alPHa
Association of Local
PUBLIC HEALTH
Agencies

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Providing leadership in public health management

MEMO

To: Chairs and Members of Boards of Health
Medical Officers of Health
alPHa Board of Directors
Presidents of Affiliate Organizations

From: Linda Stewart, Executive Director

Subject: ***alPHa Resolutions for Consideration at June 2010 Conference***

Date: May 10, 2011

Please find enclosed a package of the resolutions to be considered at the Resolutions Session which takes place at Toronto Marriott Bloor Yorkville on June 13, 2011 from 8:00 to 10:00 AM as part of alPHa's 2011 annual conference, *COUNT ON US: Accountability in Ontario Health Units.*

These resolutions were received prior to the deadline for advance circulation and have been reviewed for recommendation by the alPHa Executive Committee. The Executive Committee's recommendations serve as a guide; delegates will vote on the question before them, not on the recommendations.

Sponsors of resolutions should be prepared to have a delegate present to speak to their resolution(s) during the session.

IMPORTANT NOTE FOR LATE RESOLUTIONS:

> Late resolutions (i.e. those brought by the floor) will be accepted, but please note that any late resolution must come from a health unit, the Board of Health Section, the Council of Medical Officers of Health, the Board of Directors or an Affiliate Member Organization of alPHa. They may not come from an individual acting alone.
>
> Also, in order to have a late resolution considered it must be first submitted in writing to an alPHa staff member **by 7:00 AM the day of the Resolutions Session (Monday, June 13, 2011)** so that it may be prepared for review by the membership. Before presentation to the membership, it must be reviewed by the Resolutions Chair appointed by the Executive Committee. The Chair will quickly review the resolution to determine whether or not it meets the criteria of a proposed resolution as per the "Procedural Guidelines for alPHa Resolutions" found at www.alphaweb.org/resolutions.asp. If the resolution meets these guidelines, it proceeds to the membership to vote on whether or not there is time to consider it. A successful vote will garner 2/3 majority support. If this is

attained, it will be displayed on the screen and read aloud by its sponsor followed by a discussion and vote.

Each late resolution will go through this process. We value timely and important resolutions and want to ensure that there is a process to consider them.

IMPORTANT NOTE FOR VOTING DELEGATES:

Members must register to vote at the Resolutions Session. A registration form is attached. Health Units must indicate who they are sending as voting delegates and which delegates will require a proxy vote. Only one proxy vote is allowed per person.

Eligible voting delegates include Medical Officers of Health, Associate Medical Officers of Health, Acting Medical Officers of Health, members of a Board of Health and senior members in any of alPHa's Affiliate Member Organizations. Each delegate will be voting on behalf of their *health unit/board of health.*

Delegates are asked to obtain their voting card and proxy (if applicable) from the registration desk during the conference. They will be asked to sign off verifying that they did indeed receive their card(s). This is done so that we have an accurate record of who was present and voted during the meeting.

To help us keep paper costs down, **please bring your enclosed copy of the resolutions with you** to the Resolutions Session.

Attached is a list describing the number of votes for which each Health Unit qualifies. Please note that we have updated this list based on population statistics taken from the 2006 Statistics Canada data, "Community Profiles".

If you have any questions on the above, please feel free to contact Susan Lee, Manager, Administrative and Association Services, at 416-595-0006 ext. 25 or via e-mail at susan@alphaweb.org

Enclosures:

- Registration Form
- Number of Votes Eligible for alPHa Resolutions Session Per Health Unit
- June 2011 Resolutions for Consideration

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2011 alPHa Resolutions Session
June 13, 2011 – 8:00 – 10:00 AM
Forest Hill Ballroom, Toronto Marriott Bloor Yorkville, Toronto, Ontario

REGISTRATION FORM FOR VOTING

Health Unit ____

Contact Person & Title ____

Phone Number & E-mail ____

Name(s) of Voting Delegate(s):

Name	**Proxy*** (Check this box if the person requires a proxy voting card. Only one proxy is allowed per delegate.)	**Is this person registered for the June 12-14 Conference? (Y/N)**
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Fax this form to 416-595-0030 or
email it to susan@alphaweb.org
on or before June 6, 2011

* Each voting delegate may carry their own vote plus one proxy vote for an absent delegate. For any health unit, the total number of regular plus proxy votes cannot exceed the total number of voting delegates allotted to that health unit.

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Number of Votes Eligible for Resolutions Session Per Health Unit

HEATLH UNITS	*VOTING DELEGATES*
Toronto*	**20**
POPULATION OVER 400,000	**7**
Durham	
Halton	
Hamilton	
Middlesex-London	
Niagara	
Ottawa	
Peel	
Simcoe-Muskoka	
Waterloo	
York	
POPULATION OVER 300,000	**6**
Windsor-Essex	
POPULATION OVER 200,000	**5**
Wellington-Dufferin-Guelph	
POPULATION UNDER 200,000	**4**
Algoma	
Brant	
Chatham-Kent	
Eastern Ontario	
Elgin-St.Thomas	
Grey Bruce	
Haldimand-Norfolk	
Haliburton, Kawartha, Pine-Ridge	
Hastings-Prince Edward	
Huron	
Kingston, Frontenac, Lennox and Addington	
Lambton	
Leeds, Grenville and Lanark	
North Bay-Parry Sound	
Northwestern	
Oxford	
Perth	
Peterborough	
Porcupine	
Renfrew	
Sudbury	
Thunder Bay	
Timiskaming	

* total number of votes for Toronto endorsed by membership at 1998 Annual Conference

Health Unit population statistics taken from: Statistics Canada. 2006 Census. *Community Profiles.*
http://www12.statcan.ca/english/census06/data/profiles/community/Index.cfm?Lang=E

June 2011

RESOLUTIONS FOR CONSIDERATION

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at the
alPHa Resolutions Session, 2011 Annual Conference
Monday, June 13, 2011
Forest Hill Ballroom
Toronto Marriott Bloor Yorkville
90 Bloor Street East, Toronto, Ontario

DRAFT RESOLUTIONS FOR CONSIDERATION
at June 2011 alPHa Annual Conference

Resolution Number	Sponsor	Title	Page
A11-1	Middlesex-London Board of Health	Conduct a Formal Review and Impact Analysis of the Health and Economic Effects of Alcohol in Ontario and Thereafter Develop a Provincial Alcohol Strategy	3
A11-2	Middlesex-London Board of Health	Maintain the Current Liquor License Act (LLA) of Ontario	4
A11-3	Peterborough County-City Health Unit	Call for Immediate Release of a Comprehensive Tobacco Control Strategy for Ontario	16
A11-4	Peterborough County-City Health Unit	Promoting Public Health in Ontario	17
A11-5	Peterborough County-City Health Unit	Reducing Barriers to the Provision of Public Health Services to Ontario First Nations	18
A11-6	Board of Health of the Simcoe Muskoka District Health Unit	Inclusion of Health Care Worker Influenza Immunization Rates in Acute Care Facilities as an Indicator of Patient Safety	22
A11-7	Board of Health of the Simcoe Muskoka District Health Unit	Eligibility into Perpetuity for HPV, HBV and Tdap Vaccines	31
A11-8	alPHa Board of Directors	Public Health Supporting Early Learning and Care	37
A11-9	Haliburton, Kawartha, Pine Ridge District Health Unit	Removal of “No Access of Dental Benefits” Eligibility Criterion for the Healthy Smiles Ontario (HSO) Program	39
A11-10	Haliburton, Kawartha, Pine Ridge District Health Unit	Regulation and Reduction of Sodium in the Canadian Food Supply	42
A11-11	Council of Ontario Medical Officers of Health	Provincial Adoption and Promotion of Smoke-Free Movies to Reduce the Impact of Smoking in Movies on Youth in Ontario	49

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DRAFT ALPHA RESOLUTION A11-1

TITLE: **Conduct a Formal Review and Impact Analysis of the Health and Economic Effects of Alcohol in Ontario and Thereafter Develop a Provincial Alcohol Strategy**

SPONSOR: **Middlesex-London Board of Health**

WHEREAS There is a well-established association between easy access to alcohol and overall rates of consumption and damage from alcohol; and (Barbor et al., 2010)

WHEREAS Ontario has a significant portion of the population drinking alcohol (81.5%), exceeding the low risk drinking guidelines (23.4%), consuming 5 or more drinks on a single occasion weekly (11.2%), and reporting hazardous or harmful drinking (15.6%); and (CAMH Monitor)

WHEREAS Ontario youth (grades 9-12) have concerning levels of alcohol consumption with 69.4% having drank in the past year, 32.9% binge drinking (5 or more drinks), and 27.5% of students reporting drinking at a hazardous level; and (OSDUHS Report)

WHEREAS Each year alcohol puts this province in a $456 million deficit due to direct costs related to healthcare and enforcement; and (G. Thomas, CCSA)

WHEREAS Billions of dollars are spent each year in Canada on indirect costs associated with alcohol use (illness, disability, and death) including lost productivity in the workplace and home; and (The Costs of Sub Abuse in CAN, 2002)

WHEREAS Nearly half of all deaths attributable to alcohol are from injuries including unintentional injuries (drowning, burns, poisoning and falls) and intentional injuries (deliberate acts of violence against oneself or others); and (WHO – Alcohol and Injury in EDs, 2007)

WHEREAS Regulating the physical availability of alcohol is one of the top alcohol policy practices in reducing harm; and (Barbor et al., 2010)

WHEREAS The World Health Organization (WHO, 2011) has indicated that alcohol is the world's third largest risk factor for disease burden and that the harmful use of alcohol results in approximately 2.5 million deaths each year. Alcohol is associated with increased levels of health and social costs in Ontario and is causally related to over 65 medical conditions;

NOW THEREFORE BE IT RESOLVED that the Association of Local Public Health Agencies (alPHa) petition the Ontario government to conduct a formal review and impact analysis of the health and economic effects of alcohol in Ontario and develop a provincial Alcohol Strategy.

Backgrounders attached (2) – *see pages 5 to 15*

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DRAFT ALPHA RESOLUTION A11-2

TITLE **Maintain the Current Liquor Licence Act (LLA) of Ontario**

SPONSOR **Middlesex-London Board of Health**

WHEREAS Removing designated alcohol areas at events jeopardizes the ability of servers/bar tenders to monitor the number of drinks one person has consumed and as a result, increases the possibility of over-service, over-consumption and alcohol-related harms; and (Barbor et al., 2010)

WHEREAS Removing designated alcohol areas at events increases the risks that underage youth would be able to sneak into the event either with their own alcohol or may have access to alcohol purchased by someone of legal drinking age; and (Barbor et al., 2010)

WHEREAS Alcohol consumption affects a person's judgment, coordination and reflexes and thus allowing for tiered seating is likely to increase the amount of injuries at events; and (Barbor et al., 2010)

WHEREAS There is strong and consistent evidence from a number of countries that changes to hours or days of sale have significant impacts on the volume of alcohol consumed and on the rates of alcohol-related problems; and (Barbor et al., 2010; Vingilis et al., 2007; Vingilis et al., 2005; Stockwell & Chikritzhs, 2009)

WHEREAS Research shows that the provision of alcohol at reduced or no cost increases overall alcohol consumption; and (Barbor et al., 2010; Giesbrecht et al., 2008; Mann et al., 2005)

WHEREAS Allowing the public with alcohol into areas of a restaurant, such as the kitchen, raises concerns regarding food safety and sanitation; and

WHEREAS Allowing tourist operators to offer fixed price packages that include liquor makes it difficult for servers/bar tenders to monitor the number of drinks one person has consumed and as a result, increases the risk of over-service, over-consumption and alcohol-related harms. Under the Liquor Licence Act, it is illegal to serve customers to intoxication. In an "all-you-can-drink" environment, this law is severely compromised; (Barbor et al., 2010; Thombs et al., 2009)

NOW THEREFORE BE IT RESOLVED that the Association of Local Public Health Agencies (alPHa) petition the Ontario government to maintain the current Liquor Licence Act (LLA) of Ontario as is currently written until a formal review and impact analysis of the health and economic effects of alcohol in Ontario is completed.

Backgrounders attached (2) – *see pages 5 to 15*

alPHa Executive Committee Recommendation to the Membership: This resolution to go forward for discussion at the Resolutions Session at the June alPHa conference.

