

AGENDA
MIDDLESEX-LONDON BOARD OF HEALTH

399 RIDOUT STREET NORTH
SIDE ENTRANCE (RECESSED DOOR)
Board of Health Boardroom

Thursday, 7:00 p.m.
2017 February 16

MISSION – MIDDLESEX-LONDON HEALTH UNIT

The mission of the Middlesex-London Health Unit is to promote and protect the health of our community.

MEMBERS OF THE BOARD OF HEALTH

Ms. Maureen Cassidy
Ms. Patricia Fulton
Mr. Jesse Helmer (Chair)
Mr. Trevor Hunter
Ms. Tino Kasi
Mr. Marcel Meyer
Mr. Ian Peer
Mr. Kurtis Smith
Ms. Joanne Vanderheyden (Vice-Chair)

SECRETARY-TREASURER

Laura Di Cesare

DISCLOSURE OF CONFLICTS OF INTEREST

APPROVAL OF AGENDA

APPROVAL OF MINUTES

Board of Health meeting, January 19, 2017.

DELEGATIONS

7:00 - 7:15 p.m.	Mr. John Millson, Associate Director, Finance, re: 2017 Program & Budget Templates
7:15 - 7:30 p.m.	Mr. Jesse Helmer, Vice-Chair, Finance & Facilities Committee, re: Item #1, Finance & Facilities Committee meetings, January 26 and February 2, 2017. Receive: January 26 and February 2, 2017 Finance & Facilities Committee meeting minutes.
7:30 - 7:45 p.m.	Dr. Gayane Hovhannisyan, Acting Medical Officer of Health, re: Item # 2 Supervised Injection Services Feasibility in Middlesex-London

Item #	Report Name and Number	Link to Additional Information	Delegation	Recommendation	Information	Brief Overview
Committee Reports						
1	Finance & Facilities Committee Meeting Update January 26, 2017 February 2, 2017 (Report No. 004-17)	January 26, 2017 FFC Agenda February 2, 2017 FFC Agenda 2017 Program & Budget Templates	x	x		To receive information and consider recommendations from the January 26 and February 2, 2017 Finance & Facilities Committee meetings.
Delegation & Recommendation Reports						
2	Supervised Injection Services Feasibility in Middlesex-London (Report No. No. 005-17)		x	x		To provide an update on Supervised Injection Services (SIS) in Middlesex-London and request support to explore next steps in assessing the feasibility of the integrated SIS model in London.
3	City of London Beverage Vending Machine Review and Opportunity for Further Action on Sugary Drinks (Report No. 006-17)	Appendix A Appendix B		x		To support the receipt of funding to implement an education campaign on health risks associated with sugary drinks and support the Stop Marketing to Kids Coalition to restrict food and beverage marketing to children and youth.
Information Reports						
4	Summary Information Report, February 2017 (Report No. 007-17)	Appendix A Appendix B			x	To provide an update on Health Unit programs and services for February 2017.
5	Acting Medical Officer of Health / Acting Chief Executive Officer Activity Report, February 2017 (Report No. 008-17)				x	To provide an update on the activities of the Acting MOH / Acting CEO for February 2017.

OTHER BUSINESS

- Next Finance and Facilities Committee Meeting: Thursday, March 2, 2017 @ 9:00 a.m.
- Next Board of Health Meeting: Thursday, March 16, 2017 @ 7:00 p.m.
- Next Governance Committee Meeting: Thursday, March 16, 2017 @ 6:00 p.m.

CORRESPONDENCE

- a) Date: 2017 January 10
 Topic: Bill S-228 Endorsement
 From: Office of Bev Shipley, Member of Parliament
 To: Office of the Medical Officer of Health

Background:

The Office of Bev Shipley, Member of Parliament for Lambton-Kent-Middlesex, confirmed that correspondence regarding Bill S-228, *An Act to Amend the Food and Drugs Act* (prohibiting food and beverage marketing directed at children) was received.

Recommendation:

Receive.

- b) Date: 2017 January 13
Topic: 2016 Nutritious Food Basket Survey Results
From: Kathleen Wynne, Premier of Ontario
To: Mr. Jesse Helmer

Background:

The Premier confirmed receipt of the correspondence regarding the 2016 Nutritious Food Basket Survey Results and has noted the position presented by the Middlesex-London Health Unit for the Basic Income pilot. This correspondence was also forwarded to the Minister of Community and Social Services.

Recommendation:

Receive.

- c) Date: 2017 January 19
Topic: Ontario Basic Income Pilot
From: Association of Local Public Health Agencies
To: The Honourable Helena Jaczek and The Honourable Chris Ballard

Background:

This correspondence provides an overview of the responses to the Basic Income pilot consultation that were prepared by the Association of Local Public Health Agencies, the Ontario Public Health Association and Public Health Ontario. These responses included a cover letter, a technical response to the consultation questions and a submission titled “Measuring Community Health Outcomes for a Basic Income Pilot.”

Recommendation:

Receive.

- d) Date: 2017 January 18 [received 2017 January 20]
Topic: Changes to HPV Immunization Programs
From: Simcoe Muskoka District Health Unit
To: The Honourable Dr. Eric Hoskins

Background:

The province previously offered the human papilloma vaccine (HPV) free of charge to Grade 8 females at Ontario schools. This was expanded to include Grade 8 males beginning in the 2016–17 school year.

The Simcoe Muskoka District Health Unit urges the Ministry of Health and Long-Term Care to increase annual funding for the Vaccine Preventable Disease Program in order to meet this mandate.

Recommendation:

Receive.

- e) Date: 2017 January 18 [received 2017 January 26]
Topic: 2016 Ontario Public Health Standards Modernization/Review
From: Windsor-Essex County Health Unit
To: Ontario Public Health Standards Modernization Committee

Background:

The Windsor-Essex County Board of Health supported a Grey Bruce Board of Health recommendation that the Ministry of Health and Long-Term Care adopt a “Health in All Policies” approach when reviewing the current Ontario Public Health Standards.

Recommendation:

Receive.

- f) Date: 2017 January 25 [received 2017 January 27]
Topic: Anti-Contraband Tobacco Campaign
From: Algoma Public Health
To: The Honourable Charles Sousa

Background:

The Board of Algoma Public Health passed a resolution requesting that the Ontario Ministry of Finance consider (a) raising tobacco excise taxes, and (b) enhancing enforcement activities designed to reduce the presence of contraband tobacco.

At the December 8, 2016 Board of Health meeting, the Board decided to: (a) recognize the problem of tobacco industry lobbying through front groups; (b) call on local elected officials to formally state that they will decline meetings with such groups; (c) call on the Ontario Ministry of Finance both to raise tobacco excise taxes and to enhance enforcement activities designed to reduce the presence of contraband tobacco; (d) forward Report No. 072-16 re: Anti-Contraband Tobacco Campaign Funded by Tobacco Industry Front Groups Intend to Block Tobacco Control Measures, and its appendices, to the London City Council and the Middlesex County Council, and its eight municipal councils, recommending endorsement and action; and (e) forward Report No. 072-16 re: Anti-Contraband Tobacco Campaign Funded by Tobacco Industry Front Groups Intend to Block Tobacco Control Measures to local members of the provincial parliament and the Ontario Campaign for Action on Tobacco (OCAT).

Recommendation:

Receive.

- g) Date: 2017 January 25 [received 2017 January 27]
Topic: Restricting Marketing of Unhealthy Foods and Beverages to Children
From: Sudbury and District Health Unit
To: The Honourable Jane Philpott

Background:

Creating supportive environments for healthy food choices makes the healthier choice the easier choice. Many public health advocacy groups have recommended limitations on marketing that is targeted at children. Sudbury and District Health Unit passed a resolution to endorse Bill S-228, which seeks to address these concerns.

The Middlesex London Board of Health received a report in March 2016 entitled “Impact of Sugar Sweetened Beverage and Creating Supportive Environments.” At that month’s meeting, the Board of Health endorsed the Heart and Stroke Foundation’s position statement, which includes a wide range of recommendations, one of which is a reduction in marketing to children.

Recommendation:

Receive.

- h) Date: 2017 January 25 [received 2017 January 27]
Topic: Anti-Contraband Tobacco Campaign
From: Sudbury and District Health Unit
To: Mayors/Reeves

Background:

See item (f), above.

Recommendation:

Receive.

- i) Date: 2017 January 25 [received 2017 January 27]
Topic: Cannabis Regulation and Control
From: Sudbury and District Health Unit
To: The Honourable Eric Hoskins

Background:

The federal government plans to introduce legislation that would legalize cannabis in Spring 2017. The Sudbury and District Health Unit passed a resolution for the inclusion of marijuana (medicinal and recreational) as a prescribed product or substance under the Smoke-Free Ontario Act.

At its January 2016 meeting, the Middlesex-London Board of Health endorsed recommendations from staff to advocate for an evidence-based public health approach to cannabis legalization and to establish baseline data and mechanisms to monitor local use.

Recommendation:

Receive.

- j) Date: 2017 January 25 [received 2017 January 27]
Topic: Support for the Position of Dietitians of Canada on Taxation and Sugar-Sweetened Beverages as Part of a Comprehensive Healthy Eating Approach
From: Sudbury and District Health Unit
To: The Honourable Jane Philpott

Background:

See item (g), above.

Recommendation:

Receive.

- k) Date: 2017 January 27 [received 2017 January 30]
Topic: Opioid Addiction and Overdose

From: Grey Bruce Health Unit
To: Registrar, College of Physicians and Surgeons of Ontario

Background:

The Grey Bruce Health Unit supported the position of Dr. Mackie and the Middlesex-London Health Unit that the College of Physicians and Surgeons of Ontario ought to consider guiding physicians to have a conversation with each patient who receives opioids about addiction and overdose risks to themselves and their families, and also prescribing naloxone to each patient to have in their home.

The Middlesex-London Board of Health received a report on this subject at its November 2016 meeting and recommended that the College of Physicians and Surgeons of Ontario take the above actions.

Recommendation:

Receive.

Copies of all correspondence are available for perusal from the Secretary-Treasurer.

CONFIDENTIAL

The Board of Health will move in-camera to consider matters regarding identifiable individuals, a proposed or pending acquisition of land by the Middlesex-London Board of Health and to review confidential minutes from its February 19, 2017 meeting and February 2, 2017 Finance & Facilities Committee meeting.

ADJOURNMENT



PUBLIC SESSION – MINUTES
MIDDLESEX-LONDON BOARD OF HEALTH

399 Ridout Street, London, Ontario
Middlesex-London Board of Health Boardroom
Thursday, January 19, 2017 7:00 p.m.

MEMBERS PRESENT: Ms. Maureen Cassidy
Ms. Patricia Fulton
Mr. Jesse Helmer
Mr. Trevor Hunter
Ms. Tino Kasi
Mr. Marcel Meyer
Mr. Ian Peer
Mr. Kurtis Smith
Ms. Joanne Vanderheyden

OTHERS PRESENT: Ms. Laura Di Cesare, Acting CEO
Ms. Elizabeth Milne, Executive Assistant to the Board of Health and Communications (Recorder)
Mr. Dan Flaherty, Manager, Communications
Ms. Donna Kosmack, Manager, Southwest Tobacco Control Area Network
Ms. Heather Lokko, Director, Healthy Start
Mr. John Millson, Associate Director, Finance
Mr. Stephen Turner, Director, Environmental Health & Infectious Disease
Mr. Alex Tyml, Online Communications Coordinator
Ms. Suzanne Vandervoort, Director, Healthy Living

MEDIA OUTLETS: None

Ms. Di Cesare, Acting CEO, called the meeting to order at 7:01 p.m. and welcomed all in attendance to the 2017 inaugural meeting of the Middlesex-London Board of Health.

Ms. Di Cesare began by acknowledging the traditional Indigenous peoples and territory, including the longstanding treaty relationships between Indigenous Nations and Canada, and recognizing that all levels of government in Canada have a responsibility to honour nation-to-nation relationships, and that, individually, we all have a role to play in honouring the treaties and contributing to reconciliation.

DISCLOSURES OF CONFLICT(S) OF INTEREST

Ms. Di Cesare inquired if there were any conflicts of interest to be declared. None were declared.

APPROVAL OF AGENDA

Ms. Di Cesare asked to amend the agenda to include a confidential session to consider the confidential December 8, 2016 minutes and to discuss matters regarding identifiable individuals.

It was moved by Mr. Peer, seconded by Mr. Hunter, *that the **AGENDA** for the January 19, 2017 Board of Health meeting be approved as amended.*

Carried

MEETING PROCEDURES

1) **Election of 2017 Board of Health Executive and Other Procedures** ([Report 001-17](#))

Ms. Di Cesare opened the floor for nominations for the position of Chair of the Board of Health for 2017.

It was moved by Mr. Peer, seconded by Ms. Fulton, *that Mr. Jesse Helmer be nominated Chair for the year 2017.*

Carried

Mr. Helmer accepted and agreed to let his name stand.

Ms. Di Cesare invited further nominations three times. Hearing none, it was moved by Mr. Peer, seconded by Ms. Fulton,

- 1) *That nominations for the position of Chair be closed; and*
- 2) *That Mr. Jesse Helmer be named Chair of the Middlesex-London Board of Health for 2017 by unanimous vote.*

Carried

Chair Helmer then took over as Chair.

Chair Helmer opened the floor for nominations for the position of Vice-Chair of the Board of Health for 2017.

It was moved by Mr. Smith, seconded by Ms. Cassidy, *that Ms. Joanne Vanderheyden be nominated Vice-Chair for 2017.*

Mr. Smith confirmed that he had spoken to Ms. Vanderheyden in advance and received confirmation that she agreed to let her name stand for the position of Vice-Chair for 2017.

Chair Helmer invited further nominations three times. Hearing none, it was moved by Ms. Fulton, seconded by Mr. Meyer,

- 1) *That nominations be closed; and*
- 2) *That Ms. Vanderheyden be named Vice-Chair of the Middlesex-London Board of Health for 2017 by unanimous vote.*

Carried

Chair Helmer opened the floor for the nomination of the 2017 Secretary-Treasurer of the Board.

It was moved by Mr. Meyer, seconded by Ms. Cassidy, *that Ms. Laura Di Cesare be nominated Secretary-Treasurer for 2017.*

Carried

Ms. Laura Di Cesare agreed to let her name stand.

Ms. Di Cesare advised that upon Dr. Mackie's return to work, it is her intention to resign as Secretary-Treasurer.

Hearing no further discussion or nominations, it was moved by Mr. Meyer, seconded by Ms. Cassidy, *that Ms. Laura Di Cesare be named Secretary-Treasurer of the Middlesex-London Board of Health by unanimous vote.*

Carried

It was moved by Mr. Peer, seconded by Mr. Meyer, *that the Board of Health establish two standing Committees, the Governance Committee and the Finance & Facilities Committee, for 2017.*

Carried

Chair Helmer invited nominations to the Finance & Facilities Standing Committee for 2017 and reviewed the Committee's Terms of Reference.

It was moved by Mr. Peer, seconded by Mr. Hunter, *that Ms. Fulton be nominated to the Finance & Facilities Committee for 2017.*

Ms. Fulton agreed to let her name stand.

Chair Helmer noted Ms. Fulton's reappointment to the Board of Health for an additional three-year term.

It was moved by Mr. Smith, seconded by Mr. Hunter, *that Mr. Meyer be nominated to the Finance & Facilities Committee for 2017.*

Mr. Meyer agreed to let his name stand.

It was moved by Mr. Hunter, seconded by Ms. Fulton, *that Mr. Peer be nominated to the Finance & Facilities Committee for 2017.*

Mr. Peer agreed to let his name stand.

It was moved by Ms. Cassidy, seconded by Mr. Hunter, *that Ms. Kasi be nominated to the Finance & Facilities Committee for 2017.*

Ms. Kasi agreed to let her name stand.

Chair Helmer invited further nominations three times. Hearing none, it was moved *that nominations be closed.*
Carried

Discussion ensued about clarification of the Committee's membership, dispersion of provincial nominees on all standing committees and which provincial appointees would sit on the Committee, since three provincial appointees put their names forward.

Ms. Kasi withdrew her nomination.

Therefore, the Finance & Facilities Committee for 2017 will consist of the following Board of Health members:

- 1) Mr. Jesse Helmer (Chair)
- 2) Ms. Joanne Vanderheyden (Vice-Chair)
- 3) Ms. Trish Fulton
- 4) Mr. Marcel Meyer
- 5) Mr. Ian Peer

Chair Helmer invited nominations to the Governance Committee for 2017 and reviewed the Committee's Terms of Reference.

The following Board members allowed their names to stand for the Governance Committee:

It was moved by Mr. Meyer, seconded by Mr. Hunter, *that Mr. Smith be nominated to the Governance Committee for 2017.*

Mr. Smith agreed to let his name stand.

It was moved by Mr. Smith, seconded by Mr. Meyer, *that Mr. Hunter be nominated to the Governance Committee for 2017.*

Mr. Hunter agreed to let his name stand.

It was moved by Mr. Hunter, seconded by Mr. Smith, *that Mr. Peer be nominated to the Governance Committee for 2017.*

Mr. Peer agreed to let his name stand. Mr. Peer also advised that Ms. Kasi could take over as provincial representative if she chooses to join the Governance Committee at a later date.

It was moved by Ms. Cassidy, seconded by Mr. Hunter, *that Ms. Cassidy be nominated to the Governance Committee for 2017.*

Chair Helmer invited further nominations three times. Hearing none, it was moved *that nominations be closed.*

Carried

All nominees agreed to let their names stand.

Therefore, the Governance Committee for 2017 will consist of the following Board of Health members:

- 1) Mr. Jesse Helmer (Chair)
- 2) Mr. Kurtis Smith
- 3) Mr. Trevor Hunter
- 4) Ms. Ian Peer
- 5) Ms. Maureen Cassidy

Chair Helmer once again noted Ms. Fulton's reappointment and provided an update on Dr. Mackie's leave, noting that he is currently on medical leave with a planned parental leave to follow. Chair Helmer noted that Dr. Mackie's Parental Leave was pre-arranged and therefore the coverage and contingency plan in place for that leave has been enacted at this time.

APPROVAL OF MINUTES

It was moved by Ms. Cassidy, seconded by Ms. Fulton, *that the **MINUTES** of the December 8, 2016 Board of Health meeting be approved.*

Carried

COMMITTEE REPORTS

2) Governance Committee Meeting (Verbal Update)

Mr. Hunter, Governance Committee Chair, provided an update to the Board following the Governance Committee meeting, which commenced prior to the Board meeting at 5:00 p.m.

It was moved by Mr. Hunter, seconded by Mr. Smith, *that the Board of Health receive the December 8, 2016 Governance Committee meeting minutes.*

Carried

2017 Governance Committee Reporting Calendar and Meeting Dates (Report No. 001-17GC)

Mr. Hunter made note of a change to the reporting calendar. Where the MOH/CEO Performance Appraisal had been completed in Q1 last year, it will instead be initiated in Q2 for 2017.

Mr. Hunter noted that the next Governance Committee meeting date will follow the date chosen and approved for the March Board of Health meeting.

It was moved by Mr. Hunter, seconded by Ms. Cassidy, *that the Board of Health receive Report No. 001-17GC re: 2017 Governance Committee reporting calendar, and receive the Governance Committee reporting calendar and meeting dates.*

Carried

2017 Board of Health Self-Assessment (Report No. 002-17GC)

Mr. Hunter summarized the report, which included feedback that indicated a desire to have the survey distributed in an electronic format and/or to provide paper copies to be completed prior to the end of the February board meeting.

It was moved by Mr. Hunter, seconded by Mr. Smith, *that the Board of Health:*

- 1) *Receive Report No. 002-17GC re: 2017 Board of Health Self-Assessment*
- 2) *Approve the Board of Health Self-Assessment Tool; and*
- 3) *Initiate the Board of Health Self-Evaluation process for 2017, as recommended by the Governance Committee.*

Carried

2017 Board of Health Orientation (Report No. 003-17GC)

Mr. Hunter advised that the next scheduled Board of Health Orientation session will take place on February 7, from 11:30 a.m. to 2:30 p.m. All Board of Health members are welcome to attend.

It was moved by Mr. Hunter, seconded by Mr. Peer, *that the Board of Health receive Report No. 003-17GC re: 2017 Board of Health Orientation for information.*

Carried

Mr. Hunter provided a brief summary of the Policy Review, which continued at the Governance Committee meeting.

RECOMMENDATION REPORTS

3) Southwest Tobacco Control Area Network Single Source Vendor (Report No. 002-17)

It was moved by Ms. Cassidy, seconded by Mr. Peer, *that the Board of Health award a single source vendor contract to Rescue, The Behavior Change Agency in the amount up to \$134,844.03, as identified in Report No. 002-17 re: Southwest Tobacco Control Area Network Single Source Vendor.*

Carried

INFORMATION REPORTS

4) Medical Officer of Health/Chief Executive Officer Activity Report – January (Report No. 003-17)

It was moved by Ms. Cassidy, seconded by Mr. Hunter, *that Report No. 003-17 re: Medical Officer of Health/Chief Executive Officer Activity Report – January be received for information.*

Carried

CORRESPONDENCE

It was moved by Mr. Smith, seconded by Ms. Fulton, *that the Board of Health receive correspondence items a) through k).*

Carried

OTHER BUSINESS

- Next Finance & Facilities Committee meeting: Thursday, January 26, 2016 @ 10:30 a.m.
- Next Board of Health meeting: Thursday, February 16, 2017 @ 7:00 p.m.
- Next Governance Committee meeting: to be determined.

The Board of Health meeting schedule was discussed, and it was determined that the date of the March meeting will be set at the next Board of Health meeting on February 16, 2017.

CONFIDENTIAL

At 7:36 p.m., Chair Helmer invited a motion to move in-camera to approve the December 8, 2016 confidential minutes and discuss matters regarding identifiable individuals.

It was moved by Mr. Meyer, seconded by Mr. Peer, *that the Board of Health move in-camera to approve its December 8, 2016 confidential minutes and to discuss matters regarding identifiable individuals.*

Carried

At 7:36p.m. all visitors and Health Unit staff, except Ms. Laura Di Cesare, Ms. Suzanne Vandervoort, Ms. Heather Lokko, Mr. John Millson, and Ms. Elizabeth Milne left the meeting.

At 7:52 p.m., it was moved by Ms. Fulton, seconded by Mr. Meyer, *that the Board of Health rise and return to public session.*

Carried

Chair Helmer flagged several “save the date” items, including the Health Unit’s curling event on January 27, and the Association of Local Public Health Agencies training and Board of Health section meeting in February.

It was moved by Ms. Fulton, seconded by Ms. Kasi, *that the Board of Health send its best wishes to Dr. Mackie for a return to good health as soon as possible.*

Carried

ADJOURNMENT

At 7:53 p.m., it was moved by Mr. Smith, seconded by Mr. Meyer, *that the meeting be adjourned.*

Carried

JESSE HELMER
Chair

LAURA DI CESARE
Secretary-Treasurer



**PUBLIC MINUTES
FINANCE & FACILITIES COMMITTEE
MIDDLESEX-LONDON BOARD OF HEALTH
50 King Street, London
Middlesex-London Health Unit – Room 3A
2017 January 26, 10:30 a.m.**

COMMITTEE

MEMBERS PRESENT: **Ms. Trish Fulton (Chair)**
Mr. Jesse Helmer
Mr. Marcel Meyer
Mr. Ian Peer
Ms. Joanne Vanderheyden

OTHERS PRESENT:

Ms. Elizabeth Milne, Executive Assistant to the Board of Health & Communications (Recorder)
Ms. Laura Di Cesare, Secretary-Treasurer
Ms. Mary Lou Albanese, Manager, Child Health Team
Mr. Jordan Banninga, Manager, Strategic Projects
Mr. Ben Bechard, Acting Manager, Information Technology
Ms. Vanessa Bell, Manager, Occupational Health and Safety and Privacy
Ms. Tammy Beaudry, Accounting and Budget Analyst, Finance
Ms. Rhonda Brittan, Manager, Healthy Communities & Injury Prevention
Ms. Lisa Clayton, Manager, Human Resources
Ms. Anita Cramp, Manager, Young Adult Team
Ms. Shaya Dhinsa, Manager, Sexual Health
Mr. Dan Flaherty, Manager, Communications
Ms. Lynn Guy, Executive Assistant to the Medical Officer of Health/CEO
Ms. Donna Kosmack, Manager, South West Tobacco Control Area Network
Mr. John Millson, Associate Director, Finance
Ms. Heather Lokko, Director, Healthy Start
Mr. Chimere Okoronkwo, Manager, Oral Health
Mr. Dave Pavletic, Manager, Food Safety & Healthy Environments
Mr. Fatih Sekercioglu, Manager, Safe Water, Rabies and Vector-Borne Disease
Mr. Stephen Turner, Director, Environmental Health and Infectious Disease
Ms. Suzanne Vandervoort, Director, Healthy Living

At 10:30 a.m., Ms. Di Cesare called the meeting to order.

Ms. Di Cesare welcomed the Committee and staff to the first Finance & Facilities Committee (FFC) meeting of 2017 and noted that the position of Chair for 2017 is currently vacant. Ms. Di Cesare welcomed nominations for the Chair of the Finance & Facilities Committee for 2017.

Ms. Vanderheyden nominated Ms. Fulton for Chair of the Finance and Facilities Committee for 2017.

Ms. Fulton agreed to let her name stand.

It was moved by Ms. Vanderheyden, seconded by Mr. Meyer, *that Ms. Fulton be elected Chair of the Finance & Facilities Committee for 2017, by majority vote.*

Carried

DISCLOSURES OF CONFLICTS OF INTEREST

Chair Fulton inquired if there were any disclosures of conflicts of interest. None were declared.

