including visible and invisible differences, sexual orientation, and gender identity. Since 1998, there have been numerous reports written that support the critical need for education and awareness-raising on diversity, and for the elimination of bullying related to visible and invisible differences. Ontario must support the development of positive self-concept in all our children and youth.

In relation to the sexual health content of the new curriculum, it focuses on developing skills amongst children and youth to navigate the pressures they will be exposed to in our society. The prevention of sexually transmitted infections and the promotion of healthy sexuality are priorities for public health, and this curriculum utilizes the most current understanding in these areas.

We support the "Human Development and Sexual Health" content as proposed and thank you sincerely for your perseverance in addressing challenges. Locally, we have collaborated with our partner school board to create a low literacy information sheet to allay the anxieties of our Anabaptist population (enclosed). We will also be participating in a community information meeting to respond to questions and concerns.

Respectfully yours,

Dr. Miriam Klassen
Medical Officer of Health

Ms. Teresa Baressi
Board Chair

MK/mr

- c. Hon. Liz Sandals, Minister of Education
Hon. Dr. Eric Hoskins, Minister of Health and Long-Term Care
ADM (Acting) Martha Greenberg, Health Promotion Division
Parliamentary Assistant, Ministry of Children and Youth Services
Mr. Randy Pettapiece, MPP Perth-Wellington
Boards of Health of Ontario Public Health Units

August 6, 2015



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

Dear Minister MacCharles:

Re. Healthy Babies Healthy Children Program

On July 24, 2015 at a regular meeting of the Board for the Grey Bruce Health Unit, the Board considered the attached resolution from Sudbury District Health Unit regarding the Healthy Babies Healthy Children Program. The following motion was passed:

Motion No: 2015-62

Moved by: David Shearman Seconded by: Gary Levine

“That the Board of Health for the Grey Bruce Health Unit supports the resolution from Sudbury and District Health Unit advocating to the Minister of Children and Youth Services to fully fund all program costs related to the Healthy Babies Healthy Children program, including all staffing, operating and administrative costs.”

Carried

Sincerely,

A handwritten signature in black ink, appearing to be "Hazel Lynn".

Hazel Lynn MD, FCFP, MHSc
Medical Officer of Health

Cc: All Ontario Boards of Health

Encl.

**Ministry of Children
and Youth Services**

Minister's Office

56 Wellesley Street West
14th Floor
Toronto ON M5S 2S3
Tel.: 416 212-7432
Fax: 416 212-7431

**Ministère des Services
à l'enfance et à la jeunesse**

Bureau de la ministre

56, rue Wellesley Ouest
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Toronto ON M5S 2S3
Tél. : 416 212-7432
Téléc. : 416 212-7431



AUG 10 2015

Dr. Penny Sutcliffe
Medical Officer of Health and
Chief Executive Officer
Sudbury and District Health Unit
1300 Paris Street
Sudbury, Ontario
P3E 3A3

SUDBURY & DISTRICT HEALTH UNIT	
Medical Officer of Health and CEO	
AUG 12 2015	
Environ. Health	_____
Clinical Services	_____
Corporate Services	_____
Health Promotion	_____
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Board	_____
Committee	_____
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Return ()	P.Y.L. ()

CSS5111C-2015-1461

Dear Dr. Sutcliffe:

Thank you for your letter regarding funding for Sudbury and District Board of Health's Healthy Babies Healthy Children program. I am pleased to respond.

I recognize the importance of the Healthy Babies Healthy Children program in supporting vulnerable families at risk. I would like to acknowledge your health unit's commitment to the delivery of the program and the fact that you have had to develop a number of strategies to mitigate budget pressures.

Significant enhancements have been introduced to strengthen the Healthy Babies Healthy Children program despite a very challenging economic climate. These included the introduction of a new protocol, including investments in province-wide education and training to practitioners to enhance home visiting outcomes. This also included additional funding for liaison nurses in support of a streamlined screening process designed to get vulnerable families into services more quickly. These investments represent a renewed focus on early identification and intervention for vulnerable families.

Ministry staff will continue to support the health unit through various methods, including the recently launched continuous quality improvement process. This approach to program management has enabled health units to use program data in support of service delivery decisions and consider small quality improvement initiatives that can positively affect overall program outcomes.

.../cont'd

Again, thank your for writing and for bringing this matter to my attention. I appreciate your continued dedication to serving children and families in your community as effectively as possible within your budget allocation.

Sincerely,

A handwritten signature in black ink, appearing to read "Tracy MacCharles". The signature is fluid and cursive, with a large initial "T" and "M".