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 041-11

TO: Chair and Members of the Board of Health

FROM: Graham L. Pollett, MD, FRCPC
Medical Officer of Health

DATE: 2011 April 14

PROPOSED ALCOHOL RELATED RESOLUTIONS FOR THE 2011 ASSOCIATION OF LOCAL PUBLIC HEALTH AGENCIES ANNUAL MEETING

Recommendations

It is recommended:

1. ***That the Board of Health endorse the resolutions related to alcohol attached as Appendices A and B to Report No. 041-11; and further***
2. ***That these resolutions be forwarded to the Association of Local Public Health Agencies (alPHa) for consideration at the 2011 alPHa Annual Meeting.***

Background

The research community (Appendix C) has consistently found that increased availability and access to alcohol is associated with increases in consumption and alcohol-related harms. Furthermore, researchers have agreed that regulating the physical availability of alcohol, including restrictions on sales, is one of the top alcohol policy practices in reducing harm (World Health Organization, 2009 and Barbor et al., 2010).

Today, alcohol continues to be a prominent concern as it contributes to both economic and health impacts in our community. In 2002, the annual costs in Canada for health care, directly related to alcohol consumption was $3.3 billion, and the total direct and indirect costs was $14.6 billion (Rehm et al., 2009). Alcohol is associated with increased levels of health and social costs in Ontario and is causally related to over 65 medical conditions including injury (impaired driving, drowning, falls, fires, suicide, homicide, sexual assault and other violence) and chronic disease (liver disease, cancers, high blood pressure, mental health problems, and stroke) (Barbor et al., 2010; Rehm et al., 2009; Roerecke et al., 2007). Locally, alcohol consumption rates are higher than the provincial average and pose a significant risk to our community:

- The 2009 Ontario Student Drug Use and Health Survey indicates that general alcohol use in the last year, binge drinking, and hazardous drinking, among students Grades 9-12 was higher in the South West Local Health Integration Network (LHIN) area (82.3%, 46.5%, and 35% respectively) than the provincial average (69.4%, 32.9% , and 27.5% respectively).

- Adult alcohol use in the South West LHIN area (2007) was also higher than the province in general alcohol use in the last year (84% vs. 81%), exceeding drinking guidelines (26% vs. 23%), hazardous drinking (18% vs. 16%), and weekly binge drinking (13% vs. 11%).

Currently access to alcohol in Ontario is readily available with 7-day a week sales and at a wide variety of buying venues. As of 2009/2010 there were 611 Liquor Control Board of Ontario (LCBO) stores, 436 The Beer Store (TBS) locations, and 216 agency stores (independent local retailers authorized to sell LCBO and TBS products in smaller towns across Ontario) with a total of 188 million store transactions. In addition to these stores, as of 2008/2009 there were 16,663 Liquor Licensed Establishments (bars and restaurants) and a further 56,143 Special Occasion Permits Issued in Ontario (LCBO, TBS, and Alcohol & Gaming Commission of Ontario [AGCO] Annual Reports).

Although alcohol revenue from taxes is often touted as a financial benefit to the province, it is important to understand the countering health and economic costs associated with alcohol use. In 2002-2003, alcohol cost the province $456 million more in direct health care and law enforcement costs than the net revenue and sales tax brought in from LCBO as indicated by Gerald Thomas, senior research and policy analyst at the Canadian Centre on Substance Abuse (CCSA) in September 2010. Above and beyond these direct costs there are also billions of dollars spent in indirect costs related to alcohol including lost productivity, absenteeism, victim assistance, and addiction/preventative services.

Boards of Health play a key role in a comprehensive approach (prevention, harm reduction, treatment, criminal justice, and advocating for healthy public policy) to reduce risk of injuries and chronic disease related to alcohol. This Board of Health has proven its commitment to responsible action concerning healthy alcohol policy and supportive environments through the endorsement of the March 2008, alcohol related resolutions sent to the 2008 alPHa Annual Meeting (Report No. 026–08) (Appendix D).

Current Issue

Ontario Attorney General, The Honourable Chris Bentley, announced in February 2011 that the Ontario government would be exploring changes to the alcohol regulatory system, the Liquor Licence Act (LLA) of Ontario, in the areas of licensing and enforcement (Appendix E). Of greatest concern, are those proposed modifications that increase access/availability to alcohol. This includes the amendments "giving the public more freedom to circulate in festival areas including the retail area with drinks;" "extending the hours that alcohol can be served at special events;" and "allowing all-inclusive vacation packages to be sold in Ontario."

Prior to any changes being legislated to the current LLA it is imperative that a formal review and impact analysis of the health and economic effects of alcohol in Ontario is completed. Ontario, unlike British Columbia, Nova Scotia, Saskatchewan, Quebec and Alberta which is in progress, does not have a provincial alcohol strategy although identified as a required best practice in the prevention of alcohol related injuries, deaths and diseases.

To that end, two resolutions have been drafted for submission to the Association of Local Public Health Agencies 2011 Annual Meeting. The resolutions call for:

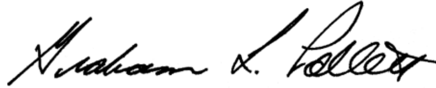
1. A formal review and impact analysis of the health and economic effects of alcohol in Ontario and thereafter the development of a provincial Alcohol Strategy (Appendix A); and
2. Maintaining the Liquor Licence Act (LLA) of Ontario in its current form until the review and development of a provincial alcohol strategy have been completed (Appendix B).

continued

Conclusion

Alcohol is a public health issue. Alcohol policies play a vital role in the health and safety of communities. While such policies can reduce harm and health risks when effectively researched and implemented, they can likewise increase harm and health risks when weakened by unsounded changes. The resolution put forward would provide a complete picture of the health and economic impact of alcohol in Ontario and thus provide information to strengthen regulatory legislation and to develop a comprehensive provincial alcohol strategy to reduce alcohol related harm, death and diseases.

This report was written by Mary Lou Albanese, Manager Healthy Communities and Injury Prevention and Melissa Rennison, PHN, Healthy Communities and Injury Prevention.



Graham L. Pollett, MD, FRCPC
Medical Officer of Health

This report addresses the following requirement(s) of the Ontario Public Health Standards: Prevention of Injury and Substance Misuse and Chronic Diseases and Injuries Appendix A

Proposed Changes to LLA – 2011

Evidence Regarding Alcohol Consumption & Related Harms

Source	Details
Paglia-Boak, A., Mann, R.E., Adlaf, E.M., & Rehm, J. (2009). Drug use among Ontario students, 1977-2009: OSDUHS highlights. (CAMH Research Document Series No. 28). Toronto, ON: Centre for Addiction and Mental Health.	• Overall, 58% (95% CI: 56%-60%) of students report drinking alcohol (more than just sips) during the 12 months before the survey. This represents about 591,700 students in grades 7 to 12 in Ontario. • The prevalence of drinking significantly differs between males (60%) and females (56%). • Overall, 25% of students report binge drinking at least once during the 4 weeks before the survey. This percentage represents about 250,700 students in grades 7 through 12. • Overall, 23% report becoming drunk at least once during the 4 weeks before the survey (about 237,400 students). • Overall, 21% of students report drinking at a hazardous level. This represents about 211,800 students in Ontario. • In 2009, 12% of drivers in grades 10 to 12 drove within an hour after consuming two or more alcoholic drinks at least one time during the past 12 months. This estimate represents about 34,700 drivers in grades 10 to 12. • The 2009 survey found that 23% of students had been a passenger in a vehicle at least once in the past year with a driver who had been drinking, and 18% with a driver who had been using drugs.
Detailed 2009 OSDUHS Report	In 2009, the perception of easy availability is highest for alcohol (56.6%), -56.6% of students (feel it is “very easy” or “fairly easy” to obtain
CAMH. (2009). Highlights from the CAMH Monitor eReport: Addiction and Mental Health Indicators Among Ontario Adults, 1977-2007. CAMH Population Studies eBulletin, 10(3). Retrieved from http://www.camh.net/Research/Areas_of_research/Population_Life_Course_Studies/eBulletins/ebv10n3_Highlights_2007 CMReport.pdf	Results from : Ontario Adults 18+ CAMH Monitor 2006/2007 • 81.5% reported drinking alcohol in 2006/2007 • 28.7% of drinkers reported exceeding the Low Risk Drinking Guidelines • 13.8% of drinkers consume 5 or more drinks on a single occasion weekly (heavy drinking) • The percentage consuming 5 or more drinks on a single occasion weekly (heavy drinking) increased over the past 20 years and currently remains at an elevated rate, especially among men and 18 to 29 year-olds. The 2007 estimate for heavy drinking among 18 to 29 year-olds is the highest on record,

	increasing from 11% in 1995 up to 26% in 2007. • 19.3% of drinkers reporting hazardous or harmful drinking (AUDIT 8+) • Indicators of hazardous/harmful drinking among the total population have been increasing since 2001, from 13% up to 16% (of the total population-drinkers & non drinkers) in 2007. This increase was especially evident among women, and 18 to 29 year olds. • 6.1 % of drivers drank and drove at least once in the past 12 months
Babor, T., Caetano, R., Casswell, S., et al. (2010). *Alcohol: No Ordinary Commodity – Research and Public Policy, Second Edition.* Oxford, UK: Oxford University Press.	• In Canada, alcohol is the third highest risk factor contributing to the burden of disease. • The social harms associated with alcohol consumption include traffic crashes, drownings, injuries, fires, suicides, homicides, sexual and physical violence and family and financial problems
5National Alcohol Strategy Working Group. (2007). *Reducing Alcohol-Related Harm in Canada: Toward a Culture of Moderation.* Canada. Retrieved from http://www.nationalframeworkcadrenational.ca/uploads/files/FINAL_NAS_EN_April3_07.pdf	• Alcohol use is associated with increased levels of health and social harms. Alcohol is causally related to over 65 medical conditions.
Giesbrecht, N., Stockwell, T., Kendall, P., Strang, R., and Thomas, G. (2011). Alcohol in Canada: reducing the toll through focused interventions and public health policies. Canadian Medical Association Journal. CMAJ 2011. DOI:10,1503/cmaj.100825	• Alcohol is a substantial contributing cause of acute and chronic disease, trauma and social problems in Canadians. • With reduced controls and increasing consumption, the high level of harm from alcohol is expected to increase. • A comprehensive public health response to reduce harm from alcohol requires combined population-level policies, improved access to services for high-risk drinkers, greater involvement by nongovernmental organizations and all public health sectors, and community-based leadership. • A two-tiered response is recommended that, at the population level, targets pricing and restrictions on access, marketing and sponsorship and, at the front-line level, involves controls on drinking and driving, interventions by servers, public education and persuasion programs, and increased access to brief intervention and treatment.
Giesbrecht, N., Petra, J., Popova, S. (2008). Changes in Access to Alcohol and Impacts on Alcohol Consumption & Damage: An overview of recent research studies focusing on alcohol price, hours and days of sale and density of alcohol outlets. Report prepared for Addiction Services, Department of Health Promotion and Protection, Halifax.	• It is feasible to curtail the rise in alcohol consumption and high risk drinking, [in Canada] and reduce the damage from alcohol -this would require 3 actions: 1) that there be no further initiatives to increase access to alcohol 2) that the most effective interventions be implemented, reinforced and evaluated

	3) that health and safety experts become central contributors to policy decisions that impact alcohol management Themes to Consider: • Alcohol policies can increase damage or reduce harm • Not all alcohol policy interventions are of equal potency -increased access through lowering the price of alcohol, discount pricing, extensive happy hours and general reduction in real price are especially important -long hours of sale and high density of outlets have been associated with increased sales or alcohol-related damage • Consider the larger context: -in Canada the recent increase in overall consumption and high risk drinking clearly points to a precautionary perspective if the damage and high costs from alcohol are to be curtailed • Health and safety experts at the decision-making table: -alcohol policy & retailing decisions have implications for health, safety & social problems –therefore, decision-making procedures need to include health & safety expertise • A priori impact assessment: a careful & wide-ranging assessment regarding any alcohol policy changes being considered • A precautionary perspective: once a change in access has been introduced, it is very difficult to reverse the decision • Pilot studies and evaluation: consider pilot studies before moving forward –it is essential that there be sufficient time & resources to gather baseline data before the change so that 'natural experiment' evaluation is feasible

Evidence regarding: All-you can drink

Source	Details
Babor, T., Caetano, R., Casswell, S., et al. (2010). *Alcohol: No Ordinary Commodity – Research and Public Policy, Second Edition.* Oxford, UK: Oxford University Press.	-2 studies by Thombs and colleagues demonstrate significant associations between patron intoxication and drink specials, particularly 'all-you-can-drink' specials (2008 & 2009) -see below for Thombs 2009 study
A field study of bar-sponsored drink specials and their associations with patron intoxication. Thombs DL, O'Mara R, Dodd VJ, Hou W, Merves ML, Weiler RM, Pokorny SB, Goldberger BA, Reingle J, Werch CC. J. Stud. Alcohol Drugs 2009; 70(2): 206-14.	Participation in "all-you-can-drink" promotions was significantly associated with higher BrAC readings after adjusting for covariates and random effects attributable to drinking establishment. Other drink specials did not have significant associations with alcohol intoxication. Conclusions: The all-you-can-drink special may be the specific discounting practice with the greatest potential for boosting patron intoxication and thus may need to be a stronger focus of

	alcohol-control policies aimed at improving the beverage service of drinking establishments.

