BUREAU DE SANTÉ DE MIDDLESEX-LONDON HEALTH UNIT
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AGENDA
MIDDLESEX-LONDON BOARD OF HEALTH

Thursday, September 16, 2021, 7:00 p.m.
Microsoft Teams

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 (Chair)
Ms. Aina DeViet (Vice-Chair)
Mr. John Brennan
Ms. Kelly Elliott
Ms. Tino Kasi
Ms. Arielle Kayabaga
Mr. Bob Parker
Mr. Matt Reid
Mr. Mike Steele
Mr. Aaron O'Donnell

SECRETARY-TREASURER

Dr. Christopher Mackie

DISCLOSURE OF CONFLICTS OF INTEREST

APPROVAL OF AGENDA

MINUTES

Approve: July 15, 2021 – Board of Health meeting

Receive: July 15, 2021 – Finance and Facilities Committee meeting
September 2, 2021 – Special Board of Health meeting
September 2, 2021 – Finance and Facilities Committee meeting

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Approve: July 15, 2021 – Board of Health meeting
September 2, 2021 – Special Board of Health meeting

Receive: July 15, 2021 – Finance and Facilities Committee meeting
September 2, 2021 – Finance and Facilities Committee meeting

Item #	Delegation	Recommendation	Information	Report Name and Number	Link to Additional Information	Overview and Lead
Reports and Agenda Items						
1.	**X**	**X**	**X**	Finance and Facilities Committee Meeting Summary from September 2, 2021 (Report No. 36-21)	September 2, 2021 Agenda	To provide an update on reports reviewed at the September 2, 2021 Finance and Facilities Committee meeting. Lead: Mr. Matt Reid, Chair, Finance & Facilities Committee
2.	**X**	**X**	**X**	Governance Committee Meeting Summary from September 15, 2021 (Verbal)	September 15, 2021 Agenda	To provide an update on reports reviewed at the September 15, 2021 Governance Committee meeting. Lead: Mr. Bob Parker, Chair, Governance Committee
3.		**X**	**X**	Proposed 2022 Budget Process (Report No. 37-21)	Appendix A	To provide information and a proposed recommendation for the Middlesex-London Health Unit's 2022 Budget process. Leads: Ms. Emily Williams, Director of Healthy Organization/Interim CEO, Dr. Christopher Mackie, Medical Officer of Health, Mr. Brian Glasspoole, Manager, Finance
4.		**X**	**X**	Q2 Financial Update and Factual Certificate Update (Report No. 42-21)	Appendix A Appendix B	To provide an update on the financial activities and factual certificate during the second quarter. Leads: Ms. Emily Williams, Director of Healthy Organization/Interim CEO and Mr. Brian Glasspoole, Manager, Finance

5.		**X**	**X**	Feedback on Proposed Regulations for Supplemented Foods (Report No. 38-21)	Appendix A	To provide information and proposed feedback to regarding Health Canada's proposed amendments to Food and Drug regulations for Supplemented Foods. Lead: Ms. Donna Kosmack, Manager, Southwest Tobacco Control Area Network
6.		**X**	**X**	Submission to Health Canada's Consultation on the Proposed Vaping Products' Flavour Regulations and Order (Report No. 39-21)	Appendix A Appendix B	To provide an update on the health unit's submission to Health Canada on proposed vaping product regulations and order. Lead: Ms. Donna Kosmack, Manager, Southwest Tobacco Control Area Network
7.		**X**	**X**	Diversity and Inclusion Assessment: MLHU Workforce Census (Report 40-21)	Appendix A Appendix B	To discuss the results and recommendations of the Workforce Census, within the Diversity and Inclusion Assessment. Lead: Ms. Heather Lokko, Director, Healthy Start/Chief Nursing Officer and Mr. Christian Daboud, Manager, Health Equity
8.	**X**		**X**	COVID-19 Disease Spread and Vaccine Update (Verbal)		To provide an update on COVID-19 matters within Middlesex-London. Leads: Dr. Alexander Summers, Associate Medical Officer of Health and Dr. Christopher Mackie, Medical Officer of Health
9.		**X**	**X**	Medical Officer of Health Activity Report for August and September 2021 (Report No. 41-21)		To provide an update on external meetings attended by the Medical Officer of Health. Lead: Dr. Christopher Mackie, Medical Officer of Health

PUBLIC MINUTES
FINANCE & FACILITIES COMMITTEE
Microsoft Teams
Thursday, July 15, 2021 at 6:00 p.m.

MEMBERS PRESENT:	Mr. Matt Reid (Chair) Ms. Aina DeViet Ms. Maureen Cassidy Ms. Tino Kasi
REGRETS:	Mr. Aaron O'Donnell
OTHERS PRESENT:	Dr. Christopher Mackie, Secretary-Treasurer/Medical Officer of Health Ms. Carolynne Gabriel, Executive Assistant to the Board of Health (Recorder) Ms. Stephanie Egelton, Senior Executive Assistant to the Medical Officer of Health/Associate Medical Officer of Health Dr. Alexander Summers, Associate Medical Officer of Health Ms. Emily Williams, Director, Healthy Organization/Interim CEO Ms. Heather Lokko, Director, Healthy Start Mr. Joe Belancic, Manager, Procurement and Operations Mr. Brian Glasspoole, Manager, Finance Ms. Kelly Elliott, Board of Health Member Ms. Arielle Kayabaga, Board of Health Member

Chair Matt Reid called the meeting to order at **6:02 p.m.**

DISCLOSURES OF CONFLICT OF INTEREST

Chair Reid inquired if there were any disclosures of conflict of interest. None were declared.

APPROVAL OF AGENDA

It was moved by **Ms. Aina DeViet, seconded by Ms. Tino Kasi,** *that the **AGENDA** for the July 15, 2021 Finance & Facilities Committee meeting be approved.*

Carried

APPROVAL OF MINUTES

It was moved by **Ms. Maureen Cassidy, seconded by Ms. Kasi,** *that the **MINUTES** of the June 3, 2021 Finance & Facilities Committee meeting be approved.*

Carried

NEW BUSINESS

Janitorial Services – Contract Extension Award (Report No. 17-21FFC)

This report was introduced by Ms. Emily Williams, Director, Healthy Organization / CEO (Interim). Ms. Williams informed the committee that Mr. Joe Belancic, Manager, Procurement and Operations, was leaving the Middlesex-London Health Unit and publicly thanked him.
Discussion about the report included:

DRAFT

- The preliminary contract for cleaning services at the Health Unit's offices at CitiPlaza was $103,367.20; however, due to increased cleaning requirements as a result of the COVID-19 pandemic, costs increased to $165,779.14.
- The initial intention was to put the contract for janitorial services up for bid in 2021, but due to the COVID-19 pandemic, non-essential staff and visitors were not permitted on site which limited the ability to re-issue a revised tender for cleaning services.
- Until the usual bidding process can proceed in 2022, the existing cleaning company, now known as Grete Services, was contacted for an extension to the existing contract. The revised quote is $163,161.11, which is a reduced cost of about 1.2%.
- The additional cleaning costs incurred due to COVID-19 are eligible for reimbursement from the province this year. However, there is currently no commitment from the Province that any additional cleaning costs will be eligible for reimbursement in 2022. Some level of extra cleaning in 2022 is anticipated.
- With so few staff in the office during the COVID-19 pandemic, the scope of services was able to be expanded.
- It was noted that the original base cost of cleaning was a significant reduction from prior to the move to CitiPlaza when MLHU had two offices in London.

It was moved by **Ms. Cassidy, seconded by Ms. DeViet,** *that the Finance and Facilities Committee make a recommendation to the Board of Health to extend a one-year contract for janitorial services to Grete Services for $163,161 for leased premises located at 355 Wellington Street, Suite 110, London Ontario.*

Carried

COVID-19 Case & Contact Management / Vaccine Budget Update (Report No. 18-21FFC)

This report was introduced by Ms. Williams.