Tracy MacCharles
Minister

August 6, 2015

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



Dear Premier Wynne:

Re. Northern Ontario Evacuations of First Nations Communities

On July 24, 2015 at a regular meeting of the Board for the Grey Bruce Health Unit, the Board considered the attached resolution from Sudbury District Health Unit regarding Evacuations of First Nations Communities in Northern Ontario. The following motion was passed:

Motion No: 2015-63

Moved by: David Shearman Seconded by: Gary Levine

“WHEREAS the Thunder Bay District Board of Health passed a resolution on March 18, 2015, and has submitted a letter dated April 10, 2015 to the Honorable Kathleen Wynne requesting that the provincial government address the ongoing lack of resources and infrastructure to ensure the safe, efficient and effective temporary relocation of First Nations communities in Northwestern Ontario and the James Bay coast when they face environmental and weather related threats in the form of seasonal flooding and forest fires; and

WHEREAS the Sudbury District Health Unit supported this resolution at its meeting on June 18, 2015;

THEREFORE BE IT RESOLVED that the Board of Health for the Grey Bruce Health Unit support the Thunder Bay District Board of Health’s resolution 50-2015 dated March 18, 2015”

Sincerely,

A handwritten signature in black ink, appearing to read "Hazel Lynn". The signature is fluid and cursive.

Hazel Lynn MD, FCFP, MHSc
Medical Officer of Health

Carried

Cc: All Ontario Boards of Health

Encl.

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1-800-263-3456

Fax 519-376-0605



TOWNSHIP OF NAIRN AND HYMAN

64 McIntyre Street • Nairn Centre, Ontario • P0M 2L0 • (705) 869-4232 • Fax: (705) 869-5248
Established: March 7, 1896 Office of the Clerk Treasurer, CAO E-mail: nairncentre@personainternet.com
web page: www.nairncentre.ca

August 12th, 2015

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

Re: Northern Ontario Evacuations of First Nation Communities

Dear Premier Wynne:

Please be advised that our Council adopted the following motion at their meeting of August 10, 2015:

RESOLUTION #2015-11-171

MOVED BY: Riet Wigzell

SECONDED BY: Rod MacDonald

RESOLVED: that Council endorses the motion adopted by the Sudbury and District Health Unit, resolution# 32-15, where they support the Thunder Bay District Board of Health in requesting the government of Ontario to address the ongoing lack of resources and infrastructure to ensure the safe, efficient and effective temporary relocation of First Nations communities in Northwestern Ontario and the James Bay coast when they face environmental and weather related threats in the form of seasonal flooding and forest fires.

SUDBURY & DISTRICT HEALTH UNIT			
Medical Officer of Health and CEO			
AUG 19 2015			
Environ. Health			
Clinical Services			
Corporate Services			
Health Promotion			
RRRB			
Board			
Committee			
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CARRIED

"Home of the Whispering Pines"

Premier of Ontario
Aug 10, 2015
Page 2

Sincerely Yours,

A handwritten signature in black ink, appearing to read 'R Deschene', with a long horizontal flourish extending to the right.

Robert Deschene,
CAO

LF/sw

cc: Sudbury & District Health Unit
Thunder Bay District Board of Health
Michael Mantha, MPP, Algoma-Manitoulin

"Home of the Whispering Pines"

August 6, 2015



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

Dear Dr. Hoskins:

Re. Smoke-Free Multi-Unit Housing

On June 26, 2015 at a regular meeting of the Board for the Grey Bruce Health Unit, the Board considered the attached resolution from Perth District Health Unit regarding smoke-free multi-unit housing. The following motion was passed:

Motion No: 2015-49

Moved by: Mitch Twolan

Seconded by: John Bell

“That the Board of Health for the Grey Bruce Health Unit support the resolution from Perth District Health Unit regarding smoke-free multi-unit housing.”

Carried

Sincerely,

A handwritten signature in black ink, appearing to read "Hazel Lynn". The signature is fluid and cursive, with a long, sweeping tail that extends to the right.

Hazel Lynn MD, FCFP, MHSc
Medical Officer of Health

Cc: Minister of Municipal Affairs and Housing
All Ontario Boards of Health

Encl.

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519-376-9420

1-800-263-3456

Fax 519-376-0605



Perth District Health Unit

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

May 19, 2015

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

Dear Minister Hoskins,

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

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

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

Carried

Yours truly,

Dr. Miriam Klassen
 Medical Officer of Health

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



The Regional
Municipality
of Durham

Corporate Services
Department -
Legislative Services

605 ROSSLAND RD. E.
PO BOX 623
WHITBY ON L1N 6A3
CANADA

905-668-7711
1-800-372-1102
Fax: 905-668-9963

www.durham.ca

Matthew L. Gaskell
Commissioner of
Corporate Services

June 25, 2015

The Right Honourable Stephen Harper
Prime Minister
House of Commons
Ottawa ON K1A 0A6

SUDBURY & DISTRICT HEALTH UNIT	
Medical Officer of Health and CEO	
JUL 06 2015	
Environ. Health	
Clinical Services	
Corporate Services	
Health Promotion	
REED Board	
Committee	
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COPY

RE: Memorandum from Dr. Robert Kyle, Commissioner & Medical Officer of Health, dated June 4, 2015 re: National Alcohol Strategy Advisory Committee (NASAC) (Our File No. P00)

Honourable Sir, please be advised the Health & Social Services Committee of Regional Council considered the above matter and at a meeting held on June 24, 2015 Council adopted the following recommendations of the Committee:

- "A) That the correspondence dated May 7, 2015 from Peterborough's Board of Health's Chair, urging the Government of Canada to continue to support the work of the NASAC be endorsed; and
- B) That the Prime Minister of Canada, Minister of Health Canada, Durham's MPs, and all Ontario Boards of Health be so advised."