Evidence related to Extended Hours of Alcohol Sales

Source	Details
Babor et al. (2010). *Alcohol No Ordinary Commodity research and public policy* (2nd ed.) (pp. 133-136). New York: Oxford University Press.	• Summary: there is strong and reasonably consistent evidence from a number of countries that changes to hours or days of trade have significant impacts on the volume of alcohol consumed and on the rates of alcohol-related problems. When hours and days of sale are increased, consumption and harm increase and vice versa. A small number of studies suggest that trading hour restrictions affect heavy drinkers in particular. The weight of evidence suggests that restrictions on opening hours and days of sale are important policy levers for managing alcohol-related harm. Increasing the hours and days of sale is typically related to increased consumption and alcohol harms (usually acute harm) and studies of reduced hours of sale or bans on days of sale are associated with reduced problems. Many studies are referred in this book –below is one example: • The extension of hotel closing times from midnight to 1am in Western Australia was studied (Chikritzhs and Stockwell, 2002, 2006, 2007): -found significant increases in assaults and in impaired driving road crashes associated with the extended hours - found increased blood alcohol concentration among male drivers aged 18-25 years who were apprehended during the later trading hours -The Vingilis Studies (2007 & 2005) and the Stockwell & Chikritzhs Review are also included in this book (see below)
Babor, Thomas. (2010). Presentation: How Alcohol Policies Reduce Harm: New Research and Recommendations A Summary of Alcohol: No Ordinary Commodity (2nd edition 2010). Alcohol No Ordinary Commodity 7 Forum, March 2, 2010.	• Restriction on hours or days of sale, outlet density is one of the top 10 best practice prevention strategies for reducing alcohol-related harm
Vingilis, E., McLeod, A.I., Stoduto, G., Seeley, J., Mann, R. (2007). Impact of extended drinking hours in Ontario on motor-vehicle collision and non-motor-vehicle collision injuries. *Journal of Studies on Alcohol and Drugs* 68, 905-11.	• Study evaluated the impact of extended drinking hours in Ontario (May 1996 -LLA changes to extend hours of service from 1am to 2am) on motor-vehicle collision (MVC) and other injuries (assault & fall-related): admitted to regional trauma units based on Ontario Trauma Registry data - examined data from 4 years before policy change to 3 years after -MVC: found no significant pre-post increases for 2-3am period

	-MVC: found decreases for 11pm-12am and 1-2am periods -non-MVC significant increase found for 2-3am period -Overall: data suggest that increased availability of alcohol as a result of extension of closing hours had an impact on non-MVC injuries presenting to Ontario trauma units, but road safety initiatives may have mediated the effects of the extension on MVC injuries. These observations are consistent with those of other studies of small changes in alcohol availability
Vingilis, E. McLeod, A.I., Seeley, J., Mann, R., Beirness, D., and Compton, C. (2005). Road safety impact of extended drinking hours in Ontario. *Accident Analysis and Prevention* 37, 549-56.	• Study evaluated the road safety impact of extended drinking hours in Ontario (May 1996 -LLA changes to extend hours of service from 1am to 2am) - examined BAC positive fatalities from 4 years before policy change to 3 years after –this was compared to neighbouring regions of New York and Michigan and to total fatalities in Ontario and to -found the BAC positive driver fatality trends reflected downward trends for Sunday-Wednesday 12-2am and Thursday-Saturday 1-2am for Ontario and downward trends for Thurs-Sat 12-1am and 2-3am for New York and Michigan after the extended drinking hour policy change. Ontario total fatality data showed similar trends to the Ontario blood alcohol positive trends. -overall, the multiple datasets converge in suggesting little impact on BAC positive fatalities with extension of the closing hours –these observations are consistent with other studies of small changes in alcohol availability
Vingilis, E., McLeod, A.I., Seeley, J., Mann, R., Voas, R., Compton, C. (2005). The impact of Ontario's extended drinking hours on cross-border cities of Windsor and Detroit. *Accident Analysis and Prevention* 38, 63-70.	• Study evaluated the cross-border safety impact of extended drinking hours from 1-2am in licensed establishments in Ontario • A significant increase in alcohol-related motor vehicle casualties was found in the Windsor region and concomitantly, significant decreases in total and alcohol-related motor vehicle casualties were found in the Detroit region after the extended drinking hours amendment. The Ontario government's belief that the extended drinking hour policy would 'reduce the number of patrons who cross the border when Ontario's bars and restaurants close' may have been realized.
Stockwell, T., and Chikritzhs, T. (2009). Do relaxed trading hours for bars and clubs mean more relaxed drinking? A review of international research on the impacts of changes to permitted hours of drinking. *Crime Prevention and Community Safety: An International Journal* 11, 171-188.	• Review informed by systematic search of studies published since 1965 which sought to evaluate the public health and safety impacts of changes to liquor trading hours for on premise consumption –namely 'pubs' and clubs in the UK, 'hotels' and 'taverns' in Australia and New Zealand and 'bars' in North America. • Supplemented with grey literature • 49 studies –only 14 included baseline and control measure and were peer-reviewed • Out of the 14, 11 studies reported at least one significant outcome indicating adverse effects of increased hours or benefits from reduced hours. Controlled studies with fewer methodological problems

	were also most likely to report such effects. • Conclusion: the balance of reliable evidence from the available international literature suggests that extended late-night trading hours lead to increased consumption and related harms. Further well-controlled studies are required to confirm this conclusion.
Giesbrecht, N., Petra, J., Popova, S. (2008). Changes in Access to Alcohol and Impacts on Alcohol Consumption & Damage: An overview of recent research studies focusing on alcohol price, hours and days of sale and density of alcohol outlets. Report prepared for Addiction Services, Department of Health Promotion and Protection, Halifax.	-Report included some of the studies reviewed in Alcohol No Ordinary Commodity Conclusions: -in Australia, an increase in the hours of sale has been associated with an increase in the amount of alcohol purchased and an increase in monthly assault rates in those licensed premises with later hours of sale -In Ontario, there was an increase in alcohol-related motor vehicle casualties in an area affected by the increase in hours of on-premise sales (licensee), compared to a control area

Evidence related to Regulation & Enforcement

Source	**Details**
Mann et al. (2005). Alcohol Distribution, Alcohol Retailing and Social Responsibility: A Report Submitted to the Beverage Alcohol System Review Panel.	• Summary: Increased regulation and enforcement effects can act to reduce alcohol problems. However, their effects are variable and often not sustained, as enforcement priorities or resources shift. • Example: research on regulation and enforcement directed to preventing underage consumption has found temporary, inconsistent or no effects of community enforcement programs

The Situation in Ontario

Source	Details
Alcohol and Gaming Commission of Ontario 2008-2009 Annual Report http://www.agco.on.ca/pdfs/en/ann_rpt/2008_09Annual.pdf	In 2008-2009 • 16,663 Liquor Sales Licensed Establishments (includes restaurants) • 56,143 Special Occasion Permits Issued • The AGCO's Liquor Enforcement Branch continues to work closely with local law enforcement agencies on joint forces projects targeting higher risk facilities and problem establishments identified with local authorities. During this fiscal year, **27,924 inspections of liquor sales licensed establishments** were conducted, together with 2,859 joint forces projects.
Rehm, J., Baliunas, D., Brochu, S., Fischer, B., Gnam, W., Patra, J., Popova, S., Sarnocinska- Hart, A., Taylor, B. (2006). *The Costs of Substance Abuse in Canada 2002.* Ottawa, ON: Canadian Centre on	• In 2002, alcohol accounted for $5.2 billion of the health and social costs in Ontario (includes law enforcement).

Substance Abuse.	
LCBO Annual Report 2008-2009.	• The LCBO does not serve those who lack proper identification to prove their age, appear intoxicated, or are suspected of shopping for those who are underage or impaired. Year –round *Check 25 program* helps make sure potential customers who appear to be under 25 years of age are routinely asked for proof of age. • In 2008-2009 staff challenged 2.4 million people who appeared underage or intoxicated

Evidence regarding further proposed changes:

Allowing bars & restaurants to serve complimentary drinks.

This relates to evidence on alcohol price/taxation:

Source	**Details**
Mann et al. (2005). Alcohol Distribution, Alcohol Retailing and Social Responsibility: A Report Submitted to the Beverage Alcohol System Review Panel.	-a substantial amount of research finds that the price of alcohol, or the amount of tax charged, is a powerful determinant of alcohol consumption and alcohol problems -the initial finding in this area was reported by Seeley (1960) using data on alcohol price, consumption and mortality rates from cirrhosis of the liver in Ontario & Canada: -the correlation between price of alcohol & per capita consumption was -.96 for Ontario and -.99 for Canada -correlation between price of alcohol & mortality rate for liver cirrhosis was -.90 for Ontario and -.88 for Canada -as price increased, alcohol consumption and cirrhosis mortality rates decreased -Adrian, Ferguson, Her (2001) found increases in prices of alcohol were associated with decreases in alcohol-related motor vehicle collision rates & alcohol-related criminal traffic offenses in Ontario -alcohol taxes are among the most effective problem-prevention tools available -increases in taxes will act to reduce alcohol problem rates and associated burden on police and health care systems -factors that affect alcohol availability such as price are known to influence consumption even among those who are heavy drinkers and may be experiencing alcohol problems such as abuse and dependence; in fact, price & other availability factors may even exert a larger impact on these groups that on the general population Summary: Research conducted in Canada and internationally shows there is a strong link between the real cost of alcohol and its consumption, and thus with the problems resulting from alcohol. The evidence demonstrates that increases in the cost of alcohol to the consumer will act to decrease consumption rates, particularly among heavy consumers, and thus to decrease alcohol-related problem rates. Conversely, a decrease in the cost of alcohol to the consumer will act to increase consumption rates, and thus to increase alcohol-related problem rates.

Giesbrecht, N., Petra, J., Popova, S. (2008). Changes in Access to Alcohol and Impacts on Alcohol Consumption & Damage: An overview of recent research studies focusing on alcohol price, hours and days of sale and density of alcohol outlets. Report prepared for Addiction Services, Department of Health Promotion and Protection, Halifax.	-as the 'real price' of alcohol is increased the damage or potential damage from alcohol is reduced; as the real price of alcohol is lowered, such as through discount pricing and sale pricing, the damage from alcohol or potential damage is elevated -Studies have found that changes in price or taxation of alcoholic beverages have an impact on alcohol consumption, i.e. a reduction in price tends to *stimulate* consumption and an increase in price tends to *deflate* overall consumption. Since increases in alcohol consumption rates have been linked with increases in alcohol-related damage-including trauma, social problems and chronic disease –there are public health and safety benefits in maintaining the real price of alcohol and, alternatively, in not resorting to discount pricing as a way of stimulating competition. Studies that examined drinking patterns found: an increase in the price of alcoholic beverages can contribute to some consumers switching to lower priced beverages; an increase in price due to taxation significantly reduced the prevalence of drinking among young adults aged 17-29. Studies have shown that an increase in alcohol prices or taxes tends to reduce alcohol-related damage, whereas a decrease in prices or taxes tends to stimulate an increase in alcohol-related damage. Change in the price of alcoholic beverages has been positively associated with the following: -alcohol-related problems as measured by the AUDIT -traffic-related fatalities among 18-20 year olds -motor vehicle mortality rates -rates of sexually-transmitted infections -rapes and robberies, spousal abuse and crime involving youth and young adults -alcohol-attributable mortality, suicide and cirrhosis mortality

Evidence re Policy Change

Source	Details
Mann et al. (2005). Alcohol Distribution, Alcohol Retailing and Social Responsibility: A Report Submitted to the Beverage Alcohol System Review Panel.	-important that a complete assessment of potential impacts be conducted before undertaking policy changes that result in substantial increases in harms and may be difficult to reverse -ex. when Ontario lowered minimum drinking age from 21 to 18 in 1971 there were significant increases in adolescent drinking driving fatalities and alcohol problems in high schools -where effects of policy change are uncertain, preliminary assessment of the impact of policy change under pilot conditions can provide valuable assistance to government decision-making Summary: Any change to alcohol distribution has the potential to increase alcohol consumption and related morbidity and mortality. Larger changes are associated with larger risk for damage. Pilot implementation and evaluation of policy changes provides the important option of identifying and avoiding policy changes that could create more damage than benefits.