Discussion about the report included:

- The MLHU budget regarding COVID-19 case and contact management and the COVID-19 vaccine continues to be monitored closely.
- MLHU still has not received the funding for COVID-19 expenses assured by the Province; however, communication is being held with the provincial Manager of Funding and Oversight and advocacy is ongoing by Ontario Public Health Units to the Ministry for funding to flow so as not to impede programming.
- The amounts included in the report do not include some significant invoices which were pending for outfitting of vaccination clinics.

It was moved by **Ms. DeViet, seconded by Ms. Cassidy** *that the Finance and Facilities Committee recommend that the Board of Health request that the Board Chair send a letter to the Ministry of Health requesting the timely delivery of funding for COVID-19-related expenses, as assured by the Province, and the maintenance of adequate cash flow from the Province, in order to ensure effective operations*.

Carried

It was moved by **Ms. Cassidy, seconded by Ms. Kasi,** *that the the Finance and Facilities Committee make a recommendation to the Board of Health to receive an update on COVID-19 Case and Contact Management and Vaccine Clinic budget as described in Report No. 18-21FFC re: "COVID-19 Case & Contact Management / Vaccine Clinic Budget Update".*

Carried

Request for Over-hire to Ensure Retention of Critical Health Human Resources (Report No. 19-21FFC)

This report was introduced by Dr. Christopher Mackie, Medical Officer of Health.

DRAFT

Discussion about the report included:

- MLHU has hired many temporary staff to fill pandemic-related roles; however, due to the temporary nature of the positions, there has been increasing turnover and difficulties with gapping.
- Going forward, MLHU will continue to require staff for ongoing COVID-19-related work as well as to play "catch-up" in programs which were put on hold during the pandemic and to support program areas where growth is required.
- There is huge competition for health human resources and MLHU needs to be able to recruit and retain staff but require the ability to offer security to do so. Over-hiring is a strategy to address this.
- The risk of over-hiring will be mitigated, and likely eliminated, by: turnover in staffing including retirements; potential additional provincial funding to support the expansion of specific programs like the COVID-19 program; and additional staff required to support key areas which the Board of Health has indicated a desire to expand, including Diversity and Inclusion and Anti-Black Racism.
- Maximum compensation levels have been increased to recruit and retain nurses into supervisory positions.
- What the COVID-19 vaccination campaign will include in the future is unclear; however, mass vaccination capacity may potentially continue to be required if COVID-19 vaccines are approved for children ages five to 11 or if a booster campaign is required.
- It is not anticipated that front-line staffing will be required to support a future second Supervised Consumption Facility.

At **6:42 p.m.,** it was moved by **Ms. Cassidy, seconded by Ms. DeViet,** *that the Finance and Facilities Committee move in camera to consider matters regarding labour relations or employee negotiations, personal matters about an identifiable individual, including municipal or local board employees.*

Carried

At **6:50 p.m.**, it was moved by **Ms. Cassidy, seconded by Ms. Kasi**, *that the Finance and Facilities Committee rise and return to public session.*

Carried

It was moved by **Ms. Kasi, seconded by Ms. Cassidy,** that *the Finance and Facilities Committee make a recommendation to the Board of Health to:*

1) *Receive for information Report No. 19-21FFC re: "Request for Over-hire to Ensure Retention of Critical Health Human Resources";*
2) *Approve the over-hiring of 22 additional permanent positions (16 Public Health Nurses, three Public Health Inspectors, one Human Resources Specialist, one Health Equity Worker, and one Manager); and*
3) *Defer permanent budget decisions to the 2022 budget process.*

Carried

OTHER BUSINESS

It was moved by **Ms. Cassidy, seconded by Ms. Kasi,** *that the August 5, 2021 Finance and Facilities Committee meeting be cancelled, such that the next meeting of the Finance and Facilities Committee be September 2, 2021.*

Carried

DRAFT

ADJOURNMENT

At **6:51 p.m.,** it was moved by **Ms. Kasi, seconded by Ms. DeViet,** *that the meeting be adjourned.*

Carried

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MATTHEW REID
Chair

CHRISTOPHER MACKIE
Secretary-Treasurer

DRAFT

PUBLIC SESSION – MINUTES
MIDDLESEX-LONDON BOARD OF HEALTH

Thursday, July 15, 2021, 7:00 p.m.
Microsoft Teams

MEMBERS PRESENT: Ms. Maureen Cassidy (Chair)
Ms. Aina DeViet (Vice-Chair)
Mr. Matt Reid
Mr. John Brennan
Mr. Bob Parker
Ms. Kelly Elliott
Mr. Mike Steele
Ms. Tino Kasi
Ms. Arielle Kayabaga
Mr. Aaron O'Donnell (arrived at 8:05 p.m.)

OTHERS PRESENT: Dr. Christopher Mackie, Medical Officer of Health (Secretary-Treasurer)
Ms. Stephanie Egelton, Senior Executive Assistant to the Medical Officer of Health/Associate Medical Officer of Health (Recorder)
Dr. Alexander Summers, Associate Medical Officer of Health
Ms. Emily Williams, Director, Healthy Organization/Interim CEO
Mr. Dan Flaherty, Manager, Communications
Ms. Carolynne Gabriel, Communications Coordinator/Executive Assistant to the Board of Health
Ms. Heather Lokko, Director, Healthy Start/Chief Nursing Officer
Mr. Stephen Turner, Director, Environmental Health and Infectious Disease
Ms. Maureen MacCormick, Director, Healthy Living
Mr. Darrell Jutzi, Manager, Child Health
Ms. Misty Golding, Manager, Oral Health
Mr. Joe Belancic, Manager, Procurement and Operations

Chair Maureen Cassidy called the meeting to order at **7:00 p.m.**

DISCLOSURE OF CONFLICT OF INTEREST

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

APPROVAL OF AGENDA

It was moved by **Ms. Arielle Kayabaga, seconded by Mr. Bob Parker,** *that the **AGENDA** for the July 15, 2021 Board of Health meeting be approved.*

Carried

APPROVAL OF MINUTES

It was moved by **Ms. Kelly Elliott, seconded by Mr. John Brennan,** *that the **MINUTES** of the June 17, 2021 Board of Health meeting be approved.*

Carried

It was moved by **Ms. Elliott, seconded by Mr. Brennan,** *that the **MINUTES** of the June 17, 2021 Governance Committee meeting be received.*

Carried

REPORTS AND AGENDA ITEMS

Verbal Finance and Facilities Committee Meeting Summary from July 15, 2021

Mr. Matt Reid, Chair of the Finance and Facilities Committee presented the Finance and Facilities Committee Summary from July 15, 2021.

It was moved by **Mr. Matt Reid, seconded by Mr. Parker,** *that the Board of Health extend a one-year contract for janitorial services to Grete Services for $163,161 for leased premises located at 355 Wellington Street, Suite 110, London Ontario.*

Carried

It was moved by **Mr. Reid, seconded by Ms. Tino Kasi,** *that the Board of Health receive an update on COVID-19 Case and Contact Management and Vaccine Clinic budget as described in Report No. 18-21FFC re: "COVID-19 Case & Contact Management / Vaccine Clinic Budget Update."*

Carried

It was moved by **Mr. Reid, seconded by Ms. Elliott,** *that the Board of Health request that the Board Chair send a letter to the Ministry of Health requesting the timely delivery of funding for COVID-19-related expenses, as assured by the Province, and the maintenance of adequate cash flow from the Province, in order to ensure effective operations.*

Carried

It was moved by **Mr. Reid, seconded by Mr. Mike Steele,** *that the Board of Health**:***

1) *Receive for information Report No. 19-21FFC re: "Request for Over-hire to Ensure Retention of Critical Health Human Resources";*
2) *Approve the over-hiring of 22 additional permanent positions (16 Public Health Nurses, three Public Health Inspectors, one Human Resources Specialist, one Health Equity Worker, and one Manager); and*
3) *Defer permanent budget decisions to the 2022 budget process.*

Carried

Program Update: Child Health

Mr. Darrell Jutzi, Manager, Child Health provided an update on the Child Health program. Highlights of this program included:

- Enhancing partnership and planning with school boards and schools through the implementation of Partnership Declarations and Data Sharing Agreements.
- Developing and coordinating an engagement and communication plan for MLHU programs and services in the school setting.
- Collaborating and planning with Settlement Service Agencies to support newcomer families in schools.
- Developing and implementing evidence informed toolkits and resources to support healthy school environments.
- Act as a school's primary public health contact for IPAC (infection prevention and control) support, guidance, surveillance, screening and management of a COVID-19 case or outbreak within a school.