D. Bowen

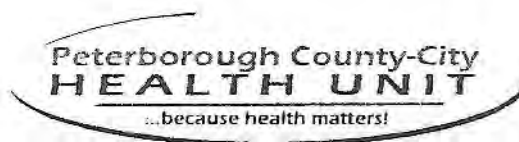
D. Bowen, AMCT
Regional Clerk/Director of Legislative Services

DB/np

- c: The Honourable Rona Ambrose, Minister of Health
Dr. Colin Carrie MP (Oshawa)
Ms Pat Perkins, MP (Whitby/Oshawa)
The Honourable Chris Alexander, MP (Ajax/Pickering)
Mr. Corneliu Chisu, MP (Pickering/Scarborough East)
Mr. Barry Devolin MP (Haliburton/Kawartha Lakes/Brock)
Mr. Erin O'Toole, MP (Durham - Clarington/Scugog/Uxbridge)
Ontario Boards of Health
R.J. Kyle, Commissioner & Medical Officer of Health

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for our Communities"

If this information is required in an accessible format, please contact the Accessibility Co-ordinator at 1-800-372-1102 ext. 2009.



May 7, 2015

The Right Honourable Stephen Harper
Prime Minister of Canada
Langevin Building
80 Wellington Street
Ottawa, ON K1A 0A2

Hon. Rona Ambrose, P.C., M.P.
Minister of Health
Brooke Claxton Building, Tunney's Pasture
Postal Locator: 0906C
Ottawa, ON K1A 0K9

Dear Prime Minister Harper and Minister Ambrose:

Re: Continued support for the implementation of Canada's National Alcohol Strategy

On behalf of the Board of Health of the Peterborough County-City Health Unit in Ontario, I am writing to express appreciation for your commitment to the prevention of harms caused by the use and misuse of alcohol and to encourage continued and enhanced support.

The work of the National Alcohol Strategy Advisory Committee (NASAC) has been made possible mainly via Health Canada's support. The resources provided have been integral to the achievements made by the NASAC which enhances the success of organizations with similar mandates, such as ours, across Canada.

Since 2008, the NASAC has undertaken the multifaceted and intricate task of reducing alcohol-related harms through their efforts to implement the 41 recommendations of Canada's National Alcohol Strategy. This initiative allows all stakeholders to take collective action through multi-sector partnerships and a shared responsibility. As a result, duplication is avoided and reach and impact are maximized. Even though the efforts of the NASAC take a national scope, their approach also serves as a model for stakeholders at provincial, regional or municipal levels to emulate. The province of Ontario is taking this approach through the report called Addressing Alcohol Consumption and Related Harms at the Local Level and the Peterborough County-City Health Unit is following suit working to create a local strategy to address alcohol in our community that is complimentary to this work.

It is well established that alcohol is no ordinary commodity and that it is associated with considerable health and social costs that impacts individuals, communities and populations. Therefore, it is vital to understand the risks involved and how to minimize those risks. The path

to a culture of moderation is being forged by the work of the NASAC through a collaborative, multi-faceted and long-term approach that is based on evidence-informed policies and practices. I urge you, therefore, to support this work through continued and augmented financial support.

Thank you for your consideration. If you require more information, please feel free to contact Deanna VandenBroek, Health Promoter, Substance Misuse Prevention Program at dvandenbroek@pcchu.ca or (705)-743-1000 ext. 223.

Yours in health,

Original signed by

Councillor Lesley Parnell
Chair, Board of Health

/at

c: Hon. Peter Gordon Mackay, P.C., M.P., Minister of Justice
Rita Notarandrea, Interim CEO, Canadian Centre on Substance Abuse; Co-chair of NASAC
Andrew Murie, CEO of MADD Canada; Co-chair of NASAC
Carolyn Davison, Director of Addiction Services in the Mental Health Children's Services Addictions Branch, Nova Scotia Department of Health and Wellness; Co-Chair of NASAC
Cheryl Arratoon, Senior Advisor, Canadian Centre on Substance Abuse
Ontario Boards of Health
Association of Local Public Health Agencies

August 11, 2015



Kelley Coulter, CAO
The County of Bruce
30 Park Street
Walkerton ON N0G 2V0

Re. Endorsement of the Bruce Grey Food Charter

On June 26, 2015, the Board of Health for the Grey Bruce Health Unit passed the following resolution.

Resolution #2015-54

Moved by: David Shearman Seconded by: David Inglis

“WHEREAS a diverse, sustainable, and just food system is integral to the overall health of any community; and

WHEREAS leaders representing all aspects of food across our community engaged in an extensive process to develop the guiding document; and

WHEREAS the Bruce Grey Food Charter recognizes the impacts of food on health, social justice, culture, education, economic development and the environment; and

WHEREAS involving people and local governments in building healthy, strong, safe and clean communities is identified as vital to the Grey Bruce Health Unit strategic plan;

NOW THEREFORE BE IT RESOLVED THAT the Board of Health for the Grey Bruce Health Unit endorse the Bruce Grey Food Charter;

AND FURTHER THAT the Grey Bruce Health Unit identify the role it can play in creating a just, sustainable, and secure food system for Bruce Grey;

AND FURTHER THAT the Grey Bruce Health Unit ask the question, in any applicable decision making process, “What impact will this have on Bruce Grey’s food system?” before decisions are finalized;

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AND FURTHER THAT the Grey Bruce Health Unit agrees to the use of its logo for endorsement purposes.”