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DRAFT ALPHA RESOLUTION A11-3

TITLE: **Call for Immediate Release of a Comprehensive Tobacco Control Strategy for Ontario**

SPONSOR: **Peterborough County-City Health Unit**

WHEREAS smoking and other forms of tobacco use still remain the single largest cause of preventable disease and contributes to the premature death of Ontarians annually; and

WHEREAS alPHa has, following a 2009 resolution, urged government to commit to the goal of preserving and enhancing reductions in tobacco use, and to this end to reinstate funding to 2008-2009 levels and in addition, enhance funding for comprehensive tobacco control efforts in Ontario; and

WHEREAS the Smoke-Free Ontario Scientific Advisory Committee (SAC) submitted its report "Evidence to Guide Action: Comprehensive Tobacco Control in Ontario" to the Ontario Agency for Health Protection and Promotion (OAHPP) in the Fall of 2010. The report presents a case for continued comprehensive tobacco control in Ontario; and

WHEREAS the SAC report was closely followed by a report from the Tobacco Strategy Advisory Group (TSAG) with the objective to advise the Ministry of Health Promotion & Sport in the development of a five-year plan to renew the Smoke-Free Ontario Strategy. The TSAG report concluded that "The government must invest in a sustained and sufficiently intensive comprehensive tobacco control strategy in Ontario at levels required to eliminate the burden of tobacco use rapidly, equitably and cost-effectively"; and

WHEREAS Ontario has an opportunity to build on and expand its achievements obtained since the introduction of the Ontario Tobacco Strategy; and

WHEREAS the province promised to release its comprehensive tobacco strategy in 2010 and has, to date, failed to do so;

NOW THEREFORE BE IT RESOLVED that alPHa urgently request the Premier of Ontario (Dalton McGuinty), the Minister of Health Promotion & Sport (Margarett Best), the Minister of Health and Long-Term Care (Deb Matthews), the Office of the Attorney General (Chris Bentley), the Minister of Finance (Dwight Duncan), the Minister of Revenue (Sophia Aggelonitis) and the Chief Medical Officer of Health (Arlene King), to adopt the entire set of recommendations within the Tobacco Strategy Advisory Group report and announce a renewed, long-term commitment to a comprehensive tobacco control strategy to reduce use and exposure to tobacco products and the illnesses and deaths they cause to Ontario's populations.

alPHa Executive Committee Recommendation to the Membership: This resolution to go forward for discussion at the Resolutions Session at the June alPHa conference.

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DRAFT ALPHA RESOLUTION A11-4

TITLE: **Promoting Public Health in Ontario**

SPONSOR: **Peterborough County-City Health Unit**

WHEREAS the term "public health"[1] [2] is not always well understood by members of the public, potential partners, and policy-makers; and

WHEREAS on a daily basis, Ontario's public health sector contributes to keeping Ontarians healthy and safe through health protection, disease prevention and management, and health promotion activities; and

WHEREAS a strong public health sector is vital to a healthy and safe Ontario and yet the public tends not to think about public health except in times of crisis; and

WHEREAS public relations campaigns provide measurable benefits to audiences and health units through increased knowledge and confidence in the public health system, improved access to services, enhanced health literacy[3] and stronger relationships with priority populations; and

WHEREAS Ontario's public health system consists of governmental, non-governmental, and community organizations operating at the local, provincial and federal levels, yet the primary responsibility for program delivery lies with 36 Boards of Health which have limited resources and access to province-wide communication providers;

NOW THEREFORE BE IT RESOLVED that alPHa request all three funding Ministries (Health and Long-Term Care, Health Promotion and Sport, and Children and Youth Services) to fund a single, centralized provincial public relations campaign to increase the profile of public health among Ontario residents.

alPHa Executive Committee Recommendation to the Membership: This resolution to go forward for discussion at the Resolutions Session at the June alPHa conference.

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[1]Last, John Dictionary of Public Health describes public health as "an organized activity of society to promote, protect, improve, and when necessary, restore the health of individuals, specified groups, or the entire population… The term 'public health' can describe a concept, a social institution, a set of scientific and professional disciplines and technologies, and a form of practice…It is a way of thinking, a set of disciplines, an institution of society, and a manner of practice."

[2] The World Health Organization (WHO) defines public health as "a social and political concept aimed at improving health, prolonging life and improving the quality of life among whole populations through health promotion, disease prevention and other forms of health intervention."

[3]Health literacy is an increasingly important concept to public health communications, which Ratzan and Parker (in Selden, et. al, 2000) define as "the degree to which individuals have the capacity to obtain, process and understand basic health information and services needed to make appropriate health decisions" (p. vi). From Selden, C., Zorn, M., Ratzan, & S., Parker R. (2000). Health literacy (bibliography online). Bethesda (MD): National Library of Medicine. Available at http://www.nlm.nih.gov/archive//20061214/pubs/cbm/hliteracy.html

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DRAFT ALPHA RESOLUTION A11-5

TITLE: **Reducing Barriers to the Provision of Public Health Services to Ontario First Nations**

SPONSOR: **Peterborough County-City Health Unit**

WHEREAS a 2002 alPHa resolution called for the establishment of an "Aboriginal Public Health system in and for Ontario First Nation citizens" that would "guarantee equitable and quality delivery of all aspects of the *Health Promotion and Protection Act* and its Regulations to all First Nation citizens of Ontario while maintaining fiduciary responsibility of the Federal government in accordance with the Canadian Constitution (British North America Act) and Treaty rights of First Nations Citizens"; and

WHEREAS Section 50 of the Health Protection and Promotion Act allows for a board of health for a health unit to sign agreements with First Nations for the organization and delivery of public health programs and services, the prevention of the spread of disease and the promotion and protection of the people in Ontario; and

WHEREAS some First Nations have signed Section 50 agreements and discussions in Ontario are ongoing concerning the provision of Ontario's public health programs to other First Nations; and

WHEREAS research has shown that the conditions in which people are born, grow, live, work and age are shaped by the distribution of money, power and resources at national and local levels and are fundamental to health status of individuals and populations; and

WHEREAS the chance of improved health outcomes from the delivery of public health services to many First Nations in Ontario would be severely limited by the effects of their current depressed socio-economic conditions; and

WHEREAS public health services should be available to all citizens of Ontario;

NOW THEREFORE BE IT RESOLVED that the Ontario Association of Local Public Health Agencies (alPHa) strongly recommend and urgently request that the Minister of Health and Long-Term Care make available to those First Nations who currently have, or are interested in pursuing, a Section 50 agreement, a provincial subsidy to cover the associated costs with the municipal portion of public health funding. In addition, Boards of Health that incur additional costs to provide requested public health services to First Nations communities within their geographic area should be reimbursed from a fund that is established for this purpose;

AND FURTHER that the Association of Public Health Agencies (alPHa) call for the Ontario government to develop policies and to coordinate and implement a long-term strategy to help improve socio-economic benefits to First Nations.

Backgrounder attached (1)
alPHa Executive Committee Recommendation to the Membership: This resolution to go forward for discussion at the Resolutions Session at the June alPHa conference.

Backgrounder – Draft alPHa Resolution A11-5

Briefing Note Re:
Proposed alPHa Resolution: Reducing Barriers to the Provision of Public Health Services to Ontario First Nations

SPONSOR:

Peterborough County-City Board of Health

ISSUE:

The full scope of Ontario public health services is currently being formally provided by only one of the Province's thirty six boards of health to two First Nations, even though the Province's *Health Promotion and Protection Act* allows for the provision of these services. There are 133 First Nation communities in Ontario and approximately 20% of Ontario's 242,495 Aboriginal people reside in First Nation communities. Twenty public health units are co-located with First Nations communities within their geographic areas. This resolution addresses the inequity in access to public health that is experienced by the 20% of on-reserve First Nations peoples in Ontario.

First Nations communities have the right to self government and this includes the right to make choices about the provision of public health services. However, substantial barriers exist. These barriers include a lack of funds for Health Units and First Nations to provide/acquire these services, and the complex jurisdictional responsibilities between the Federal, Provincial and First Nations. Unfortunately, focusing on services alone, without strengthening healthy public policy and addressing the social determinants of health, will not achieve the desired improvements in both health outcomes and equity.

BACKGROUND:

The underlying principles of this resolution are:

- Respect for the autonomy of First Nations communities: First Nations will decide which model of public health works best for their context but the financial barrier (25% municipal cost share) for a Section 50 agreement should be removed so that this option becomes more accessible;
- Recognition that the underlying socio-economic conditions that perpetuate the historical marginalization of First Nation peoples must be addressed in order to make gains in health status;
- Recognition that it is not just the provision of public health services but the inclusion and leadership of First Nations people that is necessary for a robust public health system in Ontario that is effective and proactive;
- First Nations and Boards of Health in northern and remote areas face additional economic barriers that require additional strategies and resources to resolve.

This resolution attempts to connect the need for the provision of public health programs with the need to address the social determinants of health. The difficult socio-economic conditions facing many Ontario First Nations would make the full benefits of public health programs more difficult to achieve. Our resolution therefore also deals with the need for improved socio-economic conditions as a critical determinant of the efficacy of public health services.

The provision allowing a board of health for a health unit to sign agreements with First Nations for the organization and delivery of public health programs and services is clearly defined in Section 50 of the *Health Protection and Promotion Act*. Despite this opportunity, to date, only three First Nations have entered into negotiations with their local boards of health.

There is a substantial body of evidence supporting the need for the provision of public health services and programs to First Nations. For example, in 2007 Canada's response to the World Health Organization Commission on Social Determinants of Health identified health disparities as:

> *"--differences in health status that occur among population groups defined by specific characteristics. -----The most prominent factors in Canada are socio-economic status, First Nation identity, gender, and geographic location".*

The Association for Local Public Health Agencies (alPHa) has a history of active involvement with this issue and has coordinated discussion that clearly identified the need to consider socio-economics in *assessing* and planning for the health needs and impacts of priority populations. A December 2010 Joint OPHA/alPHa Working Group on Social Determinants of Health (SDOH) reported that:

> *"Virtually all strongly agreed that community engagement, multi-sectoral collaboration, and support for policy advocacy are appropriate domains of public health unit activity on the SDOH." Health units also noted that additional roles in action on the SDOH could be adopted by health units, including increasing awareness of the SDOH and assessing and planning for the health needs and impacts of priority populations. Notably, health units did not see their role limited to their local context. They also mentioned that contribution to the provincial system to build systemic capacity and coordination was also appropriate for health units to consider."*

The Provincial government has participated in the Tripartite (Chiefs of Ontario, Ontario, and Canada) First Nations Public Health Advisory Committee that was funded federally to establish a forum for all three parties to work collaboratively in determining a future direction for First Nation public health in Ontario. As part of that dialogue, the Chiefs of Ontario have developed template Section 50 agreements that have been circulated among First Nations earlier this year.

On the economic front, the provincial Government also has taken some important initiatives that may result in improved socio-economic status for some First Nations. In 2010, the Ontario government passed Bill 191, the *Far North Act* which sets out a joint planning process between the First Nations and Ontario for land use planning in Ontario's far north. The Government also released a 2011 Northern Ontario Growth Plan which seeks to address the socio-economic gaps between First Nation and non-First Nation peoples in Northern Ontario. The Province will work with First Nation communities and organizations, and the federal government to establish and monitor the achievement of benchmarks, targets and indicators for education and health attainment.

While these initiatives are encouraging, research has shown that the conditions in which people are born, grow, live, work and age are shaped by the distribution of money, power and resources at national and local levels and are fundamental to health status of individuals and populations. To date, the Ontario government initiatives have concentrated on planning and statements of intent, but have not constituted any significant distribution of money, power and resources.