Program Update: Oral Health

Ms. Misty Golding, Manager, Oral Health provided an update on the Oral Health program. Highlights of this program included:

- Providing dental screening for all JK, SK and Grade 2 students in all publicly funded elementary schools located in Middlesex-London.
- Reporting monthly program data to the Ministry as required.
- Promoting oral health to increase awareness and access to oral health services.
- Providing preventive dental services to children who are eligible for Healthy Smiles Ontario at the Citi Plaza Dental Clinic.
- Providing preventive and treatment dental services to seniors who are eligible for Ontario Seniors Dental Care Program at the Citi Plaza Dental Clinic.
- Collaborating with stakeholders to expand the pre-school and school-based fluoride varnish program.

Verbal COVID-19 Disease Spread and Vaccine Update

Dr. Alex Summers, Associate Medical Officer of Health and Dr. Chris Mackie, Medical Officer of Health presented the verbal COVID-19 update.

Discussion about this verbal report included:

- Cases have plateaued and seen positive impacts of vaccination.
- Delta variant has demonstrated to be highly transmissible; majority are delta variant in the region.
- Five to 10 cases per day on average.
- Reproductive number was around .88, now 1 (has risen).
- Majority of cases (85-90%) are from unvaccinated clients.
- As of July 10th, the region has administered 559,109 doses of vaccine and 77.8% of those aged 12 and over have received at least one dose.
- Responded to comments from Dr. Soumya Swaminathan (WHO) about mixing vaccines (Pfizer, Astra Zeneca and Moderna) that were taken out of context. Dr. Swaminathan was referring to the United States offering additional mNRA vaccines (3rd and 4th doses) to those already vaccinated.
- Mass vaccination clinics and pop up clinics are now taking walk ins for first doses.
- The vaccine does not interfere with menstruation or male/female fertility.

It was moved by **Mr. Reid, seconded by Ms. Elliott,** *that the Board of Health receive the verbal report on COVID-19 Disease Spread and Vaccine Update for information.*

Carried

Medical Officer of Health Activity Report for July 2021 (Report No. 32-21)

Dr. Mackie presented the Medical Officer of Health Activity Report for July 2021.

It was moved by **Mr. Reid, seconded by Mr. Steele,** *that the Board of Health receive Report No. 32-21 re: "Medical Officer of Health Activity Report for July 2021" for information.*

Carried

CORRESPONDENCE

It was moved by **Mr. Reid, seconded by Mr. Brennan**, *that the Board of Health endorse correspondence item a) re: Mitigation Funding in 2022 from Simcoe Muskoka District Board of Health, dated June 21, 2021.*

Carried

DRAFT

It was moved by **Ms. Elliott, seconded by Ms. Kasi,** *that the Board of Health receive correspondence items b) through d).*

Carried

OTHER BUSINESS

It was moved by **Mr. Steele, seconded by Ms. Kasi,** *that the August 19, 2021 Board of Health meeting be cancelled, such that the next meeting of the Board of Health be September 16, 2021.*

Carried

Ms. Emily Williams, Director, Healthy Organization/Interim CEO noted that this meeting would be the last Board of Health attended by Mr. Joe Belancic, Manager, Procurement and Operations. The Board thanked Mr. Belancic for his service.

ADJOURNMENT

At **8:12 p.m.,** it was moved by **Mr. Reid, seconded by Ms. Kasi,** *that the July 15, 2021 meeting of the Board of Health be adjourned.*

Carried

MAUREEN CASSIDY	**CHRISTOPHER MACKIE**
Chair	**Secretary-Treasurer**

DRAFT

PUBLIC MINUTES
FINANCE & FACILITIES COMMITTEE
Microsoft Teams
Thursday, September 2, 2021 at 9:00 a.m.

MEMBERS PRESENT: Mr. Matt Reid (Chair)
Ms. Aina DeViet
Ms. Maureen Cassidy
Ms. Tino Kasi
Mr. Aaron O'Donnell

OTHERS PRESENT: Dr. Christopher Mackie, Secretary-Treasurer/Medical Officer of Health
Ms. Carolynne Gabriel, Executive Assistant to the Board of Health (Recorder)
Ms. Stephanie Egelton, Senior Executive Assistant to the Medical Officer of Health/Associate Medical Officer of Health
Dr. Alexander Summers, Associate Medical Officer of Health
Mr. Brian Glasspoole, Manager, Finance

Chair Matt Reid called the meeting to order at **9:03 a.m.**

DISCLOSURES OF CONFLICT OF INTEREST

Chair Reid inquired if there were any disclosures of conflict of interest. None were declared.

APPROVAL OF AGENDA

It was moved by **Mr. Aaron O'Donnell, seconded by Ms. Maureen Cassidy,** *that the **AGENDA** for the September 2, 2021 Finance & Facilities Committee meeting be approved.*

Carried

APPROVAL OF MINUTES

It was moved by **Ms. Aina DeViet, seconded by Ms. Tino Kasi,** *that the **MINUTES** of the July 15, 2021 Finance & Facilities Committee meeting be approved.*

Carried

NEW BUSINESS

Financial Borrowing Update (Report No. 20-21FFC)

Mr. Brian Glasspoole, Manager, Finance introduced this report.

Discussion regarding this report included:

- The Middlesex-London Board of Health had previously approved a line of credit for $8 million; however, by July, 2021, a significant portion of the line of credit had been used largely dur to salaries for additional COVID-19-related hires and the delay in receipt of provincial funds.
- Proactively requested a temporary increase in the line of credit to $10 million in early August, 2021 based on the knowledge that provincial funds were being delivered and the gap was a timing issue.

DRAFT

- At the end of July, 2021, the Ministry of Health announced they were going to provide interim funding of approximately 50% of the estimated eligible COVID-19 extraordinary costs submitted by the Middlesex-London Health Unit in March. This amount, $13,781,600 was received by the Middlesex-London Health Unit in early August, bring the Health Unit into a cash surplus.
- The increase of $2 million to the line of credit has expired and the Health Unit's overdraft protection has returned to $8 million.
- The provincial government has requested an interim report due September 17, 2021 to provide a detailed analysis of all spending this year to the end of June 30, 2021 for vaccine clinics and case and contact management activities.
- The detailed analysis interim reports will differentiate between what are truly extraordinary costs due to COVID-19 and what are costs typically covered by the Health Unit's non-COVID-19 budget, including staff seconded to support COVID-19 programming away from their regular programs. This analysis will be done at the individual staff level.

It was moved by **Ms. DeViet, seconded by Ms. Kasi,** *that the Finance and Facilities Committee make a recommendation to the Board of Health to receive report No. 20-21FFC re: "Financial Borrowing Update" for information.*

Carried

MLHU Draft Financial Statements – March 31, 2021 (Report No. 21-21FFC)

This report was introduced by Mr. Glasspoole.

Discussion regarding this report included:

- This is an annual report from Middlesex-London Health Unit to provide audited financial reports to funders whose fiscal cycles occur from April 1 to March 31. This is a special-purpose audited financial report that shows that funds were spent appropriately.
- The programs included in these audited financial statements have changed from previous years due to many programs now being supported by the Thames Valley Children Services and the Healthy Babies / Healthy Children program now being delivered by the Middlesex-London Health Unit.
- These program reflect $2.8 million of the Health Unit's total operating budget for the year.
- The large differences between the amounts budgeted for 2021 and the actual amounts spent in certain categories in 2021 are due in part to COVID-19 affecting how programs are delivered.
- The large differences between the actual amounts for 2020 and 2021 may be attributed to the different mix of programs between years included in the financial reports as different programs require different types of expenditures.