Carried

Together we build healthy communities,



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

Copies to: Larry Miller, MP Bruce-Grey-Owen Sound
 Benn Lobb, MP Huron-Bruce
 Kellie Leitch, MP Simcoe-Grey
 Bill Walker, MPP Bruce-Grey-Owen Sound
 Lisa Thompson, MPP Huron-Bruce
 Jim Wilson, MPP Simcoe-Grey
 Municipalities in Grey & Bruce Counties
 Ontario Boards of Health

Encl.

August 11, 2015



Sharon Vokes, Acting CAO
Corporation of the County of Grey
595 9th Avenue East
Owen Sound ON N4K 3E3

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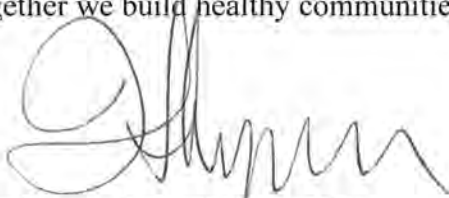
Working together for a healthier future for all..

101 17th Street East, Owen Sound, Ontario N4K 0A5 www.publichealthgreybruce.on.ca

AND FURTHER THAT the Grey Bruce Health Unit agrees to the use of its logo for endorsement purposes.”

Carried

Together we build healthy communities,

A handwritten signature in black ink, appearing to read 'Hazel Lynn', written over a faint, illegible stamp.

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

Copies to: Larry Miller, MP Bruce-Grey-Owen Sound
 Benn Lobb, MP Huron-Bruce
 Kellie Leitch, MP Simcoe-Grey
 Bill Walker, MPP Bruce-Grey-Owen Sound
 Lisa Thompson, MPP Huron-Bruce
 Jim Wilson, MPP Simcoe-Grey
 Municipalities in Grey & Bruce Counties
 Ontario Boards of Health

Encl.

**Ministry of Health
and Long-Term Care**

Chief Medical Officer of Health

Public Health Division
21st Floor, 393 University Avenue
Toronto ON M7A 2S1Telephone: (416) 212-3831
Facsimile: (416) 325-8412**Ministère de la Santé
et des Soins de longue durée**

Médecin hygiéniste en chef

Division de la santé publique
393 avenue University, 21^e étage
Toronto ON M7A 2S1Téléphone: (416) 212-3831
Télécopieur: (416) 325-8412

August 19, 2015

MEMORANDUM**To:** Board of Health Chairs
Medical Officers of Health and Associate Medical Officers of Health**Re:** Amendment to the Protocol under the Ontario Public Health Standards – Public Health
Emergency Preparedness Protocol, 2015

I am writing to inform you of the following changes to the Ontario Public Health Standards (OPHS):

- The *Public Health Emergency Preparedness Protocol, 2008* has been replaced with the *Public Health Emergency Preparedness Protocol, 2015*.

The changes to the Protocol were made by the Ministry of Health and Long-Term Care (the ministry) based on input from Public Health Ontario (PHO) and Public Health Units.

Amendments in the *Public Health Emergency Preparedness Protocol, 2015* include:

- Clarification of requirements throughout the protocol including requirements for:
 - Engagement and collaboration with relevant local government bodies and community partners;
 - Reviewing and updating the hazard-identification and risk-assessment;
 - Updating the continuity of operations plan and the emergency response plan;
 - Conducting annual exercises of the continuity of operations plan, emergency response plan, and 24/7 notification protocol;
 - Identifying high-risk populations in the community relevant to specific hazards or threats and assessing potential for disproportionate health impacts to high-risk populations;
 - Evaluating the use of the continuity of operations plan after each use; and
 - Reviewing and updating contacts for 24/7 notifications.
- Minor wording changes to clarify language.

The new *Public Health Emergency Preparedness Protocol, 2015* is attached for your reference and will come into effect immediately.

It will be available in English and French, respectively, through the OPHS website at the following links:

http://www.health.gov.on.ca/en/pro/programs/publichealth/oph_standards/docs/emergency_preparedness.pdf

http://www.health.gov.on.ca/fr/pro/programs/publichealth/oph_standards/docs/emergency_preparednessf.pdf

.../2

The ministry will communicate further details regarding these changes to public health units via regular communications to ensure continued compliance with the *Health Protection and Promotion Act* and the OPHS.

I would like to express my thanks to you and your staff for your ongoing work in upholding the OPHS and Protocols to ensure the continued strength of the public health system in Ontario.