APPROVAL OF AGENDA

Ms. Fulton noted a change to the meeting agenda: Item 5.1, the Finance & Facilities Committee meeting schedule for 2017, which will be deferred to the February 2, 2017 meeting, at which time the dates will be reviewed in conjunction with the 2017 FFC Reporting Calendar.

It was moved by Ms. Vanderheyden, seconded by Mr. Peer *that the [AGENDA](#) for the January 26, 2017 Finance and Facilities Committee meeting be approved as amended.*

Carried

APPROVAL OF MINUTES

It was moved by Ms. Vanderheyden, seconded by Mr. Helmer *that the [MINUTES](#) from the December 1, 2016 Finance and Facilities Committee meeting be approved.*

Carried

NEW BUSINESS

4.1 2016 Board of Health Remuneration ([Report No. 002-17FFC](#))

It was moved by Mr. Peer, seconded by Mr. Helmer, *that the Finance and Facilities Committee make recommendation to the Board of Health to receive Report No. 002-17FFC, "2016 Board of Health Remuneration" for information.*

Carried

Chair Fulton noted that this information will also be forwarded to the City of London and Middlesex County once received by the Board of Health.

4.2 2017 Budget – FFC Review ([Report No. 001-17FFC](#))

Chair Fulton reviewed the 2017 Program & Budget Templates document, commending the work done by staff and expressing appreciation for the format of the document. Chair Fulton outlined the order in which the budget will be reviewed for the day.

Division #1 Corporate Services

Ms. Laura Di Cesare introduced the Corporate Services Managers in attendance, Ms. Lisa Clayton, Ms. Vanessa Bell, Mr. Jordan Banninga, and Mr. Ben Bechard. Ms. Di Cesare provided a summary of key performance indicators, key initiatives and highlights as well as the FTE, budgeted expenditures and pressures and challenges for the teams within Corporate Services which include: Finance, Human Resources, Information Technology, Privacy and Occupational Health and Safety, Procurement & Operations and Strategic Projects.

Discussion ensued about the following items:

- Changes to service areas that might put additional pressure and challenges on the Division, such as Acting CEO responsibilities, negotiations, staffing changes, and retirements.
- The ratio of benefits to salaries and wages and the timelines for replacing the Finance FRX Accounting software system.

- Staff development budgets for organization-wide training in particular in the areas of occupational health & safety but also as it relates to embedding previous learnings from the Leadership Development Program.
- How living wage clauses will be integrated into contracts going forward.
- The intake line review for MLHU phone systems and the IT Helpdesk ticket resolution rate.

The committee spent time discussing the impacts of the workload of the Acting CEO role for the Director of Corporate Services and flagged they would consider supporting temporary resources if required which would have budgetary impacts.

The Committee agreed that it will go forward with the recommended budget to the Board of Health after all Program Budget Templates are reviewed and finalized as a whole.

Mr. Millson noted that a budget summary recommendation will be finalized and brought to the Feb 2 FFC meeting based on discussion and updates from today's meeting.

Division #2 - Foundational Standard

Dr. Gayane Hovhannisyian, Associate Medical Officer of Health, provided a summary of the Program & Budget Templates for the first year of this new Division, clarifying the roles of the Associate Medical Officer of Health, the Medical Director and the Director, Foundational Standard. Dr. Hovhannisyian also clarified and reviewed the medical directives associated with and supported in her role.

Discussion ensued about the following items:

- The role that Environmental Health and Infectious Disease will take in supporting HIV work going forward.
- The hiring of a Medical Director to assist with work in the Sexual Health Clinic during Dr. Hovhannisyian's coverage of Dr. Mackie's leave; the prioritization of work and the payment for additional Physician fees for the clinic.
- Dr. Hovhannisyian's role in the review and development of medical directives.

At 12:03 p.m. it was moved by Mr. Helmer, seconded by Mr. Peer, *that the Finance and Facilities Committee take a 12-minute recess before moving on to the next Division template.*

Carried

Chair Fulton called the meeting back to order at 12:14 p.m. and requested that the new guests in attendance introduce themselves.

Ms. Anita Cramp, Mr. Chimere Okoronkwo, Ms. Donna Kosmack, Ms. Mary Lou Albanese and Ms. Rhonda Brittan introduced themselves.

Division #3 – Healthy Living

Ms. Suzanne Vandervoort, Director, Healthy Living requested a change to re-order the review of Program & Budget Templates for the Healthy Living Division and provided a summary of key performance indicators, key initiatives and highlights as well as the FTE, budgeted expenditures and pressures and challenges for the teams within this Division.

Discussion ensued about the following items:

- The regulation and inclusion of Marijuana in the Smoke-Free Ontario Act, and the regulation of contraband cigarettes.

- The current challenges faced by the Oral Health Team which include: implementing Healthy Smiles Ontario; working with school boards to achieve consent for school-based screening and fluoride varnish; and enhancing strategies to improve communication with parents and school boards to increase consent and dental screening.

Division # 4 - Office of the Medical Officer of Health

Ms. Di Cesare provided a summary of the key performance indicators, key initiatives and highlights as well as the FTE, budgeted expenditures and pressures and challenges for this Division for 2017.

Mr. Dan Flaherty, Communications Manager and Ms. Lynn Guy, Executive Assistant to the Medical Officer of Health/CEO attended to answer questions.

Discussion ensued about the following items:

- The Health Unit's rankings in social media compared to other health units: On Twitter, MLHU is third in the Province, only next to Toronto and Ottawa Public Health; First in the Province for the number of video views on YouTube (700,000).
- The benefits of promoting programs and services through social media and video content, major 2017 initiatives planned for Communications for 2017 and how the changing media landscape effects the Health Unit's ability to reach target audiences, share information and share stories in the news.
- The review of the Health Unit's branding and graphic standards.

Division #5 – Environmental Health and Infectious Disease (EHID)

Mr. Stephen Turner, Director, Environmental Health and Infectious Disease introduced his Management Team in attendance, Mr. Dave Pavletic, Ms. Shaya Dhinsa and Mr. Fatih Sekercioglu. Mr. Turner provided an overview of key performance indicators, key initiatives and highlights as well as the FTE, budgeted expenditures and pressures and challenges for the teams within EHID.

Discussion ensued about the following items:

- The assurance that no service interruptions will occur during the recruitment of a new Manager of Emergency Management.
- Potential to streamline the liaison with the City to include at-home tattoo operator licensing inspections and if there are plans to pursue this in Middlesex County as well.
- The work plan, funding, pressures and evaluation plans for the HIV Outreach Program, which will include leveraging support from partner agencies, enhanced surveillance and work with clients at street-level.
- The pressures and challenges faced by the Vaccine Preventable Disease team due to the changes and expansion of the Immunization of School Pupils Act.

Division # 6 - Healthy Start

Ms. Heather Lokko, Director, Healthy Start provided a summary of key performance indicators, key initiatives and highlights as well as the FTE, budgeted expenditures and pressures and challenges for the teams within the Division.

Discussion ensued about the following items:

- The Healthy Start Planning Initiative to build capacity in staff and program planning.
- Screening at-risk clients through the Healthy Babies Healthy Children program, informed feeding and maintaining funding for this program going forward.

- Car seat checks and buckle up baby programs in Middlesex County, prenatal education, breastfeeding support and the scale of demand for the Prenatal Immigrant Program.
- Early intervention screening and why the salaries and wages did not increase in the Screening, Assessment and Intervention program budget.
- Clarification of the Chief Nursing Officer role and how it works with the Associate Medical Officer of Health on Medical Directives.

General Expenses and Revenues

Mr. John Millson, Associate Director, Finance, reviewed the expenses in this Budget Template that are not allocated to front line staff or program costs, which includes: facilities, occupancy, legal fees, board expenses and post-employment (retiree) benefits.

Discussion ensued about the following items:

- Planning for potential insurance increases going forward.
- How the provincial introduction of cap and trade might affect Health Unit operations/budgets.

The recommendations outlined this report (**2017 Budget – FFC Review [Report No. 001-17FFC](#)**) were deferred until the final completion of the budget review at the next Finance & Facilities Committee meeting on February 2, 2017.

OTHER BUSINESS

5.1 Next meeting: Thursday, February 2, 2017 at 9:00 a.m.

Chair Fulton provided a brief summary of the reports expected for the next meeting.

Mr. Helmer noted that he stepped out of the meeting earlier to do a live interview with AM 980 on the budget process.

Chair Fulton thanked staff and the Senior Leadership Team for putting together such a comprehensive budget document.

ADJOURNMENT

It was moved by Ms. Vanderheyden, seconded by Mr. Meyer, *that the Finance and Facilities Committee adjourn the meeting.*

Carried

At 3:44 p.m. Chair Fulton *adjourned the meeting.*

TRISH FULTON
Chair

LAURA DI CESARE
Secretary-Treasurer



**PUBLIC MINUTES
FINANCE & FACILITIES COMMITTEE
MIDDLESEX-LONDON BOARD OF HEALTH**
50 King Street, London
Middlesex-London Health Unit – Room 3A
2017 February 2, 9:00 a.m.

COMMITTEE

MEMBERS PRESENT: **Ms. Trish Fulton (Chair)**
Mr. Jesse Helmer
Mr. Marcel Meyer
Mr. Ian Peer
Ms. Joanne Vanderheyden

OTHERS PRESENT: Ms. Elizabeth Milne, Executive Assistant to the Board of Health and Communications (Recorder)
Ms. Laura Di Cesare, Secretary-Treasurer
Dr. Gayane Hovhannisyanyan, Acting Medical Officer of Health
Mr. John Millson, Associate Director, Finance
Ms. Heather Lokko, Director, Healthy Start
Ms. Suzanne Vandervoort, Director, Healthy Living

At 9:02 a.m., Chair Fulton called the meeting to order.

DISCLOSURES OF CONFLICTS OF INTEREST

Chair Fulton inquired if there were any conflicts of interest. None were declared.

APPROVAL OF AGENDA

It was moved by Mr. Peer, seconded by Mr. Meyer, *that the [AGENDA](#) for the February 2, 2017 Finance & Facilities Committee meeting be approved.*

Carried

APPROVAL OF MINUTES

It was moved by Ms. Vanderheyden, seconded by Mr. Meyer, *that the [MINUTES](#) of the January 26, 2017 Finance & Facilities Committee meeting be approved as amended.*

Carried

NEW BUSINESS

4.1 Finance and Facilities Committee – Reporting Calendar ([Report No. 003-17FFC](#))

Ms. Di Cesare answered questions in the course of a discussion about various aspects of the Reporting Calendar, including the Finance & Facilities Committee Terms of Reference, the bi-annual review of policies and bylaws, and the review of meeting dates for 2017.

It was moved by Mr. Meyer, seconded by Ms. Vanderheyden, *that that Report No. 003-17FFC re: Finance and Facilities Committee – Reporting Calendar be received for information.*

Carried

4.2 2016 Fourth Quarter Budget Variance Report & Factual Certificate ([Report No. 004-17FFC](#))

Mr. Millson summarized the fourth quarter budget variance report and flagged some highlights, which included:

- The \$188,000 favourable variance, of which approximately \$99,000 will go back to the Ministry, with the remaining \$97,000 returned to the City and County.
- The final audit, which will take place in early April.
- The Dental Treatment Clinic deficit and an update that staff will continue their discussions with the Ministry on this item.
- Answers to questions about WSIB premiums and claims.

Mr. Millson proposed a change to the report's second recommendation, namely to include a note to fund the dental program deficit only "if required."

Mr. Helmer arrived at 9:10 a.m.

In reference to the Factual Certificate, Ms. Vanderheyden disclosed her position on the Board of Governors for Western Fair.

It was moved by Mr. Peer, seconded by Mr. Helmer, *that the Finance & Facilities Committee review and recommend that the Board of Health:*

- 1) *Receive Report No 004-17FFC re: 2016 Fourth Quarter Budget Variance Report and Factual Certificate be received for information; and*
- 2) *Fund the 2016 Dental Treatment Program deficit from the general Cost-Shared Program surplus, if required.*

Carried

4.3 2016 Visa/Vendor Payment ([Report No. 005-17FFC](#))

Mr. Millson introduced the report and summarized key highlights, including the reason for the increase in the Visa credit card purchase amounts, which was related to increased purchases of Facebook ads.

Ms. Di Cesare answered questions, and discussion ensued about the costs paid to Hicks Morley Hamilton Steward Storie LLP, as well as costs associated with contraceptives, needle exchange services, and photocopying and consumables.

It was moved by Mr. Peer, seconded by Mr. Helmer, *that the Finance & Facilities Committee receive Report No. 005-17FFC, re: 2016 Vendor/VISA Payments for information.*

Carried

4.4 Public Sector Salary Disclosure Act – 2016 Record of Employees' Salaries and Benefits ([Report No. 006-17FFC](#))

It was moved by Mr. Meyer, seconded by Mr. Helmer, *that the Finance & Facilities Committee recommend that the Board of Health receive Report No. 006-17FFC re: Public Sector Salary Disclosure Act – 2016 Record of Employees' Salaries and Benefits for information.*

Carried

4.5 2017 Proposed Budget ([Report No. 007-17FFC](#))

Mr. Millson summarized the updates made to the budget since its last review at the January 26, 2017 meeting.

Ms. Lokko noted a change to the Healthy Start Division. Ms. Di Cesare also noted a minor change and clarified the method of titling for program assistants, administrative assistants and executive assistants.

It was moved by Mr. Helmer, seconded by Mr. Peer, *that the Finance & Facilities Committee recommend that the Board of Health:*

- 1) *Approve the 2017 Operating Budget in the gross amount of \$35,405,626 as per the appended Report No. 007-17FFC re: 2017 Proposed Budget;*
- 2) *Forward Report No. 007-17 to the City of London and the County of Middlesex for information; and*
- 3) *Direct staff to submit the 2017 Operating Budget in the various formats required by the different funding agencies.*

Carried

OTHER BUSINESS

5.1 Next meeting: Thursday, March 2, 2017 @ 9:00 a.m.

CONFIDENTIAL

At 9:33 a.m., it was moved by Mr. Meyer, seconded by Mr. Helmer, *that the Finance & Facilities Committee move in-camera to discuss matters regarding a proposed or pending acquisition of land by the Middlesex-London Board of Health.*

Carried

At 9:41 a.m., it was moved by Mr. Peer, seconded by Mr. Meyer, *that the Finance & Facilities Committee return to public session.*

Carried

ADJOURNMENT

It was moved by Mr. Helmer, seconded by Ms. Vanderheyden, *that the Finance & Facilities Committee adjourn the meeting.*

Carried

At 9:42 a.m., Chair Fulton *adjourned the meeting.*

TRISH FULTON
Chair

LAURA DI CESARE
Secretary-Treasurer



MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 004-17

TO: Chair and Members of the Board of Health

FROM: Dr. Gayane Hovhannisyan, Acting Medical Officer of Health
 Laura Di Cesare, Acting Chief Executive Officer

DATE: 2017 February 16

FINANCE & FACILITIES COMMITTEE MEETINGS – JANUARY 26 AND FEBRUARY 2

The Finance & Facilities Committee met [on Thursday, January 26, 2017, at 10:30 a.m.](#), and [on Thursday, February 2, 2017, at 9:00 a.m.](#) A summary of the discussion at each meeting can be found in the [minutes](#).

The following reports were reviewed and recommendations made at the January 26, 2017 meeting:

Reports	Recommendations for the Board of Health’s Consideration and Information
2016 Board of Health Remuneration (Report No. 002-17FFC)	It was moved by Mr. Peer, seconded by Mr. Helmer, <i>that the Finance & Facilities Committee recommend that the Board of Health receive Report No. 002-17FFC re: 2016 Board of Health Remuneration for information.</i> Carried
2017 Budget – FFC Review (Report No. 001-17FFC)	Upon review of the 2017 Program Budget Templates, Chair Fulton and the Committee agreed to defer the recommendations outlined this report until the final completion and review of the budget at the February 2, 2017 FFC meeting.

The following reports were reviewed and recommendations made at the February 2, 2017 meeting:

Reports	Recommendations for Board of Health’s Consideration and Information
Finance and Facilities Committee – Reporting Calendar (Report No. 003-17FFC)	It was moved by Mr. Meyer, seconded by Ms. Vanderheyden, <i>that Report No. 003-17FFC re: Finance and Facilities Committee – Reporting Calendar be received for information.</i> Carried
2016 Fourth Quarter Budget Variance Report and Factual Certificate (Report No. 004-17FFC)	It was moved by Mr. Peer, seconded by Mr. Helmer, <i>that the Finance & Facilities Committee review and recommend that the Board of Health:</i> 1) <i>Receive Report No 004-17FFC re: 2016 Fourth Quarter Budget Variance Report and Factual Certificate for information; and</i> 2) <i>Fund the 2016 Dental Treatment Program deficit from the general Cost-Shared Program surplus, if required.</i> Carried
2016 Visa/Vendor Payments (Report No. 005-17FFC)	It was moved by Mr. Peer, seconded by Mr. Helmer, <i>that the Finance & Facilities Committee receive Report No. 005-17FFC re: 2016 Vendor/VISA Payments for information.</i> Carried
Public Sector Salary Disclosure Act – 2016 Record of Employees’ Salaries and Benefits (Report No. 006-17FFC)	It was moved by Mr. Meyer, seconded by Mr. Helmer, <i>that the Finance & Facilities Committee recommend that the Board of Health receive Report No. 006-17FFC re: Public Sector Salary Disclosure Act – 2016 Record of Employees’ Salaries and Benefits for information.</i> Carried

<p>2017 Proposed Budget <u>(Report No. 007-17FFC)</u></p>	<p>It was moved by Mr. Helmer, seconded by Mr. Peer, <i>that the Finance & Facilities Committee recommend that the Board of Health:</i></p> <ol style="list-style-type: none"> 1) <i>Approve the 2017 Operating Budget in the gross amount of \$35,405,626 per the appended Report No. 007-17FFC re: 2017 Proposed Budget;</i> 2) <i>Forward Report No. 007-17 to the City of London and the County of Middlesex for information; and</i> 3) <i>Direct staff to submit the 2017 Operating Budget in the various formats required by the different funding agencies.</i> <p style="text-align: right;">Carried</p>
---	--

The next Finance & Facilities Committee meeting will be on Thursday, March 2, 2017, at 9:00 a.m.

This report was prepared by Elizabeth Milne, Executive Assistant to the Board of Health and Communications.



Dr. Gayane Hovhannisyanyan, MD, MHSc, CCFP, FRCPC
Acting Medical Officer of Health



Laura Di Cesare, CHRE
Acting Chief Executive Officer

TO: Chair and Members of the Board of Health

FROM: Dr. Gayane Hovhannisyanyan, Acting Medical Officer of Health
Laura Di Cesare, Acting Chief Executive Officer

DATE: 2017 February 16

SUPERVISED INJECTION SERVICES FEASIBILITY IN MIDDLESEX-LONDON

Recommendation

It is recommended that the Board of Health:

- 1. Receive Report No. 005-17 re: “Supervised Injection Services (SISs) Feasibility in Middlesex-London” for information;***
- 2. Endorse recommendation number 1 from the Ontario Integrated Supervised Injection Services (SIS) Feasibility Study for London, Ontario; and***
- 3. Direct staff to explore the next steps in assessing the feasibility of the integrated SIS model in London and potential locations.***

Key Points

- The SIS feasibility study results indicate that all key stakeholders interviewed were supportive of SIS although they had differing opinions on the location and model of SIS. Over 80% of the study participants in London expressed a willingness to use SIS.
- Injection drug use continues to be associated with severe morbidity, mortality and significant health care burden due to overdose and HIV, Hepatitis C and other infections in Middlesex-London.
- Supervised injection services (SIS) reduce unsafe injection practices, rates of HIV, hepatitis C, injection related wounds and infections, and fatal and non-fatal overdoses.

Background

The [Supervised Injection Services Feasibility study](#) released on February 8, 2017 was conducted in London, Ontario in 2016 to explore the potential willingness to use Supervised Injection Services (SIS) and what would be the envisioned services among local people who inject drugs (PWID), in addition to acceptability and feasibility of SIS from community stakeholders’ perspectives. Given the ongoing challenges associated with injection drug use in this setting, as well the evidence indicating that SIS prevent harms associated with injection drug use and promote health among PWID, two recommendations were made: it was recommended that SIS be implemented in London (1); SIS be integrated within existing services and implemented in Old East and/or Downtown London (2).

A SIS is a health service that provides a safe and hygienic environment where people can inject pre-obtained drugs under the supervision of trained staff SIS have been implemented in Europe, Australia and Canada to help reduce the harms of injection drug use. Currently over 90 SISs are operating worldwide. There is extensive evidence supporting the positive public health and safety outcomes of these services. Among people who inject drugs, supervised injection services help reduce rates of HIV, hepatitis C, injection related wounds and infections, and fatal and non-fatal overdoses. While supervised injection services don’t solve the complex and long-standing problems associated with substance use, they help reduce health risks and can be part of a larger strategy to address addiction, and can help get people into addiction treatment.

Among 199 survey participants in the Feasibility Study, 86% participants reported willingness to use a SIS if one were available, while only 7% said they would not be willing to use such services. Participants also reported high rates of injecting in public or semi-public spaces, with 72% stating that they had done so in the previous six months. Risks for infectious disease transmission were also evident, with 22% participants noting

that they had borrowed and/or loaned used syringes in the previous six months. One in four participants reported a history of non-fatal overdose.

The overall overdose/alcohol toxicity rate in the Middlesex-London region in 2015 was 6.0 per 100,000 people versus the provincial rate of 5.1 per 100,000 (preliminary data from Coroner's office). Emergency Medical Services (EMS) in London-Middlesex administered 47 doses of naloxone in 2015 and 31 doses as of October in 2016 when responding to 9-1-1 calls for overdoses, and rates of emergency department visits for opioid-related issues were 1.5 times higher than the Ontario average. Demand for treatment remains high with rates of those seeking treatment for methamphetamine use also being higher than the provincial average (See Board of Health Report 032-14). Further, 234 naloxone kits have been distributed from the Middlesex-London Health Unit (MLHU), Regional HIV/AIDs Connection and London Intercommunity Health Centre between June 2014 and December 2016. Use of these kits resulted in 17 reported successful resuscitations (See [Board of Health Report No. 062-16](#)).

Fifty-eight new diagnoses of HIV were reported in Middlesex-London in 2016, surpassing the total number of cases diagnosed in all of 2015 (42). Approximately 70% of new diagnoses are attributed to the "Injection Drug Use" category for 2016). Additionally, Hepatitis C continues to be an issue, with 231 cases reported in 2016. Invasive Group A Streptococcal disease has been on the rise in PWID as well, with 7 cases in PWID in 2015 and 28 cases in PWID in 2016. Infective endocarditis also continues to be important health issue affecting PWID, with a case-fatality rate in the range of 30-40% (See Board of Health Reports [No. 040-16](#) and [No. 051-16](#)). There is a high demand for harm reduction services in Middlesex-London with over 2 million needles distributed yearly through the CounterPoint program.

Legal operation of an SIS in Canada requires an exemption under section 56.1 (2) of the Controlled Drugs & Substances Act (CDSA), which is granted by the federal Minister of Health. The Respect for Communities Act, introduced in 2015, requires 26 criteria when seeking an exemption under Section 56. One of the key requirements under the Act is community engagement. The current application includes an extensive list of documentation and letters of opinion from various stakeholders, including police, regulatory agencies and the municipal government. The Act is currently under revision with an objective to simplify the application process.

The Health Unit believes that SIS can be important part of the comprehensive Community Drug and Alcohol Strategy to address harms associated with unsafe injection practices, and we would like to ask the Board of Health to direct MLHU staff to explore the next steps in assessing the feasibility of the integrated SIS model in London.

This report was prepared by Shaya Dhinsa, Manager of Sexual Health.



Dr. Gayane Hovhannisyanyan, MD, MHSc, CCFP, FRCPC
Acting Medical Officer of Health



Laura Di Cesare, CHRE
Acting Chief Executive Officer



TO: Chair and Members of the Board of Health

FROM: Dr. Gayane Hovhannisyan, Acting Medical Officer of Health
Laura Di Cesare, Acting Chief Executive Officer

DATE: 2017 February 16

CITY OF LONDON BEVERAGE VENDING REVIEW AND OPPORTUNITY FOR FURTHER ACTION ON SUGARY DRINKS

Recommendation

It is recommended that the Board of Health:

- 1. Receive Report No. 006-17 re: City of London Beverage Vending Review and Opportunity for Further Action on Sugary Drinks;*
- 2. Support the receipt of \$15,000 from the Healthy Kids Community Challenge fund from the City of London's Child and Youth Network to implement a community education campaign on the health risks associated with sugary drinks and the benefits of water;*
- 3. Direct staff to complete the online endorsement of the [Stop Marketing to Kids Coalition's \(Stop M2K\) Ottawa Principles](#) to communicate its support to restrict food and beverage marketing to children and youth 16 years of age and younger; and*
- 4. Communicate support for STOP M2K's Ottawa Principles by sending Report No. 006-17 re: City of London Beverage Vending Review and Opportunity for Further Action on Sugary Drinks, and its appendices to other Boards of Health in Ontario.*

Key Points

- Sugary drinks are the single-largest source of sugar in our diets.
- Public education about the health risks associated with sugary drinks is required, as are policies at the municipal, provincial and federal levels that help to restrict access to unhealthy choices.
- A comprehensive strategy that includes federal legislation to restrict commercial food and beverage marketing to children and youth 16 years and under is necessary.