It was moved by **Ms. Cassidy, seconded by Ms. Kasi,** *that the Finance and Facilities Committee make a recommendation to the Board of Health to approve the audited Consolidated Financial Statements of Middlesex-London Health Unit March 31st Programs, for the year ended March 31, 2021 as appended to Report No. 21-21FFC.*

Carried

OTHER BUSINESS

The next meeting of the Board of Health Finance and Facilities Committee will be held Thursday, October 7, 2021 at 9:00 a.m.

ADJOURNMENT

At **9:19 a.m.,** it was moved by **Ms. Cassidy, seconded by Mr. O'Donnell,** *that the meeting be adjourned.*

Carried

DRAFT

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MATTHEW REID
Chair

CHRISTOPHER MACKIE
Secretary-Treasurer

DRAFT

PUBLIC SESSION – MINUTES
MIDDLESEX-LONDON BOARD OF HEALTH
Special Meeting

Thursday, September 2, 2021 at 10:00 a.m.
Microsoft Teams

MEMBERS PRESENT:	Ms. Maureen Cassidy (Chair) Ms. Aina DeViet (Vice-Chair) Mr. Matt Reid Mr. John Brennan Mr. Bob Parker Mr. Mike Steele Mr. Aaron O'Donnell Ms. Tino Kasi
REGRETS:	Ms. Arielle Kayabaga Ms. Kelly Elliott
OTHERS PRESENT:	Dr. Christopher Mackie, Medical Officer of Health (Secretary-Treasurer) Ms. Stephanie Egelton, Senior Executive Assistant to the MOH/AMOH (Recorder) Dr. Alexander Summers, Associate Medical Officer of Health Ms. Carolynne Gabriel, Executive Assistant to the Board of Health and Communications Coordinator

Chair Maureen Cassidy called the meeting to order at **10:03 a.m.**

DISCLOSURE OF CONFLICT OF INTEREST

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

APPROVAL OF AGENDA

It was moved by **Ms. Tino Kasi, seconded by Mr. Aaron O'Donnell,** *that the **AGENDA** for the September 2, 2021 Special Board of Health meeting be approved.*

Carried

CONFIDENTIAL

At **10:04 a.m.,** it was moved by **Mr. Matt Reid, seconded by Mr. John Brennan,** *that the Board of Health will move in-camera to consider personal matters about an identifiable individual, including municipal or local board employees.*

Carried

At **10:18 a.m.,** it was moved by **Mr. Reid, seconded by Mr. Brennan,** *that the Board of Health rise and return to public session.*

Carried

ADJOURNMENT

At **10:19 a.m.** it was moved by **Ms. Kasi, seconded by Ms. Aina DeViet,** *that the Special meeting of Board of Health be adjourned.*

Carried

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MAUREEN CASSIDY
Chair

CHRISTOPHER MACKIE
Secretary-Treasurer

DRAFT

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 36-21

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2021 September 16

FINANCE & FACILITIES COMMITTEE MEETING – SEPTEMBER 2, 2021

The Finance & Facilities Committee (FFC) met at 9 a.m. on Thursday, September 2, 2021. A summary of the Committee's discussions can be found in the **draft minutes**.

Reports	Recommendations for Information and Board of Health Consideration
Financial Borrowing Update (Report No. 20-21FFC)	It was moved by **Ms. Aina DeViet, seconded by Ms. Tino Kasi,** *that the Finance and Facilities Committee make a recommendation to the Board of Health to receive report No. 20-21FFC re: "Financial Borrowing Update" for information.* Carried
MLHU Draft Financial Statements – March 31, 2021 **(Report No. 21-21FFC)**	It was moved by **Ms. Maureen Cassidy, seconded by Ms. Tino Kasi,** *that the Finance and Facilities Committee make a recommendation to the Board of Health to approve the audited Consolidated Financial Statements of Middlesex-London Health Unit March 31st Programs, for the year ended March 31, 2021 as appended to Report No. 21-21FFC.* Carried

This report was prepared by the Office of the Medical Officer of Health.

Christopher Mackie, MD, MHSc, CCFP, FRCPC
Medical Officer of Health

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 37-21

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health
Emily Williams, Chief Executive Officer (Interim)

DATE: 2021 September 16

PROPOSED 2022 BUDGET PLANNING PROCESS

Recommendation

It is recommended that the Board of Health:

1. ***Approve the revised budget planning process for 2022 outlined herein;***
2. ***Approve the PBMA criteria and weighting that is proposed in Appendix A to Report No. 37-21.;***
3. ***Approve requesting the full amount of the provincial cost sharing reductions from the municipal funders, in the same amount as requested in 2021, recognizing there may be a request for additional funds to address any shortfall in surplus identified from the PBMA process; and***
4. ***Approve MLHU staff and the Board of Health to partner with the municipality Government Relations leads to advocate for additional funding from the Provincial government to offset inflationary pressures.***

Key Points

- MLHU is operating in a Volatile, Uncertain, Complex and Ambiguous (VUCA) environment which presents the need for a revised 2022 Budget Planning Process, including a review of the organization structure.
- The PBMA process remains a critical component of the budgeting process for 2022; no changes are currently proposed to the PBMA criteria and weightings for 2022.
- It is anticipated that base funding from the province will remain flat at 2019 levels; inflationary pressures for 2022 are approximately $500,000.
- The provincial cost sharing reductions will be requested from the municipalities, despite confirmation of mitigation funding, to address inflationary pressures and required investments.

Background

The current Volatile, Uncertain, Complex and Ambiguous (VUCA) environment in which MLHU is operating has presented the organization with significant challenges in budget planning for 2022, due to a number of contributing factors. These include the rapidly evolving COVID-19 pandemic situation, uncertainty with respect to funding from the provincial government, inflationary pressures facing the organization, and the current status of public health programs and services. For example, MLHU only recently received confirmation of the 2021 budget on August 9th and received only partial funding for the year. Many public health services and programs have been paused due to staff redeployment to COVID-19 related work, making budget planning incredibly difficult for those teams. Staff and leaders have also identified several emerging needs for MLHU, as staff and leaders consider how to integrate COVID-19 ongoing operational requirements into existing structures and programs at the health unit, as well as plan for recovery and address related strategic priorities.

Program Budgeting Marginal Analysis (PBMA) is a criteria-based budgeting process that facilitates reallocation of resources based on maximizing service, which has been in place at MLHU for a number of years, and has served the health unit tremendously well in balancing it's budget consistently. PBMA is done through the transparent application of pre-defined criteria and decision-making processes to prioritize where proposed funding investments and disinvestments are made. Changes can be proposed at the program, division, or agency-wide level, which are then reviewed collectively by the Senior Leadership Team (SLT) for viability prior to submission to the BOH. Feedback from SLT during the development of this year's budget process emphasized a concern that program leaders and staff found it extremely difficult to identify marginal savings within programs last year, and service-level reductions were made. For example, in 2021, Ultraviolet Radiation (UVR) Health Promotion services were discontinued, and Pre-conception Health services were deprioritized within the Healthy Living and Healthy Start divisions respectively. This experience influenced a desire from SLT to incorporate a process for strategic financial decisions at the organization-wide level, into the budget planning process.

As challenging as it has been for MLHU to operate in the current VUCA environment, it also offers an opportunity for the organization to reevaluate the programs and services provided. For example, staff and leaders can evaluate alignment to the strategy and mission of the organization, assess impact on and value for clients and partnering organizations, and incorporate any new learnings with respect to models of service delivery, such as the use of virtual platforms. From a financial perspective, a zero-based budgeting technique is a critical adjunct to this process, as funds are subsequently allocated based on prioritization and necessity, not historical budget amounts. Using zero-based budgeting, the leadership team essentially builds a program budget from scratch, to assess every aspect of program and service activity to determine its worth.

2022 Proposed Budget Planning Process

A revised budget process is being proposed in response to the feedback from SLT and the current complex environmental context in which the health unit is operating. In the proposed process, the current state of programs directly influences the type of budget planning the respective teams will undertake, and the work is divided into four tranches detailed below.