The fact remains that in 2011 only one of Ontario's 36 boards of health has Section 50 agreements in place with two First Nations and one other is in the process of finalizing a Section 50 agreement. In light of the increased discussion being given to the provision public health services to Ontario's First Nations and an increased understanding of the need to frame the discussion in the context of the Social Determinants of Health, the public health sector can and should advocate that the provincial government remove existing barriers for both Section 50 agreements and to fund boards of health who require additional funds to respond to requests from their neighbouring First Nations.

PROPOSED ACTION

The two components of our resolution therefore are intended to encourage the Province to increase its support for the establishment of strong relationships between interested First Nations and boards of health to address the provision of public health services while at the same time tackling the more

fundamental determinants of health related to the depressed social economic conditions of some First Nation communities.

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DRAFT ALPHA RESOLUTION A11-6

TITLE: **Inclusion of Health Care Worker Influenza Immunization Rates in Acute Care Facilities as an Indicator of Patient Safety**

SPONSOR: **Board of Health of the Simcoe Muskoka District Health Unit**

WHEREAS member organizations within the Association of Local Public Health Agencies (alPHa) are required by the Ontario Public Health Standards to "influence the development of healthy public policy and its programs and services to reduce or eliminate the burden of vaccine preventable diseases" and ensure "target coverage rates for provincially funded immunizations are achieved" [1]; and

WHEREAS influenza vaccination is the cornerstone of influenza prevention[2]; and

WHEREAS the National Advisory Committee on Immunization (NACI) recommends that influenza immunization programs target those "capable of transmitting influenza to individuals at high risk of complications and those who provide essential community services (including) healthcare and other care providers in facilities and community settings"[2]; and

WHEREAS both symptomatic and asymptomatic influenza-infected health care workers (HCWs) can transmit influenza to vulnerable patients[3]; and

WHEREAS HCWs influenza vaccination rates in hospitals have remained low over the three decades that HCWs influenza vaccination has been recommended[9]; and

WHEREAS seasonal influenza vaccination of HCWs has demonstrated 20 – 44% reductions in all cause mortality of residents in long-term care facilities[4-7]; and

WHEREAS as the percentage of vaccinated HCWs increases, healthcare-associated influenza infection decreases[8]; and

WHEREAS influenza immunization of HCWs protects vulnerable patients and improves patient safety[9]; and

WHEREAS the transmission of influenza in healthcare settings are a significant safety concern that places patients and staff at risk[10]; and

WHEREAS NACI, the Ontario Hospital Association, the Ontario Medical Association, and many other health care organizations consider influenza vaccination of HCWs as an essential component of the standard of care for the protection of their patients[2]; and

WHEREAS NACI states "HCWs who have direct patient contact should consider it their responsibility to provide the highest standard of care, which includes annual influenza vaccination. In the absence of contraindications, refusal of HCWs who have direct

patient contact to be immunized against influenza implies failure in their duty of care to patients”[2]; and

WHEREAS alPHa had passed a currently unresolved resolution urging introduction of provincial legislation mandating annual vaccination against influenza for all health care workers and other service providers in facilities and community settings;[11] and

WHEREAS Ontario’s acute care Patient Safety Indicators were introduced in 2008 to reduce the risk factors that contribute to the spread of infections.[12] and

WHEREAS shared disclosure of HCW vaccination rates in acute care facilities as a component of patient safety has been shown to significantly improve influenza immunization rates among HCWs[13];

NOW THEREFORE BE IT RESOLVED that the Association of Local Public Health Agencies requests that the Minister of Health and Long-Term Care in consultation with the Chief Medical Officer of Health to include healthcare worker influenza immunization rates in hospitals as a publicly reported Patient Safety Indicator as a means of protecting the health of patients by improving influenza vaccination rates among health care workers in hospitals.

Backgrounders attached (3)

alPHa Executive Committee Recommendation to the Membership: This resolution to go forward for discussion at the Resolutions Session at the June alPHa conference.

Appendix A

Statement of Sponsor Commitment

The Simcoe Muskoka District Health Unit (SMDHU) will support an initiative to include Staff Influenza Immunization Rates as part of Ontario's acute care Patient Safety Indicators.

In 2009, SMDHU in collaboration with the North Simcoe Infection Control Network (NSMICN) launched an initiative entitled the "Influenza Immunization Challenge". This challenge publicly recognizes facilities that achieves high (or greatly improved) influenza immunization rates. The Influenza Immunization Challenge was developed to improve influenza immunization rates in Acute Care and Long Term Care facilities in Simcoe County and the District of Muskoka.

The challenge was presented to the North Simcoe Muskoka LHIN Leadership Council and they noted support for this initiative. Due to the pH1N1 activities, however, the challenge was put on hold but is currently underway for the 2010-2011 season

A copy of the resolution to include Healthcare Worker Influenza Immunization Rates as a Patient Safety Indicator has been proposed to the Association of Local Public Health Agencies as a sponsored resolution to be considered at their next Annual General meeting.

alPHa Resolution: Inclusion of Health Care Worker Influenza Immunization Rates in Acute Care Facilities as an Indicator of Patient Safety

Update: New **Date:** March 9, 2011

Issue:

Influenza is an infectious disease associated with high burden of morbidity and mortality that can be largely preventable by immunization. Health care workers (HCWs) are in daily contact with populations at greatest vulnerability for influenza complications. Influenza vaccination rates among HCWs in acute care facilities in SMDHU and in Ontario have, however, remained low. Ontario's acute care Patient Safety Indicators were introduced in 2008, with rates reported to the public. The Association of Local Public Health Agencies (alPHa) accepts resolutions at its annual meetings in June that become part of the Association's ongoing advocacy efforts on healthy public policy.

Recommendation:

THAT the Board of Health endorse and submit the appended resolution and background document to alPHa to support "Healthcare Worker Influenza Immunization Rates as a Patient Safety Indicator".

Current Facts:

On average, influenza and its complications send about 20,000 Canadians to hospital every year, and results in between 2,000 to 8,000 deaths annually.[ii] The most effective strategy to reduce the burden of influenza is to prevent the disease through immunization, shown to be 70-90% effective in healthy adults.[iii]

Health care workers (HCWs) are in daily contact with populations at greatest vulnerability for influenza complications. The National Advisory Committee on Immunization (NACI) notes "refusal of HCWs who have direct patient contact to be immunized against influenza implies failure in their duty of care to patients". The Ontario Hospital Association, the Ontario Medical Association, and other health professional organizations have identified compliance with influenza immunization recommendations as a standard of care. Rates of influenza immunization among HCWs in acute care facilities in SMDHU and across Ontario, however, have remained low at below 50%.
Figure 1 below shows the trends in influenza immunization rates at SMDHU facilities from 2003/04 to 2010/11 seasons. These rates were stable at approximately 80% for Long Term Care staff and approximately 50% for acute care staff from the 2003/04 to the 2006/07 seasons. Starting in 2007/08, the rates started to decline in all staff and the seasonal influenza immunization rate hit an all time low in the 2009/10 pandemic influenza season. The immunization rate for the pandemic influenza vaccine was 65% for acute care staff compared to a seasonal vaccine coverage rate of 21%. The most recent

influenza season showed an improvement on the pandemic year immunization rates but not as high as the pre-2007/08 rates.

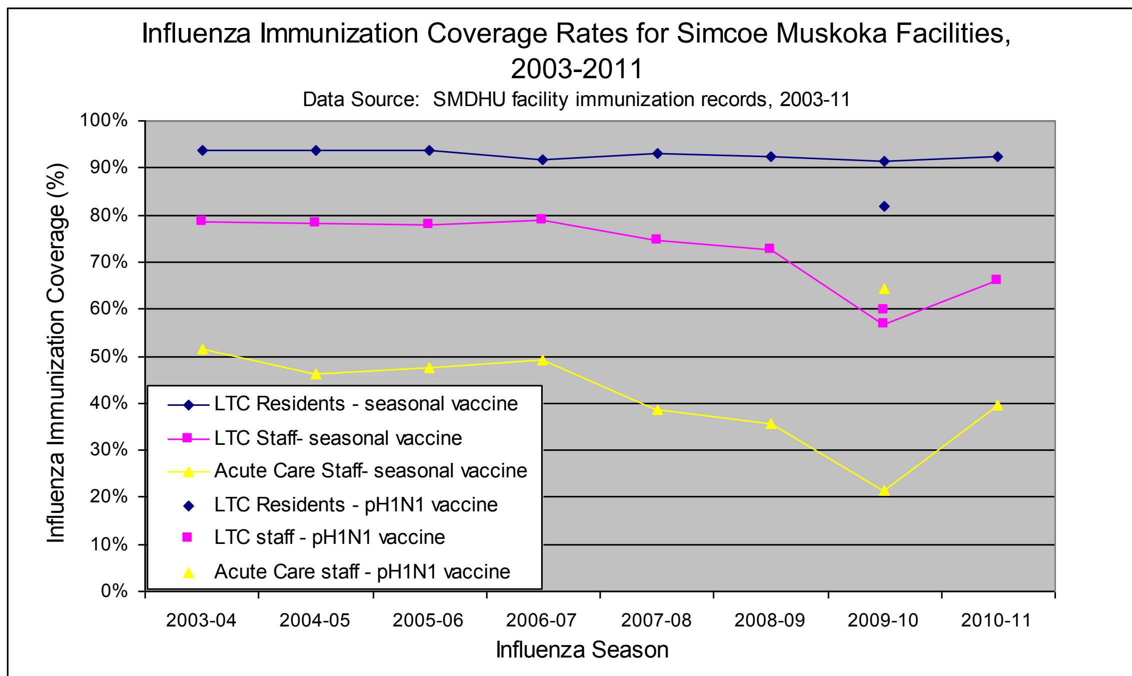

Figure 1. Influenza Immunization Coverage Rates for SMDHU Facilities, 2003-2011.

As of February 19, 2011, there have been 43 respiratory outbreaks in the current influenza season, of which 23 had Influenza A identified as the causative agent (Figure 2). Of the 23 Influenza A outbreaks, 17 occurred in long-term care homes, 4 in rest and retirement homes and 2 in acute care facilities.

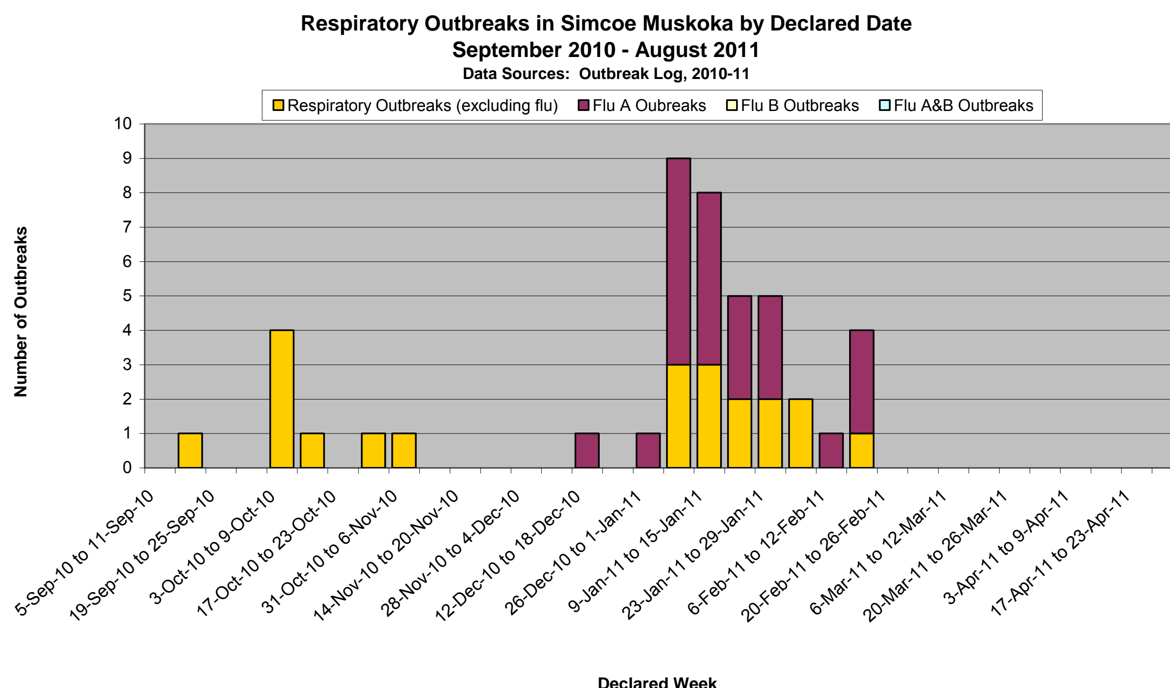

Figure 2. Respiratory Outbreaks in SMDHU, by declared date, during the 2010-2011 outbreak season, as of February 19, 2011.