Update on the City of London Beverage Vending Review

In September 2016, staff from both the City of London and the Health Unit began working together to: assess current beverage vending machine offerings; conduct a survey to seek input from facility users and City of London residents on what changes could be made to the beverage vending machine environment in city-run facilities; review the literature and conduct an environmental scan to inform proposed changes; and propose five policy options for consideration. The survey methodology, research findings and policy options can be found in the Health Unit's report ([Appendix A](#)).

The Health Unit's recommendation to remove beverage vending machines was not adopted by the City of London; however, the Health Unit remains committed to working with city staff to determine how best to improve vending machine offerings. The Health Unit's survey results and the community dialogue around sugary drinks have highlighted the need for greater public awareness regarding the public health concerns associated with consumption and marketing of sugary drinks. The Health Unit has the opportunity to receive \$15,000 from the Healthy Kids Community Challenge fund, from the City of London's Child and Youth Network, to implement a public education campaign to reinforce the fact that sugary drinks should only be consumed sparingly and that water is the best choice for hydration and health. The Health Unit will also

continue to work closely with Middlesex County's Healthy Kids Community Challenge partners to improve the food and beverage environments in community centres, schools and childcare settings.

Reducing the Availability of Sugary Drinks

Municipal and family-focused centres are priority settings for supporting healthy eating behaviours among children, youth and families. The removal of beverage vending machines makes the healthy choice (plain tap water) the easy choice, and reduces consumer confusion around sugary drinks, which are marketed by the beverage industry as "healthier" ("health-washed"), because such drinks would no longer be available for sale. From a health perspective, sports drinks, vitamin waters and juices also contribute to the negative health effects of too much sugar in the diet. [Appendix B](#) provides considerations for consumers when selecting drinks often found for sale in vending machines.

Rationale for a Ban on Marketing and Advertising

Brand logos and product advertisements are positively associated with consumers' purchasing decisions, specifically of unhealthy foods (e.g., salty snacks, candy and sugar-sweetened beverages). Vending machines not only act as mini-billboards, but provide quick, easy access to energy-dense, nutrient-poor sugary drinks. The Heart and Stroke Foundation of Canada's [2017 Report on the Health of Canadians](#) takes aim at the food and beverage industry for marketing directly to children and youth, and shows how industry marketing reaches them in the home, at school, on the street and in recreational centres. The most accessible and heavily marketed choices are often energy-dense, nutrient-poor processed foods and sugary drinks, like those found in vending machines. According to the report, "parents are doing the best job they can but our environment makes it hard." The report recommends legislation restricting food and beverage marketing aimed at children and youth, and calls for a comprehensive strategy that includes public awareness and policies that support reduced sugar consumption and access, especially in "liquid form." Policies at the municipal, provincial and federal levels, which increase access to healthy food and beverage choices and restrict access to unhealthy choices, are required.

Opportunity to Take Action on Food and Beverage Marketing

There is greater understanding today about how commercial food and beverage marketing prevents children and youth from developing healthy habits that would extend into adulthood. The [Stop Marketing to Kids Coalition](#) (Stop M2K), founded by the Heart and Stroke Foundation in collaboration with the Childhood Obesity Foundation, is working to restrict all food and beverage marketing to children and youth 16 years and under. The Coalition has developed the [Ottawa Principles](#), which provide definitions, scope and requirements that should be used to guide development of federal legislation to restrict commercial marketing to children and youth. There is an opportunity for all Ontario Boards of Health to continue to work with local municipal governments to implement healthy changes within the food environment at the local level, while at the same time communicating Board of Health support for the Stop M2K Coalition's recommendations, by signing the online [endorsement](#). It is recommended that the Middlesex-London Board of Health direct Health Unit staff to complete the online endorsement and communicate its support by sending this report and its appendices to the other Boards of Health.

This report was prepared by Ellen Lakusiak, Kim Loupos and Heather Thomas, Health Unit Registered Dietitians, and Linda Stobo, Program Manager, Chronic Disease Prevention and Tobacco Control.



Dr. Gayane Hovhannisyan, MD, MHSc, CCFP, FRCPC
Acting Medical Officer of Health



Laura Di Cesare, CHRE
Acting Chief Executive Office

This report addresses the following requirements of the Ontario Public Health Standards (revised May 2016): Foundational Standard 1, 3, 4, 5, 8; Chronic Disease Prevention 1, 3, 4, 5, 6, 11; Child Health 1, 4.

Appendix A

City of London Beverage Vending Review



January 6th, 2017

For information, please contact:

Linda Stobo
Middlesex-London Health Unit
50 King St.
London, Ontario
N6A 5L7
phone: 519-663-5317, ext. 2388
e-mail: health@mlhu.on.ca

© Copyright 2017
Middlesex-London Health Unit
50 King Street
London, Ontario
N6A 5L7

Cite reference as: Middlesex-London Health Unit (2017).

City of London Beverage Vending Review.

London, Ontario: Iman Algheriany, Todd Coleman, Ellen Lakusiak, Kim Loupos, Linda Stobo, Heather Thomas

Authors: Iman Algheriany, Todd Coleman, Ellen Lakusiak, Kim Loupos, Linda Stobo, Heather Thomas

All rights reserved.

Table of Contents

Acknowledgements.....	i
Executive Summary.....	1
Introduction.....	4
Survey Methods.....	6
Survey Results.....	7
Evidence-Informed Recommendations: Behaviour and Policy Considerations	11
Selected Lessons from the Field: What have other municipalities done?.....	15
Policy Options for Municipally Run Facilities.....	17
Recommended Policy Option: Remove All Beverage Vending Machines.....	21
Next Steps and Conclusions.....	23
References	25
Appendix A – Survey Tool.....	30
Appendix B – Data Collection Quotas per Location	36
Appendix C – Recommendations Summarized from the Evidence	37
Appendix D – Lessons from the Field: What have other municipalities done? – Additional Examples	38
Appendix E – Q&A: Sale of Sugar-Sweetened Beverages on Municipal Property.....	42

Acknowledgements

The authors would like to thank the following colleagues who assisted in the development of this research project and report:

Carolynne Gabriel, Librarian, Program Planning and Evaluation, Middlesex-London Health Unit

Yvonne Tyml, Librarian, Program Planning and Evaluation, Middlesex-London Health Unit

Bernie Lueske, Data Analyst, Program Planning and Evaluation, Middlesex-London Health Unit

Khoaja Khaled, Data Analyst, Program Planning and Evaluation, Middlesex-London Health Unit

Dr. Christopher Mackie, Medical Officer of Health and CEO, Middlesex London Health Unit

Suzanne Vandervoort, Director, Healthy Living Division, Middlesex-London Health Unit

Theresa Kirk, Administrative Assistant, Healthy Living Division, Middlesex-London Health Unit

Darlene Foster, Administrative Assistant, Healthy Start Division, Middlesex-London Health Unit

Amy Castillo, Program Assistant, Chronic Disease Prevention and Tobacco Control Team, Middlesex-London Health Unit

Alex Tyml, Online Communications Coordinator, Middlesex-London Health Unit

Sarah Neil, Public Health Nurse, Chronic Disease Prevention and Tobacco Control Team, Middlesex-London Health Unit

Youth Leaders from *One Life One You*, Middlesex-London Health Unit

Catherine Andru, Jennifer Beverley, Johanna Selga and Samantha Breau, Student Volunteers, Brescia University College

Scott Oldham, Manager of Business Solutions and Customer Service, City of London

Cassie Vivyurka and Noreen Spruyt, Staff, City of London

Heart and Stroke Foundation of Ontario

Executive Summary

On the recommendation of the Managing Director of Parks and Recreation, the Community and Protective Services Committee of London City Council approved an extension not to exceed six months to the current beverage vending contract with PepsiCo Beverages Canada to allow Civic Administration additional time to review beverage vending options. In September 2016, staff from both the City and the Middlesex-London Health Unit (Health Unit) began working together on the City of London Beverage Vending Review Project. A research team comprised of representatives from the Health Unit and the City of London was created to:

- assess current beverage vending machine offerings;
- conduct a survey to seek input from facility users and City of London residents on what changes could be made to the beverage vending machine environment in city-run facilities;
- review the literature and conduct an environmental scan to inform proposed changes; and
- propose policy options for consideration based on the survey results, recommendations documented in the literature on how to improve the food environment and lessons learned from other municipalities.

A cross-sectional questionnaire of patrons of city-run facilities, including arenas, aquatic centres, community centres, Storybook Gardens and the cafeteria in City Hall, was used to seek public input. In-person and online surveys were collected over a three-week period, from October 6 to 26, 2016. The survey results indicate that the majority (82.5%) of facility users are bringing beverages from home into city-run facilities: water in a refillable bottle (75%); coffee and/or tea (58%); water in a single-use bottle (23%); and sports drinks (21%). The survey results highlight that facility users are ready for some changes to be made to drink options available within beverage vending machines, including the removal of pop and soft drinks (48.3% agreed/strongly agreed) and the removal of energy drinks (63.5% agreed/strongly agreed). The results in support of the continuation of the sale of certain sugar-sweetened beverages (SSBs), including sports drinks, vitamin waters and juices indicate a misconception that some SSBs are needed for hydration during physical activity, or that these are “healthier” choices. Further, the results highlight that the majority of facility users (60.8%) support the sale of single-use bottled water in beverage vending machines, because water is a healthy drink and should be made available as a choice (67%) and in the event that facility users forget their own water or are unaware of the water stations (75%) within city-run facilities.

While the scope of the review was limited to beverage vending, public support for changes to snack and bulk candy vending machines in city facilities was also gauged. The majority of facility users (58.1%) support the removal of bulk candy vending machines from city-run facilities; however, there was clear disagreement (66.3% disagreed/strongly disagreed) regarding the removal of snack vending machines. The Health Unit recommends that the bulk candy vending machines be removed. The removal of these machines will reduce the distribution of bulk candy—candy which is nutrient-poor and very high in sugar (e.g., gumballs, hard candies, chocolate snacks, etc.). The Health Unit recommends that the City conduct a review of the snack food environment, specifically addressing snack food options within vending machines and concession stands, to see what improvements could be made.

After careful consideration of five different policy options for beverage vending, the Middlesex-London Health Unit recommends that the City of London implement policy option #1, the removal of all beverage vending machines in city-run facilities.

Rationale for Policy Option #1 – Remove All Beverage Vending Machines

Arenas, aquatic centres and community centres are priority settings for supporting healthy eating behaviours among children, youth and families (Naylor, Olstad & Themen, 2015). The complete removal of vending machines containing SSBs and the installation and promotion of water fountains, versus the addition of “healthier” beverages, is recommended because children are more likely to purchase SSBs regardless of the availability of healthier drink choices (Chen & Wang, 2016; Jones, Gonzalez & Frongillo, 2009).

- SSBs are the single largest source of sugar in the diet. A single 355 mL can of sugar-sweetened soda contains approximately 40 grams (about 10 teaspoons) of sugar with no health benefits (World Health Organization (WHO), 2015).
- The elimination of the sale of all sugary beverages from vending machines, including sports drinks, vitamin water and juices sends a consistent health message that all sugary drinks contribute to the negative health effects of too much sugar in the diet. This approach avoids “health washing,” which labels some SSBs as “healthier” compared to others.
- Water is the best choice to satisfy thirst, to stay hydrated and to feel energetic and alert (Centers for Disease Control and Prevention (CDC), 2010).
- Plain tap water is safe and easily accessible to children and adults both at home and in city-run facilities from water fountains and bottle-filling stations.
- When children are encouraged to drink water at a young age, they are more likely to drink water later in life (Birch, Savage & Ventura, 2007).
- Children with high intakes of SSBs are more likely to be overweight or obese. Each additional SSB consumed per day increases a child’s risk of becoming obese by 60% (Ludwig, Peterson & Gortmaker, 2001).
- The sugar in SSBs promotes bacterial growth and the acid in carbonated drinks weakens teeth, which can lead to cavities.
- The majority of London facility users (82.5%) bring beverages, of their choice, from home.
- The removal of beverage vending machines will reduce the number of plastic bottles that find their way into recycling and waste systems. This approach supports the City’s current ban on the sale of bottled water.
- Decreased distribution of SSBs by the City of London demonstrates leadership in promoting health and creating healthy environments for those families who access programs and services.

This change in support of healthy environments for children has already started in the City of London with the removal of beverage vending machines from most, if not all, local elementary schools. All single-use bottles require fossil fuels for their production and transport, and contribute to plastic bottle

waste regardless of the type of beverage they contain; therefore, the removal of beverage vending machines would have a positive impact from both a health and an environmental perspective. Municipally run facilities serve as community hubs and have the ability to reach and impact a broad cross-section of the population, including higher-need individuals and families. These facilities have the opportunity to help set a foundation for lifelong healthy lifestyles, and are ideal settings for the promotion of a healthy food environment.

Changes to the distribution of SSBs in vending machines at city-run facilities will have a positive health impact on our community. Given the survey results, the promotion of water consumption through the Healthy Kids Community Challenge community initiatives, and this beverage vending machine review, this is an opportune time for the Health Unit and the City of London to engage in public education activities: to promote municipal water as the beverage of choice; to address the “health washing” of various SSBs; and to increase public awareness regarding the health risks associated with the consumption of all SSBs.

The City of London is a leader in public service collaboration and innovation, and has identified health promotion and protection as a strategic priority. This report clearly outlines potential long-term health benefits that could be achieved by making improvements to the food environment within city facilities. This report and its recommendations highlight the unique role that municipal governments and health units can play in working together to improve our food environment and to make the healthy choice the easy choice.

Introduction

Sugar consumption has progressively become a major public health concern. Data reveals that one in every five calories consumed by Canadians originates from sugar (Langlois & Garriguet, 2011). Excessive intake of “free” sugar (both added sugar and sugar naturally found in food) has been linked to obesity, type 2 diabetes, cardiovascular disease, dental caries, metabolic syndrome and a lower intake of nutrient-dense beverages such as milk (Standing Senate Committee, 2016; WHO, 2015).

Sugar-sweetened beverages (SSBs) are any beverage to which sugar has been added, including soft drinks, fruit drinks, sports drinks, sweetened tea and coffee drinks, energy drinks and sweetened milk or milk alternatives (CDC, 2010). In recent guidelines, the WHO (2015) included sugar naturally present in fruit juices as “free” sugars, which increase individual risk of chronic diseases. In 2004, Statistics Canada reported that beverages including soft drinks, fruit drinks, juice and milk contributed to 44% of the average daily sugar intake of children and adolescents and 35% of adults’ average daily sugar intake (Langlois & Garriguet, 2011).

The Institute of Medicine (2012) has concluded that the intake of SSBs is one of the dietary factors leading to the increase in obesity and overweight rates in the United States. In children, studies reveal that a higher intake of SSBs increases risk of overweight or obesity by 55% (Te Morenga, Mallard & Mann, 2013).

According to the most recent Ontario statistics, close to 60% of adults self-report being overweight or obese, and in Middlesex-London this rate is somewhat higher, at almost 64% (Canadian Community Health Survey (CCHS), 2014). In Ontario, 25.5% of youth aged 12–17 self-report being overweight or obese (CCHS, 2014).

In addition to physical health, dietary choices impact mental health, cognitive function, the ability to focus and sleep patterns. The evidence shows that healthy children perform better academically, have better attendance and behaviour at school, and have improved concentration, memory and mood (CDC, 2014). Properly nourished children are more likely to grow and develop into healthy, active adults (Ontario Ministry of Child and Youth Services, n.d.).

Foods and drinks sold in recreation centers, schools, variety stores and workplaces have been recognized for having a significant influence on diet and health (National Collaborating Centre for Environmental Health (NCCEH), 2014). As such, considering improvements to the food environment is a priority for the Middlesex-London Health Unit (Health Unit). When choosing a beverage, water is the best choice for health and hydration, containing no sugar, calories, additives, preservatives or caffeine. When children and youth drink water instead of choosing an SSB, they are likely to consume fewer total calories per day (Han-Markey, Wang, Scholterbeck, Jackson, Gurm, Leidal & Eagle, 2012).

On the recommendation of the Managing Director of Parks and Recreation, the Community and Protective Services Committee of London City Council approved an extension not to exceed six months to the current beverage vending contract with PepsiCo Beverages Canada to allow Civic Administration additional time to review beverage vending options in arenas, community centres, aquatic centres, Storybook Gardens and the cafeteria in City Hall. In September 2016, City staff, in partnership with the Health Unit, initiated the City of London Beverage Vending Review Project. The alignment of this

vending review project with the City of London and Middlesex-London Health Unit strategic priorities and community initiatives is summarized in Table 1.

Table 1

Alignment of the Beverage Vending Review Project with City of London and Middlesex-London Health Unit Strategic Priorities and Community Initiatives

London City Council Strategic Priorities
<ol style="list-style-type: none"> 1. Strengthening Our Community: Work with the Middlesex London Health Unit to promote and protect the health of the community. 2. Leading in Public Service: Foster collaboration and innovation through a variety of mechanisms.
Middlesex-London Health Unit Strategic Priorities
<ol style="list-style-type: none"> 1. Program Excellence: Foster strategic integration and collaboration; optimize evidence-informed planning and evaluation. 2. Client and Community Confidence: Seek and respond to community input.
Community Initiatives
<ol style="list-style-type: none"> 1. London’s Child and Youth Network Healthy Eating Healthy Physical Activity Priority: A community network composed of over 170 agencies and individuals. This priority is focused on improving healthy eating and physical activity through engagement and influencing habits. 2. Healthy Kids Community Challenge: A province-wide initiative coordinated at the municipal level funded by the Ministry of Health and Long-Term Care. The focus of the 2016/2017 theme is on drinking more water and fewer sugary drinks. The 2017/2018 theme is on promoting the consumption of vegetables and fruit.

A research team comprised of representatives from the Health Unit and the City of London was created to:

- assess current beverage vending machine offerings;
- conduct a survey to seek input from facility users and City of London residents on what changes could be made to the beverage vending machine environment in city-run facilities;
- review the literature and conduct an environmental scan to inform proposed changes; and
- propose policy options for consideration based on the survey results, recommendations documented in the literature on how to improve the food environment and lessons learned from other municipalities.

This report documents the results of the survey, recommendations from the literature and the environmental scan, and policy options for consideration. The report makes a recommendation to the City of London on which policy option would have the greatest positive health and environmental impact and outlines some proposed steps if a policy change were to be implemented.

The recommendations contained within this report highlight the unique and significant role that municipal governments and health units can play in working together to influence our food environment to make the healthy choice the easy choice.

Survey Methods

A cross-sectional questionnaire of patrons and employees of city-run facilities, including arenas, aquatic centres, community centres, Storybook Gardens and the cafeteria in City Hall, was used to seek input from facility users and London residents. The self-administered, sixteen-item questionnaire (see Appendix A) was available to complete both in paper-and-pencil and online formats. Two different modes (paper-and-pencil and online) of the questionnaire were developed to ensure broad representation of respondents from across the City of London. The questionnaire was developed by Health Unit staff and piloted by Health Unit administrative assistants not directly involved in this project.

For the paper-and-pencil versions, sample size estimations calculated a minimum required sample of 384 individuals, rounded up to 400. To determine an appropriate sample size of survey respondents from each facility, City staff provided the number of annual visits by patrons at each facility. Using representative proportions of attendees at city-run facilities, including the cafeteria at City Hall, quotas were established for peer research assistants (RAs) to collect data in paper-and-pencil format at every facility (see Appendix B). The RAs were casual staff from the City of London, Youth Leaders from the Health Unit's *One Life One You* youth advocacy team, student volunteers, a Dietetic Intern from Brescia University College and two members of the research team. All RAs received in-person training and procedural instructions for survey administration. They worked in pairs and visited each facility where in-person data collection occurred. RAs attended facilities at peak times during week and weekend days and evenings to facilitate obtaining the quotas set for the in-person survey completion. Due to survey collection timing, in-person data collection did not occur at Storybook Gardens.

The research team used a supplementary method to collect surveys by distributing the link to the survey online via the Health Unit website. The online survey link was promoted to City of London employees on the City of London Intranet, and the online survey link was sent directly to 3,000 residents that subscribe to the City of London e-newsletter, to ensure broad representation. The online version of the questionnaire was delivered using SurveyMonkey® software. Paper-and-pencil surveys were entered into the SurveyMonkey® software to merge data.

The survey took approximately five minutes to complete, and was conducted from October 6 to 26, 2016. Overall, 491 patrons at city facilities completed the paper-and-pencil survey. An additional 465 participants completed the online survey. The total number of surveys completed, both in-person and online, was 956.

Data from both paper-and pencil and online surveys were analyzed using Stata (version 14.1), available in SurveyMonkey®. The distinction between paper-and-pencil surveys and online surveys was captured in the survey's introductory question, to facilitate separate analysis of specific sites, if warranted. Counts and frequencies were assessed and summarized, reviewed based on the combined sample, the survey completion type (online vs. physical venue) and the combined total of all respondents who had ever attended a city-run facility.

Survey Results

A total of 956 surveys were completed, with 51.4% completing paper copies of the survey and 48.6% completing the survey online. The majority of all patrons surveyed were between the ages of 25 and 44 years (45.5%). Patrons indicated they typically used arenas most frequently (30.0%) of all city facilities, and they did so a few or more times per week. As depicted in Figure 1, the majority of all respondents to both the online and in-person survey that accessed city facilities (82.5%) indicated they bring beverages from home for consumption when in city facilities.

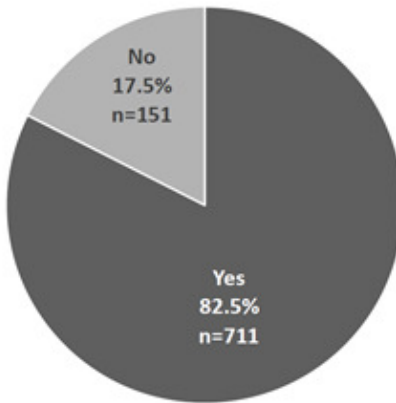


Figure 1. Proportion of city facility users that bring beverages from home into city facilities.

Most patrons brought water in a refillable bottle (83.1%) and coffee and/or tea (64.7%). Figure 2 provides a summary of the types of drinks that facility users reported bringing from home.

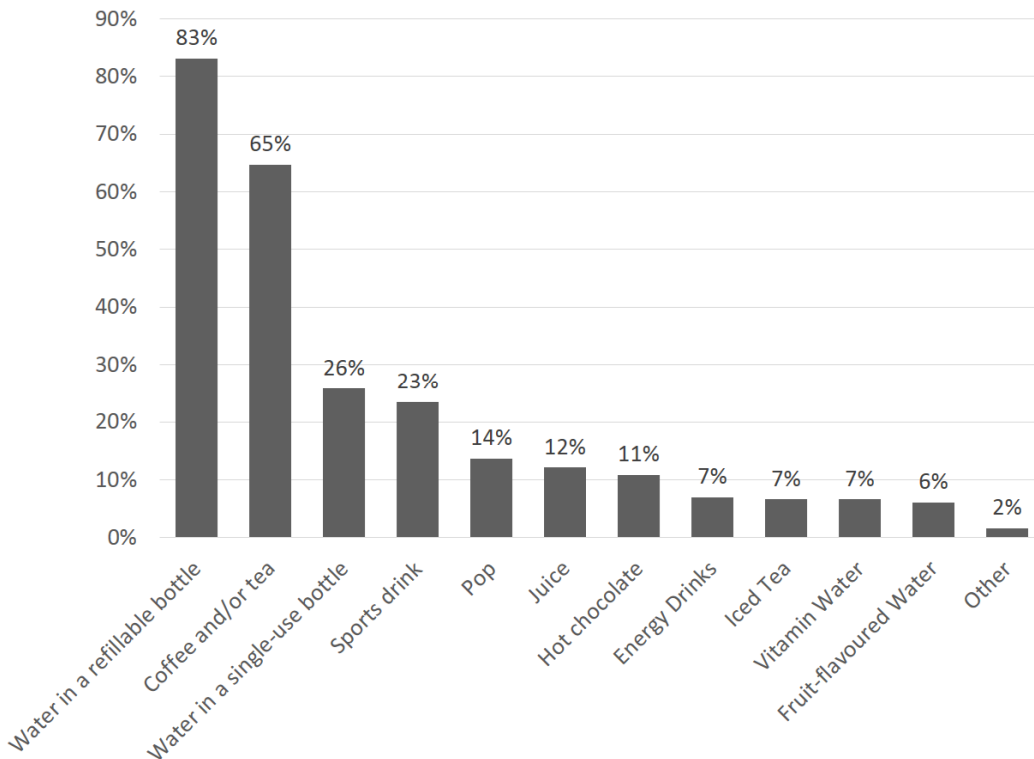


Figure 2. Proportion of types of drinks brought from home by city facility users.

A majority of all respondents who access city facilities (65.5%) have purchased drinks from vending machines in city facilities. Most frequently, they purchase one drink (81.2%) for either themselves (61.5%) or their children (50.6%).

Sugar-Sweetened Beverages

When asked about their opinions related to restricting the sale of specific beverages from beverage vending machines, depending on the method of answering the survey (online versus in-person) and the type of beverage to be restricted, the results vary. In general, all respondents indicated agreement on *keeping* the following beverages in the beverage vending machines: sports drinks, flavoured water, juice, iced tea, vitamin water and coffee beverages. All respondents shared stronger agreement in *removing* energy drinks with caffeine from the beverage vending machine. Of all respondents who completed the online survey and in-person survey who use city facilities, 48% indicated they agreed/strongly agreed to have pop and soft drinks removed. In comparison, 42% indicated they disagreed/strongly disagreed with the removal of pop and soft drinks from beverage vending machines. Figure 3 provides a summary of the responses for this question.