1) *Programs offering full (or nearly full) service or program offerings.*
   These programs will undertake the traditional PBMA disinvestment process, using the attached criteria and weighting found in Appendix A.

2) *Programs offering expanded service or program offerings due to demands related to the COVID-19 pandemic or related MLHU provisional strategic plan goals.*
   These programs will develop program proposals, which will be evaluated using the PBMA investment process, using the attached criteria and weighting found in Appendix A. Examples include the expansion of the Infectious Disease Control and Vaccine Preventable Disease teams, as well as the Health Equity and Occupational Health and Safety teams.

3) *Programs offering reduced (or paused) service or program offerings due to staff redeployments to the COVID-19 CCM or Vaccine programs.*
   These teams will repatriate a small number of leadership and staff from COVID-19 work to undertake an Evaluation and Planning Exercise, to comprehensively assess the work of the division. For the 2022 budget, these programs and services will be attributed 2021 funding, plus inflation, and will undertake a zero-based budgeting exercise that will inform the 2023 budget and assist with funding allocation/re-allocation during the 2022 quarterly variance analysis process.

4) *Review of organization structure.*
   As staff and leaders consider how to integrate COVID-19 ongoing operational requirements into existing structures and programs at the health unit, and as specific leadership positions have become vacant, opportunities have been identified to potentially realign programs and services. Additionally,

the use of the Supervisor role in the pandemic response at MLHU has highlighted an opportunity to evaluate the leadership structure across the organization. The staffing model utilized at the Mass Vaccination Clinics introduced the health unit to the use of Registered Practical Nurses (RPNs) and there is an opportunity to assess their use across the organization more broadly. There may be efficiencies associated with this review that would also be evaluated in alignment with the first tranche of work described above.

The 2022 PBMA process consists of:

a) Validation of the assessment criteria and weighting for disinvestments by the Senior Leadership Team;
b) Approval of criteria and weighting by the Board of Health;
c) Proposal development and evaluation as outlined above;
d) Proposal review and recommendations by the Senior Leadership Team;
e) Review by the Finance and Facilities Committee and approval by the Board of Health.

Baseline Assumptions

From a funding perspective, the forecasting process is focused on assumptions with respect to provincial funding and the incremental costs related to salaries and benefits, as well as other inflationary pressures. For 2022, on August 19th, the MoH confirmed it will continue to provide mitigation funding to health units to offset the previously planned changes to cost sharing with the municipalities for public health services; MLHU will receive the amount identical to the past two years. Even with the mitigation funding, the base funding for MLHU is expected to remain unchanged at 2019 funded levels, which does not account for inflationary pressures or the need for expanded programs and services to address recovery and related strategic priorities. This places tremendous pressure on the organization, and the 2021 budget represented the first request for increased funding from the municipalities in 12 years.

For 2021, the province has currently funded approximately 50% of the COVID-19 CCM and Vaccine program costs budgeted by MLHU. They have committed to a process for further expense recovery throughout the remainder of the year; the first opportunity to do so includes an expense submission due September 17th. It is important to note that only extraordinary expenses are funded provincially, which means that MLHU must fully use its operating budget prior to submitting expenses for reimbursement. For example, in the case of staff who have been redeployed to COVID-19 related work, their salary is covered by operational funding, unless their position was backfilled. This is critical to understand as teams undertake the budget planning process. To date, no information related to funding for COVID-19 extraordinary costs for 2022 has been received.

As outlined in the process above, programs and services that are operating fully will attempt to identify proposed disinvestments and there may be efficiencies identified through the organization review. These will be considered, but it is anticipated that insufficient surplus funds will be available to address both inflationary pressures and the investments required. Inflationary pressures for 2022 represent a budget shortfall of approximately $500,000. In light of this, and the other challenges noted, staff considered a number of options in building the 2022 budget which included the following:

1) Request the entire amount of the provincial cost sharing reductions and inflationary shortfall from the municipalities;
2) Disinvest in MLHU programs and services that represent the full amount of the cost-sharing reductions as well as the full amount of the inflationary pressures; or
3) Request the provincial cost sharing reductions from the municipalities and through the PBMA process, attempt to find MLHU disinvestments representing the remaining inflationary pressures.

Staff are recommending a hybrid of the above options. It is recommended that MLHU request any provincial cost sharing reductions from the municipalities (in the same amount as requested in 2021), and through the

PBMA process and organization review, attempt to find MLHU disinvestments representing the inflationary pressures. Any shortfall in the surplus required to address the needs of the organization would subsequently be requested from the municipalities. A critical adjunct to this proposal is the recommendation that MLHU staff and the Board of Health partner with the municipality Government Relations leads to advocate for additional funding from the Provincial government to offset inflationary pressures. Preliminary conversations to identify key stakeholders have been initiated with respect to this recommendation.

2023 Budget Planning

The zero-based budgeting approach utilized by teams participating in the Evaluation and Planning Exercise will be evaluated for lessons learned and applied to the remaining programs across MLHU during the 2023 budget planning process. It is anticipated that PBMA will continue to play a significant role in evaluating proposals for investment and disinvestment at MLHU.

Next Steps

Following approval of the proposed 2022 budget planning process, staff and leaders will develop proposals or initiate evaluation and planning accordingly, and the PBMA criteria and weights approved by the Board of Health will be applied as described. MLHU Leadership will also conduct a review of the organization structure. Recommended proposals will be brought to the Finance & Facilities Committee and the Board of Health for approval in October 2021. Staff will work towards the development of the 2022 budget based on the direction of the Board.

This report was prepared by the Chief Executive Officer (Interim).

Christopher Mackie, MD, MHSc, CCFP, FRCPC
Medical Officer of Health

Emily Williams, BScN, RN, MBA
Chief Executive Officer (Interim)

2022 PBMA Criteria

Criteria	2021 Weight	Change	2020 Weight
Legislative Requirement	14	-	14
Other Requirement – Alignment	6	-	6
Health Need – Burden of Illness	7	-	7
Health Need – SDOH	8	-	8
Impact – Burden of Illness	14	-	14
Impact – SDOH	14	-	14
Impact – Customer Service	11	-	11
Community Capacity	4	-	4
Collaboration / Partnership	7	-	7
Organizational Risks / Benefits – reputation/litigation	7	-	7
Organizational Risks / Benefits – implementation	3	-	3
Organizational Risks / Benefits – culture	5	-	5
Total	**100**		**100**

Legislative Requirement

Criteria	Weight	Ratings
Assess the impact of the proposed change on the ability of the program to meet the legislative requirements for this program / activity (if any)	14	DISINVESTMENT - Major negative impact on ability to meet the legislative requirements (-3.00) DISINVESTMENT - Moderate negative impact on ability to meet the legislative requirements (-2.00) DISINVESTMENT - Minor negative impact on ability to meet the legislative requirements (-1.00) BOTH - No impact on ability to meet the legislative requirements (0.00) INVESTMENT - Minor positive impact on ability to meet the legislative requirements (1.00) INVESTMENT - Moderate positive impact on ability to meet the legislative requirements (2.00) INVESTMENT - Major positive impact on ability to meet the legislative requirements (3.00)

- In the rationale section, indicate whether this program / activity is specifically mandated under: (a) the Health Protection and Promotion Act via the OPHS, (b) other legislation, or (c) not mandated under legislation. Provide a hyper-link(s) (website address) where possible.
- If mandated under the OPHS, indicate which standard/protocol mandates the requirement/activity and quote the specific requirement for this program / activity.
- Indicate if there is an accountability agreement indicator associated with this program and if so, what the indicator is.
- If mandated by other legislation, provide a hyper-link to the requirements under the legislation.