In 2009, SMDHU in collaboration with the North Simcoe Infection Control Network (NSMICN) launched an initiative entitled the “Influenza Immunization Challenge”. The Influenza Immunization Challenge was developed to improve influenza immunization rates in Acute Care and Long Term Care facilities in Simcoe County and the District of Muskoka. The goals for the challenge are

- To enhance staff and resident / patient influenza immunization rates (in order to protect all of the above).
- To provide public recognition for the facilities that achieves high (or greatly improved) immunization rates.

The challenge was presented to the North Simcoe Muskoka LHIN Leadership Council and they noted support for this initiative. Due to the pH1N1 activities however, the challenge was put on hold until the 2010-2011 season and is currently underway.

Background:

Influenza contributes a significant disease burden that can be reduced by vaccination. Health care workers and administrators have a duty to protect the health of the patients they serve by ensuring high rates of immunization among HCWs. Ontario's acute care patient safety indicators attempt to ensure the provision of the best possible care to Ontarians. The Patient Safety Initiative strives to reduce the risk factors that contribute to the spread of infections. The Initiative currently requires Ontario hospitals to report on a public website their site specific rates for 8 patient indicators, including rates of Clostridium difficile infection, rates of surgical site infections, and rates of hand hygiene compliance among health care workers. Shared disclosure of influenza vaccination rates as a measure of patient safety has been shown to be a component of an effective strategy to improve HCW vaccination rates. In one setting, 115 acute care facilities undertook this strategy to increase median vaccination rates from 68% to 91% in 3 years (2006/7 to 2009/10).[iv]

Appended is a resolution and background information we propose to submit to alPHa to include influenza immunization rates among health care workers in acute care facilities as an official Patient Safety Indicator in Ontario.

Contacts:

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Colin Lee, Associate Medical Officer of Health	Ext. 7235

References

[i] Public Health Agency of Canada. (2011). What is flu? http://www.fightflu.ca/whatisflu-eng.html
[ii] CCDR August 2010 Volume 36.
[iii] Iowa Hospital Association. 2010.
http://www.ihconline.org/userdocs/reports/HAI_6_Health_Care_Worker_Flu_Immun.pdf.

Background Information for alPHa Resolution

Influenza is an infectious disease that is associated with high burden of morbidity and mortality. On average, influenza and its complications send about 20,000 Canadians to hospital every year, and results in between 2,000 to 8,000 deaths annually[1]. Health care workers (HCWs) are in daily contact with populations at greatest vulnerability for influenza complications. These high risk groups include the elderly, the immunocompromised, the critically ill, and young children.

The influenza virus can be transmitted to clients by symptomatic and asymptomatic HCWs. Consequently, having HCWs stay at home while ill will not prevent all possible transmissions to vulnerable populations[2-3]. In addition, studies have shown that HCWs may continue to work, while symptomatic. [4-5] The most effective strategy to reduce the burden of influenza is to prevent the initial acquisition of the disease through immunization, shown to be 70-90% effective in immuno-competent individuals.[6] Four randomized controlled trials of long-term care facilities have shown that influenza vaccination of HCWs leads to a 20–44% reduction in all cause mortality of residents in long-term care facilities.[7-10]

The National Advisory Committee on Immunization (NACI) notes "refusal of HCWs who have direct patient contact to be immunized against influenza implies failure in their duty of care to patients".[11] Numerous healthcare professional organizations, such as the Ontario Hospital Association and the Ontario Medical Association, have identified compliance with influenza immunization recommendations as a standard of care.[12] The Association for Professionals in Infection Control and Epidemiology (APIC), the Infectious Disease Society of America (IDSA), along with other national societies further recommend acute care hospitals and long term care facilities require annual influenza immunization as a condition of employment.[13-14] A currently unresolved alPHa resolution urges introduction of legislation mandating annual vaccination against influenza for all health care workers and other service providers in facilities and community settings.[15] The Society for Healthcare Epidemiology of America (SHEA) views influenza vaccination of HCWs as a core patient safety issue where non-compliance should not be tolerated.[14]

Ontario's acute care patient safety indicators were introduced in 2008 to ensure the provision of the best possible care to Ontarians. The Patient Safety Initiative strives to reduce the risk factors that contribute to the spread of infections. It focuses on minimizing infections and keeping patients safe[16]. Shared disclosure of influenza vaccination rates as a measure of patient safety has been shown to be a component of an effective strategy to improve HCW vaccination rates.[14,17] In one setting, 115 acute care facilities undertook this strategy to increase median vaccination rates from 68% to 91% in 3 years (2006/7 to 2009/10).[17] Influenza contributes a significant disease burden that can be reduced by vaccination. Health care workers and administrators have a duty to protect the health of the patients they serve by ensuring high rates of immunization among HCWs.

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DRAFT ALPHA RESOLUTION A11-7

TITLE: **Eligibility into Perpetuity for HPV, HBV and Tdap Vaccines**

SPONSOR: **Board of Health of the Simcoe Muskoka District Health Unit**

WHEREAS immunization is one of the most effective public health strategies, saving more lives than any other single health intervention in Canada in the last 50 years [2]; and

WHEREAS the Ontario Public Health Standard requires Boards of Health to engage in activities to reduce or eliminate the burden of vaccine preventable diseases[1]; and

WHEREAS Human Papillomavirus and Hepatitis B virus are among the top ten, and Pertussis is among the top 35 pathogens causing death[2]; and

WHEREAS the respective vaccines for these pathogens (HPV; HBV; and Tetanus, Diphtheria and Acellular Pertussis [adolescent/adult type vaccine Tdap, a.k.a. *Adacel*]) are only funded for specific school grades or ages; and

WHEREAS children who do not receive these vaccines in these specific times are not authorized by the province to receive these vaccines through public funding for the entire age ranges recommended by National Advisory Committee on Immunization (NACI) (i.e. these vaccines are not funded into perpetuity); and

WHEREAS a significant proportion of children eligible to receive these vaccines do not receive them during the grade or age requirements of the province; and

WHEREAS provincially funded provision of these vaccines for the full age range recommended by NACI would remove a cost barrier for a significant number of people, thereby increasing overall vaccination rates; and

WHEREAS there is no such age restrictions for eligibility for other publicly funded vaccines in Ontario;

NOW THEREFORE BE IT RESOLVED that the Association of Local Public Health Agencies urge the Minister of Health and Long-term Care in consultation with the Chief Medical Officer of Health to expand the eligibility of publicly funded HPV, HBV and *Adacel* vaccination, such that children who do not receive these vaccines at the provincially-specified grade or age continue to be eligible to receive these vaccines through public funding for the entire age ranges recommended by NACI.

Backgrounders attached (3)

alPHa Executive Committee Recommendation to the Membership: This resolution to go forward for discussion at the Resolutions Session at the June alPHa conference.

Appendix A

Statement of Sponsor Commitment

The Simcoe Muskoka District Health Unit (SMDHU) will be offering vaccination against the Human Papilloma virus (HPV), Hepatitis B virus (HBV) and Tetanus, Diphtheria and acellular Pertussis (Tdap a.k.a Adacel™) at its regularly scheduled vaccination clinics. In addition, SMDHU will plan for additional clinics as necessary for the anticipated initial increase in interested individuals seeking these vaccines.

A copy of the resolution for Eligibility into Perpetuity for HPV, HBV and Tdap Vaccines has been proposed to the Association of Local Public Health Agencies as a sponsored resolution to be considered at their next Annual General Meeting.

Appendix B

alPHa Resolution: Extending Eligibility into Perpetuity to All Universal Vaccines

Update: New **Date:** March 9, 2011

Issue:

The current publicly funded vaccination program in Ontario for Human Papillomavirus (HPV), Hepatitis B (HBV) and adolescent/adult type pertussis (formulated in a single Tetanus, Diphtheria and Acellular Pertussis [adolescent/adult type vaccine Tdap, a.k.a. *Adacel*]) is restricted to certain age groups. HPV vaccine is funded for grade 8 girls, HBV vaccine is funded for grade 7 students and those persons who are considered to be high risk, and adolescent/adult type pertussis vaccine is funded for adolescents 14 to 16 years of age. The National Advisory Committee on Immunizations recommends a much broader age range for these vaccines. All these vaccines are offered primarily in school based clinics; they are also available from health care providers (HCPs)

The age limited criteria for these vaccines are barriers to improving the coverage rates for these vaccine preventable diseases and ultimately reducing or eliminating the burden of these diseases. All other publicly funded childhood vaccines for diseases, which are now well controlled or eliminated (i.e. measles, mumps rubella, tetanus, diphtheria, haemophilus influenza type B [HiB] and polio), have no time restriction in terms of eligibility.

The Association of Local Public Health Agencies (alPHa) accepts resolutions at its annual meetings in June that become part of the Association's ongoing advocacy effort on health public policy.

Recommendation:

THAT the Board of Health endorse and submit the appended resolution and background document to alPHa for "Eligibility into Perpetuity for HPV, HBV and Tdap Vaccines".

Current Facts:

Immunization is acknowledged as one of the top ten public health interventions in the last 50 years. The recent Ontario Burden of Infectious Disease Study (ONBOIDS), completed by the Institute of Clinical Evaluation Sciences (ICES) of the Ontario Agency for Health Protection and Promotion (OAHPP) [1], identified HBV and HPV, both vaccine preventable diseases (VPD), as being among the top ten infectious agents for societal burden of illness. Of these top ten diseases, nearly 50% of the total burden can be attributed to the top five pathogens, including both HBV and HPV. Pertussis is also a significant cause of illness that in recent years has been identified to cause more illness in young adults than previously appreciated.[1] All three of these diseases have highly effective vaccines.

Currently in Ontario, publicly funded vaccination is offered for HPV to grade 8 girls, for HBV to all students in grade 7, and for pertussis to adolescents aged 14 to 16 years old in

a combination vaccine with tetanus and diphtheria (*Adacel*).[2] The future burden of these diseases can only be reduced with a broader uptake of these vaccines. A significant proportion of children in these age groups and ages miss receiving these vaccines despite our best efforts. They do not have access to these vaccines later in life without incurring private cost which is a significant barrier to vaccination. It is noteworthy that the diseases routinely covered by publicly funded vaccine programs (i.e. measles, mumps, rubella, tetanus, diphtheria, HiB and polio) have almost been eliminated as a result of very successful childhood immunization that includes no time limiting cost barriers to access to the vaccine; in other words, where "eligibility into perpetuity" is the norm.

Background:

In 2004 with the introduction of three new childhood vaccines for pneumococcal conjugate, meningococcal C-conjugate and varicella, the Public Health Division of the MOHLTC, introduced the "eligibility into perpetuity" concept in a memo to all health units. The key message in the November 7, 2005 memo was that individuals who were eligible to receive any of the new vaccines, but who had not yet been immunized were eligible to receive the vaccine at any time as long as the vaccine was currently recommended for their age or any other condition (e.g. high risk).

Contacts:

Laurie Stanford, Manager, Vaccine Preventable Disease — Ext. 7233
Bill Mindell, Director, Clinical Service — Ext. 7375

Background for "Eligibility in Perpetuity" alPHa resolution

Immunization is acknowledged as one of the top ten public health interventions in the last 50 years. The Ontario Public Health Standards' (OPHS) goal for vaccine preventable diseases (VPDs) is to reduce or eliminate the burden of vaccine preventable diseases.[1] The December 2010 Ontario Burden of Infectious Disease Study (ONBOIDS), completed by the Institute of Clinical Evaluation Sciences (ICES) and the Ontario Agency for Health Protection and Promotion (OAHPP)[2] identified that the human papillomavirus (HPV) and hepatitis B virus (HBV) were among the top ten infectious agents in contribution to societal burden of illness. Of these top ten diseases, nearly 50% of the total burden can be attributed to the top five pathogens, including both HBV and HPV. Pertussis is also a significant cause of illness that in recent years has been identified to cause more illness in young adults than previously appreciated.[2] All three of these diseases have highly effective vaccines. Currently in Ontario, publicly funded vaccination is offered for HPV to grade 8 girls, for HBV to all students in grade 7, and for pertussis to adolescents aged 14 to 16 years old in a combination vaccine with tetanus and diphtheria (Tetanus, Diphtheria and Acellular Pertussis [adolescent/adult type vaccine Tdap, a.k.a. *Adacel*]).[3] The future burden of these diseases can only be reduced with a broader uptake of these vaccines. A significant proportion of children in these age groups and ages miss receiving these vaccines despite our best efforts. They do hot have the access to these vaccines later in life without incurring private cost which is significant barrier to vaccination.