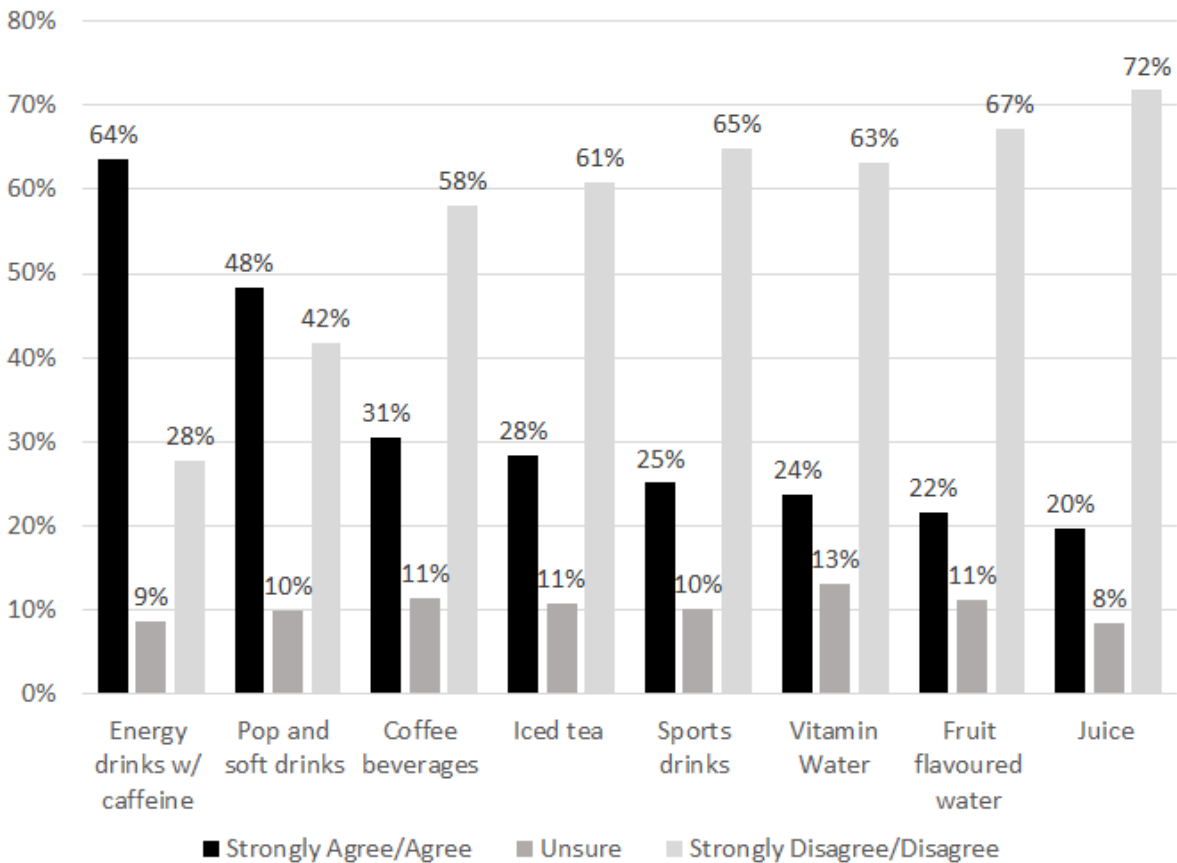


Figure 3. Facility users’ opinions related to restricting the sale of specific beverages from beverage vending machines.

Bottled Water

In 2008, London City Council discontinued the sale of single-use bottled water in the City Hall cafeteria, from city-owned or city administered concessions and in vending machines in public facilities where easy

access to municipal tap water exists. Civic Administration consulted with many community stakeholders, including the Health Unit, to inform the development and implementation of the bottled-water ban. The Health Unit provided public health considerations both for and against bottled water. Namely, the Health Unit expressed concerns about discontinuing the sale of bottled water in city-run facilities where bottled SSBs remain to be offered for sale. If bottled water is not available, and access to or use of municipal drinking water fountains is limited, then the public may opt for drinks with high levels of sugar, limited nutrition value and a high acid content. The Health Unit highlighted that both the sugar content and the acidity of SSBs can have negative impacts on overall health.

Therefore, public opinion was sought through this survey to determine whether or not the City should reconsider the single-use bottled water ban. Figures 4 and 5 outline facility users’ opinions related to single-use bottled water being made available for sale in city-run facilities within beverage vending machines and the reasons why respondents think single-use bottled water should be made available.

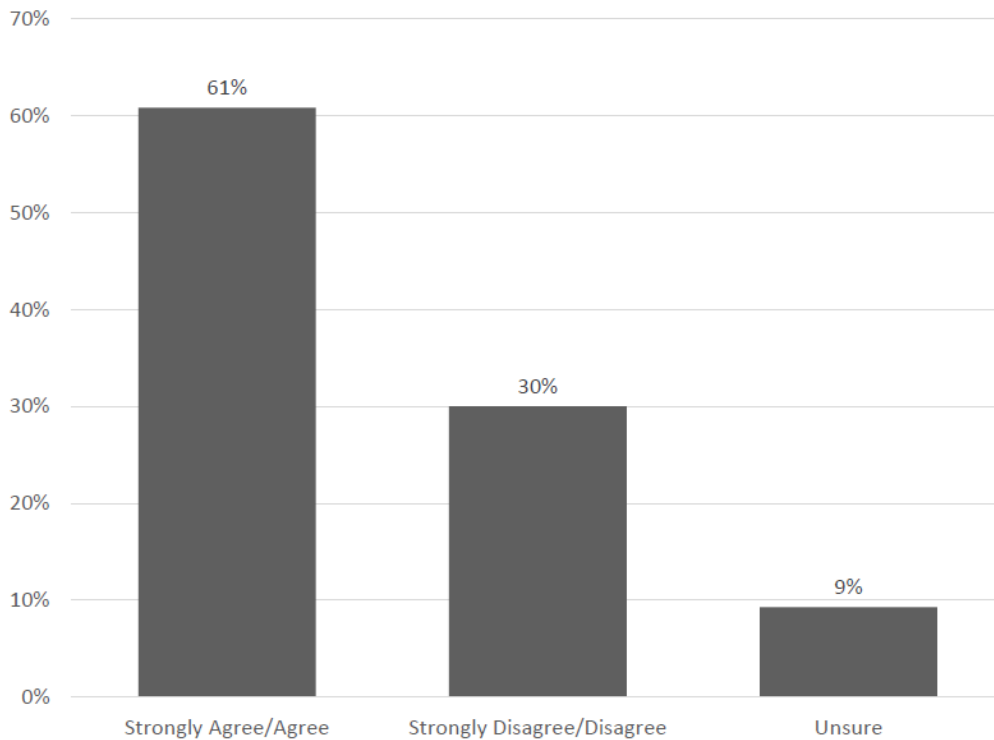


Figure 4. Facility users’ opinions related to single-use bottled water being made available for sale in City of London facilities.

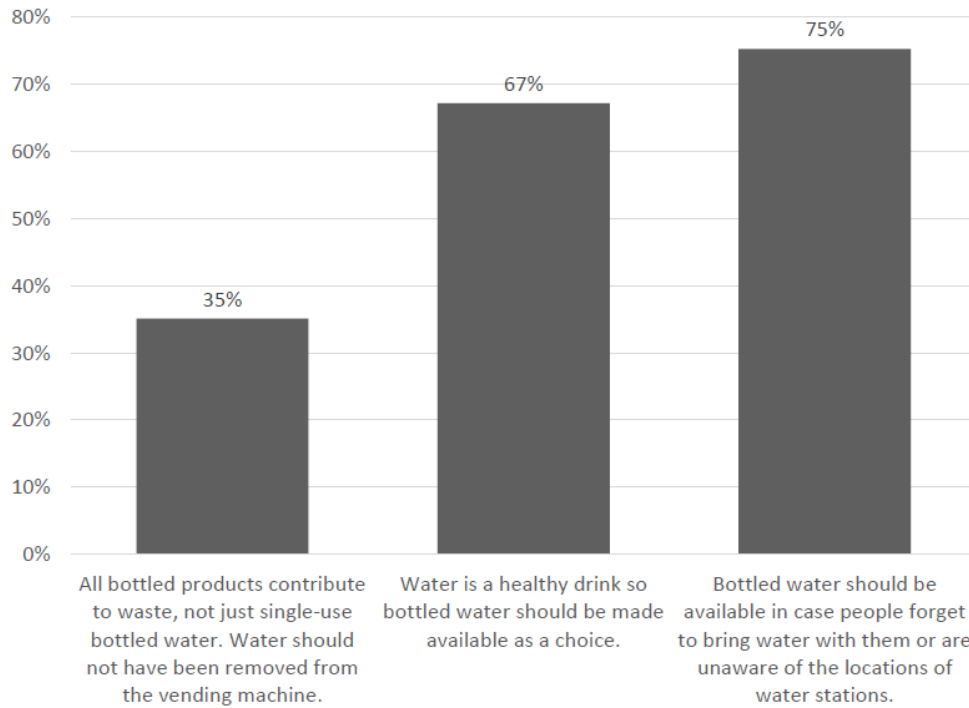


Figure 5. Facility users’ reasons provided to support the sale of single-use bottled water in City of London facilities.

Of all respondents who access city facilities, 60.8% indicate they agreed/strongly agreed that single-use bottled water should be made available for sale in city facilities. In fact, of the respondents who completed the survey *in person* at city facilities, 62.7% agreed/strongly agreed with making bottled water available for sale. Facility users indicated that single-use bottled water should be made available because water is a healthy drink (67.2%), and that it should be made available in vending machines in case people forget to bring their refillable bottles or are unaware of the availability of water bottle-filling stations (75.3%).

Of the 30% of facility users that disagreed/strongly disagreed with the sale of bottled water in beverage vending machines in city facilities, the majority indicated that water is available for free from water fountains and bottle-filling stations (64.6%), and that all single-use bottles are an environmental waste issue (64.1%). Some of these facility users (35.1%) also indicated that since they bring their own water from home to the facility, they would not buy it from a beverage vending machine.

Snack Vending and Candy Machines

While the purpose of the survey was focused on the issue of beverage vending, City staff solicited public input regarding the removal of snack vending and bulk candy vending machines. Facility users clearly disagreed with having snacks removed from the snack vending machines (66.3%); however, 58.1% agreed/strongly agreed with the removal of bulk candy vending machines from city-run facilities.

Evidence-Informed Recommendations: Behaviour and Policy Considerations

A healthy food environment in city-run facilities provides healthy options that can improve dietary behaviour while making it easier for consumers to make the healthier choice for themselves and their families. The following evidence was collected from a literature search focused on policies affecting beverage vending machines and influencers of beverage choice behaviour from vending machines. Three databases were searched—Medline, PsysInfo and ERIC—highlighting the issues, interventions, settings and outcomes. Full search strategies, including a full list of terms used, are available from the authors.

Availability of Foods and Beverages in Vending Machines

An individual's food and beverage selections are directly related to hunger level, rather than health outcome (Olstad, Goonewardene, McCargar & Raine, 2015). The environment in which food is provided can make it challenging for people to make healthy choices, depending on what types of food are available for consumption at these sites. Individuals who are influenced by environmental factors to unintentionally make less healthy choices may have a higher risk for becoming overweight or obese (Harrington, 2008; James, Thomas, Cavan & Kerr, 2004; Johnson, Bruemmer, Lund, Evens & Mar, 2009; Minaker, 2011; Shi, 2010). Municipally run facilities are priority settings for supporting healthy dietary behaviours among children, youth and families (Naylor, Olstad & Themen, 2015).

Public Settings

Vending machines have become a vehicle to increase the availability and convenience of unhealthy foods in public settings. Research findings show the availability of vending machines is positively correlated to vending machine use (Lawrence, Boyle, Carypo & Samuels, 2009; Park & Papadaki, 2016). The majority of food and beverage options in public settings are located in vending machines or canteens, but the opportunity to use such settings to promote and provide healthier dietary choices is often forgotten (Irby, Drury-Brown & Skelton, 2014; Olstad et al., 2015; Thomas & Irwin, 2010). Studies show that parents who frequent municipally run facilities, such as recreation centres, use vending machines to purchase foods and beverages mainly for their children and themselves (Thomas & Irwin, 2010). The majority of foods and beverages purchased from such venues are SSBs and high-energy snack foods. Many parents visiting recreational centres with their children also rely on snacks and beverages purchased from vending machines to replace meals (Irby et al., 2014; Olstad et al., 2015; Thomas & Irwin, 2010). Ongoing exposure and easy access to vending machines containing unhealthy foods and beverages influences dietary choices and makes unhealthy eating options more prevalent in these environments (Kelly, 2010; Shimotsu, French, Gerlach & Hannan, 2007).

School Environments

Students in an educational environment can easily access unhealthy foods and beverages from vending machines. The majority of snacks sold in vending machines are high in sugar, fat and saturated fats, and vended beverages are high in sugar (Ermetici et al., 2016). Findings from Park and Papadaki (2016) confirm that the accessibility and use of vending machines were positively associated with snacks and soft drinks consumed by students in school settings. Minaker (2011) explains that the presence of vending machines encourages children to adopt the habit of snacking and consuming SSBs. Furthermore, accessibility of vending machines also encourages students to bring similar unhealthy snacks and

beverages from home (Minaker, 2011). Fostering an unhealthy food environment in one location encourages equally unhealthy food environments elsewhere.

A systematic review conducted by Matthews and Horacek (2015) reported that inaccessibility of vending machines to children, adolescents and adults reduced their purchasing of vended snacks and beverages. The food environment has a strong influence on individuals' dietary habits; therefore, if healthy snacks and beverage choices are offered, individuals will improve their dietary choices. As shown in studies at public transportation sites and workplaces, it is difficult for individuals to make healthy choices when healthy products are not accessible in vending machines (Escoto et al., 2010; French et al., 2010; Kelly et al., 2010; Matthews & Horacek, 2015). It is clear that increasing the availability of healthier choices in vending machines can strongly influence individuals' food and beverage purchasing in recreational settings (Irby et al., 2014; Olstad et al., 2015; Thomas & Irwin, 2010), and, by extension, other municipally run facilities.

Nutrition Information (Food Labels) and Promotions (Advertisements and Logos)

Food is often categorized in the literature as healthy or unhealthy based on the type of food (e.g., milk, vegetables/fruit), its nutritional content (e.g., sugar, sodium), or eating behaviours (e.g., moderation, balanced, variety) (Matthews & Horacek, 2015). Providing children, youth and families with information about healthy eating, along with the rationale for changes to the food environment in municipally run facilities, is necessary to modify their beliefs about the consumption of a healthy diet. For instance, Kocken (2015) demonstrated that factors in the school food environment, such as food labelling or product advertisements, influenced students' consumption of SSBs, energy-dense foods, fruits and vegetables. A similar study by Wouters (2010) revealed that lower nutrition education was directly associated with higher consumption of soft drinks found in school vending machines. A systematic review reported that brand logos and product advertisements are positively associated with consumers' purchasing decisions, specifically of unhealthy foods (e.g., salty snacks, candy and sugar-sweetened beverages) (Matthews & Horacek, 2015). Furthermore, nutrition labels and content claims had a direct impact on product knowledge and consumption (Matthews & Horacek, 2015). Current research confirmed that the use of educational posters was successful in promoting healthy, nutrient-dense products in vending machines (Ermetici et al., 2016).

A major contributor to excessive energy intake is the increased consumption of SSBs commonly purchased from vending machines (Bergen & Yeh, 2006). In addition to the poor nutritional content of beverages sold in vending machines, the new mega-sizing of beverages is a phenomenon that has increased the amount of SSBs consumed. A study by Bergen and Yeh (2006) indicated the addition of energy-content labelling and motivational posters on vending machines was an effective strategy to influence beverage selections purchased from vending machines. As nutrition recommendations and guidelines are constantly evolving, it is difficult for individuals to remain informed about the most current information. Therefore, studies suggest that it is more worthwhile for policy makers to investigate the healthfulness of vended products, such as nutritional content and portion sizes, before offering them to the public (Mathews & Horacek, 2015).

Prices of Healthy versus Unhealthy Foods and Beverages

Food environments and the growing accessibility of lower-priced, calorie-dense foods and beverages are key contributors to the obesity epidemic (Bergen & Yeh, 2006). Studies show that nutrition-dense products are usually perceived as more expensive than calorie-dense products, which seem to have a strong influence on individuals' dietary choices (Matthews & Horacek, 2015). A study by French and colleagues (2010) showed lowering prices of healthy snacks in vending machines increased the sales volumes of healthy vended products at bus garages, similar to other studies conducted at schools and worksite settings. Schultz (2010) reports that multiple studies across the United States demonstrated continued revenue generation after imposing changes to the price of healthy vended products, and in some cases increased profit was seen with increased accessibility of healthy foods and beverages in vending machines. Kocken and colleagues (2012) found that a 25 to 50% price reduction of healthy vended products is the most effective strategy to increase the consumption of healthy foods and beverages, such as bottled water. Similarly, in a systematic review conducted by Grech and Iman-Farinelli (2015), price reductions on healthier options were successful in changing the purchases of adults and children, and produced a significant positive change in the purchase of the discounted items when the incentive was greater than 10%. Alternatively, Block and colleagues (2010) found increasing the price of soft drinks resulted in decreased sales of these products. Grech and Iman-Farinelli (2015) concluded that price incentives are an effective method for changing the buying practices of vending machine consumers.

Pouring Rights Contracts, Sponsorship Agreements and Revenue

Pouring rights contracts are common between schools, municipalities or other agencies, and soft drink companies, where funding is provided to these institutions in return for beverage companies being granted permission to sell and promote their beverage products. Most of the evidence focuses on pouring rights within the school setting.

Pouring rights, and being exposed to unhealthy options and beverage industry marketing, are most contentious in schools, because this is a learning environment where children and youth spend the majority of their day. In Ontario, approximately all secondary schools and almost half of all elementary schools have vending machines (Minaker et al., 2011). The food and beverage industry provides incentives for schools to use highly accessible vending machines in promoting unhealthy beverage products, such as soft drinks, sports drinks and vitamin water. The food and beverage industry takes advantage of less fortunate schools where funding is needed, and schools in neighbourhoods where families have a lower socioeconomic status are more likely to permit sponsorship and promotion (Johnston, Delva & O'Malley, 2007). The result of pouring rights in these neighbourhood schools is the consumption of low-nutrient, energy-dense foods and beverages during children's developmental years. Additionally, with greater exposure in a school environment to food industry logos, colours and other marketing efforts, children are more likely to develop "brand" and "taste" preferences, which may lead to the development of poor dietary habits and impact their health during adulthood (Johnston et al., 2007; Shi, 2010).

Increasing the availability of healthier choices in vending machines can strongly influence individuals' food and beverage purchasing in recreational settings (Irby et al., 2014; Olstad et al., 2015; Thomas & Irwin, 2010). Operators in these settings are often resistant to increasing healthy food and beverage options due to the preconceived notion that healthy foods are not revenue-generating (Olstad et al., 2015).

A recent study by Olstad and colleagues (2015) revealed the number of sales and revenue generated per customer was maintained when healthier vending machine products were introduced. This demonstrates the potential for mutual agreement and partnership benefits between public health and community settings to increase the accessibility of healthier vending machine products (Olstad et al., 2015). Research recommends public health officials review the strategies used by the food and beverage industry to make unhealthy food consumption the normative action in most environments. These strategies may assist operators at municipal facilities to increase sales of healthy products in vending machines (Olstad et al., 2015).

While pouring rights increase access to SSBs, the negative health impact of SSB consumption can be mitigated with wellness policies and nutrition guidelines to influence healthier choices, and is associated with lower SSB availability (Terry-McElrath, O'Malley & Johnston, 2011). The development of targeted nutrition guidelines for municipally run venues results in reduced SSB supplier involvement in choices offered (Terry-McElrath et al., 2011).

Increased Availability of Water

Childhood obesity prevention strategies require environmental changes that support children in making healthy choices. Whether at schools or in recreational/sports settings, children and youth engage in physical activities throughout their day. Physical activity triggers thirst and may increase children's risk of dehydration (Chen & Wang, 2016). Studies have proven that the best rehydration choice in any sports venue is water, and schools are excellent at increasing the accessibility of water fountains to prevent adverse dehydration (Chen & Wang, 2016). However, the high availability of beverage vending machines containing SSBs may increase competition for water consumption and offset energy expenditure from physical activity (Chen & Wang, 2016).

A recent study by Chen and Wang (2016) recommended the complete removal of vending machines containing SSBs from schools and the installation of more water fountains. Jones, Gonzalez and Frongillo (2009) found similar results. These researchers noted that children are three times more likely to purchase SSBs if they are available, regardless of whether healthy drink choices are available. If the availability of SSBs was eliminated, students would purchase and consume fewer SSBs. Providing alternatives to SSBs is not as effective as completely eliminating their availability (Jones, Gonzalez & Frongillo, 2009).

Aside from the availability of SSBs, children's decisions to use water fountains were dependent on water-quality factors, such as taste, temperature and colour. The concern with water quality found in water fountains was later addressed by suggesting the substitution of SSBs in vending machines with single-use bottled water. A number of studies indicate that allowing bottled water and other healthy beverages in vending machines in schools and recreation facilities encourages patrons to purchase healthier options, with preference for water (Ermetici et al., 2016; Irby et al., 2014; Johnston, Delva & O'Malley, 2007; Olstad et al., 2015; Park & Papadaki, 2016; Wiecha, Finkelstein, Troped, Fagala & Peterson, 2006; Wordell, 2012).

A summary of key considerations contained within the evidence is available as Appendix C.

Selected Lessons from the Field: What have other municipalities done?

Recommendations for comprehensive, district-wide policy in coordination with professional education, community-identified tools and technical assistance can translate into sustained, healthy food environments (Mozaffarian et al., 2016). Cradock and colleagues recommend policies that promote community-wide changes to make healthier beverage options more accessible on city-owned properties.

The Ontario Society of Nutrition Professionals in Public Health (OSNPPH) has developed a list of essential elements of a healthy recreation food environment (OSNPPH, 2016), which has been adapted and utilized at a number of municipally run facilities in Ontario and possibly beyond. Below are some examples of municipalities that have implemented changes to the food environment in their municipally run facilities.

Blandford-Blenheim (Oxford County), Ontario

This collaborative project with the Blandford-Blenheim arena in rural Oxford County (Oxford County Public Health, 2016) demonstrated that a healthier food environment is financially feasible and can be achieved by implementing a number of different actions, such as: strategic product purchasing and menu planning to increase availability of healthy foods and beverages; decreasing availability of unhealthy foods and beverages; ensuring competitive pricing of healthier foods and beverages; and effectively using product placement and promotional strategies.

The Blandford-Blenheim recreation facility experienced an increase in revenue and success in implementing the recommendations of the healthier recreation concession project.

Kingston, Frontenac and Lennox & Addington (KFL&A) Public Health

The KFL&A Recreation Centre Food and Beverage Survey Report (KFL&A, n.d.) provided staff at that agency with information pertaining to: recreation centre patrons' food and beverage purchasing behaviours; patrons' perceptions of food and beverages available in recreation facilities; and patron acceptance of healthier alternatives that could be sold in recreation centres. This information helped KFL&A staff to understand user opinions, anticipate barriers and identify opportunities to change the food environment.

The results of their survey indicate public support for increasing the availability of healthy food and beverages in public recreation centres. The results also identify many opportunities to improve the food environment to meet patron demands along with the potential to influence the health of recreation centre patrons.

KFL&A Public Health identify five recommendations that support recreation centres in improving their food environments: engagement with key stakeholders, including municipal recreation departments, recreation centre management, food service providers and vending operators; employment of a phased approach to increase the availability of healthy choices in recreation facilities; addressing identified patron preferences; providing promotional tools to promote healthy choices; and advocating for policies that support healthy food and nutrition environments in recreation centres.

City of Toronto: Parks, Forestry and Recreation

In 2011, Toronto’s City Council started a process to change the food environment in Toronto recreation settings, which was supported by political leadership and collaboration between the health department and the city. Their process included voluntary participation in a project to offer and promote healthier food and beverage choices at concessions: a request for proposal (RFP) process for cold beverage vending machine contracts that included a requirement for 50% healthier beverage choices; an RFP for a new snack vending machine contract that included a requirement for 20% healthier snack choices across the city (with a progression to 50% healthier snack choices); and a 100% healthy vending choices pilot project in twenty recreation settings in Toronto.

Though a number of barriers to achieving healthy food environments in recreation settings were cited, the Toronto City Council adopted the RFP for the operation of beverage services for cold drink vending machines and pouring within Parks and Recreation facility locations. For more information about the City of Toronto’s cold beverage vending report, please review their staff report (City of Toronto, 2011).

Lucan Biddulph (Middlesex County), Ontario

Changes to the food environment at a recreation facility in Lucan Biddulph, Ontario, occurred over three years through a process of change that focused on: gaining greater control over municipally run facilities; education of council, staff and citizens; taking specific action to affect the food environment within this setting; and working with suppliers to provide improved and competitive pricing.

Results in this municipality included: elimination of advertising of non-nutritional foods; removal of candy machines, a slushy machine and a nacho machine; reduction in the number of beverage vending machines from three to one; reduction in the size of selected snack and beverage portions available; increases in the price of pop to offset the lower price of single-use bottled water; implementation of a water bottle-filling station in a common location in recreation facilities; and the addition of milk, chocolate milk, fruits and eggs to the concession stand menu. For additional information about this project, please contact the author of this report.

King County, Washington, USA

In King County, one local board of health developed a policy approach for healthy food access through vending machine guidelines, and reviewed its impact and approach. They found that the guidelines and recommendations provided “policy guidance” in settings where the board of health does not have any regulatory authority, and facilitated the opportunity to create a healthy beverage environment within municipally run settings frequented by children, youth and families. For more information about this approach, please review the work by Quinn and colleagues (2015).