Other Requirement

Criteria	Weight	Ratings
Assess the alignment of the proposed change with MLHU's Strategic Plan or other guidance documents	6	DISINVESTMENT - Considerable dis-alignment with MLHU's Strategic Plan or other documents (-3.00) DISINVESTMENT - Some dis-alignment with MLHU's Strategic Plan or other documents (-2.00) DISINVESTMENT - Little dis-alignment with MLHU's Strategic Plan or other documents (-1.00) BOTH - No alignment with MLHU's Strategic Plan or other documents (0.00) INVESTMENT - Little alignment with MLHU's Strategic Plan or other documents (1.00) INVESTMENT - Some alignment with MLHU's Strategic Plan or other documents (2.00) INVESTMENT - Considerable alignment with MLHU's Strategic Plan or other documents (3.00)
• Consider how this proposed change aligns with the Health Unit's strategic plan and other strategic documents such as the Ontario Public Health Sector Strategic Plan, Chief Medical Officer of Health reports, etc.		

Health Need

Criteria	Weight	Ratings
Assess the need for this program / activity in terms of the burden of illness it is intended to prevent and/or the risk factor it is intended to reduce	7	DISINVESTMENT - Major health need (high prevalence & high severity) (-3.00) DISINVESTMENT - Moderate health need (either high prevalence or high severity) (-2.00) DISINVESTMENT - Minor health need (low prevalence & low severity) (-1.00) BOTH - No health need (0.00) INVESTMENT - Minor health need (low prevalence & low severity) (1.00) INVESTMENT - Moderate health need (either high prevalence or high severity) (2.00) INVESTMENT - Major health need (high prevalence & high severity) (3.00)
• Using local statistics if possible, consider one or more of the following related to the burden of illness or risk factor being addressed by the program / activity: (a) potential years of life lost, (b) mortality rate, (c) hospitalization rate, (d) rate of illness or rate of risk factor in our community compared to other communities or the province as a whole		

Health Need

Criteria	Weight	Ratings
Assess the need for this program/activity in terms of the social determinant of health (SDOH) it is intended to address and/or health inequities	8	DISINVESTMENT - Major SDOH or health inequity addressed by this program/activity (-3.00) DISINVESTMENT - Moderate SDOH or health inequity addressed by this program/activity (-2.00) DISINVESTMENT - Minor SDOH or health inequity addressed by this program/activity (-1.00) BOTH - No SDOH or health inequity addressed by this program/activity (0.00) INVESTMENT - Minor SDOH or health inequity addressed by this program/activity (1.00) INVESTMENT - Moderate SDOH or health inequity addressed by this program/activity (2.00) INVESTMENT - Major SDOH or health inequity addressed by this program/activity (3.00)
• Using local statistics if possible, consider how the issue being address by this program / activity affects the social determinants of health (SDOH) and/or health inequities		

Impact

Criteria	Weight	Ratings
Assess the expected impact of the proposed change to the program/activity on the burden of illness it is intended to prevent and/or the risk factor it is intended to reduce	14	DISINVESTMENT - Major increase in illness/risk factors (-3.00) DISINVESTMENT - Moderate increase in illness/risk factors (-2.00) DISINVESTMENT - Minor increase in illness/risk factors (-1.00) BOTH - No reduction/prevention of illness/risk factors (0.00) INVESTMENT - Minor reduction/prevention of illness/risk factors (1.00) INVESTMENT - Moderate reduction/prevention of illness/risk factors (2.00) INVESTMENT - Major reduction/prevention of illness/risk factors (3.00)
• Consider how the proposed change is expected to impact on the health needs (outlined above) or other indicators, such as quality adjusted life years, when compared to current service. If these are unavailable, impact on shorter term outcomes of the program / activity can be considered (e.g., impact on knowledge, skills, attitudes etc.) • Sources of the information above can be published literature, evaluation reports, health status reports, surveillance data etc.		

Impact

Criteria	Weight	Ratings
Assess the expected impact of the proposed change to the program / activity on the SDOH and/or health inequities	14	DISINVESTMENT - Major increase in health inequities / negative effect on a SDOH (-3.00) DISINVESTMENT - Moderate increase in health inequities / negative effect on a SDOH (-2.00) DISINVESTMENT - Minor increase in health inequities / negative effect on a SDOH (-1.00) BOTH - No impact on health inequities / effect on a SDOH (0.00) INVESTMENT - Minor reduction of health inequities / positive effect on a SDOH (1.00) INVESTMENT - Moderate reduction of health inequities / positive effect on a SDOH (2.00) INVESTMENT - Major reduction of health inequities / positive effect on a SDOH (3.00)
• Using local statistics if possible, consider how the issue being address by this program / activity affects the social determinants of health and/or health inequities		

Impact

Criteria	Weight	Ratings
Assess the expected impact of the proposed change to the program / activity on client experience	11	DISINVESTMENT - Major decline in client experience (-3.00) DISINVESTMENT - Moderate decline in client experience (-2.00) DISINVESTMENT - Minor decline in client experience (-1.00) BOTH - No impact on on client experience (0.00) INVESTMENT - Minor improvement to client experience (1.00) INVESTMENT - Moderate improvement to client experience (2.00) INVESTMENT - Major improvement to client experience (3.00)
• Consider how the change will impact the client experience which includes: (a) the extent to which the service respects client and family needs and values, (b) client safety, (c) cultural appropriateness, and (d) how the client will perceive the experience with regard to communication, staff professionalism, and being client focused.		

Community Capacity

Criteria	Weight	Ratings
Is there duplication of a program / activity in the community? Assess if others in the community are doing some or all of this program / activity or if it is unique to the Health Unit.	4	DISINVESTMENT - No capacity in the community (-3.00) DISINVESTMENT - Limited capacity in the community (-2.00) DISINVESTMENT - Some capacity in the community (-1.00) BOTH - Considerable capacity in the community (0.00) INVESTMENT - Some capacity in the community (1.00) INVESTMENT - Limited capacity in the community (2.00) INVESTMENT - No capacity in the community (3.00)
• Is there duplication of a program / activity in the community? • Consider if there are others in the community who are doing all or part of this program / activity. Specifically, are others likely to fill in the gap in cases of disinvestment. • If proposing possible discontinuation of the program / activity, if appropriate, use the rationale section to indicate those in the community who could take on this role.		

Collaboration / Partnership

Criteria	Weight	Ratings
How does the proposed change affect collaboration/partnerships that contribute to meeting the Health Unit's goals outside of impact?	7	DISINVESTMENT - Major negative impact on collaboration/partnerships (-3.00) DISINVESTMENT - Moderate negative impact on collaboration/partnerships (-2.00) DISINVESTMENT - Minor negative impact on collaboration/partnerships (-1.00) BOTH - No impact on collaboration/partnerships (0.00) INVESTMENT - Minor improvement to collaboration/partnerships (1.00) INVESTMENT - Moderate improvement to collaboration/partnerships (2.00) INVESTMENT - Major improvement to collaboration/partnerships (3.00)
• Consider the community partners involved in this program / activity and how being involved in this collaboration / partnership supports the Health Unit in achieving its goal and building goodwill in the community, as well as how the proposed change will affect this collaboration/partnership.		

Organizational Risks / Benefits

Criteria	Weight	Ratings
Assess the risks/benefits to the Health Unit of implementing the proposed change. Specifically consider organizational reputation and risk of litigation that exists separately from our legislative mandates.	7	DISINVESTMENT - Major risk to reputation / of litigation (-3.00) DISINVESTMENT - Moderate risk to reputation / of litigation (-2.00) DISINVESTMENT - Minor risk to reputation / of litigation (-1.00) BOTH - No risk/benefit to reputation / of litigation (0.00) INVESTMENT - Minor benefit to reputation / decreased risk of litigation (1.00) INVESTMENT - Moderate benefit to reputation / decreased risk of litigation (2.00) INVESTMENT - Major benefit to reputation / decreased risk of litigation (3.00)

• Consider how this change will impact the reputation of the Health Unit and/or if this change puts the Health Unit at risk for litigation.