Yours truly,

Original signed by

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

Attachment

c: Roselle Martino, Executive Director, Public Health Division
Clint Shingler, A/Director, Emergency Management Branch, Public Health Division
Paulina Salamo, A/Director, Public Health Standards, Practice and Accountability Branch, Public Health Division
Dr. Peter Donnelly, President and Chief Executive Officer, Public Health Ontario
Dr. George Pasut, Vice-President, Science and Public Health, Public Health Ontario
Dr. Brian Schwartz, Chief, Communicable Diseases, Emergency Preparedness and Response, Public Health Ontario
Lisa Fortuna, Director, Communicable Diseases, Emergency Preparedness and Response, Public Health Ontario

August 17, 2015

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

Dear Minister Hoskins:

We, the undersigned, are 194 physicians providing clinical and public health services in Ontario. We are seeking your leadership in advancing consideration by the Ontario government for introducing a basic income guarantee (BIG) for the people of Ontario. More specifically, we ask for you to encourage the Ontario government, in support of the Poverty Reduction Strategy and the health of Ontarians, to establish a BIG trial program or demonstration project. We would welcome a meeting with you to discuss a BIG for Ontarians and options for advancing this idea, e.g., striking an experts group to study basic income in depth and to help design a trial program or demonstration project.

The government's commitment to poverty reduction positions Ontario to model basic income for Canada, and the world, in the 21st century. We are confident that a BIG trial or demonstration would be highly complementary to the government's current array of measures to combat poverty and social exclusion in Ontario.

As physicians we regularly witness what the Canadian Medical Association has attested, that "income is the great divide when it comes to Canadians' health."¹ So profound is the income-health nexus that Ontario family physicians are now taught to prescribe income-based solutions to the health problems of low income patients.² As well, the University of Toronto undergraduate medical program includes seven mandatory hours of teaching focused specifically on this issue. As one of us has written:

*The link between health and income is solid and consistent—almost every major health condition, including heart disease, cancer, diabetes, and mental illness, occurs more often and has worse outcomes among people who live at lower income. As people improve their income, their health improves. It follows that improving my patients' income should improve their health.*³

We appreciate how the government is trying to improve the well-being of lower income Ontarians. Progress has been made but great strides are still needed, as evidenced by a child poverty rate of 19.9% for Ontario in 2012⁴, representing 550,000 children.⁵ Research has clearly shown that the experience of poverty in early childhood can lead to

what is termed “toxic stress”, with profound implications for physical and mental health from childhood through to adulthood.⁶ This evidence alone suggests the imperative of a BIG for Ontario’s children and their families.

More is needed to improve social security for Ontarians. In this context we note that the 2014 Mandate Letter given to you by Premier Wynne asks “that you explore long-term options for a sustainable program that provides health benefits to lower-income Ontarians.”⁷ In our view, this directive provides an opening for the government to explore the idea of establishing a BIG trial program or demonstration project, a move which could eventually lead to significant health and social improvements for all Ontarians, and especially those living at or vulnerable to low income. Surely this is one of the most upstream and sustainable of health interventions.

As defined by Basic Income Canada Network (BICN), a BIG “ensures everyone an income sufficient to meet basic needs and live with dignity, regardless of work status.” As BICN further explains, a BIG for all:

“ensures that everyone can meet their needs, participate in society and live with dignity. It reduces steep income inequalities and contributes to better health and fewer societal problems, opening the door to long-term savings in health care and other public services. It enables people to manage transitions and setbacks, supports creativity and entrepreneurship, and keeps money moving and producing in our economy.”⁸

As Barry Ward, Chair of the Simcoe Muskoka District Health Unit, wrote in the Unit’s recent letter to you et al.⁹:

Basic income is a concept that has been examined and debated for decades, including through pilot projects in the United States, Canada, and other countries more recently.^{10,11} [The Dutch city of Utrecht is currently embarking on its own test of basic income.¹²] As you may be aware, Mincome, in particular, was an encouraging pilot project of basic income for working age adults conducted jointly by the Government of Manitoba and the Government of Canada in the 1970s, which demonstrated several improved health and educational outcomes.¹³ Basic income also resembles income guarantees currently provided in Canada for seniors and children, which have contributed to health and social improvements in those age groups.^{14,15}

We anticipate that policy makers will continue to place great emphasis on job creation and employment readiness as central to combating poverty. Of course, everything that

can practically be done to create and maintain employment should be pursued. The reality, however, is that labour is undergoing profound change due globalization, outsourcing and automation. This change is giving rise to a swelling “precariat”—those whose participation in the labour market is precarious. Twenty-two percent of jobs in Ontario are in this category¹⁶ and in Canada’s urban heartland in and around Toronto, “[t]his type of employment has increased by nearly 50% in the last 20 years. Another 20% are in employment relationships that share at least some of the characteristics of precarious employment.”¹⁷

As BICN states, a BIG “safeguards the future as automation transforms the way people work and live together.”¹⁸ And as Barry Ward wrote (in his recent letter to you et al.):

“[i]n addition to providing an effective policy response to poverty and inequality, a basic income guarantee would be a key societal support in the face of rising precarious employment in Canada. Given the trend towards fewer opportunities for secure, permanent jobs, providing living wages and benefits, a basic income guarantee could help buffer the effects of precarious employment by providing a form of ‘disaster insurance’ that protects people from slipping into poverty during challenging times.”¹⁹

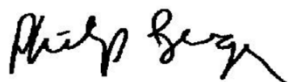
We recognize that, optimally, the federal government would be involved in establishing a BIG for all in Canada, in cooperation with the provinces and territories. While we are hopeful that a future federal government will demonstrate leadership for a BIG, we believe that Ontario could act on its own (as analysis by Toronto-based social policy expert John Stapleton suggests²⁰)—at the very least moving forward with a focused, well-designed and evaluated trial program or demonstration project.