Boston, Massachusetts, USA

This project implemented and evaluated the impact of the Healthy Beverage Executive Order for all city agencies. The project provided policies to support access to healthy beverages on city-owned properties to make the healthier choice the easier one. For more information about this approach, please review the work by Cradock and colleagues (2015).

Additional examples from other municipalities can be found in Appendix D.

Policy Options for Municipally Run Facilities

In Australia, Miller and colleagues (2014) implemented a policy approach called *Better Choice*, with the goal of improving the food and drink supply in public sector health facilities. This program increased supply and promotion of healthy foods and drinks and decreased supply and promotion of energy-dense, nutrient-poor choices in all food supply areas of municipally run facilities. *Better Choice* is one example of the implementation of a public policy approach to improving the food and drink supply in complex, real-world settings. This is also an effective way to support healthy dietary behaviours and body weights among children (Naylor et al., 2015).

Policy Options for the City of London

Targeting the food environment in schools, workplaces, recreation facilities, community centres and other locations where children, youth and families live, work, play and learn is an important strategy that has gained considerable appeal in the public health community over the past several years (Garner et al., 2014). Health promotion activities are central to the mission of the Health Unit. Consequently, this report outlines policy options which have an opportunity to enhance the food environment to improve health outcomes. The following policy options are informed by the survey results, the review of the evidence and lessons learned from other municipalities. Whichever policy option is selected and implemented, the Health Unit recommends that it be supported with a comprehensive implementation plan, including a communication campaign to maximize reach and impact.

Snack Vending, Bulk Candy Vending and Concession Stands

While the scope of the review was limited to beverage vending, there was an opportunity to gauge public support for changes to snack and bulk candy vending machines that are available in most city-run facilities. Given the level of public support (58.1% agree/strongly agree), the Health Unit recommends that the bulk candy vending machines be removed. The removal of these machines will reduce the distribution of bulk candy—candy that is nutrient-poor and very high in sugar (e.g., gumballs, hard candies, chocolate snacks, etc.).

The results of the survey related to snacks (e.g., gum, chips, chocolate bars, peanuts, etc.) indicate that the snack food environment requires further review and discussion prior to making changes to snack vending machines. There was clear disagreement (66.3% of respondents who access city facilities) to remove snack vending machines from city facilities. However, a healthy food environment in city-run facilities would have a significant, positive impact on the health and behaviour of children, youth and families in our community. A review of the food environment within city facilities, specifically addressing snack food options within vending machines and concession stands, could be of benefit. The report highlights the unique role that municipal governments and health units can play in influencing the food environment to make the healthy choice the easy choice; therefore, the Health Unit recommends continued collaboration with City staff.

Beverage Vending Options

Policy Option #1: Remove all beverage vending machines

This option meets Health Unit recommendations to eliminate the distribution of SSBs in city-run facilities and encourages facility users to drink tap water from fountains and at bottle-filling stations. The removal

of beverage vending machines will help to reduce consumer confusion around those SSBs that are marketed by the beverage industry as “healthier” beverages (“health washed”), because they will no longer be available for sale. From a health perspective, sports drinks, vitamin water and juices also contribute to the negative health effects of too much sugar in the diet, and should not be labelled “healthy” or “healthier” compared to soft drinks and energy drinks. The drink of choice for hydration and health is plain water. Since all single-use bottles generate waste, the removal of vending would have a positive impact on reducing the City’s generation of plastic bottle waste.

The key challenge with this policy option relates to public perception about consumer choice. Removing all vending machines may be interpreted by some facility users as removing choices from parents, and leaves no drink options available except for water fountains, water bottle filling stations and concession stands (when available). However, 82.5% of facility users are already bringing beverages of their choice from home to city facilities. The removal of beverage vending machines would send a clear message that all sugary drinks are known negatively to impact the health of its facility users and that facility users are encouraged to choose water from water fountains and bottle filling stations to satisfy thirst.

Removing all beverage vending machines also results in a small loss of revenue. However, if the City of London stops receiving funds from the sale of beverages that increase the risk of unhealthy weights and other chronic diseases, this aligns with the City of London’s strategic plan to work with the Health Unit to promote and protect the health of the community. This also aligns with other City-supported community initiatives that are currently promoting the health benefits of drinking water and reducing the consumption of SSBs, such as the Healthy Kids Community Challenge. Decreased distribution of SSBs by the City of London would demonstrate leadership in promoting health and creating healthy environments for families from London and surrounding communities who are accessing programs and services.

Policy Option #2: Beverage vending machines with single-use and reusable bottled water only

This option enables the City of London to continue to generate revenue through beverage vending sales, while promoting the consumption of water—the healthiest beverage option. The majority of facility users (60.8%) would like single-use bottled water to be made available for sale in city facilities, both because it is a healthy choice and for those instances when people forget their own water or are unaware of the availability of water fountains/water bottle filling stations.

The environmental impact of adding single-use bottled water to beverage vending machines needs to be considered. The purchase of bottled water may increase, generating additional plastic bottle waste, contrary to the intent behind the bottled-water ban instituted in 2008. However, it is important to note that all bottled beverages for sale in beverage vending machines generate waste, and many facility users reported bringing their own water from home in a refillable bottle (83.1%). Therefore, even with the sale of bottled water in beverage vending machines, the net volume of plastic bottle waste may in fact decrease because of the removal of all other SSBs. The concern about waste could further be mitigated with increased availability of reusable water bottles at city facilities, and by exploring whether or not water in reusable water bottles could be sold from the vending machines.

Last, the increased availability of bottled water may call into question the safety of the municipal water supply by the public. It would be necessary to mitigate this potential misperception with a strong educational campaign that promotes water fountains and bottle-filling stations within city facilities.

Overall, there are long-term positive health impacts by including only single-use and reusable bottled water in the vending machines, and it is supported strongly by the evidence as a means to increase awareness about the health risks associated with consumption of SSBs and the health benefits of drinking water. While the bottled-water issue is complex, this policy option should be considered.

Policy Option #3a: Remove all pop and energy drinks from beverage vending machines and add single-use and reusable bottled water at discounted prices. Decrease serving sizes of remaining SSBs and increase the price of SSBs

This policy option calls for the removal of pop and energy drinks from beverage vending machines. The removal of pop and soft drinks is supported by facility users, with 48% indicating that they agreed/strongly agreed to have them removed, versus only 42% who disagreed/strongly disagreed. Respondents shared even stronger agreement in removing energy drinks with caffeine (63.5%). The removal of these particular SSBs sends a clear message to children, youth and families that these drinks are unhealthy and should not be distributed at city facilities. At the same time, the addition of low-cost, single-use and reusable bottled water to vending machines will help to reinforce the fact that water is the healthiest drink choice. The sale of SSBs in smaller-sized bottles at higher cost would help to decrease sugar consumption and reinforces healthy-eating messaging that SSBs should be consumed sparingly.

The literature recommends providing water at a lower cost compared to SSBs in the beverage vending machine (French et al., 2010; Grech & Iman-Farinelli, 2015; Kocken et al., 2010; Schultz, 2012). Water should be at most half the price of SSBs. Not only would a less expensive option be appealing to the public, but returning water to the beverage vending machine is supported by the survey results.

This policy option, however, is not without its own challenges. Because there is no agreed-upon definition by health experts of the term “healthy” as it relates to vending machine options, it will be difficult to decide and consistently implement changes to this food environment. For example, if vitamin water and sports drinks are kept in the beverage vending machines, SSBs will still be readily available for consumption. The removal of some SSBs and leaving others for sale is sending an incorrect message about the health benefits of sports drinks, vitamin water and other SSBs. This approach encourages “health washing” of so-called “healthier” beverage vending machine choices.

This policy option has some identified challenges from a health perspective and has been identified in the evidence as potentially problematic; however, there are benefits as it relates to facility users’ freedom of choice, portion control and public education around the health risks associated with pop and energy drinks. In addition, it may be more appealing from a business perspective, and is in line with the results from the survey. Further exploration of the unintended consequences of “health washing” and how this policy option would be monitored would be required if this direction were chosen.

Policy Option #3b: Remove all pop and energy drinks from beverage vending machines and decrease serving sizes of remaining beverages

The sale of single-use and reusable bottled water within vending machines is complex, as outlined in Policy Option #2; therefore, this policy option may yield some potential positive health impacts, while eliminating both the benefits and challenges related to the sale of bottled water. Overall, the potential positive health impact of this policy option is lower than Option #3a, because water, as the healthiest choice, is not being added; however, it may be worth consideration as an intermediate action that could be

taken by Civic Administration. This policy option allows for a more robust review of the bottled water ban, while implementing some changes that will improve the food environment at city facilities.

Policy Option #4: Add single-use bottled water to beverage vending machines, keep all other SSBs available for sale and price SSBs higher than water

In reality, water is the healthiest beverage option in beverage vending machines (that do not also sell lower-fat white milk) and should be made available to those who do not have a refillable water bottle available or who choose to refrain from drinking directly out of fountains. Adding water back into the beverage vending machines provides choice to the consumer while generating additional revenue for the City of London.

As recommended in the literature, water should be available at most half the price of SSBs in beverage vending machines (French et al., 2010; Grech & Iman-Farinelli, 2015; Kocken et al., 2010; Schultz, 2012). A less expensive option is appealing to the public and the availability of water in beverage vending machines is supported by the survey results.

The environmental impact of adding single-use bottled water to beverage vending machines needs to be considered. The purchase of bottled water may increase, generating additional plastic bottle waste; however, it is important to note that all bottled beverages for sale in beverage vending machines generate waste, and many facility users reported bringing their own water from home in a refillable bottle (83.1%). Therefore, even with the addition of bottled water to beverage vending machines, the net volume of plastic bottle waste may in fact balance, as those who had previously purchased SSBs switch to the purchase of bottled water. This potential consequence could further be mitigated by increased availability of reusable water bottles at city facilities, and the exploration of whether or not water in reusable water bottles could be sold from the vending machines.

Last, the increased availability of bottled water may call into question the safety of the municipal water supply by the public. It would be necessary to mitigate this potential misperception with a strong educational campaign that promotes water fountains and bottle-filling stations within city facilities. Overall, long-term positive health impacts can be achieved by adding single-use bottled water into the vending options, which would aid in shifting the culture and perception of healthy drinks in this food environment. This policy option is worth consideration given the results of the survey and the potential health benefits.

Policy Option #5: Status quo—beverage options remain the same

While this policy option is the easiest to implement and would yield no loss in revenue and no increase in cost to the City of London, it does nothing to create a healthier food environment within city-run facilities. Further, the survey results indicate that facility users are ready for some changes to be made to drink options available within beverage vending machines. Failure to implement any changes would be ill-advised, especially when steps were taken to solicit public input and the documented benefits associated with municipal policy change are significant.

Recommended Policy Option: Remove All Beverage Vending Machines

After careful consideration of the survey results, the review of the evidence, lessons learned from other municipalities and the five policy options, the Middlesex-London Health Unit recommends that the City of London remove all beverage vending machines from city-run facilities (i.e., Policy Option #1). A summary of the rationale for why this policy option is the preferred approach for the City of London is provided in Table 2.

Table 2. Summary Rationale for the Removal of All Beverage Vending Machines within City of London Facilities

Rationale for the Removal of Beverage Vending Machines
<ul style="list-style-type: none"> • The majority of London facility users (82.5%) bring beverages of their choice from home. • SSBs are the single largest source of sugar in the diet. • Eliminating the sale of all sugary drinks from vending machines, including sports drinks, vitamin water and juices, sends a consistent message that all sugary drinks contribute to the negative health effects of too much sugar in the diet. This approach avoids “health washing,” which labels some SSBs as “healthier” than others. • Water is the best choice to satisfy thirst, to stay hydrated and to feel energetic and alert. • Plain tap water is safe and easily accessible to children and adults, both at home and in city-run facilities from water fountains and bottle-filling stations. • When children are encouraged to drink water at a young age, they are more likely to drink water later in life. • Children with high intakes of SSBs are more likely to be overweight or obese. Each additional SSB consumed per day increases a child’s risk of becoming obese by 60%. • The sugar in SSBs promotes bacterial growth and the acid in carbonated drinks weakens teeth, which can lead to cavities. • The removal of beverage vending machines will reduce the number of plastic bottles that find their way into recycling and waste systems. This approach supports the City’s current ban on the sale of bottled water. • Decreased distribution of SSBs by the City of London demonstrates leadership in promoting health and creating healthy environments for those families who access programs and services.

Sugar consumption is a major public health concern, with SSBs being the single largest contributor of sugar to children’s diets (Langlois & Garriguet, 2011). Excessive intake of sugar has been linked to obesity, type 2 diabetes, cardiovascular disease, dental caries, metabolic syndrome and a lower intake of nutrient dense beverages, such as milk (Standing Senate Committee, 2016; WHO, 2015). In children, a higher intake of SSBs increases the risk of overweight or obesity by 55% (Te Morenga, Mallard & Mann, 2013). Just over 25% of Ontario youth aged 12–17 and almost 64% of Middlesex-London adults self-report being overweight or obese (CCHS, 2014).

In addition to physical health, dietary choices impact mental health, cognitive function, the ability to focus and sleep patterns. The evidence shows that healthy children perform better academically, have better

attendance and behaviour at school, and enjoy improved concentration, memory and mood (CDC, 2014). Properly nourished children are more likely to grow and develop into healthy, active adults (Ontario Ministry of Child and Youth Services, n.d.).

Food and drinks sold in recreation centres, schools, variety stores and workplaces have a significant influence on diet and health (National Collaborating Centre for Environmental Health (NCCEH), 2014). Individuals who are influenced by environmental factors to make less healthy choices may have a higher risk for becoming overweight or obese (Harrington, 2008; James, Thomas, Cavan & Kerr, 2004; Johnson, Bruemmer, Lund, Evens & Mar, 2009; Minaker, 2011; Shi, 2010). Improvements to the food environment are a priority for reducing the prevalence of unhealthy weights and improving health. Municipally run facilities, specifically, are priority settings for supporting healthy dietary behaviours among children, youth and families (Naylor, Olstad & Themen, 2015). Municipally run facilities often serve as community hubs and have the ability to reach and impact a broad cross-section of the population, including higher-need individuals and families. These facilities have the opportunity to help set the foundation for lifelong healthy lifestyles.

In school environments, accessibility of vending machines encourages students to bring similar unhealthy snacks and beverages from home (Minaker, 2011). Fostering an unhealthy food environment in one location encourages equally unhealthy food environments elsewhere. This relationship likely translates to municipally run-facilities, whereby accessibility of vending machines in city facilities also promotes unhealthy food choices in other settings.

Removing all beverage vending machines is recommended from a health perspective, rather than increasing the proportion of “healthier” beverages, the approach taken by other select municipalities. Children are more likely to report purchasing SSBs if they are available, regardless of whether healthy drink choices are available or not (Chen & Wang, 2016; Jones, Gonzalez & Frongillo, 2009). Providing alternatives to SSBs, including water, is not as effective as completely eliminating their availability (Chen & Wang, 2016; Jones, Gonzalez & Frongillo, 2009). As such, researchers recommend the complete removal of vending machines containing SSBs and the installation of water fountains (Chen & Wang, 2016; Jones, Gonzalez & Frongillo, 2009). This change in support of healthy environments for children has already begun in the City of London, with the removal of beverage vending machines from most, if not all, local elementary schools.

There are concerns with increasing the proportion of “healthier” beverages in vending machines, instead of removing all beverage vending machines. Classifying certain beverages as healthier because they contain less sugar than beverages with the highest sugar content, typically soft drinks, is misleading. This practice, often used in beverage marketing by the beverage industry, encourages “health washing” of certain beverages, leading to the consumer misconception that these beverages are healthy. From a health perspective, sports drinks, vitamin water and juices are still SSBs, and, like all SSBs, contribute to the negative health effects of too much sugar in the diet. The beverage of choice for hydration and health is plain water.

Over 60% of City of London facility users surveyed supported the sale of single-use bottled water in city facilities. When facility users decide to purchase a beverage from a vending machine, they want the choice to purchase a healthy option (i.e., plain water) instead of an SSB. From a health perspective, water is the ideal beverage choice. However, from an environmental perspective, single-use water bottles

contribute to environmental concerns, which previously led the City of London to discontinue the sale of single-use water bottles from public facility vending machines, replacing it with easy access to municipal tap water (e.g., water fountains). All single-use bottles, however, require fossil fuels for their production and transport, and contribute to plastic bottle waste, regardless of the type of beverage they contain. The total removal of beverage vending machines would have a positive impact from both a health and an environmental perspective.

Removing all beverage vending machines may be interpreted by some facility users as removing choices from parents and leaving no beverage options available except for municipal water sources (e.g., water fountains) and concession stands (when available). However, 82.5% of facility users are already bringing beverages of their choice from home to city facilities. The beverages most often reported to be taken to these facilities included water in a refillable bottle, coffee, or tea. This common practice of facility users bringing beverages from home offers families the opportunity to make their own beverage choices, supports the health of their families and is more cost-effective than paying premium vending machine prices.

As stated in the current Strategic Plan, the City of London is committed to working with the Health Unit to promote and protect the health of the community. Decreased distribution and sale of SSBs by the City of London would demonstrate leadership in promoting health and creating healthy environments for families from London and the surrounding communities who are accessing programs and services. This also aligns with other City-supported community initiatives that are currently promoting the health benefits of drinking water and reducing the consumption of SSBs, such as the Healthy Kids Community Challenge.

Next Steps and Conclusions

This report outlined the results of the public input survey, summarized a review of the literature and an environmental scan, and provided policy options for consideration by Civic Administration on how best to make improvements to the food environment in city-run facilities. After careful consideration of the policy options, the Health Unit recommends that the City of London remove all beverage vending machines and bulk candy vending machines from city-run facilities. It is recommended that a more comprehensive review of the snack food environment be initiated to explore snack food vending and concessions to identify opportunities to further improve the food environment in these important community hubs.

The City of London prides itself on being a leader in public service collaboration and innovation, and has identified health promotion and protection as a strategic priority. This report clearly outlines the potential long-term health benefits that could be achieved by eliminating the distribution of SSBs through beverage vending machines. Appendix E provides additional information, in a question-and-answer format, about the health risks associated with the consumption of SSBs and the benefits of reducing the availability of SSBs in publicly funded settings.

The survey results show the majority of patrons of city facilities are already bringing their own beverages from home, most often water in a refillable container. However, the results also show that there is support

for the continuation of the sale of certain sugary drinks, including sports drinks, vitamin waters and juices. This indicates the misconception that some sugary drinks are needed for hydration during physical activity, or that these are “healthier” choices. This is an opportune time for the Health Unit to work collaboratively with the Healthy Kids Community Challenge initiative and the City of London to engage in public education activities that: promote municipal water as the beverage of choice; address the “health washing” of various SSBs; and make known the health risks of excessive sugar consumption. There is a lack of awareness regarding the health risks associated with the consumption of all SSBs, and a lack of consumer awareness regarding beverage industry marketing practices. Providing children, youth and families with information about healthy eating, along with the rationale for changes to the food environment in city-run facilities, is necessary to modify beliefs about what constitutes a healthy diet.

When implementing health promotion policies, like making changes to the food environment in community hubs such as city-run facilities, the impact of policy changes is significantly enhanced when supported by a comprehensive communication strategy. In 2017, the Health Unit will work collaboratively with the City of London’s Healthy Kids Community Challenge initiative and the City’s Parks and Recreation Department to implement an education campaign in and around arenas, aquatic centres and community centres to make known the health risks associated with the consumption of SSBs and the benefits of water. The Health Unit is also committed to working with the Healthy Kids Community Challenge partners to support the upcoming 2017 theme of increasing vegetable and fruit intake because of the importance of the food environment as a whole.

City facilities, like arenas, recreation centres and City Hall, are vital hubs within our community and they can positively impact the health and wellness of children, youth and families. These settings are ideal for the promotion of a healthy food environment, and since food and beverages sold in recreation centres and workplaces have been recognized as having a significant influence on diet and health (NCCEH, 2014), improvements to the food environment remain a priority for the Health Unit. The Health Unit is committed to continuing its work in collaboration with the City of London, now and into the future.

References

- Bergen, D., & Yeh, M. C. (2006). Effects of energy-content labels and motivational posters on sales of sugar-sweetened beverages: Stimulating sales of diet drinks among adults study. *Journal of the American Dietetic Association*, 106(11), 1866–69.
- Birch L., Savage J. S., & Ventura, A. (2007). Influences on the development of children's eating behaviours: from infancy to adolescence. *Canadian Journal of Dietitian Practice Research*. 68, 1–56.
- Brambila-Macias, J., Shankar, B., Capacci, S., Mazzocchi, M., Perez-Cueto, F. J., Verbeke, W., & Traill, W.B. (2011). Policy interventions to promote healthy eating: A review of what works, what does not, and what is promising. *Food & Nutrition Bulletin*, 32(4), 365–75.
- Statistics Canada. (2014). *Canadian Community Health Survey*. [Data file]. Retrieved from <http://www.statcan.gc.ca/daily-quotidien/140612/dq140612b-eng.htm>
- Centers for Disease Control and Prevention (CDC). (2010). *The CDC guide to strategies for reducing the consumption of sugar sweetened beverages*. Retrieved from http://www.cdc.gov/SiteCollectionDocuments/StratstoReduce_Sugar_Sweetened_Bevs.pdf
- Centers for Disease Control and Prevention (CDC). (2014). *Health and academic achievement*. Retrieved from https://www.cdc.gov/healthyyouth/health_and_academics/pdf/health-academic-achievement.pdf
- Chen, H. J., Xue, H., Kumanyika, S., & Wang, Y. (2016). School beverage environment and children's energy expenditure associated with physical education class: An agent-based model simulation. *Pediatric Obesity*. Advance online publication. <http://dx.doi.org/10.1111/ijpo.12126>
- City of Toronto. (2011). *The health rationale for offering healthy choices in beverages*. Retrieved from <http://www.toronto.ca/legdocs/mmis/2011/gm/bgrd/backgroundfile-36766.pdf>
- Committee on Accelerating Progress in Obesity Prevention. Food and Nutrition Board. Institute of Medicine of the National Academies. (2012). *Accelerating progress in obesity prevention: Solving the weight of the nation*. Retrieved from <https://www.nap.edu/catalog/13275/accelerating-progress-in-obesity-prevention-solving-the-weight-of-the>
- Cradock, A. L., Kenney, E. L., McHugh, A., Conley, L., Mozaffarian, R. S., Reiner, J. F., & Gortmaker, S. L. (2015). Evaluating the impact of the healthy beverage executive order for city agencies in Boston, Massachusetts, 2011–2013. *Preventing Chronic Disease* 12, E147.

- Escoto, K. H., French, S. A., Harnack, L. J., Toomey, T. L., Hannan, P. J., & Mitchell, N. R. (2010). Work hours, weight status, and weight-related behaviors: A study of metro transit workers. *International Journal of Behavioral Nutrition and Physical Activity*, 7, 91. <http://dx.doi.org/10.1186/1479-5868-7-91>
- French, S. A., Hannan, P. J., Harnack, L. J., Mitchell, N. R., Toomey, T. L., & Gerlach, A. (2010). Pricing and availability intervention in vending machines at four bus garages. *Journal of Occupational & Environmental Medicine*, 52, Supp. 33.
- Grech, A., & Iman-Farinelli, M. (2015). A systematic literature review of nutrition interventions in vending machines that encourage consumers to make healthier choices. *Obesity Reviews*, 16(12), 1030–41.
- Han-Markey, T. L., Wang, L., Schlotterbeck, S., Jackson, E. A., Gurm, R., Leidal, A., & Eagle, K. (2012). A public school district's vending machine policy and changes over a 4-year period: Implementation of a national wellness policy. *Public Health*, 126(4), 335–37.
- Harrington, S. (2008). The role of sugar-sweetened beverage consumption in adolescent obesity: A review of the literature. *Journal of School Nursing*, 24(1), 3–12.
- Irby, M. B., Drury-Brown, M., & Skelton, J. A. (2014). The food environment of youth baseball. *Childhood Obesity*, 10(3), 260–65.
- James, J., Thomas, P., Cavan, D., & Kerr, D. (2004). Preventing childhood obesity by reducing consumption of carbonated drinks: Cluster randomized controlled trial. *British Medical Journal*, 328, 1237.
- Johnston, L. D., Delva, J., & O'Malley, P. M. (2007). Soft drink availability, contracts, and revenues in American secondary schools. *American Journal of Preventive Medicine*, 33(4 Supp.), S209–25. <http://dx.doi.org/10.1016/j.amepre.2007.07.006>
- Johnson, D. B., Bruemmer, B., Lund, A. E., Evens, C. C., & Mar, C. M. (2009). Impact of school district sugar-sweetened beverage policies on student beverage exposure and consumption in middle schools. *Journal of Adolescent Health*, 45(3 Supp.), S30–37. <http://dx.doi.org/10.1016/j.jadohealth.2009.03.008>
- Jones, S. J., Gonzalez, W., & Frongillo, E. A. (2009). Policies that restrict sweetened beverage availability may reduce consumption in elementary-school children. *Public Health Nutrition*, 13(4), 589–95.
- Kelly, B., Baur, L. A., Bauman, A. E., King, L., Chapman, K., & Smith, B. J. (2010). Examining opportunities for promotion of healthy eating at children's sports clubs. *Australian & New Zealand Journal of Public Health*, 34(6), 583–88.