Organizational Risks / Benefits

Criteria	Weight	Ratings
ORGANIZATIONAL RISKS / BENEFITS: Assess the risks/benefits to the Health Unit of implementing the proposed change. Specifically consider implementation challenges (incl. ease of sustainment and impact on other frontline/support services)	3	DISINVESTMENT - Major implementation challenges (-3.00) DISINVESTMENT - Moderate implementation challenges (-2.00) DISINVESTMENT - Minimal implementation challenges (-1.00) DISINVESTMENT - No implementation challenges / INVESTMENT - Major implementation challenges (0.00) INVESTMENT - Minimal implementation challenges (1.00) INVESTMENT - Moderate implementation challenges (2.00) INVESTMENT - No implementation challenges (3.00)
• Consider the following as possible implementation challenges in addressing this criteria: (a) how easy or difficult it will be to implement this change in the short-term? (b) how easy or difficult will the change be to sustain over the long-term? (c) how much impact will the change have on front line staff and/or support services?		

Organizational Risks / Benefits

Criteria	Weight	Ratings
ORGANIZATIONAL RISKS / BENEFITS: Assess the risks/benefits to the Health Unit of implementing the proposed change. Specifically consider the impact on workplace culture and our values (e.g., morale, the ability to be innovative, internal collaboration)	5	DISINVESTMENT - Major risk to workplace culture (-3.00) DISINVESTMENT - Moderate risk to workplace culture (-2.00) DISINVESTMENT - Minor risk to workplace culture (-1.00) BOTH - No risk/benefit to workplace culture (0.00) INVESTMENT - Minor benefit to workplace culture (1.00) INVESTMENT - Moderate benefit to workplace culture (2.00) INVESTMENT - Major benefit to workplace culture (3.00)
• Consider the impact of the change on factors such on our values, workplace morale, personal and professional growth opportunities, teamwork, the Health Unit's ability to be innovative, etc.		

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 42-21

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health
Emily Williams, CEO (Interim)

DATE: 2021 September 16

Q2 FINANCIAL UPDATE AND FACTUAL CERTIFICATE

Recommendation

It is recommended that the Board of Health receive Report No. 42-21 re: "Q2 Financial Update and Factual Certificate" for information.

Key Points

- The 2021 approved budget consists of a zero percent increase in Mandatory Program funding from the Ministry of Health (MoH).
- Funding received from the MoH for COVID-19 related activities amounted to $13.9 million or approximately half the original budget submitted; after adjusting COVID-19-related spending for seconded staff costs from Mandatory Programs, approximately $12.3 million has been spent year-to-date to June 30.
- The Health Unit is not currently projecting a spending surplus as favourable variances across the organization will fully offset the planned agency gapping budget of $1.3 million.
- Included in the financial update is a signed factual certificate, which provides assurance that financial and risk management functions are being performed.

Background

The Board of Health approved the 2021 operating budget on February 18, 2021 (Report No. 004-21FFC). The approved budget consists of no increase in Mandatory Program funding from the MoH but does reflect a change of funding mix between the province and municipalities for previously 100% provincially funded programs.

Financial Highlights

The Budget Variance Summary, which provides budgeted and actual expenditures for the six months ended June 30th for the programs and services governed by the Board of Health, is attached as Appendix A. This analysis is based on the original budget for 2021 as approved by the Board of Health.

Themes within the Q2 variance analysis contributing to positive variances within some program areas are related to staffing gaps and reduced travel, staff development, professional services, and program supply costs.

The Health Unit is currently expecting to fully spend the budget during the year after fully offsetting the expected agency gapping budget of $1,257,473.

COVID-19 and Extraordinary Funding

In response to the COVID-19 pandemic, the Health Unit has hired temporary personnel and reassigned staff from Mandatory Programs that have been paused, to roles related to Case and Contact Management (CCM) and the Vaccine Program. The Budget Variance Summary has been modified to show the costs related to supporting the response to COVID-19, and to demonstrate what costs were covered by approved budgets for salaries and benefits of redeployed staff, and which costs were extraordinary. Extraordinary costs continue to be funded through a one-time funding mechanism established by the MoH.

In July, 2021, the MoH announced that funding for Mandatory Programs would be flat at prior year levels and that extraordinary funding for COVID-19 related activities, including CCM and the Vaccine Program, would initially be funded at approximately 50% of budgeted levels submitted, amounting to $13,860,000 for MLHU. Spending on COVID-19-related activities to June 30th amounted to $12,295,731. The MoH has committed to providing further funding on an interim basis in connection with mandated interim reporting; the first report to the MoH outlining COVID-19-related spending to June 30th is required by September 17th.

Factual Certificate

A factual certificate, attached as Appendix B, is to be signed by senior Health Unit administrators responsible for ensuring certain key financial and risk management functions are being performed to the best of their knowledge. The certificate is revised as appropriate on a quarterly basis and submitted with each financial update.

This report was prepared by the Finance Team, Healthy Organization Division.

Christopher Mackie, MD, MHSc, CCFP, FRCPC
Medical Officer of Health

Emily Williams, BScN, RN, MBA
Chief Executive Officer (Interim)

MIDDLESEX-LONDON HEALTH UNIT
NET BUDGET VARIANCE SUMMARY
As at June 30, 2021

	2021 YTD ACTUAL (NET)	COVID RECLASS	2021 YTD RESTATED (NET)	2021 YTD BUDGET (NET)	VARIANCE (OVER) / UNDER	% VARIANCE	DECEMBER FORECAST	FUNDING ADJUSTMENTS	2021 ANNUAL NET BUDGET	ANNUAL SURPLUS / (DEFICIT)	% VARIANCE	Comment / Explanation
Environmental Health & Infectious Disease												
Office of the Director	$ 124,638	$ 342	$ 124,980	$ 135,336	$ 10,356	7.7%	$ 265,156		$ 270,673	$ 5,517	2.0%	Lower spending in salaries $3,079 partly offset by higher benefits costs ($799). Lower than planned program supplies $2,030, travel $1,129, staff development $976, professional services $3,000 and other program costs $1,282.
Emergency Management	5,511	59,618	65,129	67,765	2,636	3.9%	134,126		135,530	$ 1,404	1.0%	Favourable variances in program supplies $4,624 and other program costs $3,295 were partly offset by unplanned professional fees ($4,968) as focus shifted to emergency response to the pandemic.
Food Safety & Healthy Environments	625,394	118,418	743,812	900,013	156,201	17.4%	1,716,820		1,800,026	$ 83,206	4.6%	Reduced spending in salaries & wages $115,912, benefits $21,322, travel $6,878, program supplies $5,957 and staff development $3,812.
Infectious Disease Control	838,954	73,581	912,535	893,601	(18,934)	-2.1%	1,797,288		1,787,202	$ (10,086)	-0.6%	Higher than planned overtime and on call premium ($29,780) to address IDC priorities. Offsetting favourable variances from travel $3,202, staff development $1,659, program supplies $3,696, and other program costs $2,289.
Safe Water, Rabies & Vector-Borne Disease	347,310	112,334	459,643	690,060	230,417	33.4%	1,380,120		1,380,120	$ -	0.0%	Lower spending in salaries $75,056 and benefits $16,769. Lower than planned program supplies $16,538, travel $14,183, staff development $5,075, other program costs $15,141 and lower than planned professional service fees $81,769 which primarily include mosquito ID and abatement programs.
Sexual Health	819,166	57,792	876,957	1,235,222	358,264	29.0%	2,279,600		2,470,443	$ 190,843	7.7%	Lower spending for salaries $195,150 and benefits $50,005 due to decreased clinics and less need for casual employees, and lower spending for travel $5,161, staff development $2,687 and other program costs $9,961. Lower than planned clinic revenues ($58,566) are partly offset by lower program supplies $119,369 and professional services $33,708.
Vaccine Preventable Disease	580,903	126,765	707,668	768,064	60,396	7.9%	1,503,956		1,536,128	$ 32,172	2.1%	Lower salaries $52,524 and benefits $20,622. Lower revenues ($48,100) due to reduction in paid vaccine in the MLHU Immunization clinics and reimbursable vaccines due to school closures, partly offset favourable variances in program supplies $40,128, staff development $949, partly offset by higher than planned equipment costs ($7,735) which included a refrigerator.
COVID-19	8,270,363	(1,939,620)	6,330,744	3,637,392	(2,693,352)		12,661,488	5,386,705	7,274,783	$ -	0.0%	Incremental costs to support COVID-19 beyond transfer of operating budgets for staff redeployed. Assume that all out-of-budget incremental costs for COVID 19 will be funded by Ministry of Health. Budget to be adjusted in response to actual costs incurred.
COVID-19 Vaccine	6,360,974	(272,205)	6,088,770	10,711,577	4,622,807		12,177,540	(9,245,613)	21,423,153	$ -	0.0%	Incremental costs to support COVID-19 Vaccine Clinics to be fully finded by the Ministry of Health. Budget to be adjusted in response to actual costs incurred.
Total Environmental Health & Infectious Disease	***$ 17,973,214***	***$ (1,662,975)***	***$ 16,310,238***	***$ 19,039,029***	***$ 2,728,791***	***14.3%***	***$ 33,916,093***	***$ (3,858,909)***	***$ 38,078,058***	***$ 303,056***	0.8%	
Healthy Living												
Office of the Director	$ 87,416	$ 169	$ 87,585	$ 133,407	$ 45,822	34.3%	$ 242,405		$ 266,814	$ 24,409	9.1%	Lower spending in salaries $28,707 and benefits $6,660 due to gapping. In addition, lower spending occurred in travel $2,000, program supplies $2,724, staff development $1,999 and professional services $2,500.
Child Health	504,899	509,574	1,014,473	831,771	(182,703)	-22.0%	1,790,864		1,663,541	$ (127,323)		Higher spending for salaries ($165,015) and benefits ($46,857) primarily for additional casual public health nurses and higher overtime hours. Offset partly by lower spending in travel $9,095, program supplies $22,980 and staff development $2,500.
Chronic Disease and Tobacco Control	300,440	52,168	352,608	805,972	453,364	56.3%	1,378,733		1,611,944	$ 233,211	14.5%	Lower spending in salaries $302,579 and benefits $79,963 due to staffing gaps. Lower than planned program supplies $57,074, travel $5,723, staff development $1,00 and professional services $5,762.
Healthy Communities and Injury Prevention	(47,526)	61,702	14,176	567,606	553,430	97.5%	920,584		1,244,496	$ 323,912	26.0%	Lower spending in salaries $422,827 and benefits $104,941 due to staffing gap and reassignment of roles. Additional savings in travel $4,054, program supplies $13,796, staff development $2,650, professional services $2,750 and other program costs $2,100 as program delivery was delayed due to COVID.