Indeed, an initial trial or project would help to inform program design considerations in the phase of full implementation. It would help identify how a BIG could best intersect with other parts of health and social systems. It would also help evaluate the cost savings in health and elsewhere to make the case for a larger national shift.

The establishment of a BIG for Ontarians would be a magnificent legacy for those with the vision to act, and the Ontario government has an opportunity to be the provincial groundbreaker and innovator for this policy. We would be pleased to help you and your colleagues in thinking about how to move this forward. Please advise if a delegation from our ranks can meet with you soon to discuss this idea. Thank you for your consideration and we look forward to hearing from you: please direct your response to Philip Berger, MD (bergerp@smh.ca) and Lisa Simon, MD (lisa.simon@smdhu.org).

Sincerely,

On behalf of the 194 physician signatories listed on the attached pages



Philip B. Berger MD
Medical Director, Inner City Health Program,
St. Michael's Hospital
Associate Professor, Faculty of Medicine,
University of Toronto
30 Bond Street
Toronto, ON M5B 1W8
Phone: 416- 867- 7440
Fax: 416- 867- 3739
Email: bergerp@smh.ca



Lisa Simon, MD
Associate Medical Officer of Health
Simcoe Muskoka District Health Unit
15 Sperling Drive
Barrie, ON L4M 6K9
Phone: 705-721-7520 ext. 7244
Email: lisa.simon@smdhu.org

Cc. Hon. Kathleen Wynne, Premier
Hon. Deb Matthews, Deputy Premier, President of the Treasury Board, Minister
Responsible for the Poverty Reduction Strategy

List of Physician Signatories

1. Risa Adams, MD CCFP (Guelph, ON)
2. Diana R. Ahmed, MD CCFP FCFP (Brantford, ON)
3. Wajid Ahmed, MBBS MSc MAS FRCPC (Windsor, ON)
4. Mohanad Shalan Al-Gazi, MBChB FRCPC (Hamilton, ON)
5. Ian Arra, MD MSc (Sudbury, ON)
6. Neil Arya, BAsC MD CCFP FCFP D Litt (Waterloo, ON)
7. Tobey Audcent, MD, FRCP(C) (Ottawa, ON)
8. Jillian Baker, MD FRCP (Toronto, ON)
9. Jeff Balderson, MD MA CCFP FCFP (Sioux Lookout, ON)
10. Lucy Barker, MD (Toronto, ON)
11. Tony Barozzino, MD FRCP (Toronto, ON)
12. Sarah Basma, MD CCFP (Toronto, ON)
13. Ahmed Bayoumi, MD MSc FRCPC (Toronto, ON)
14. Imaan Bayoumi, MD MSc FCFP (Napanee, ON)
15. Linda Beckett, MD CCFP (Kingston, ON)
16. Michaela Beder, MD FRCPC (Toronto, ON)
17. Justin Bell, MD BHsc (Kingston, ON)
18. Sue Bennett, MB ChB FRCP DTM&H DRCOG DCH Dip Psych (Ottawa, ON)
19. Mike Benusic, MD (Toronto, ON)
20. Philip B. Berger, MD CCFP FCFP FRCPC(Hon), O.ONT (Toronto, ON)
21. Kate Bingham, MD MSc CCFP (EM) FRCPC (Toronto, ON)
22. Gary Bloch, MD CCFP (Toronto, ON)
23. Wendell Block, MD CCFP FCFP (Toronto, ON)
24. Herbert Bonifacio, MD FRCP (Toronto, ON)
25. Dona Bowers, MD CCFP FCFP (Ottawa, ON)
26. Lindsay Bowman, BMSc MD (Toronto, ON)
27. Corey Bricks, MD BMSc CCFP Candidate (Toronto, ON)
28. Jason Brophy, MD MD MSc DTM FRCPC (Ottawa, ON)
29. Sandy Buchman, MD CCFP FCFP (Toronto, ON)

30. Gary Burrows, MD FRCP (Toronto, ON)
31. Samantha Buttemer, BHSc MD (Kingston, ON)
32. Douglas Campbell, MD FRCP (Toronto, ON)
33. Jennifer Campbell, MPH MD (Toronto, ON)
34. Tesha Casella, MD CCFP (Uxbridge, ON)
35. Ian Casson, MD MSc FCFP (Kingston ON)
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168. Jason St-Hilaire, MD (Port Colborne, ON)
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170. Alexander Summers, BSc MD (Toronto ON)
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172. Itamar E. Tamari, MD CCFP FCFP (Toronto, ON)
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185. C. Ruth Wilson, MD FCFP MC (Kingston, ON)
186. Angela Wong, MD FCFP (Toronto, ON)
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189. Yeung-Seu Yoon, MD FRCPC FAAP (Markham, ON)
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191. Kelvin Young, MD FRCPC (Toronto, ON)
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References