<u>Origin of the "Eligibility in Perpetuity" clause</u>

The burden of diseases, routinely covered in publicly funded vaccine programs (i.e. measles, mumps, rubella, tetanus, polio, haemophilus influenza B and diphtheria) have almost been eliminated as a result of very successful childhood immunization programs that exclude any time limiting barriers to access to the vaccine; "eligibility into perpetuity" is the norm.

In 2004, with the introduction of three new childhood vaccines for pneumococcal conjugate, meningococcal C-conjugate and varicella, the Public Health Division of the MOHLTC introduced the "eligibility into perpetuity" concept in a memo to all health units. The key message in the November 7, 2005 memo was that individuals who were eligible to receive any of the new vaccines, but who had not yet been immunized, were eligible to receive the vaccine at any time as long as the vaccine was currently recommended by the National Advisory Committee on Immunization (NACI) for their age and/or their risk profile (e.g. high risk).[4]

<u>Best Practice Guidelines</u>

NACI has developed 17 best practice guidelines for health care providers (HCP) who provide immunization. These guidelines are published in the Canadian Immunization Guide. Guideline # 3 identifies that every visit with a HCP is an opportunity to screen a client for needed vaccines and, when indicated, the HCP should vaccinate.[5] Eligibility into perpetuity would allow for a catch-up for those who were missed in the initial (usually school based) offering of a vaccine.

<u>Barrier to Immunization</u>

Currently in Ontario HPV, HBV and Adacel vaccines are offered in school based clinics targeting specific ages. While school based clinics are recognized as an efficient strategy to offer immunization, the age group currently eligible for these three vaccines may be strongly influenced by parental concerns about a vaccine as well as by peer opinion of the risks and benefits of a vaccine. There is no sound rationale for limiting the availability of such an effective intervention to 12 or 15 year olds.

<u>HPV Specific Data</u>

The ICES report shows that HPV infection is the most common sexually transmitted disease, (STI) in Ontario. The burden of disease is higher in females and is greatest in those over 20 years of age, peaking at ages 40 to 64 years. Currently females who are in grade 8 are the only ones eligible to receive public funding for the vaccine while the risk for HPV infection clearly continues for many years.[1] NACI recommends HPV vaccine for females between the ages of 9 to 26 years.[6]

<u>HBV Specific Data</u>

The ONBOIDS study estimates that on average, the annual number of deaths due to HBV in Ontario is 346. Most of the disease burden affects males between ages 40 to 79 years of age: well after the year of eligibility in grade 7 in Ontario.[1]

Pertussis Specific Data

The ONBOIDS study speaks to the continued presence of pertussis in our communities (despite reasonable coverage rates in infants), estimating that there are 28.3 cases of pertussis for every one case reported.[1] Most of the burden of pertussis is in young children under four years of age. Parents or grandparents of young children are felt to be the source of pertussis in unimmunized young children and infants.[7] Currently only 14 to 16 year olds are eligible for public funding for the adoslecent/adult pertussis vaccine (*Adacel*). This is an age group that does not access HCPs on a regular basis. New Brunswick has just implemented a publicly funded *Adacel* immunization program for all women in hospital post partum in an effort to protect unimmunized infants.[8]

Consent

Key elements of consent as defined in the Health Care Consent Act[9] are that consent must be informed and voluntary. Potential vaccine recipients need to be informed about the vaccine, risks, benefits, side effects, alternative courses of action and consequences of not having the vaccine. For consent to be truly informed and voluntary there should not be a time limitation, pressuring the parent or child to decide on whether or not to have a vaccine. Students and/or parents need time to make an informed choice.

It is noted that the MOHLTC when planning and implementing a publicly funded vaccine program does so anticipating that 85% of the initially selected cohort will take advantage of the vaccine. The intent of the program is to protect the entire cohort going forward until the disease is reduced or eliminated. Therefore, enforcing a time limitation on the eligibility of the vaccine is an impediment to this objective of the program and is counter intuitive to achieving success.

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DRAFT ALPHA RESOLUTION A11-8

TITLE: **Public Health Supporting Early Learning and Care**

SPONSOR: **alPHa Board of Directors**

WHEREAS the report "With our Best Future in Mind" (Charles E. Pascal, 2009) has been provided to the Premier of Ontario and provides recommendations on early childhood development in Ontario; and

WHEREAS supporting families and healthy early childhood development is a core part of the mandate of public health; and

WHEREAS public health work is driven by the population health approach; and

WHEREAS the evidence supports investing in early childhood development as a strategy to enable health and resilience throughout life; and

WHEREAS high quality early childhood interventions are extremely cost effective with significant societal returns on investment; and

WHEREAS achieving a politically sustainable system to support early childhood development will require support from decision-makers and the general public across the political spectrum; and

WHEREAS local public health has a unique role in early childhood development as a community agency that can take early learning and development beyond the walls of centres to reach the most vulnerable children and their families in their preferred setting; and

WHEREAS both local and provincial public health agencies have a key role to play in guiding the overall approach to supporting early childhood development; and

WHEREAS a comprehensive approach to early childhood development needs to include core services for all children and families, locally adapted services to address community context and intensive services to address the individual needs of the most vulnerable children and families; and

WHEREAS local and provincial public health agencies should continue to work with partners to clearly define better outcome measures and disseminate information about progress toward early childhood development goals more broadly;

NOW THEREFORE BE IT RESOLVED that alPHa will actively engage in advocacy to strengthen public health programs to support families and healthy early childhood development;

AND FURTHER that alPHa will forward this resolution to the Ministry of Health and Long-Term Care, Ministry of Children and Youth Services, Ministry of Health Promotion and Sport, the Chief Medical Officer of Health and the Early Learning Advisor and in addition alPHa encourages all member agencies

to transfer knowledge and information to decision-makers and the general public about the value of supporting early childhood development and the importance of adequate investment in early childhood development;

AND FURTHER that alPHa and both local and provincial public health agencies should work with partners to more clearly define, better measure and more broadly disseminate information about progress toward early childhood goals;

AND FURTHER that alPHa will advocate for the inclusion of early childhood development in political platforms;

AND FURTHER that alPHa commits to helping health units to share examples of best practices, useful approaches for local integration and examples of achieving seamless and integrated services.

Supported in principle by those assembled in Toronto on February 11, 2011.
March 14, 2011 - Reviewed by the February 9 organizing committee.
March 25, 2011 - Reviewed by alPHa's Board Executive Committee.
April 15, 2011 – Sponsored by alPHa's Board of Directors.

alPHa Executive Committee Recommendation to the Membership: This resolution to go forward for discussion at the Resolutions Session at the June alPHa conference.

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DRAFT ALPHA RESOLUTION A11-9

TITLE: **Removal of "No Access of Dental Benefits" Eligibility Criterion for the Healthy Smiles Ontario (HSO) Program**

SPONSOR: **Haliburton, Kawartha, Pine Ridge District Health Unit**

WHEREAS dental decay is the most prevalent chronic disease to affect children; and

WHEREAS oral health is an important component of general health and impacts directly on a child's speech development, ability to thrive and readiness to learn; and

WHEREAS dental care is excluded from the Ontario Health Insurance Program leaving many families without access to dental care; and

WHEREAS the province has introduced the new Healthy Smiles Ontario (HSO) program covering basic dental treatment and preventive care as an important component of its Poverty Reduction Strategy; and

WHEREAS the Ontario Ministry of Health and Long Term Care estimates that 130,000 children, from low income families with an adjusted net annual family income of $20,000 or less, will qualify for the HSO program; and

WHEREAS a number of the estimated 130,000 HSO children will be ineligible and denied access to the program because their families have some form of dental insurance; and

WHEREAS a family with an adjusted net annual family income of $20,000 or less with limited dental benefits will be unable to pay for any uninsured portion of their child's dental bill or any amount of the dental bill up front as many dental providers require; and

WHEREAS consequently the children from these low-income families will be denied the basic dental treatment and preventive care offered by the HSO program; and

WHEREAS introducing coordination of benefits with private insurance coverage to HSO would eliminate this barrier to care and contribute to, and thereby reduce, the relative cost to the provincial program;

NOW THEREFORE BE IT RESOLVED that the Association of Local Public Health Agencies request that the Ministry of Health and Long-Term Care remove the "no access to dental benefits" eligibility criterion from the HSO program thereby eliminating the discrimination these programs impose on segments of the working poor.

Backgrounder attached (1)

alPHa Executive Committee Recommendation to the Membership: This resolution to go forward for discussion at the Resolutions Session at the June alPHa conference.

Background

Removal of "No Access of Dental Benefits" Eligibility Criterion for HSO

Childhood dental decay is a result of a bacterial infection and is the most common chronic disease to affect children. This can contribute negatively to a child's development and ability to learn at school. Importantly, research has found that the pain and infection associated with serious tooth decay can lead to disturbed eating and sleeping patterns and decreased weight gain. Such factors can in turn interrupt normal physical and mental growth [1].

Clearly, oral health contributes to overall health. Nevertheless, coverage for dental treatment is excluded from the Ontario universal health care system. Since dental services are so expensive, cost is one of the most serious and common barriers to accessing regular dental care particularly for families with lower incomes. According to the Canada Health Measures Survey released in May 2010, 17 per cent of Canadians avoid the dentist because of cost [2].

It is evident that the province recognizes this problem as, in addition to its social assistance programs, there are now two publicly funded, dental treatment programs for children 17 years of age and under from low income families: an urgent dental treatment program called Children In Need Of Treatment (CINOT) program and, since this past October, a new preventive and basic dental care program called Healthy Smiles Ontario (HSO).

To be eligible for the HSO program a child must:

1. be 17 years of age or under,
2. come from a family with an adjusted net family income of $20,000 or less,
3. have no other form of dental insurance, and
4. be a resident of Ontario.

The Ministry of Health and Long Term Care estimates that 130,000 children across Ontario will qualify for this program. A concern is that a number of these children will be denied access to the program because of the "no access to dental benefits" eligibility criterion.

Health units have found that low-income families are often unable to pay for the uninsured portion of their dental bill or the often substantial, up front, payment required by many dental providers. Not only does having some insurance preclude them from qualifying for government assistance programs like HSO, these individuals are often left in situations where they are unable to access any dental care at all. These observations are in line with the information collected by Quinonez and Locker (2010), which states that 37% of families making $20,000 or less with private dental insurance experience financial related barriers with respect to accessing dental care [3]. It seems that having some dental insurance may actually be more of an impediment than a benefit for families in a challenging economic situation.

continued

Evidently, the HSO program's "no dental insurance" criterion will exclude many of the children included in the number estimated to be eligible for the program, further stigmatizing this already vulnerable population. Introducing coordination of benefits to HSO would eliminate this barrier to care for such children. The private insurance coverage would contribute to, and thereby reduce, the relative cost to the provincial program. More importantly, expanding HSO eligibility to those families with some form of dental insurance would ensure that all of the most-in-need children in the province have the

opportunity to use the program and enjoy life long improvements to their self-esteem, well-being and overall health.

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DRAFT ALPHA RESOLUTION A11-10

TITLE: **Regulation and Reduction of Sodium in the Canadian Food Supply**

SPONSOR: **Haliburton, Kawartha, Pine Ridge District Health Unit**

WHEREAS the *Sodium Reduction Strategy for Canada* released in July 2010 by the Sodium Working Group recommends that:

a) Health Canada continues to work with the food industry to establish voluntary sodium reduction targets by food category.

b) Health Canada, in collaboration with the Provinces and Territories, continue to work with the restaurant and food service industries to establish voluntary sodium reduction targets for meals and menu items sold in restaurants and food services establishments.

c) manufacturers lower the sodium content of their products to meet the voluntary targets and go beyond those targets over time to the lowest level possible, taking into consideration microbial food safety, quality and consumer acceptance.

d) a mechanism be established on Health Canada's sodium website that would allow individual companies to commit to the Sodium Reduction Strategy.

e) the *Food and Drug Regulations* be amended to change the basis of the Daily Value (DV) for sodium in the Nutrition Facts Table (NFT) from 2,400 mg to 1,500 mg to reflect the Adequate Intake (AI) level.

f) the federal government, together with provincial and territorial governments, develop more consistent sodium guidelines and procurement policies for use by food service operations in publicly-funded institutions such as schools, daycares, hospitals, care facilities, correctional institutions and for the armed forces.