KFL&A Health Unit (no date). *KFL&A recreation centre food and beverage survey report*. Retrieved from https://www.kflaph.ca/en/resourcesGeneral/Rec-Centre-Page/KFLA_Recreation_Centre_Food_and_Beverage_Survey_Report_O2015.pdf

Kocken, P. L., Eeuwijk, J., van Kesteren, N. M., Dusseldorp, E., Buijs, G., Bassa-Dafesh, Z., & Snel, J. (2012). Promoting the purchase of low-calorie foods from school vending machines: A cluster-randomized controlled study. *Journal of School Health, 82*(3), 115–22.

Kocken, P. L., van Kesteren, N. M., Buijs, G., Snel, J., & Dusseldorp, E. (2015). Students' beliefs and behaviour regarding low-calorie beverages, sweets or snacks: Are they affected by lessons on healthy food and by changes to school vending machines? *Public Health Nutrition, 18*(9), 1545–53.

Langlois, K., & Garriguet, D. (2011). *Sugar consumption among Canadians of all ages*. Statistics Canada, Health Reports. Retrieved from <http://www.statcan.gc.ca/pub/82-003-x/2011003/article/11540-eng.htm>

Lawrence, S., Boyle, M., Craypo, L., & Samuels, S. (2009). The food and beverage vending environment in health care facilities participating in the healthy eating, active communities program. *Pediatrics, 123*, Supp. 92.

Ludwig D. S., Peterson K. E. & Gortmaker S. L. (2001). Relation between consumption of sugar-sweetened drinks and childhood obesity: a prospective, observational analysis. *Lancet. 357*, 505–8.

Matthews, M. A., & Horacek, T. M. (2015). Vending machine assessment methodology. A systematic review. *Appetite, 90*, 176–86. <http://dx.doi.org/10.1016/j.appet.2015.03.007>

Minaker, L. M., Storey, K. E., Raine, K. D., Spence, J. C., Forbes, L. E., Plotnikoff, R. C., & McCargar, L. I. (2011). Associations between the perceived presence of vending machines and food and beverage logos in schools and adolescents' diet and weight status. *Public Health Nutrition, 14*(8):1350–56.

Miller, J., Lee, A., Obersky, N., & Edwards, R. (2015). Implementation of a Better Choice healthy food and drink supply strategy for staff and visitors in government-owned health facilities in Queensland, Australia. *Public Health Nutrition, 18*(9), 1602–9.

Mozaffarian, R. S., Gortmaker, S. L., Kenney, E. L., Carter, J. E., Howe, M. C. W., Reiner, J. F., & Craddock, A. L. (2013). Assessment of a district-wide policy on availability of competitive beverages in Boston public schools. *Preventing Chronic Disease, 3*, E32.

Narain, K., Mata, A., & Flores, J. (2016). Nutrition policy decreases sugar-sweetened beverages in municipal parks: Lessons learned from Carson, California. *Journal of Public Health Management & Practice, 22*(4), 392–94.

National Collaborating Centre for Environmental Health. (2014). *Policy options for healthier food environments in city regions: A discussion paper*. Retrieved from http://opha.on.ca/getmedia/d1e88d3a-fc46-4cf0-b5bf-e5b343336362/Policy_Options_Healthier_Food_Environments_Dec_2014.pdf.aspx

Naylor, P. J., Olstad, D. L., & Therrien, S. (2015). An intervention to enhance the food environment in public recreation and sport settings: A natural experiment in British Columbia, Canada. *Childhood Obesity, 11*(4), 364–74. <http://dx.doi.org/10.1089/chi.2014.0148>

Olstad, D. L., Goonewardene, L. A., McCargar, L. J., & Raine, K. D. (2015). If we offer it, will children buy it? Sales of healthy foods mirrored their availability in a community sport, commercial setting in Alberta, Canada. *Childhood Obesity 11*(2), 156–64.

Ontario Ministry of Child and Youth Services. (n.d.). Healthy Eating Matters: Food and nutrition toolkit for residential care settings. *Ontario Ministry of Children and Youth Services*. Retrieved from http://www.children.gov.on.ca/htdocs/english/specialneeds/healthy_eating.aspx

Ontario Society of Nutrition Professionals in Public Health. (2016). *Building healthier food environments within recreation spaces*. Retrieved from https://www.osnpnh.on.ca/upload/membership/document/2016-02/healthy-eating-in-the-recreational-setting-final_1.pdf#upload/membership/document/2016-02/healthy-eating-in-the-recreational-setting-final_1.pdf

Oxford County Public Health. (2016). *A healthier recreation concession pilot project evaluation*. Retrieved from <http://www.oxfordcounty.ca/Portals/15/Documents/BB%20A%20Healthier%20Recreation%20Concession%20Pilot%20Evaluation%20July%202016.pdf>

Park, H., & Papadaki, A. (2016). Nutritional value of foods sold in vending machines in a UK University: Formative, cross-sectional research to inform an environmental intervention. *Appetite, 1*(96), 517–25.

Quinn, E., Johnson, D. B., Krieger, J., MacDougall, E., Payne, E., & Chan, N. L. (2015). Developing local board of health guidelines to promote healthy food access—King County, Washington, 2010–2012. *Preventing Chronic Disease, 12*, E58.

Parliament of Canada: Report of the Standing Senate Committee on Social Affairs, Science and Technology. (2016). *Obesity in Canada: A whole-of-society approach for a healthier Canada*. Retrieved from <http://www.parl.gc.ca/Content/SEN/Committee/421/soci/RMS/01mar16/Report-e.htm>

Schultz, C. R. (2010). Removing junk food and beverages from school vending machines. *Minnesota Medicine, 93*(9), 32–35.

Shi, L. (2010). The association between the availability of sugar-sweetened beverage in school vending machines and its consumption among adolescents in California: A propensity score matching approach. *Journal of Environmental and Public Health*. <http://dx.doi.org/10.1155/2010/735613>

Shimotsu, S. T., French, S. A., Gerlach, A. F., & Hannan, P. J. (2007). Worksite environment physical activity and healthy food choices: Measurement of the worksite food and physical activity environment at four metropolitan bus garages. *International Journal of Behavioral Nutrition & Physical Activity*, 4, 17.

Te Morenga, L., Mallard, S., & Mann, J. (2013). Dietary sugars and body weight: Systematic review and meta-analyses of randomised controlled trials and cohort studies. *British Medical Journal*, 346. Retrieved from <http://www.bmj.com/content/346/bmj.e7492>

Terry-McElrath, Y. M., O'Malley, P. M., & Johnston, L. D. (2012). Factors affecting sugar-sweetened beverage availability in competitive venues of US secondary schools. *Journal of School Health*, 82(1), 44–55.

Thomas, H. M., & Irwin, J. D. (2010). Food choices in recreation facilities: Operators' and patrons' perspectives. *Canadian Journal of Dietetic Practice & Research*, 71(4), 180–85.

Wiecha, J. L., Finkelstein, D., Troped, P. J., Fragala, M., & Peterson, K. E. (2006). School vending machine use and fast-food restaurant use are associated with sugar-sweetened beverage intake in youth. *Journal of the American Dietetic Association*, 106(10), 1624–30.

World Health Organization (WHO). (2015). *WHO Guideline: Sugars intake for adults and children*. Retrieved from http://www.who.int/nutrition/publications/guidelines/sugars_intake/en/

Wouters, E. J., Larsen, J. K., Kremers, S. P., Dagnelie, P. C., & Geenen, R. (2010). Peer influence on snacking behavior in adolescence. *Appetite*, 55(1), 11–17.

Appendix A – Survey Tool

City of London Beverage Vending Machine Review – SURVEY

www.surveymonkey.com/r/city-of-london-beverage-vending-machine-review

What is the purpose of the survey?

- The City of London is reviewing what drinks are available for purchase from their vending machines and would like to seek input from city residents who use these facilities.

How will the results be used?

- We want to know what you think about the types of drinks that are available for sale from vending machines at city facilities, including arenas, aquatic centres, Storybook Gardens, community centres and the City Hall cafeteria to help us make the best decision for our city.
- The results will be made available in a report that will be posted on the Middlesex-London Health Unit's website and presented to the City of London's Community and Protective Services Committee in December.

What will I be asked to do?

- The survey will take approximately 5 minutes to complete.
- You may decline to answer any question.
- This survey is voluntary and responses will be kept confidential.

Data Storage and Questions about this Survey

Survey responses are stored by Survey Monkey® and not by the Middlesex-London Health Unit or the City of London, and are governed by the Survey Monkey® Terms of Use. Survey data may remain on Survey Monkey® servers for up to 12 months and are subject to the laws of a jurisdiction outside of Canada.

Any questions about the survey can be directed to:

Linda Stobo, Program Manager
Chronic Disease Prevention and Tobacco Control Team
Middlesex-London Health Unit
Tel: (519) 663-5317 ext. 2388
Email: linda.stobo@mlhu.on.ca

Please select where this survey is being completed. Please check (✓) one only.

- | | |
|--|---|
| <input type="checkbox"/> Argyle Arena | <input type="checkbox"/> Nichols Arena |
| <input type="checkbox"/> Canada Games Aquatic Centre | <input type="checkbox"/> North London Community Centre |
| <input type="checkbox"/> Carling Arena | <input type="checkbox"/> Oakridge Arena |
| <input type="checkbox"/> Carling Heights Community Centre | <input type="checkbox"/> Silverwoods Arena |
| <input type="checkbox"/> City Hall Cafeteria | <input type="checkbox"/> Stronach Arena and Community Centre |
| <input type="checkbox"/> Farquharson Arena | <input type="checkbox"/> Storybook Gardens |
| <input type="checkbox"/> Glen Cairn Arena | <input type="checkbox"/> South London Community Centre |
| <input type="checkbox"/> Kinsmen Arena and Community Centre | <input type="checkbox"/> I completed this survey online and not in a city facility. |
| <input type="checkbox"/> Lambeth Arena and Community Centre | |
| <input type="checkbox"/> Medway Community Centre/Ray Lanctin | |

1a. During a typical year, how often do you go to any of the following city facilities?

(Please check (✓) in the appropriate box for each facility)

	Never	Once a year	A few times a year	Once a month	A few times a month	Once a week	A few or more times a week
Arenas							
Aquatic Centres							
Community Centres							
Storybook Gardens							
City Hall Cafeteria							

2. What is your age?

- 17 years old or under
- 18 to 24 years old
- 25 to 44 years old
- 45 to 64 years old
- 65 years old or older
- Prefer not to answer

3a. Do you bring beverages from home into city facilities (e.g., arenas, aquatic centres, community centres, Storybook Gardens, City Hall cafeteria)?

- Yes (if yes, proceed to 3b)
- No (if no, skip to 4a)

3b. If yes, what do you bring with you? Please check (✓) all that apply.

- Water in a refillable bottle
- Water in a single-use bottle (e.g., Aquafina, Dasani, Nestle, store-brands, etc.)
- Coffee and/or tea
- Fruit-flavoured Water
- Energy Drinks
- Hot chocolate
- Iced Tea
- Juice
- Pop
- Sports drink (e.g., Gatorade)
- Vitamin Water
- Other (please specify) _____

4a. Have you ever purchased drinks from vending machines at city facilities (e.g., arenas, aquatic centres, community centres, Storybook Gardens, City Hall cafeteria)?

- Yes (if yes, proceed to 4b)
- No (if no, skip to 5)

4b. If yes, at your last visit to a city facility, how many drinks did you purchase from beverage vending machines?

- One
- Two
- Three or more

4c. For whom were these drinks purchased? Please check (✓) all that apply.

- Self
- Children
- Other family members (e.g., spouse, partner, extended family)
- Friends
- Other (please specify): _____

5. Please indicate the level at which you agree or disagree with the following statements by placing a check mark (✓) in the appropriate box:

5a. The following drinks should not be available for sale from the vending machines at city facilities (e.g., arenas, aquatic centres, community centres, Storybook Gardens, City Hall cafeteria).

	Strongly Agree	Agree	Disagree	Strongly Disagree	Unsure
Pop and soft drinks (e.g., Pepsi, Diet Pepsi, 7UP, Mountain Dew, Ginger Ale, and Dr. Pepper)					
Sports drinks (e.g., Gatorade)					
Fruit flavoured water (e.g., Perrier Lime, Aquafina Plus)					
Juice (e.g., Dole, Ocean Spray, Tropicana Orange, Lemonade, Apple, or Cranberry)					
Iced tea (e.g., Lipton, Lipton Green, Lipton White)					
Vitamin Water					
Coffee beverages (e.g., Starbucks Frappuccino, Starbucks Ice Coffee, Starbucks Refreshers)					
Energy drinks with caffeine (e.g., AMP)					

5b. Snacks (e.g. gum, chips, chocolate bars, peanuts, candy, etc.) should not be available for sale from snack vending machines at city facilities (e.g. arenas, aquatic centres, community centres, Storybook Gardens, City Hall Cafeteria).

Strongly Agree	Agree	Disagree	Strongly Disagree	Unsure

5c. Bulk candy (e.g. Jawbreakers, Gum Balls, Chews, Runts, etc.) should not be available for sale from candy vending machines at city facilities (e.g. arenas, aquatic centres, community centres, Storybook Gardens, City Hall Cafeteria).

Strongly Agree	Agree	Disagree	Strongly Disagree	Unsure

6. In 2008, a decision was made by the City of London to stop the sale of single-use bottled water from the City Hall cafeteria and from city-owned or city-operated concessions and vending machines in public facilities. Please indicate the level at which you agree or disagree with the following statements by placing a check mark (✓) in the appropriate box:

6a. Since city-owned or operated facilities have water fountains and water bottle filling stations, there should be no beverage vending machines in these facilities.

Strongly Agree	Agree	Disagree	Strongly Disagree	Unsure

6b. Single-use bottled water should be made available for sale in the City Hall cafeteria and in beverage vending machines in city facilities (e.g., arenas, aquatic centres, community centres, Storybook Gardens and City Hall).

Strongly Agree (Proceed to 6c)	Agree (Proceed to 6c)	Disagree (Skip to 6d)	Strongly Disagree (Skip to 6d)	Unsure

6c. If you agreed or strongly agreed with the above statement, why?
(Please check (✓) all that apply)

- All bottled products contribute to waste, not just single-use bottled water. Water should not have been removed from the vending machine.
- Water is a healthy drink so bottled water should be made available as a choice.
- Bottled water should be available in case people forget to bring water with them or are unaware of the locations of water stations.
- Other (please specify): _____

(Skip to End)

6d. If you disagreed or strongly disagreed with the above statement, why?

(Please check (✓) all that apply)

- I don't buy anything from the beverage vending machine so it doesn't matter to me.
- There are water fountains and water bottle filling stations available for free so I would not pay to get water from the vending machine.
- I always bring my own water to the facility with me so would not buy it.
- All single-use bottles are an environmental waste issue.
- Other (please specify): _____

Thank you for taking the time to complete the survey!

Appendix B – Data Collection Quotas per Location

City Facility	Annual Visits	Proportion of Total	Survey Quota
Argyle Arena	215,000	6.79%	27
Canada Games Aquatic Centre	300,000	9.47%	38
Carling Arena	108,000	3.41%	14
Carling Heights Community Centre	125,000	3.95%	16
City Hall Cafeteria	146,500	4.62%	18
Farquharson Arena	173,000	5.46%	22
Glen Cairn Arena	99,000	3.12%	12
Lambeth Arena and Community Centre	191,000	6.03%	24
Medway Community Centre/Ray Lanctin	146,500	4.62%	18
Nichols Arena	314,000	9.91%	40
North London Community Centre	75,000	2.37%	9
Oakridge Arena	150,000	4.73%	19
Silverwoods Arena	124,000	3.91%	16
Stronach Arena and Community Centre	447,500	14.12%	56
Storybook Gardens	135,000	4.26%	17
South London Community Centre	150,000	4.73%	19

Appendix C – Recommendations Summarized from the Evidence

<p>Vending Machine Options</p>	<p>Offer healthy snacks and beverages in vending machines to enable consumers to make healthier choices when eating and drinking away from home.</p> <p>When revising options available for vending machines, evaluate the healthfulness of proposed products based on nutritional content, portion size and price before agreeing to make them available to the public.</p> <p>Work with food industry representatives to increase the availability and accessibility of healthier vending machine products, specifically reinstating single-use bottled water as a priority option in vending machines.</p>
<p>Water</p>	<p>Offer single-use bottled water at a discounted price compared to sugar-sweetened beverages and beverages that are nutrient-poor (e.g., pop, diet pop, sports drinks, vitamin water, fruit drinks, energy drinks, sweetened tea and coffee beverages, and energy drinks). The discount should be at 50% less than the unit cost for the other beverages to encourage a change in buying practices.</p> <p>Remove SSBs from the beverage vending machine and replace with single-use bottled water.</p>
<p>Policy Development</p>	<p>Review existing wellness policies and nutrition guidelines that have been successfully implemented, evaluated and monitored in municipally run facilities.</p> <p>When implementing a policy change, ensure that there is a comprehensive implementation, monitoring and communications plan to maximize reach and impact.</p>
<p>Education</p>	<p>Implement educational posters to promote healthy, nutrient-dense products available in vending machines, as well as municipally available water.</p>

Appendix D – Lessons from the Field: What have other municipalities done? – Additional Examples

Health Unit	Purpose	Target Population	Key Elements and Resources Developed
Algoma Public Health	To increase healthy choices in recreation settings	Children, youth and adults	<p>Surveys evaluating the food environment and consumer preferences.</p> <p><u>Reports (2015):</u> http://www.algomapublichealth.com/media/2009/healthy-eating-in-recreational-facilities-a-review-of-the-food-environment-in-algoma-march-2015.pdf</p> <p>http://www.algomapublichealth.com/media/2008/consumer-preferences-for-food-and-beverages-in-algoma-recreation-facilities-in-algoma-report-nov-2015.pdf</p>
Grey Bruce Health Unit	To raise awareness and help change attitudes toward food choices offered in recreation centres	Municipal councillors, recreation staff and patrons	<p>Environmental scan report and online survey.</p> <p>88% would like healthier food and drink options available at recreational spaces.</p> <p><u>Recommendation:</u> Report is not enough; recreational departments want help with deputations to council to speak to survey results and help convince council to support changing the environment.</p> <p><u>Next Steps:</u> Create key messages document and talking points to counter any opposition and a presentation for council deputation.</p> <p><u>Report and Infographic (2016):</u> https://www.publichealthgreybruce.on.ca/About-Us/News-Releases/ArticleID/380</p>
Halton Region Health Department	To investigate the food environment in recreation centres	Recreation centre food environment managers and supervisors	<p><u>Goal:</u> To establish a baseline of how food is procured in recreation centres and to determine if there is interest from recreation centres in working with the Health Department to make improvements in the food environment.</p> <p><u>Policy:</u> To assist the City, as part of the Healthy Kids Community Challenge, to implement a Healthy Eating Policy for municipal facility vending and concession kiosks (needs City Council approval to move forward).</p>

Haliburton, Kawartha, Pine Ridge District Health Unit (HKPR)	To increase the availability of healthy foods; To address the placement, promotion and pricing of healthy foods	Municipalities (i.e., Healthy Environments and Policy)	<u>Goal:</u> To continue advocacy efforts with Community Centre to identify types of healthy foods that could be offered, placement of foods, pricing and point-of-purchase promotion To support staff at the Centre, recruit volunteers and develop partnerships (i.e., sourcing suppliers that could provide healthy foods at reasonable prices, or securing funding to assist with promotions)
Kingston, Frontenac and Lennox & Addington (KFL&A) Public Health	To improve healthy food environments in municipal recreation centres	Children, youth and adults	Completed patron survey and recreation facility assessments. Meeting with recreation managers to plan improvements to food offered in canteen, vending machines, etc. City released request for proposal for “25% Choose Most / 25% Choose Less / 50% Not Recommended” criteria for vending machines, with language for position and pricing of “Choose Most / Not Recommended” items <u>Report, Infographic and Promotional Material:</u> https://www.kflaph.ca/en/The-Super-Snackables.aspx
Niagara Region Public Health (NRPH)	To help improve the food environment in recreation facilities by offering healthier food choices	Children, youth and adults	<u>Report (2015):</u> Received comprehensive evaluation of the second phase of the Fuelling Healthy Bodies program, completed by external consultants. Report noted many recommendations beyond the scope and capacity of NRPH public health. Loss of Healthy Communities Fund, which funds this program. <u>Next Steps:</u> With support of health promoter and policy analyst, explore a municipal policy approach, while continuing to support local vendors on a consultative basis. <u>Fuelling Healthy Bodies: Healthy Eating Policy for Sports Teams:</u> http://niagararegion.ca/living/health_wellness/healthy_lifestyles/fuelling-healthy-bodies.aspx
North Bay Parry Sound District Health Unit	To help improve the food environment in	Youth and adults	<u>Overview:</u> <ul style="list-style-type: none"> • Advocacy letters distributed to all municipal recreational staff and managers in Jan 2016. • Food charter endorsed by many municipalities in

	recreation facilities by offering healthier food choices		<p>2016.</p> <ul style="list-style-type: none"> Plan to work with health promoter to leverage charter in 2017. <p><u>Long-Term Goal:</u> To have municipalities implement policy related to healthy food options and a healthy eating environment in local recreation settings</p> <p><u>Request for Proposal (2016):</u> http://www.myhealthunit.ca/en/partnerandhealthproviderresources/resources/rfp-2016-01-general-insurance-and-risk-management-services-program.pdf</p>
Oxford County Public Health	Healthier Recreational Concession Pilot Project, sustainability and expansion plans	Children, youth and adults	<p>Three pilot projects and evaluations for year one complete.</p> <p>Worked with city concession to introduce healthy menu for summer 2016 (sold > 1,300 units healthy product in two months).</p> <p><u>Next Steps:</u> Share pilot project results and recommendations with recreational managers and municipalities to inform their plans and decision making for food provision and operational costs. Continue working on menu implementation with local Agricultural Society (local berry and dairy suppliers for smoothies).</p> <p><u>Evaluation Reports:</u> http://www.oxfordcounty.ca/Partners-professionals/Reports-and-publications</p>
Peel Public Health	Healthy Food Policy and Environments	Children, youth and adults	<p>The Peel Healthy Eating Recreation Organization (HERO) evolved into three municipality based projects: Brampton, Mississauga and Caledon.</p> <p><u>Common Elements:</u></p> <ul style="list-style-type: none"> Using Peel Nutrition Guidelines (“Healthy” food and drink and “Other” categories). Developing Foods Offered and Used master list (packaged foods, ingredients and recipes). <p><u>Nutrition Pitfalls: Vending Machines and Workplaces:</u> http://www.peelregion.ca/health/workplace/employees/eating/busy-vending.htm</p> <p><u>Healthy Vending Machine Choices:</u> http://www.peelregion.ca/health/workplace/health/eati</p>

			ng/vending.htm
Peterborough Public Health (formerly Peterborough County City Health Unit)	To explore opportunities to work with municipal recreational centres on healthy eating initiatives; To promote water in municipal recreation centres	County arenas	<p><u>Goal:</u> To improve vending with beverages that align with PPM 150 and encourage water consumption.</p> <p>Start with one pilot municipal recreation centre.</p> <p><u>Goal:</u> To offer healthy beverage options and promote water consumption in recreation facilities. To develop a healthy food and beverage policy.</p> <p>Install water bottle filling stations at county centres and city arenas.</p> <p>Food Policy Report (2011): http://www.foodinpeterborough.ca/wp-content/uploads/2014/07/844_Food+Policy+CFN+Report+March+2011.pdf</p>
Sudbury and District Health Unit (SDHU)	To create supportive environments that make the healthy choice the easy choice	Children, youth, adult influencers and key decision makers	<p>Annual Report (2015): https://www.sdhu.com/uncategorized/2015-annual-report-community-first</p> <p><u>No Time to Wait: Healthy Kids in the Sudbury and Manitoulin Districts (Change the Food Environment: SDHU Grade = C+):</u> https://www.sdhu.com/resources/research-statistics/research-evaluation/reports-knowledge-products/no-time-wait-healthy-kids-sudbury-manitoulin-districts</p>

Appendix E – Q&A: Sale of Sugar Sweetened Beverages on Municipal Property

1) What are sugar-sweetened beverages?

- Sugar-sweetened beverages (SSBs) are any beverages to which sugar has been added, including soft drinks, fruit drinks, sports drinks, sweetened tea and coffee drinks, energy drinks and sweetened milk or milk alternatives.

2) What are the health concerns with drinking SSBs?

- Excess sugar consumption is linked with poor health outcomes including heart disease, stroke, diabetes, high blood cholesterol, cancer and dental problems.
- Beverages, including soft drinks, fruit drinks, juice and milk contributed to 44% of the average daily sugar intake of children and adolescents and 35% of adults' average daily sugar intake.
- Children with high intakes of SSBs are more likely to be overweight or obese. Each additional SSB consumed per day increases a child's risk of becoming obese by 60%.
- There is a clear link between drinking SSBs and risk of poor diets. When children drink more SSBs, they also drink less water and milk.

3) What is the impact of SSBs on teeth?

- The sugar in SSBs allows for bacteria growth that can lead to tooth decay.
- The acid in carbonated SSBs can weaken teeth and lead to cavities.
- When children drink soft drinks their risk of dental caries nearly doubles.

4) Is there still a concern if people only have one SSB in a day or only once in a while?

- To promote health, the World Health Organization (WHO), Canadian Diabetes Association and Heart and Stroke Association recommend limiting the intake of free sugars to less than 10% of daily calorie intake, which is about 10 teaspoons for a 1700 calorie diet.
- One 355mL can of a typical SSB contains 10 to 12 teaspoons of sugar.
- When children drink SSBs from a young age, they are more likely to prefer the taste of sugary drinks rather than enjoying plain water.

5) Why is water the best choice for hydration?