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- ² www.ocfp.on.ca/cpd/povertytool
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- ⁴ www.campaign2000.ca/anniversaryreport/CanadaRC2014EN.pdf
- ⁵ www.thestar.com/news/gta/2014/11/24/ontario_falling_behind_its_own_poverty_reduction_goals.html
- ⁶ http://developingchild.harvard.edu/index.php/resources/briefs/inbrief_series/inbrief_the_impact_of_early_adversity/
- ⁷ www.ontario.ca/government/2014-mandate-letter-health-and-long-term-care
- ⁸ www.basiceincomecanada.org
- ⁹ May 28, 2015 letter from Barry Ward, Chair of the Simcoe Muskoka District Health Unit, to three federal and four Ontario provincial ministers
- ¹⁰ www.utpjournals.press/doi/pdf/10.3138/cpp.37.3.283
- ¹¹ www.thebigpush.net/uploads/2/2/6/8/22682672/basic_income_programs_and_pilots_february_3_2014.pdf
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- ¹⁶ www.lco-cdo.org/en/vulnerable-workers-interim-report-quick-facts
- ¹⁷ www.unitedwaytoronto.com/document.doc?id=91
- ¹⁸ www.basiceincomecanada.org
- ¹⁹ May 28, 2015 letter from Barry Ward, Chair of the Simcoe Muskoka District Health Unit, to three federal and four Ontario provincial ministers
- ²⁰ <http://vibrantcanada.ca/blogs/john-stapleton/they-cant-we-can#segal>

**Ministry of Health
and Long-Term Care**

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August 10, 2015

MEMORANDUM**To:** Board of Health Chairs
Medical Officers of Health and Associate Medical Officers of Health**Re:** Amendments to the Protocol under the Ontario Public Health Standards – *Food Safety Protocol, 2015*

I am writing to inform you of the following changes to the Ontario Public Health Standards (OPHS):

- The *Food Safety Protocol, 2013* has been replaced with the *Food Safety Protocol, 2015*.

The changes to the Protocol were made by the Ministry of Health and Long-Term Care (the ministry) based on input from public health units.

Amendments in the *Food Safety Protocol, 2015* include:

- Revisions to the annual risk categorization process for food premises. The protocol has been updated to mandate boards of health to conduct risk categorization in accordance with the *Guidance Document for the Risk Categorization of Food Premises, 2015*. As such, the *Guidance Document for the Risk Categorization of Food Premises, 2015* is legally binding and must be followed during the risk categorization process; and
- Clarification regarding routine inspection frequency of seasonal fixed premises. These premises, if in operation for six months or less, are to be inspected at least once per calendar year.

The new *Food Safety Protocol, 2015* is attached for your reference and will come into effect immediately. It will be available in English and French, respectively, through the OPHS website at the following links:

http://www.health.gov.on.ca/en/pro/programs/publichealth/oph_standards/docs/food_safety.pdf

http://www.health.gov.on.ca/fr/pro/programs/publichealth/oph_standards/docs/food_safetyf.pdf

The ministry will communicate further details regarding the changes to the *Food Safety Protocol, 2015* to public health units via regular communications to ensure continued compliance with the *Health Protection and Promotion Act* and the OPHS.

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I would like to express my thanks to you and your staff for your ongoing work in upholding the OPHS and Protocols to ensure the continued strength of the public health system in Ontario.

Yours truly,

Original signed by

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

Attachments:

Food Safety Protocol, 2015

- c: Roselle Martino, Executive Director, Public Health Division
- Nina Arron, Director, Public Health Policy and Programs Branch, Public Health Division
- Paulina Salamo, A/Director, Public Health Standards, Practice and Accountability Branch, Public Health Division
- Dr. Peter Donnelly, President and Chief Executive Officer, Public Health Ontario
- Dr. George Pasut, Vice-President, Science and Public Health, Public Health Ontario
- Dr. Ray Copps, Chief, Environmental and Occupational Health, Public Health Ontario

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AUG 10 2015

Dr. Penny Sutcliffe
Medical Officer of Health
and Chief Executive Officer
Sudbury & District Health Unit
1300 Paris Crescent
Sudbury ON P3E 3A3

SUDBURY & DISTRICT HEALTH UNIT	
Medical Officer of Health and CEO	
AUG 21 2015	
Environ. Health	_____
<u>Clinical Services</u>	_____
Corporate Services	_____
Health Promotion	_____
RRED	_____
Board	_____
Committee	_____
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HL TC2966MC-2014-9462

BS

Dear Dr. Sutcliffe:

Thank you for your letter regarding Sudbury & District Board of Health's resolution regarding the Low Income Dental Integration (LIDI) commitment through which six publicly funded provincial dental programs will be integrated into one program for low income children and youth. I value your input and the time you have taken to express your concerns. I do apologize for the delay in responding.

As you know, in December 2013, the government of Ontario announced that it would streamline six oral health programs and/or benefits for children and youth from low-income families into a single 100 per cent provincially-funded program. A number of concerns related to this commitment were raised with respect to eligibility once the programs were integrated and the aggressiveness of the implementation time lines.

I want to reassure you that I have heard your concerns and they have been addressed. The advice of the public health and other sectors has been invaluable as work proceeds.