NOW THEREFORE BE IT RESOLVED that the Association of Local Public Health Agencies encourage the federal Minister of Health, the Chief Public Health Officer for Canada, Ontario's Minister of Health and Long-Term Care, and the Chief Medical Officer of Health of Ontario to support and implement the aforementioned recommendations outlined in the 2010 Report of the former Federal Sodium Reduction Working Group.

Backgrounder attached (1)

alPHa Executive Committee Recommendation to the Membership: This resolution to go forward for discussion at the Resolutions Session at the June alPHa conference.

DRAFT ALPHA RESOLUTION A11-10

TITLE: **Regulation and Reduction of Sodium in the Canadian Food Supply**

SPONSOR: **Haliburton, Kawartha, Pine Ridge District Health Unit**

WHEREAS the *Sodium Reduction Strategy for Canada* released in July 2010 by the Sodium Working Group recommends that:

a) Health Canada continues to work with the food industry to establish voluntary sodium reduction targets by food category.
b) Health Canada, in collaboration with the Provinces and Territories, continue to work with the restaurant and food service industries to establish voluntary sodium reduction targets for meals and menu items sold in restaurants and food services establishments.
c) manufacturers lower the sodium content of their products to meet the voluntary targets and go beyond those targets over time to the lowest level possible, taking into consideration microbial food safety, quality and consumer acceptance.
d) a mechanism be established on Health Canada's sodium website that would allow individual companies to commit to the Sodium Reduction Strategy.
e) the *Food and Drug Regulations* be amended to change the basis of the Daily Value (DV) for sodium in the Nutrition Facts Table (NFT) from 2,400 mg to 1,500 mg to reflect the Adequate Intake (AI) level.
f) the federal government, together with provincial and territorial governments, develop more consistent sodium guidelines and procurement policies for use by food service operations in publicly-funded institutions such as schools, daycares, hospitals, care facilities, correctional institutions and for the armed forces.

NOW THEREFORE BE IT RESOLVED that the Association of Local Public Health Agencies encourage the Minister of Health and Long-Term Care to support and implement the aforementioned recommendations outlined in the 2010 Report of the former Federal Sodium Reduction Working Group.

Backgrounder (1) - attached

Technical Brief
September 13, 2010

Michael Schwandt, MD MPH
Community Medicine Resident Physician, OAHPP

Population reduction of dietary sodium intake

Included among the legislated objects of the Ontario Agency for Health Protection and Promotion (OAHPP) Act, the OAHPP is mandated *to provide scientific and technical advice and support to the health care system and the Government* (Object A), *to develop, disseminate and advance public health knowledge, best practices and research* (Object B), and *to inform and contribute to policy development processes across sectors of the health care system and within the Government* (Object C).[1] As such, OAHPP is pleased to provide our public health partners with information on the public health impact of excessive sodium intake, and population level interventions to address this significant issue.

Background

Observational studies and randomized controlled trials have consistently demonstrated the relationship between sodium intake and elevated blood pressure, a risk factor for conditions including ischemic heart disease and stroke.[2] Evidence suggests that high sodium intake is also a risk factor for renal dysfunction and stomach cancer, and may have negative effects on metabolism of bone.[3,4,5]

Reducing sodium intake at the population level presents an opportunity for the primary prevention of hypertension and its complications.[6] Health Canada recommends daily sodium intake of less than 2,300 mg for adults,[7] with a suggested adequate intake of 1,500 mg/d. However, over 85% of men and 60% of women in Canada exceed the recommended upper limit, [8] and the Canadian mean sodium intake is approximately 3,400 mg/d.[9] Although it is encouraging that the average sodium intake in Ontario is slightly lower than the national average, the population intake for the province still remains greater than recommended.

Success in population sodium intake reduction initiatives has been documented in the United Kingdom, Australia, New Zealand, France, Belgium, Finland and Japan.[10] Evidence suggests that mean population decreases in sodium intake by as little as 1,840 mg/day could reduce hypertension prevalence by 30%,[11] and mortality rates for ischemic heart disease and stroke by 9% and 14%, respectively.[2]

In Canada, modeling has demonstrated that a reduction in dietary sodium intake by 1840 mg/day could result in one million fewer cases of hypertension with an estimated $430 million in direct cost savings.[11]

General recommendations

Reduction of population salt intake should follow a comprehensive approach to programs and policies, including public education and environmental changes.[10,12,13] An Expert Working Group, established in collaboration between Health Canada and the Canadian Coalition for High Blood Pressure Prevention and Control, has developed and disseminated a policy statement on for reducing the burden of hypertension. This strategy calls for multi-sectoral involvement in policy formation to support the reduction of risk factors including sodium intake.[13]

The World Health Organization suggests that population interventions to reduce sodium intake should be based on three pillars,[10] which this document applies to the context of Ontario:

- **Consumers (awareness, education)**
- **Product reformulation (of commercially processed and prepared foods)**
- **Environment (for healthy consumer decisions)**

1. Consumer awareness and education

Consumer education regarding the risks and sources of dietary sodium is recommended by bodies including the Canadian Public Health Association and the Canadian Medical Association.[12] This education may be provided through programs based in the community (e.g. schools, workplaces), by health professionals or through media campaigns. Where media are employed, it is important to ensure that the venues selected (e.g. television, radio, internet including social media) allow messages to effectively target all sub-populations, including vulnerable and hard-to-reach groups.

Crucial elements of consumer education include increased awareness of risks associated with excess sodium intake, as well as knowledge on selecting and preparing foods lower in sodium. Such programs should reflect the diversity of Ontario's population, with respect to (for example) cultural and religious factors in dietary choices.

2. Product reformulation by the food industry

Approximately 75% of sodium consumption in North America is in the form of salt added to foods during industry processing and preparation, with the remainder added by individuals during cooking or consumption.[14] Since approximately 85% of food is consumed in the home (with an increasing proportion consumed in restaurants and cafeterias), reduction of sodium consumed in foods sold through groceries and supermarkets is crucial to reducing sodium intake.[15,16]

Because most sodium consumed is added during preparation and processing, it is difficult for consumer decisions alone to facilitate a diet lower in sodium, and even intensive counselling has modest effects in terms of hypertension prevention.[17] Low-sodium foods must be available in order for consumer education to be effective; food industry reductions in food sodium content are necessary for a population reduction in salt intake.[2,6] As such, The American Public Health Association and the American Heart Association have recommended that by 2020 sodium added to food should be reduced by 50%.[18,19]

The food processing, sales and restaurant industries should be actively involved in the process of product reformulation, both by reducing sodium content in product and acting as expert stakeholders in the identification and monitoring of products high in sodium.

Voluntary measures

Jurisdictions including the United States and the United Kingdom have supported processes encouraging voluntary industry reduction of sodium content.[20,21] The United Kingdom has set voluntary target sodium reductions for various categories of foods, aiming to reduce sodium consumption by 33% over the course of five years. To incentivize these voluntary reductions, government has mandated a system of clear product labeling of foods as high, medium or low in sodium, leading to consumer demand for products lower in sodium.[21]

Regulatory measures

In some jurisdictions where industry has advocated for voluntary measures for sodium reduction by the food industry, this strategy has not been successful in lowering food sodium content.[2] A World Health Organization forum and technical meeting on salt intake reduction concluded that if industry self-regulation is insufficient to reduce the salt content of commercial foods, legislative approaches should be taken.[10]

Monitoring
Mechanisms should be established to monitor and enforce decreases in food sodium content products, both packaged and sold by restaurants and caterers. This presents an opportunity for partnerships with academic institutions and public health agencies.

Assistance
Programs should be developed to assist producers and retailers of foods, particularly smaller-scale businesses, to improve the availability of food products lower in sodium. This assistance may be provided in the form of information sessions, materials developed by experts, or other modes appropriate to the recipients.

3. Environment
Policies should support an environment facilitating healthy consumer decisions regarding sodium intake. Foods lower in sodium should be available, affordable and clearly identified. The consumption of foods high in sodium should preferably be discouraged.

Improved food labelling
Current regulations permit food labels which demand close reading by consumers in order to determine sodium content. Mandatory simplified and consistent labelling improves consumers' ability to make healthy decisions based on the content of foods,[22,23] and should be clear regardless of literacy or cultural background. For example, in the UK a 'traffic light'-based system of mandatory labelling has been legislated, requiring that sodium content of food products be identified in clear terms: red, yellow and green labels for products high, medium and low in sodium, respectively. The UK Food Standards Agency has developed best practices for effective food labels.[23] Policies on food labelling should be developed in consultation with public health agencies, consumer groups and the food industry.

Procurement policies
Venues for the sale or distribution of foods in public and private institutions (e.g. school, hospital and workplace cafeterias; community centre concessions; licensed vendors at public events) may be mandated to restrict the availability of high-sodium products, while promoting foods lower in sodium.[24] This strategy may be particularly valuable in venues serving consumers with less awareness or ability to make healthy dietary decisions, such as young children.

Role of OAHPP
Within the Mission, Goals and Objectives of OAHPP is an opportunity to assist our public health partners in the development of interventions to reduce salt intake at the population level. Such assistance may include scientific and technical support, advice on better practices, data collection and analysis, and ongoing monitoring relevant to the improvement of health in Ontario.

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alPHa
Association of Local
PUBLIC HEALTH
Agencies

DRAFT ALPHA RESOLUTION A11-11

TITLE: **Provincial Adoption and Promotion of Smoke-Free Movies to Reduce the Impact of Smoking in Movies on Youth in Ontario**

SPONSOR: **Council of Ontario Medical Officers of Health**

WHEREAS Tobacco use is the leading cause of preventable death and disability in Canada, accounting for the deaths of approximately 13,000 people in Ontario alone each year; and

WHEREAS the tobacco industry has a long, well-documented history of promoting tobacco use and particular brands on-screen, while obscuring its true purpose in doing so; and

WHEREAS adolescents watch more films than any other age group; movie-going is popular entertainment for youth and tobacco imagery in films is currently unavoidable; and

WHEREAS nearly 90 percent of tobacco impressions delivered to theatre audiences in Canada in 2009 were delivered by large US media conglomerates; and

WHEREAS Canadian movie rating systems classify more movies as 14A or PG that are rated R in the US resulting in 60% more tobacco imagery exposure by youth-rated films; and

WHEREAS exposure to smoking in movies is estimated to be responsible for 44% of youth uptake; and

WHEREAS an estimated 130,000 Canadian smokers aged 15-19 have been recruited to smoke by exposure to on-screen smoking, and 43,000 of them will eventually die of tobacco-caused diseases; and

WHEREAS the World Health Organization has advised all nations that have ratified the Framework Convention on Tobacco Control, a global treaty obligating Parties including Canada to prevent youth smoking and end tobacco promotion through all channels, to give an adult rating to all new films that depict smoking, whether domestically produced or imported;

NOW THEREFORE BE IT RESOLVED that the Association of Local Public Health Agencies call for the Province of Ontario to rate new movies with smoking "18A" in Ontario, and require that such films be ineligible for federal and provincial subsidies, with the sole exceptions being a clear and unambiguous demonstration of the dangers and consequences of tobacco use or a true representation of a real historical figure, who was known to smoke

AND FURTHER that the Association of Local Public Health Agencies call for the Province of Ontario to require producers to certify on-screen that no one involved in the production of the movie received any remuneration, compensation or anything of value in consideration for using or displaying tobacco.

AND FURTHER that the Association of Local Public Health Agencies call for the Province of Ontario to require strong anti-smoking ads to be shown before any movie with tobacco use at the distributor's expense, regardless of rating and distribution channel.

AND FURTHER that the Association of Local Public Health Agencies call for the Province of Ontario to require movie producers to stop identifying tobacco brands in films.

alPHa Executive Committee Recommendation to the Membership: This resolution to go forward for discussion at the Resolutions Session at the June alPHa conference.