- Water contains no sugar, calories, additives, preservatives or caffeine.
- In most cases, water is the best choice to replace water lost through physical activity.
- When children drink water at a young age, they are more likely to drink water as they get older.
- When children drink water instead of SSBs they are likely to take in fewer total calories per day.
- Children who consume healthy diets learn better, perform better in school and socially and have more energy to be physically active.
- Municipal tap water is a convenient and free source of hydration.

6) Why should the City of London remove beverage vending machines from their facilities?

- Providing healthy environments fits with the City's strategic plan to promote and protect the health of its residents. It positions the City as a role model for healthier food environments.
- City facilities are often community hubs where families participate in recreation and should help promote lifelong healthy lifestyles.
- Beverage vending machines contain mostly SSBs and contribute to an already high daily sugar intake, especially with local children and youth.
- Consumers, particularly children, are more likely to buy and drink SSBs if they are available.
- Most Londoners already bring their own drinks, mostly water in refillable containers, to City facilities.
- Removing beverage vending machines encourages municipal water consumption.
- This is a business decision to not profit from the sale of SSBs.
- Removing beverage vending machines aligns with other City-supported community initiatives that are currently promoting the health benefits of drinking water and reducing the consumption of SSBs (e.g., the Healthy Kids Community Challenge).
- By removing beverage vending machines, the City is supporting the health of Londoners and making the healthy choice the easy one for Londoners. Providing only municipal water at City facilities takes away the pressure to choose between water and less healthy, more expensive SSBs.

7) Why can't the City of London just add healthier choices into the vending machines?

- Plain water and white milk are the only healthy drink choices for vending machines. All other vended beverages contain sugar, carbonation and/or artificial sweeteners.
- For hydration and health, drinking water is most often the best choice before, during and after physical activity.
- Consumers are more likely to choose a less healthy drink even when a healthier drink is available.
- Selling SSBs with less sugar in the vending machines encourages the public to think these drinks are healthier or healthy, but they are still SSBs.
- In 2008, the City of London was a leader by removing bottled water from City facilities and has the opportunity to continue to lead in reducing environmental waste from disposable plastic bottles.

8) Why are you taking away my freedom to choose what I want to drink?

- Most Londoners already bring drinks, of their own choice, to City facilities.
- If they choose to do so, facility users may purchase drinks readily available for sale elsewhere.
- The argument that facility users' freedom to choose is being affected is similar to arguments used in the past against tobacco legislation. Selling SSBs is not in the best interest of the public, and therefore, it is appropriate for publicly-funded organizations to implement policies that create health promoting environments.

9) What is the issue with 100% fruit juice?

- The natural sugar in juice has a similar effect on teeth and overall health as sugar from other SSBs.

- It is recommended that children drink at most ½ cup (125 mL) juice per day. Juice containers commonly available from vending machines are much larger than this.
- Eating a whole piece of fruit provides water and extra nutrients and is more filling than juice.

10) What is the issue with artificially sweetened soft drinks (i.e., diet soft drinks)?

- Like regular soft drinks, diet soft drinks provide no nutritional value.
- Drinking artificially sweetened drinks can increase the desire for sweet tasting drinks, instead of enjoying plain water.
- The acid in diet soft drinks can weaken teeth and lead to cavities.
- The safety of artificial sweeteners is not well studied in children, especially if they consume a lot over time.

11) What is the issue with vitamin waters or sweetened carbonated waters?

- Vitamin waters and sweetened carbonated waters are still SSBs or contain artificial sweeteners.
- Added sugar provides extra, unnecessary calories.
- Vitamins commonly added to vitamin water are already adequate in the diets of the majority of Canadian children and adults. The body does not use the extra vitamins, but gets rid of them in the urine.
- The acid in carbonated waters can weaken teeth and lead to cavities.

12) Aren't sports drinks the best choice for active people?

- Sports drinks are SSBs that contain electrolytes.
- The beverage industry promotes sports drinks as needed for hydration during and after physical activity. However, the need for extra electrolytes only occurs when physical activity is intense and longer than 1 hour or done in extreme heat.
- For the typical child doing routine physical activity for less than 3 hours in normal temperature conditions, use of sports drinks in place of water is not needed.

Considerations for Vending Machine Beverages

There are a wide range of beverage options available for vending machines, with different health issues depending on additives or ingredients.

Additive or Ingredient	Issue(s)
Artificial sweeteners	<ul style="list-style-type: none"> • Intensely sweet • Can increase desire for artificially sweet-tasting drinks and foods, instead of plain water and naturally sweet foods (e.g., fruit) • Safety is not well studied in children, especially if they consume a lot over time
Caffeine	<ul style="list-style-type: none"> • May cause jitteriness, nervousness, anxiety, gastrointestinal upset, tachycardia, insomnia and other negative impacts • Children are more sensitive to effects
Carbonation	<ul style="list-style-type: none"> • Acidity can weaken tooth enamel and lead to cavities
Sugar (added or natural)	<ul style="list-style-type: none"> • Contributes to excess sugar in the diet • Can promote bacterial growth and lead to cavities

Note: All single-use beverage containers contribute to environmental waste concerns

Vending Machine Beverages Available

Water

Plain water

- Sugar-free, calorie-free
- Best choice for hydration and to quench thirst

Flavoured waters (e.g., Perrier, Aquafina, Nestle)

- Usually contain added sugar, artificial sweeteners and/or carbonation

Vitamin waters

- Contain added sugar or artificial sweeteners
- Vitamins commonly added are typically already adequate in the Canadian diet

Milk or Soy-Based Drinks

White milk or plain fortified soy beverage

- No added sugar
- Contain vitamins, minerals and protein (amount varies depending on product)

Flavoured milks (e.g., chocolate milk) or flavoured fortified soy beverages

- Contain added sugar or artificial sweeteners
- Contain vitamins, minerals and protein (amount varies greatly depending on product)

Fruit Based Drinks

100% fruit or vegetable juices

- Contain natural sugar
- Contain vitamins and minerals (amount varies depending on product)
- Vegetable juices contain sodium, which causes high blood pressure in excessive amounts (amount varies depending on product)
- Container sizes currently sold in vending machines are larger than daily maximum fruit juice recommended for children (1/2 cup or 125 mL)

Fruit drinks, fruit cocktails, or fruit punch

- Contain added sugar and/or artificial sweeteners
- Usually contain minimal amounts of vitamins and minerals

Drinks that Contain Caffeine

Energy drinks (e.g., AMP, Red Bull)

- Contain added sugar or artificial sweeteners
- May contain carbonation
- Contain high amounts of caffeine
- Contain other additives and herbal ingredients that may have negative impacts
- Additional health concerns when combined with alcohol or physical activity
- Not recommended for children or teenagers

Iced tea (regular and diet)

- Contain added sugar or artificial sweeteners
- Contain caffeine

Flavoured coffee or espresso beverages (e.g., iced coffee, Frappuccino)

- Contain added sugar or artificial sweeteners
- Contain caffeine

Pop and soft drinks (regular and diet)

- Contain added sugar or artificial sweeteners
- Contain carbonation
- May contain caffeine

Other Drinks

Sport drinks (e.g., Gatorade, Powerade)

- Contain added sugar or artificial sweeteners
- Added electrolytes and sugar are only needed when physical activity is intense and longer than one hour, or performed in extreme heat

TO: Chair and Members of the Board of Health

FROM: Dr. Gayane Hovhannisyan, Acting Medical Officer of Health
Laura Di Cesare, Acting Chief Executive Officer

DATE: 2017 February 16

SUMMARY INFORMATION REPORT FOR FEBRUARY 2017

Recommendation

It is recommended that Report No. 007-17 re: Summary Information Report for February 2017 be received for information.

Key Points

- Upon the direction of the Board of Health, Health Unit staff made a written submission to the [Ontario Government's Basic Income Pilot Consultation](#).

Health Unit Response to Ontario's Basic Income Consultation

Health Unit staff were directed to prepare a written submission to the [Ontario Government's Basic Income Pilot Consultation](#) as part of the recommendations in [Report No. 063-16 re: 2016 Nutritious Food Basket Survey Results and Implications for Government Public Policy](#). The submission (attached as [Appendix A](#)) included endorsement of the Technical Submission prepared by the Association of Local Public Health Agencies (alPHA), the Ontario Public Health Association (OPHA) and Public Health Ontario (PHO) (attached as [Appendix B](#)). The recommendations within the Technical Submission will help guide the development of a basic income pilot project with the strong research design and long-term follow-up needed to help inform public policy decisions.



Dr. Gayane Hovhannisyan, MD, MHSc, CCFP, FRCPC
Acting Medical Officer of Health



Laura Di Cesare, CHRE
Acting Chief Executive Officer

January 25, 2017

Honourable Helena Jaczek
Minister of Community and Social Services
Hepburn Block 6th Floor – 80 Grosvenor St.
Toronto, Ont M7A 1E9

Honourable Chris Ballard
Minister of Housing
College Park – 777 Bay St.
Toronto, Ont M5G 2E5

Dear Minister Jaczek and Minister Ballard,

On behalf of the Middlesex-London Board of Health, I am writing to express our support for the Ontario basic income pilot and the Technical Submission jointly submitted by the Association of Local Public Health Agencies (alPHa), the Ontario Public Health Association (OPHA) and Public Health Ontario (PHO).

Social determinants of health, such as income, food, housing and employment, help explain the wide health inequalities in Ontario, and are strongly determined by government public policy decisions. As consistently demonstrated by our local Nutritious Food Basket survey results, and the results across Ontario, many individuals and families cannot afford to eat healthy after meeting other essential needs for basic living. People living with a low income have a greater risk of preventable medical conditions across the lifespan, including cancer, diabetes, heart disease, mental illness, and their associated health care costs. Living in poverty also negatively impacts childhood growth and development.

We strongly support the Technical Submission jointly submitted by alPHa, OPHA and PHO. The recommendations within this submission will help guide the development of a basic income pilot project with the strong research design and long-term follow-up needed to help inform public policy decisions. As addressed in the Technical Submission, the basic income pilot requires sufficient funding to ensure an appropriate sample size, an adequate benefit level for participants and an adequate pilot duration. Data collection also needs to include sufficient details about changes in participants' behaviours and quality of life.

We also agree that to significantly impact poverty, precarious employment and health, a basic income guarantee must be part of a comprehensive approach that includes other key policies and programs, including affordable high quality child care, affordable housing, expanded health benefits and labour law reform.

Ensuring everyone has an income sufficient to meet basic needs and live with dignity would be one of the most important initiatives the provincial government could pursue to promote health, well-being and equity amongst Ontarians. As such, while the basic income pilot is in progress, we also strongly urge the province to increase social assistance rates to reflect the rising cost of nutritious food and safe housing.

Thank you for the opportunity to comment.

Sincerely,



Jesse Helmer, Chair
Middlesex-London Board of Health

cc: Dr. Valerie Jaeger, alPHa President
Ellen Wodchis, OPHA President



Collaborative Public Health Technical Submission to Ontario's Basic Income Pilot Project Consultation

Prepared by The Association of Local Public Health Agencies (alPHA), The Ontario Public Health Association (OPHA), and Public Health Ontario (PHO); January 17, 2017

Response to Consultation Guide Discussion Questions

Section 1: Determine eligibility for the Pilot

1.1 Are there specific groups of people or populations who should be targeted in the Pilot, such as the under-employed, social assistance recipients, or newcomers? Why?

The Pilot should include a cross-section of people living with insecure income, so that the experience and outcomes of Basic Income for different such groups of people can be assessed. All individuals whose income falls below the pre-determined threshold, regardless of their source of income, should be potentially eligible. In particular, however, the Pilot should target:

- **Social assistance recipients.** This will allow the Pilot to determine the impact of a change from a traditional welfare approach to a Basic Income approach, as well as a change (increase) in the income amount. The Honourable Hugh Segal's discussion paper clearly outlines the rationale to emphasize this population (1).

The working poor, including those precariously employed and under-employed. The poor health consequences of precarious employment have been well demonstrated (2, 3). As Lewchuk and colleagues note, precarious workers have the potential to "face more difficult working conditions, experience higher levels of job insecurity, have lower levels of control over their working conditions and arrangements, experience poorer quality social interactions, or be exposed to particular demands associated with their employment arrangements." (4) The working poor do not currently qualify for substantive benefits, and the precariously employed often fall through the cracks of current income security programs. Rates of precarious employment are already considerable and are anticipated to increase in the coming years (4, 5). In Ontario, the trend continues to shift towards a low-wage economy with substantial increases in part-time and temporary employment and fewer gains made in full-time employment opportunities (6). It is therefore imperative that the Pilot explore the implications of Basic Income for this population and phenomenon. Further, attention should be paid to the employment experience of populations over-represented as precarious workers, including women, racialized persons, indigenous persons, immigrants, people with disabilities, and youth (7, 8).

- **Young adults transitioning from school to the labour market.** According to Forget and colleagues, young adults transitioning from education into the labour market are very likely to experience precarity in the job market and, therefore, their labour market participation is more likely to be affected by a basic income than most other age groups (9). While a Basic Income allows them to gain valuable experience and train further as appropriate, it also makes it possible for them to delay committing to a full-time paying job. Forget and colleagues note the potential concern from this delay, as reduced attachment to the workplace at a young age has long-term negative impacts on wage and career outcomes (9). Therefore, they recommend that young adults be closely examined by the Basic Income (BI) Pilot, to understand how to achieve the most positive outcomes for this population (9). Given the known health impacts of future income level and employment conditions (10, 11), we support this recommendation.

In addition to these target populations, we recommend that the Pilot also include:

- **Youth between the ages of 16 and 17 years old living independently of a parent or guardian.** The Honourable Hugh Segal's discussion paper suggests restricting the age for Pilot participation to 18-64 year olds (1). However, at the age of 16 years old, young people are legally able to move out of the residence of their parent/guardian but are no longer eligible to receive the Canada Child Benefit, and are not yet eligible to receive benefits through OW or ODSP until they reach the age of 18 unless they are able to identify a trustee¹. Youth is a critical transitional stage in the lifecourse between childhood and adulthood. Opportunities and experiences that occur in youth can set lifelong trajectories and can have long-term impacts on health and development in areas including employment and health (12). Youth who are forced to flee from unsafe family or domestic living arrangements (e.g., domestic violence, child abuse) are at heightened risk of adverse financial, educational, socio-emotional and health outcomes stemming from lack of familial, social and economic supports. These vulnerable youth should have access to a secure income source to provide them with the financial supports to live independently from adverse home environments, without facing homelessness. Therefore, it would be appropriate to include them in the Basic Income Pilot, in order to understand the implications of basic income for them as part of the eligible 16-64 year old population.

1.2 What should the Pilot use to determine eligibility? Should eligibility be based on an individual's income, or should eligibility be determined by total family income? Why?

We agree with Hugh Segal's recommendation that eligibility be based on family income level, while also respecting the need for individual income autonomy (1). He has suggested that the amount of benefits received by participants would be a function of both their net family income and their family composition, but that Basic Income payments would be equally divided and paid to all adults in the family in order to provide each adult with financial autonomy (1). He also suggests that mechanisms

¹ Note: If the Child, Youth and Family Services Act that was introduced by Minister Coteau in December 2016 is passed before Basic Income is piloted, this age recommendation may be reconsidered. If the Bill is passed, the age of eligibility for protection services would be raised from 16 to 18, which may address this gap in supports for this vulnerable population (Ministry of Children and Youth Services, 2016).

should be in place to allow for changes in family income and composition to be reflected in the payments within a given year, including circumstances such as divorce (1). Together, these recommendations would provide the ability for individuals to leave unhealthy relationships if necessary, without the fear of being without a source of income.

Section 2: Select the sites

2.1 What are the most important things to think of when selecting a Pilot location? Why?

The most important consideration is selecting a Pilot location that enables the primary research question(s) of the BI Pilot to be answered. The choice of BI Pilot location will have a significant impact on important factors related to the experiment, such as: the study population, project budget, hypothesized outcomes, etc. The context of the Basic Income experiment will impact the hypothesized outcomes across potential sites. Therefore, it is important to select a site that most appropriately allows the primary research questions to be investigated while maximizing BI Pilot efficiencies (e.g., costs, sample size).

2.2 How do you think Pilot sites should be selected?

As stated above, the BI Pilot site should be selected to most effectively and efficiently answer the primary research questions, prioritizing scientific principles. The population demographics of a proposed site will be critical to selecting an appropriate study population. The study population should be representative of the group of individuals to which the BI Pilot results should be generalizable to (i.e., the target population). For example, this may be those who would be eligible to receive a basic income should the Pilot be adopted for the whole province. Ideally, the BI Pilot should be designed to assess whether the impact of receiving a Basic Income is consistent across specific sub-populations of interest (e.g. social assistance recipients or the working poor) and geographic contexts (such as rural, small urban, large urban, and First Nations communities). This decision should be made prior to the initiation of the BI Pilot as these sub-populations will need to be oversampled within an RCT, or prevalent within a saturation site community, to ensure there is enough sample size to properly investigate the impact of the Basic Income within these groups. For example, to study the impact of receiving a Basic Income on perinatal outcomes, which have been shown to be positive(13, 14), a sufficient number of expectant mothers would have to be included in the BI Pilot to investigate this potential outcome. Similarly, sufficient low-income families with school-age children would need to be sampled to examine whether increased income through a Basic Income would translate into the hypothesized improvements in child test scores (15, 16) or Readiness to Learn (or Early Development Vulnerabilities) based on the Early Developmental Instrument (EDI)(17). Therefore, special consideration should be given to ensure that the study population from any proposed Pilot site is representative of the target population, to ensure the generalizability of the BI Pilot findings to the intended groups.

Community characteristics should also be considered in selecting a site. The degree to which a community is geographically isolated may also be important if a saturation site approach is selected, to reduce contamination of intervention effects across geographical borders. Additionally, available infrastructure, the working relationships between different sectors (e.g., housing, children's services,

social assistance) and available data resources may also be considered to improve efficiency in administration and management of the BI Pilot.

Finally, a community's willingness to participate in the BI Pilot should also be considered.

2.3 Do you think it's important to have saturation and RCT sites? Why?

The choice of main research questions and outcomes should drive the design of the BI Pilot. It should be emphasized that there is no "best" study design for the BI Pilot without a specific research question. Different study designs will be more or less effective for answering specific research and policy questions. For example, an RCT design may be more effective in answering questions related to the optimal parameters of the negative income tax model, whereas a saturation site would be necessary to measure the community level impact, or social multiplier effect, resulting from the interactions between individuals receiving a Basic Income. Not measuring the social multiplier would result in an underestimation of the impacts of receiving a Basic Income. Forget hypothesized a social multiplier was at work during the MINCOME experiments, helping to explain why high school students in Dauphin were more likely to complete high school than their rural or urban counterparts (16). Therefore, the BI Pilot study design should be closely linked to research questions to enable the impacts of receiving a Basic Income to be detected, and to causally link Basic Income to the main study outcomes.

Independent of the choice of study design, the comparability of the selected control group is an important factor for consideration. Selecting control participants or community(s) (i.e., those that do not receive the Basic Income intervention) that are as similar as possible to the intervention community (e.g., in demographic characteristics and health status) is essential for minimizing potential confounding effects (both measured and unmeasured) and therefore ensuring that any observed effects are caused by the Basic Income intervention. For example, concerns have previously arisen around the comparability of the intervention and control groups when examining the effects of unconditional income transfers on birth outcomes (18). Methodologically, there are a number of approaches that should be considered for deriving control groups, such as: collecting primary data from controls, propensity score matching and synthetic control groups.

2.4 Should the government consider phases for sites e.g. starting with RCT and doing saturation sites later?

No. There is sufficient evidence to proceed with investigating the benefits of the BI Pilot for both the RCT and saturation sites simultaneously. Delaying the experiment in phases will only delay the evidence to move forward with policy-options informed by the BI Pilot.

However, it would be advised that the distribution method of the intervention (i.e., getting the income to the participants), regardless of the Pilot design, be tested before initiation of the main BI Pilot. This will reduce any complications associated with the delivery of the intervention that would have an impact on potential outcomes. This may require committing additional resources to help participants navigate delivery of the intervention.

Section 3: Design the benefits

3.1 Should the Basic Income amount be enough to significantly raise incomes and reduce poverty, or should it provide a base level of financial modest income floor to provide a certain level of stability? Should the benefit amount alone get people out of poverty or should it be a combination of benefits and earnings that accomplish this goal? Why?

The Basic Income amount should provide enough money to meet basic needs, and to live with dignity and the opportunity for societal participation (i.e. reduce many aspects of the poverty experience). The benefit amount alone should be sufficient to raise people out of poverty, as that is the intention of Basic Income: to ensure that, regardless of circumstance, all individuals have enough money to meet their basic needs. There will always be people who cannot participate in paid work or are unable to find a job for a range of reasons. The Basic Income amount should be sufficient to ensure that these individuals are not living in poverty, and that the health consequences of poverty are prevented.

It is difficult to suggest a Basic Income amount that would be 'sufficient' from a health perspective, as there is a gradient in health improvement with each level up the income ladder (11). Simulation modelling could be undertaken prior to the Pilot commencement to better estimate health improvements at different levels of the LIM. However, 100% of the low income measure (LIM) is a reasonable estimate to achieve the intended purpose of Basic Income and to anticipate health improvements. Using the Nutritious Food Basket Survey approach required of all Ontario Boards of Health within an example health unit area (19), data suggests that 100% of LIM would have the benefit of allowing a family of four to purchase healthy food and to sit below the threshold for spending 30% or more of their total household income on shelter expenses – a marker of housing affordability (data available upon request). For one-person households receiving 100% of LIM, after purchasing healthy food one would still need to spend over 30% of income on shelter, but a considerably lower proportion of income than current OW and ODSP recipients do (data available upon request). Therefore, these calculations indicate that a Basic Income amount of 100% of LIM would lead to greater likelihood of all Ontarians being able to afford adequate food and housing – key determinants of health - regardless of personal financial circumstances. Furthermore, it is known that Canadians in the lowest income quintile experience a disproportionately high burden of morbidity and mortality; a recent report from the Public Health Agency of Canada estimates that socio-economic health inequalities cost the health care system \$6.2 billion annually, with the lowest income quintile accounting for 60% (or \$3.7 billion) of those costs (20). At 100% of LIM for individuals (\$19,460 after-tax) (21), people would be brought above the current upper threshold for the lowest income quintile (\$16,000 after-tax in 2010)(22), holding promise for improved health.

With that said, it has been calculated that guaranteeing 100% of the LIM or the LICO to all individuals would represent a very large increase in public expenditure(23, 24), even though it is likely in the short, medium, and long-term to lead to progressive savings in health care spending and many other areas of public spending. If there is potential that this expenditure will not achieve the necessary public and political will for long-term implementation, it is prudent to also pilot a lesser amount that is still a substantial improvement from current social assistance rates. As such, we support the piloting of 75% and 100% of LIM as recommended by Hugh Segal, in order to compare the outcomes of these

approaches. Either way, if a Basic Income program were to be fully implemented in future, it would be imperative that it be indexed to inflation so that benefits rise with costs of living.

Beyond the health impacts of individual income levels, evidence strongly suggests that the extent of income inequality in society is an important determinant of population rates of a range of poor health and social outcomes (25). While the Basic Income amount itself may only go a moderate distance in addressing the large income inequalities that currently exist in Canadian society, the choice of taxation approach through which it is funded has strong potential to help address this important issue.

3.2 Beyond money, what other services and supports (e.g. employment, mental health, housing, etc.) are needed to accompany the Basic Income? Which are most important? AND

3.3 What elements of Ontario Works and ODSP should Basic Income replace? What about other benefits outside of Ontario Works and ODSP, such as help with childcare, employment start-up benefits to help cover the costs of trade tools, uniforms, etc., or drug and dental benefits? Why or Why not?

Response to 3.2 and 3.3:

We recommend that Basic Income should replace direct money payments to current OW and ODSP recipients, and should also provide these payments to others in low income who are not currently receiving OW or ODSP (as per our response to Section 1.1). Basic Income should not, however, replace other benefits currently provided to OW and ODSP recipients, such as medical and dental coverage, employment and housing assistance benefits and other mandatory and discretionary benefits as indicated by the Ministry of Community and Social Services (26). These benefits should continue to be provided to OW and ODSP recipients as well as to anyone else receiving Basic Income, as many of these benefits are otherwise unaffordable on a modest income and people may be faced with having to make a choice to purchase them or purchase other essential goods and services. In turn, foregoing benefits that are vital for adequate prevention or early treatment could lead to detrimental health and social outcomes.

We strongly support and see a great deal of promise in a BI Pilot and program in Ontario. We would like to emphasize, however, that a Basic Income can only have a strong impact on the health-damaging conditions of poverty and precarious employment if it is part of a comprehensive approach that includes progress on other key policies and programs. These include an affordable high quality child care system, affordable housing, labour law reform, and expanded health benefits, amongst others, as has been advocated for by public health organizations (27-29).

3.4 What other factors should be considered when determining the Basic Income level. Why?

We support Hugh Segal's recommendation to provide more income to people with disabilities, due to the additional barriers faced to paid employment and the extra costs of living with certain disabilities (1). We also suggest that it may be warranted to provide additional income to lone parents, given the unique barriers they also face to paid employment, their considerable over-representation amongst low income families, and the substantial health and social consequences faced by children raised in poverty

(30). Rates of food insecurity are also higher among lone parent households than non-lone parent households (31).

Section 4: Deliver the Basic Income Pilot project

4.1 The Discussion Paper recommended a NIT model for the Basic Income. Do you agree with this recommendation? Why or why not? If not, what model would you prefer?