On May 29, 2015, my ministry announced that to successfully implement the new integrated dental program, the full implementation date will be extended to January 2016. The decision was made after thorough consultation and collaboration with our valued delivery partners, including the public health units (PHUs) to best inform and guide implementation of this streamlined program. While I feel it is important for children and families to benefit from this initiative as soon as possible, I share your commitment to getting it right.

As such, I am pleased to reassure you that this new date does not impact those children currently enrolled in existing dental programs. Also, children who are currently eligible for free dental services will continue to be eligible in the new integrated program. The announcement is available on my ministry's website at:
http://www.health.gov.on.ca/en/news/bulletin/2015/hb_20150529_1.aspx.

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Dr. Penny Sutcliffe

I understand that the shift in implementation date, at this point, may have implications for PHU budgets for the 2015 fiscal year. My ministry staff will work closely with each health unit to mitigate these potential impacts and ensure that all health units are able to continue to meet the needs of the current programs until the launch of the integrated program, taking place in January 2016.

The new integrated program will provide a simplified enrolment and renewal process and access to a full range of oral health services, from preventive care, such as cleanings and fluoride treatments to basic care such as fillings, extractions and x-rays. The integration of these six oral health programs will also help build community capacity to deliver oral health prevention and treatment services to children and youth from low-income families in Ontario. Providing more children and youth with access to free dental care is part of Patients First: Action Plan for Health Care, and Ontario's Poverty Reduction Strategy.

The new integrated program will also ensure that currently eligible children will continue to be eligible in the future state integrated program. This will include ensuring that they have access to preventive services as well as emergency and essential care.

With respect to preventive services, PHUs will be asked to assess eligibility for preventive services which will be available to clinically eligible children whose families attest to financial hardship. The services that will be included in this component of the program have been considered by the Dental Services Schedule Review Expert Panel (DSSREP) based on the three services currently in the Preventive Services Protocol of the *Ontario Public Health Standards* (OPHS). This approach will, in fact, make more children eligible than in the current state under the Protocol which currently defines financial eligibility as one of the following: enrollment in the Children in Need of Treatment Program (CINOT) program; the child is a dependent of a recipient of the Ontario Child Benefit, or the family's income is below the financial eligibility cut-off (the cut-off is set at 20 per cent above Statistic Canada's low income cut-offs).

In terms of urgent, or emergency and essential, treatment, access to this stream of the program will continue to be based on clinical need and attestation of financial hardship. The DSSREP has been asked to provide advice regarding a definition of urgent need as well as a related basket of services. The DSSREP has provided its advice to government which includes advising that children should be provided with access to an appropriate course of treatment to fully address the urgent need. Providers will also have the discretion to be able to provide additional treatment to children where other clinical needs would soon become urgent if not addressed. Further operational details related to this component of the program will continue to be developed once advice from the DSSREP is received. My ministry will also provide further direction to PHUs on a common approach to be employed to assess financial hardship for preventive and urgent treatment.

Ongoing engagement and dialogue with key stakeholders will continue through the LIDI Implementation Technical Advisory Committee and the Service Schedule Review Expert Panel. My ministry will also provide updates to PHUs through regularly scheduled Chief Medical Officer of Health teleconferences.

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Dr. Penny Sutcliffe

A working group is also being established to review the current protocols under the OPHS related to all aspects of oral health within the context of the newly integrated program. This group will be providing advice to my ministry in the coming months regarding new and related requirements to be included in the OPHS.

Providing free dental care and helping to break down barriers for low-income children and youth is part of Ontario's Poverty Reduction Strategy. To date, more than 47,000 children and their families have been lifted out of poverty, and between 2008 and 2011, 61,000 were prevented from falling into poverty. In fact, the child poverty rate in Ontario fell from 15.2 per cent in 2008 to 13.6 per cent in 2011. Ensuring that children have the ability to escape the cycle of poverty is a priority for this government.

Again, thank you for writing to me. Your level of commitment to Ontario's children and advocacy is appreciated. I look forward to your continued advice and collaboration as this work continues.

Yours sincerely,



Dr. Eric Hoskins
Minister

ACCEPTANCE OF NEW BUSINESS ITEMS

MOTION: THAT this Board of Health receives New Business items 8 i) to ii).

9. ITEMS OF INFORMATION

i)	alPHa Information Break	July 8, 2015 July 21, 2015 August 11, 2015 September 1, 2015
ii)	SDHU Workplace Health Newsletter (English and French versions)	Spring/Summer 2015
iii)	2014 Snapshot of Public Health (English and French versions)	Chapleau Area
iv)	2014 Snapshot of Public Health (English and French versions)	Lacloche Foothills
v)	2014 Snapshot of Public Health (English and French versions)	Manitoulin Island
vi)	SDHU Commentary on Health Quality Ontario Report	July 2015

These items are available upon request.

ADDENDUM

MOTION: THAT this Board of Health deals with the items on the Addendum.

The Board Chair will inquire whether there are any announcements and or enquiries.

Please remember to complete the Board Evaluation following the Board meeting:
<https://fluidsurveys.com/s/sdhuBOHmeeting/>

ADJOURNMENT

MOTION: THAT we do now adjourn. Time: _____ p.m.