Both a universal demogrant or a negative income tax (NIT) model would inherently increase incomes for those in low income groups. While the demogrant model has the potential of eliminating the stigma of income benefits due to its universal nature (32), the NIT model used in the MINCOME experiment has also been demonstrated to reduce stigma (33). An NIT is considerably less costly to fund at the outset, and therefore it has been suggested that it is the more feasible model in the Canadian setting and (34), as such, may be the most appropriate model to pilot.

4.2 Should the Pilot consider delivering payments in an alternative method to the Canada Revenue Agency delivery system proposed in the Discussion Paper, if they are available?

Whichever method is selected should be simple, reliable, and work smoothly in conjunction with other benefit payments. One advantage of using the Canada Revenue Agency is that it would build infrastructure for other basic income experiments to take place in other provinces, and also test a more sustainable model should the policy be scaled up to the full populations of Ontario or all of Canada.

4.3 How should the Basic Income respond to changes in income circumstances?

An important feature of Basic Income is its ability to respond to changes in income circumstances, so that it provides income security (with its associated health implications) to people with anticipated and unanticipated fluctuations in income. This may include job loss, personal illness, need to care for a young child or aging parent, changes in marital status, etc. The ability for income level and Basic Income payments to be assessed and change on a frequent basis if required, as recommended in Hugh Segal's discussion paper, is a necessary element (1).

Section 5: Evaluate the Pilot's outcomes

As outlined in Hugh Segal's Discussion Paper, the receipt of Basic Income is hypothesized to impact a number of potential outcomes (1). How to incorporate the required complexity into an evaluation framework presents an important challenge and should not be underestimated. For both Basic Income advocates and sceptics alike, the selection and measurement of appropriate outcomes on which to base the success of the BI Pilot will be essential to the evaluation of this important social experiment.

With this in mind, we support two recommended actions articulated in Hugh Segal's Discussion Paper to evaluate the outcomes of the BI Pilot (1). **First, the establishment of both a Basic Income Pilot Advisory Council (AC) and a Research Operations Group (ROG) is essential to oversee the planning and execution of the BI Pilot's evaluation.** With a function of advising on and overseeing the operations of the Pilot, the AC should be representative of the perspectives of community members, community agencies as well as public health organizations such as the Association of Local Public Health Agencies

and the Ontario Public Health Association. The ROG should bring together a group of experts from the proposed outcome areas who will assist in selecting primary research questions to test regarding the impacts of the BI Pilot, identify outcomes and advise on evaluation methodology. For example, Public Health Ontario is ideally situated to provide scientific and technical advice on population/public health outcomes. Ideally, the ROG would also inform the study design, participant selection, availability of data and data collection procedures including how best to measure the proposed outcomes. **Second that the proposed phased implementation for the BI Pilot be adopted to ensure that appropriate infrastructure (e.g., data sharing agreements, data infrastructure and standardized measurement tools) are in place prior to rolling out the BI Pilot.** Collecting data from pre-baseline (if possible), baseline, during the experiment as well as longitudinal follow-up (either directly or through administrative data) would be advantageous to evaluate the impact of the BI Pilot. An organized approach will maximize synergies to allow for efficient data collection and analyses to evaluate the impact of the BI Pilot.

5.1 The discussion paper recommends measuring ten outcome areas. Rank these outcome areas in order of importance:

The time horizon of the BI Pilot is an important factor when considering which outcomes are likely to be impacted. With this in mind, it is necessary to specify whether a meaningful change in a potential outcome from receiving a Basic Income would be expected over the short-, medium- or long-term. Outcomes that are highly sensitive to short-term income relief are most likely to show meaningful change during the time horizon of the BI Pilot. For example, in the short-term receiving a Basic Income is hypothesized to alleviate **poverty and food insecurity** (i.e., lack of access to adequate food because of financial constraints) (35-37), **reduce psychosocial risk factors** such as life stress (i.e., worrying less about money) (38), and **increase mental bandwidth** (resulting from decreased participation in social assistance system) (39).

Moreover, significant health impacts over the short term that have been associated with providing increased incomes or rent-geared-to-income housing include those related to mental health, psychological distress, and pain (38, 40, 41). In the BI Pilot it will be important to collect data regarding the impact of receiving a Basic Income on acute measures of mental and physical health. Where possible, this information should be collected using validated measurement tools similar to existing population-level data sources to allow for comparability across other study populations in Ontario and Canada, such as the Canadian Community Health Survey (CCHS). This will facilitate the comparison of BI Pilot participants with the Ontario population and sub-populations of interest. Further, oversampling of the CCHS or other Statistics Canada surveys could possibly be done in areas where the basic income is implemented as an efficient and cost effective way to build on existing data collection infrastructure using validated survey tools.

In addition to health outcomes, the impact of receiving a Basic Income could impact health-care utilization and costs, which are also indirect measures of health outcomes. Both low socioeconomic status (i.e., low income) and food insecurity are highly associated with high-cost health care users in Ontario (42, 43). In addition, *future* high cost health care utilization has been shown to be associated with income, education, food security and housing in Ontario (44). In the MINCOME experiments, Forget

highlighted the impact of receiving a Basic Income on decreasing the gap between intervention and control communities for hospitalizations related to “accidents and injuries”, hypothesizing that influencing factors may be that individuals with more income security would not need to work in dangerous jobs, would be less likely to consume alcohol and other substances that put them at risk for injuries, and children may have greater parental supervision (16). Further, hospitalization due to mental health diagnoses followed a pattern very similar to that of accidents and injuries (16).

Where possible the BI Pilot should collect information on outcomes that have been questioned by some as potential unintended consequences of receiving a Basic Income; for example reduction in labour force participation or increased prevalence of negative health behaviours (e.g. smoking, alcohol and drug use). While there is often no or little evidence to support these claims, it is important to understand, anticipate and measure potential unintended consequences of interventions.

It is necessary to consider more than solely which outcomes to evaluate in the BI Pilot. **A detailed theory of change describing the complex mechanisms through which receiving a Basic Income is hypothesized to change the primary outcomes should be developed before the BI Pilot is initiated** (45). By clearly articulating the proposed mechanisms, and resulting data collection, a more complete understanding of how outcomes were changed can be used to possibly explain circumstances when the hypothesized change did not occur.

Within the proposed time horizon in Hugh Segal’s Discussion paper (1), it will be challenging to assess the impact of the Basic Income on mid- to long-term outcomes. It is important that consent to be followed up for research and evaluation purposes be sought from all participants in the BI Pilot. This will enable secondary research and evaluation, not part of the original BI Pilot timetable, and thereby enhance the potential learning opportunities from this important social experiment. For example, consent to follow-up would enable Basic Income recipients to be invited to participate in focus groups or key informant interviews to better understand for whom, how and in what contexts the intervention works. In addition, permission and the necessary information to link BI Pilot participant data to administrative and health databases will greatly enhance research and evaluation efforts to understand the impact of the BI Pilot on both primary and secondary outcomes over longer time horizons. The benefit of administrative health data in evaluating population health interventions were observed in evaluating the health impacts of the MINCOME experiment (16).

More details are provided in the alpha-OPHA discussion paper on “Measuring Community Health Outcomes for a BI Pilot” submitted to the Honourable Hugh Segal as part of his consultations for the Basic Income Discussion paper.

We have commented primarily on health outcomes including food insecurity, though we see value in measuring many of the other listed outcome areas as well, particularly to establish a theory of change. Some of these are essential in order to understand the operational aspects of basic income (i.e. administrative efficiency, and functionality for users), and many others are themselves important determinants of health (i.e. social inclusion, housing, education, etc.). We would suggest that ‘work behaviour’ be replaced by or supplemented with ‘time use’, so that non-market forms of work and

caregiving and time for personal health are also captured (e.g. volunteer work, child care, parental care, personal sick leave in absence of other benefits, etc.).

To facilitate research and evaluation operations a number of considerations should be taken into account to evaluate the BI Pilot:

1. Build a flexible research infrastructure, similar to the Social Data Research Initiative described by Hugh Segal in his Discussion Paper (1), and make it available to independent researchers. This will greatly increase opportunities for research and evaluation outside of the main objectives of the BI Pilot, and therefore enable the Pilot itself to have more focused objectives. For example, adding income information collected for tax purposes to administrative datasets will provide a more objective measure of income and wealth in study participants. The data infrastructure should aim to enhance data collected as part of the BI Pilot through linkage with routinely collected administrative data. This process would leverage existing data routinely collected by the government to build a rich new data resource while reducing administrative costs and complexity of collecting data on all potential outcomes of the BI Pilot (9). Ideally, the effort would result in the creation of harmonized datasets including information on income, health, health care utilization, education, employment, interactions with the judicial system and other relevant public organizations, including municipalities and regions. Making this resource available to independent researchers, whether through Statistics Canada Research Data Centre Networks or other means such as the Institute for Clinical Evaluative Sciences (ICES), would greatly increase the utility of this resource to produce policy-relevant evidence regarding the effectiveness of the BI Pilot.
2. Identify areas of potential synergy between research infrastructure and the administration of the BI Pilot more generally during pilot development phase. For example, cooperation between Provincial and Federal Government could be used as a model for Basic Income experiments across Canada (of which there is great interest). In addition, it is also worth considering how any infrastructure used to evaluate the BI Pilot could be used if a universal Basic Income policy was scaled up.
3. Dedicated funding should be specifically allocated to support research and evaluation of the BI Pilot, including the proper research and evaluation infrastructure. Moreover, providing funding opportunities to support independent researcher projects, for example in collaboration with the Canadian Institutes for Health Research (CIHR), will greatly enhance the evidence generated from the BI Pilot.

5.2 Do you think that data and evaluation results should be made public in an ongoing basis?

Yes. A robust knowledge translation (KT) strategy will be essential to explain to the public the BI Pilot findings and their implications, including recommendations on why a Basic Income policy should or should not be undertaken. Critically, public awareness needs to be built over the course of the Pilot, and not only at the end.

5.3 What changes in behavior would you expect to see with a BI? What kind of results should we see from the Pilot to call it a success? Why?

Much of this question has been discussed above. However, one additional point is that success should not be determined based on cost-effectiveness of the BI Pilot alone. Regardless of the study design, it will be impossible to truly measure the impact (on any outcome including costs) of receiving a Basic Income. The degree to which the BI Pilot helps support the values related to the alleviation of poverty (e.g., respect for human dignity) and the improvement of social assistance programs (e.g., ease of receiving benefits and reduction of stigma) are important outcomes.

5.4 What strategies can we use to encourage people to participate in the Pilot?

For participants who are offered a Basic Income, it will be necessary to provide assurance that payments will be secure, sufficient, and adaptable to their changing circumstances. Also, they should be assured that no one will be worse off as a result of their participation.

For those selected as controls, if they are required to dedicate time for their participation, then a small additional amount of income could be given to respect their time spent answering questions, to potentially improve their willingness to participate, and to reduce attrition.

5.5 To measure outcomes, we would need people to share their personal information, including linking administrative data together. What concerns would you have about using this information to see how people use benefits and services differently after getting a BI? How can we make you feel that your information is secure?

Any data collected as part of the Pilot should be governed by the highest standard of research ethics and privacy, for example those set out in the *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans* (46).

5.6 So that we can compare the outcomes of BI to the status quo, we would need people to share their personal information, even if they didn't receive the BI. Would you be comfortable with this so that we can understand these differences?

Yes, as long as any data collected as part of the Pilot should be governed by the highest standard of research ethics and privacy, for example those set out in the *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans* (46).

5.7 If you are a Pilot participant, should you receive results prior to any public report release?

Yes. BI Pilot participants should receive aggregate level results prior to the release of any public report. This is consistent with standard research ethics.

Additional comments

Two additional points raised in a Mowat Centre report by Forget and colleagues warrant emphasis (9). First, the experience of MINCOME made clear that it is essential that a proactive approach be taken to

ensure the complete implementation of the BI Pilot, along with its full analysis and reporting, regardless of economic or political circumstances. Consideration should be given to legislating this (9).

Second, a robust community engagement strategy will be critical as the Pilot is planned, implemented, and evaluated, to ensure that the public is well informed and engaged throughout, as the notion of a Basic Income is a considerable shift in social policy that most of the Ontario public is likely not yet familiar with. This engagement strategy should be deliberate and inclusive, in order to begin to address frustration and mistrust that exists among some individuals and organizations across the province on the issue of social assistance and poverty, and to help overcome this potential barrier to successful implementation of the BI Pilot.

Thank you for this opportunity to provide feedback into the design of Ontario's Basic Income Pilot.

References

1. Segal H. Finding a better way: a basic income pilot for Ontario: Government of Ontario; 2016 [cited 2017 January 9th]. Available from: https://files.ontario.ca/discussionpaper_nov3_english_final.pdf.
2. European Foundation for the Improvement of Living Working Conditions. Quality of work and employment in Europe: Issues and challenges. Foundation paper. 2002;1. Available at: <http://www.eurofound.europa.eu/publications/foundation-paper/2002/working-conditions/quality-of-work-and-employment-in-europe-issues-and-challenges-foundation-paper-no-1-february-2002>
3. Quinlan M, Mayhew C, Bohle P. The global expansion of precarious employment, work disorganization, and consequences for occupational health: a review of recent research. *International Journal of Health Services*. 2001;31(2):335-414.
4. Lewchuk W, Lafleche M, Dyson D, Goldring L, Meisner A, Procyk S, et al. It's more than poverty: Employment precarity and household well-being. Poverty and Employment Precarity in Southern Ontario Research Group. United Way Toronto, McMaster University. 2013.
5. Thomas Granofsky MC, Sunil Johal, Noah Zon. Renewing Canada's Social Architecture Framing Paper: The Mowat Centre; 2015. Available from: <https://mowatcentre.ca/renewing-canadas-social-architecture/>.
6. Gellatly M. Still working on the edge: building decent jobs from the ground up 2015 January 3 2017. Available from: http://www.workersactioncentre.org/wp-content/uploads/dlm_uploads/2015/03/StillWorkingOnTheEdge-WorkersActionCentre.pdf.
7. Law Commission of Ontario. Vulnerable workers and precarious work. Toronto: 2012. Available at: <http://www.lco-cdo.org/vulnerable-workers-final-report.pdf>
8. Wilson RM, Landolt P, Shakya YB, Galabuzi G, Zahoorunissa Z, Pham D, et al. Working rough, living poor: Employment and income insecurities faced by racialized groups in the Black Creek area and their impacts on health. Toronto: Access Alliance Multicultural Health and Community Services. 2011.
9. Forget EL, Marando D, Surman T, Urban MC. Pilot lessons: how to design a basic income pilot project for Ontario 2016. Available from: https://mowatcentre.ca/wp-content/uploads/publications/126_pilot_lessons.pdf.
10. Jackson A, Rao G. The unhealthy Canadian workplace. In: Raphael D, editor. *Social determinants of health: Canadian perspectives*. 3rd ed. Toronto, ON: Canadian Scholars' Press Inc; 2016. p. 99-113.
11. Auger N, Alix C. Income, Income distribution and Health in Canada. In: Raphael D, editor. *Social determinants of health: Canadian perspectives*. 3rd ed. Toronto, Ontario: Canadian Scholars' Press Inc; 2016. p. 61-74.
12. Willms JD. *Vulnerable children: Findings from Canada's national longitudinal survey of children and youth*. Edmonton: University of Alberta Press; 2002.

13. Brownell MD, Chartier MJ, Nickel NC, Chateau D, Martens PJ, Sarkar J, et al. Unconditional prenatal income supplement and birth outcomes. *Pediatrics*. 2016;137(6):e20152992.
14. Shankardass K, O'Campo P, Dodds L, Fahey J, Joseph K, Morinis J, et al. Magnitude of income-related disparities in adverse perinatal outcomes. *BMC pregnancy and childbirth*. 2014;14(1):1.
15. Milligan K, Stabile M. Do child tax benefits affect the well-being of children? Evidence from Canadian child benefit expansions. *American Economic Journal: Economic Policy*. 2011;3(3):175-205.
16. Forget EL. The town with no poverty: the health effects of a Canadian Guaranteed Annual Income Field Experiment. *Canadian Public Policy*. 2011;37(3):283-305.
17. Canadian Institute for Health Information. Children vulnerable in areas of early development: a determinant of child health. Ottawa, ON: 2014. Available at: https://secure.cihi.ca/free_products/Children_Vulnerable_in_Areas_of_Early_Development_EN.pdf
18. Racine AD. Buying a Better Baby: Unconditional Income Transfers and Birth Outcomes. *Pediatrics*. 2016:e20154673.
19. Sudbury & District Health Unit. Nutritious Food Basket Report 2016 [updated November 1 2016; cited 2017 January 9]. Available from: <https://www.sdhu.com/resources/research-statistics/research-evaluation/reports-knowledge-products/nutritious-food-basket-report>
20. Public Health Agency of Canada. The Direct Economic Burden of Socioeconomic Health Inequalities in Canada: An Analysis of Health Care Costs by Income Level Ottawa, ON: Public Health Agency of Canada; 2016 [cited 2016 December 28]. Available from: <http://www.phac-aspc.gc.ca/publicat/hpcdp-pspmc/36-6/assets/pdf/ar-03-eng.pdf>.
21. Statistics Canada. Table 3.2 Low-income measures thresholds (LIM-AT, LIM-BT and LIM-MI) for households of Canada, 2010. Ottawa, ON: Statistics Canada; 2010. Available at: <https://www12.statcan.gc.ca/nhs-enm/2011/ref/dict/table-tableau/t-3-2-eng.cfm>
22. Statistics Canada. Survey of Labour and Income Dynamics. Ottawa, ON: Statistics Canada; 2010.]. Available at: <http://www.statcan.gc.ca/pub/75-202-x/2010000/analysis-analyses-eng.htm>
23. Macdonald D. A Policymaker's Guide to Basic Income. Ottawa: Canadian Centre for Policy Alternatives; 2016.
24. Roos N, Forget EL. The time for a Guaranteed Annual Income might finally have come. *The Globe and Mail*. 2015 August 4th, 2015;Sect. Commentary.
25. Pickett KE, Wilkinson RG. Income inequality and health: a causal review. *Social Science & Medicine*. 2015;128:316-26.
26. Ministry of Community and Social Services. Social assistance policy directives Toronto, ON2016 [cited 2016 December 21]. Available from: <http://mcss.gov.on.ca/en/mcss/programs/social/directives/index.aspx>.

27. Social Determinants of Health Across the Life-Span Conference. Strengthening the Social Determinants of Health: The Toronto Charter for a Healthy Canada 2002 [cited 2017 January 4th]. Available from: <http://www.toronto.ca/legdocs/2003/agendas/committees/hl/hl030303/it006.pdf>
28. Association of Local Public Health Agencies (ALPHA). ALPHA resolution A10-10: Dental Health for Low-Income Ontarians: Association of Local Public Health Agencies 2011 [cited 2017 January 9]. Available from: https://c.ymcdn.com/sites/alphaweb.site-ym.com/resource/collection/5F5ADAAC-3DD4-40F7-8DA4-FA24DDCC88C1/alpha_resolution_A10-10_DentalHealthLowIncomeOntario.pdf.
29. Association of Local Public Health Agencies (ALPHA). ALPHA resolution A11-8: Public health supporting early learning and care 2011 [cited 2017 January 9]. Available from: https://c.ymcdn.com/sites/alphaweb.site-ym.com/resource/collection/CE5429CC-076E-4327-B45C-862B34CE9766/alpha_resolution_A11-8_PublicHealthSupportingEarlyLearning.pdf.
30. Lipman EL, Offord DR, Dooley MD, Boyle MH. Children's outcomes in differing types of single-parent families. In: Willms J, editor. *Vulnerable Children: Findings from Canada's National Longitudinal Survey of Children and Youth*: University of Alberta Press; 2002. p. 229-42.
31. Health Canada. *Canadian Community Health Survey Cycle 2.2, Nutrition (2004): Income-Related Household Food Security in Canada*. Ottawa, ON: Health Canada 2007.
32. Pasma C, Mulvale J. *Income Security for All Canadians: Understanding Guaranteed Income*. Ottawa: Basic Income Earth Network Canada. 2009.
33. Calnitsky D. "More Normal than Welfare": The Mincome Experiment, Stigma, and Community Experience. *Canadian Review of Sociology/Revue canadienne de sociologie*. 2016;53(1):26-71.
34. Boadway R, Cuff K, Koebel K. *Designing a Basic Income Guarantee for Canada*. 2016.
35. McIntyre L. Impact of a guaranteed annual income program on Canadian seniors' physical, mental and functional health. *Canadian Journal of Public Health*. 2016;107(2):E176.
36. McIntyre L, Dutton DJ, Kwok C, Emery JH. Reduction of Food Insecurity among Low-Income Canadian Seniors as a Likely Impact of a Guaranteed Annual Income. *Canadian Public Policy*. 2016;42(3):274-86.
37. Emery J, Fleisch V, McIntyre L. How a guaranteed annual income could put food banks out of business. *SPP Research Paper*. 2013(6-37).
38. Dunn JR. *Housing Improvement and Mental Health: Preliminary Results of the GTA West Social Housing & Health Study*. Presentation to the National Housing Research Committee [PowerPoint slides]2015.
39. Mani A, Mullainathan S, Shafir E, Zhao J. Poverty impedes cognitive function. *science*. 2013;341(6149):976-80.
40. Costello EJ, Compton SN, Keeler G, Angold A. Relationships between poverty and psychopathology: A natural experiment. *Jama*. 2003;290(15):2023-9.

41. Gibson M, Thomson H, Banas K, Bambra C, Fenton C, Bond L. Welfare to work interventions and their effects on health and well-being of lone parents and their children. The Cochrane Library. 2012.
42. Rosella LC, Fitzpatrick T, Wodchis WP, Calzavara A, Manson H, Goel V. High-cost health care users in Ontario, Canada: demographic, socio-economic, and health status characteristics. BMC health services research. 2014;14(1):1.
43. Tarasuk V, Cheng J, de Oliveira C, Dachner N, Gundersen C, Kurdyak P. Association between household food insecurity and annual health care costs. Canadian Medical Association Journal. 2015;187(14):E429-E36.
44. Fitzpatrick T, Rosella LC, Calzavara A, Petch J, Pinto AD, Manson H, et al. Looking beyond income and education: socioeconomic status gradients among future high-cost users of health care. American journal of preventive medicine. 2015;49(2):161-71.
45. Sridharan S, Dunn JR, Nakaima A. Addressing health equities in social epidemiology: Learning from evaluation (s). In: O'Campo P, Dunn JR, editors. Rethinking Social Epidemiology: Springer; 2012. p. 247-63.
46. Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, Social Sciences and Humanities Research Council of Canada. Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans Ottawa, ON: Government of Canada; 2014 [cited 2017 January 11]. Available from: http://www.pre.ethics.gc.ca/pdf/eng/tcps2-2014/TCPS_2_FINAL_Web.pdf.



TO: Chair and Members of the Board of Health

FROM: Dr. Gayane Hovhannisyan, Acting Medical Officer of Health
Laura Di Cesare, Acting Chief Executive Officer

DATE: 2017 February 16

**ACTING MEDICAL OFFICER OF HEALTH / ACTING CHIEF EXECUTIVE OFFICER
ACTIVITY REPORT – FEBRUARY**

Recommendation

It is recommended that Report No. 000-17 re: Acting Medical Officer of Health / Acting Chief Executive Officer Activity Report – February be received for information.

The following report highlights activities of the Acting Medical Officer of Health (Acting MOH)/Acting Chief Executive Officer (Acting CEO) for the period of January 9, 2017, to February 3, 2017.

The Acting MOH/Acting CEO attended the following events:

- January 19 The Acting MOH/Acting CEO attended the Board of Health meeting and the Governance Committee meeting.
- January 24 The Acting MOH attended a meeting with internal staff regarding Community Drug Strategy initiatives.
On behalf of the MOH/CEO, Suzanne Vandervoort, Director, Healthy Living, and Linda Stobo, Manager, Chronic Disease Prevention and Tobacco Control, attended the Community and Protective Services meeting in regard to vending machines and sugar-sweetened beverages.
- January 25 The Acting CEO attended a meeting in downtown London regarding a Downtown London Market Assessment.
- January 26 The Acting MOH/Acting CEO attended the Board of Health Finance & Facilities Committee meeting.
- January 31 On behalf of the MOH/CEO, Suzanne Vandervoort, Director, Healthy Living, and Linda Stobo, Manager, Chronic Disease Prevention and Tobacco Control, attended the City Council meeting regarding vending machines and sugar-sweetened beverages.
- February 1 The Acting MOH attended a meeting with external partners at Elgin St. Thomas Public Health in regard to opioid overdose situational awareness, together with representatives from Elgin St. Thomas Public Health, Thames Valley Addiction Services, EMS, police, the regional coroner, the Fire Department and the Emergency Department.
- February 2 The Acting MOH attended an internal meeting to discuss the Health Unit's role at the February 8 Safe Injection Site Launch.
- February 3 The Acting MOH participated in a teleconference with the BC Center for Excellence in HIV/AIDS and the Ontario HIV Treatment Network regarding supervised injection services.

- February 6 The Acting MOH met with Brian Lester, Executive Director, Regional HIV/Aids Connection, regarding supervised injection services.
- February 7 The Acting MOH met with Scott Courtice, Executive Director, London InterCommunity Health Centre, regarding supervised injection services.
- February 8 The Acting MOH attended the Ontario Supervised Injection Services Feasibility Study Results Presentation at the Central London Public Library.

This report was prepared by Lynn Guy, Executive Assistant to the MOH/CEO.



Dr. Gayane Hovhannisyian, MD, MHSc, CCFP, FRCPC
Acting Medical Officer of Health



Laura Di Cesare, CHRE
Acting Chief Executive Officer