MIDDLESEX-LONDON HEALTH UNIT
NET BUDGET VARIANCE SUMMARY
As at June 30, 2021

	2021 YTD ACTUAL (NET)	COVID RECLASS	2021 YTD RESTATED (NET)	2021 YTD BUDGET (NET)	VARIANCE (OVER) / UNDER	% VARIANCE	DECEMBER FORECAST	FUNDING ADJUSTMENTS	2021 ANNUAL NET BUDGET	ANNUAL SURPLUS / (DEFICIT)	% VARIANCE	Comment / Explanation
Oral Health	212,007	52,629	264,636	505,122	240,486	47.6%	882,139		1,010,243	$ 128,104		Favourable variances for salaries $160,570, benefits $42,034 and lower spending for travel $7,996, program supplies $14,163 equipment costs $9,276 and other program costs $3,154.
Senior Dental Program	747,979		747,979	$ 835,764	87,785	10.5%	1,671,528		1,671,528	$ -		Senior Dental Program is 100% funded by Ministry of Health. Any unspent funds during the year must be returned. Funding received in 2021 includes $700,000 for a second dental clinic to be built in Strathroy which can be utilized until Mar 2022.
Southwest Tobacco Control Area Network	74,559	43,589	118,148	221,151	103,003	46.6%	387,433		442,301	$ 54,868	12.4%	Favourable variances in program supplies $77,460, other program costs $18,740 and travel $2,430 contributed to positive variances as program delivery was delayed due to COVID.
Young Adult Health	408,150	295,532	703,682	561,522	(142,160)	-25.3%	1,198,771		1,123,044	$ (75,727)	-6.7%	A portion of the Young Adult Team were seconded to Covid. Higher spending in wages ($88,764) overtime ($47,729) and benefits ($29,588) partly offset by favourable spending in travel $5,691, program supplies $14,078, staff development $1,825 and professional services $2,000.
Total Healthy Living	***$ 2,287,923***	***$ 1,015,363***	***$ 3,303,286***	***$ 4,462,314***	***$ 1,159,028***	***26.0%***	***$ 8,472,457***	***$ -***	***$ 9,033,911***	***$ 561,454***	6.2%	
Healthy Start												
Office of the Director	$ 95,131	$ 2,903	$ 98,034	$ 107,653	$ 9,619	8.9%	$ 210,182		$ 215,306	$ 5,124	2.4%	Lower than planned salaries $1,284 and benefits $321, travel $1,203, program supplies $3,875, equipment $1,562 and other program costs $850.
Best Beginnings	1,452,258	205,549	1,657,807	1,692,583	34,776	2.1%	3,360,642		3,385,167	$ 24,525		Healthy Babies Healthy Children and Smart Start for Babies Programs are included with March 31 year-end programs (MLHU2) - assume that funding will be fully spent by March 31, 2022. Lower than planned spending in shared-funding programs for salaries $8,000 and benefits $2,093 from gapping, travel $1,909, program supplies $6,626, staff development $912 and professional services $14,206.
Early Years Health	666,909	56,236	723,144	767,562	44,417	5.8%	1,511,213		1,535,123	$ 23,910	1.6%	Lower than planned salaries $29,327 and benefits $5,954 due to gapping. Additional savings from lower than planned travel $7,766 and program supplies $965.
Reproductive Health	85,264	113,221	198,484	632,356	433,872	68.6%	1,033,594		1,264,712	$ 231,118	18.3%	Lower spending in salaries $323,964 and benefits $82,532 due to staffing gap. Lower than planned program supplies $13,016, travel $3,985, staff development $2,275, professional services $6,132 and other program costs $1,700.
Total Healthy Start	***$ 2,299,561***	***$ 377,908***	***$ 2,677,470***	***$ 3,200,154***	***$ 522,684***	***16.3%***	***$ 6,115,631***		***$ 6,400,308***	***$ 284,677***	4.4%	
Office of the Chief Nursing Officer	$ 207,497	$ 24,658	$ 232,155	$ 367,482	$ 135,327	36.8%	$ 698,876		$ 734,963	$ 36,087	4.9%	Lower spending in salaries $82,873 and benefits $22,084 due to staffing gap. Lower than planned spending occurred for travel $3,000, program supplies $7,310, staff development $3,347, professional services $1,100 and other program costs $15,522.
Office of the Medical Officer of Health												
Office of the Medical Officer of Health	$ 237,176	$ (190)	$ 236,986	$ 236,483	$ (503)	-0.2%	$ 473,233		$ 472,965	$ (268)	-0.1%	Higher than planned wages for overtime ($9,075) was partly offset by lower spending for travel $3,000, program supplies $1,322, staff development $2,500, professional services $850 and other program costs $900.
Communications	281,272	1,458	282,731	296,534	13,803	4.7%	583,611		593,067	$ 9,456	1.6%	Lower than planned spending for salaries $5,779 and benefits $1,463 due to gapping coupled with lower spending for travel $1,510, staff development $1,132 and other program costs $7,675 were partly offset by higher spending for program supplies ($1,092).
Associate Medical Officer of Health	179,138	250	179,388	154,207	(25,181)	-16.3%	321,827		308,413	$ (13,414)	-4.3%	Higher spending for salaries ($22,119) and benefits ($4,607) was partly offset by lower spending for staff development $1,000.
Population Health Assessment & Surveillance	237,861	46,412	284,273	301,536	17,262	5.7%	593,876		603,071	$ 9,195	1.5%	Favourable spending occurred in salaries $8,867, benefits $4,832 travel $1,500 and staff development $1,500.
Community Outreach & Clinical Support Servic	464,294	4,550	468,844	435,477	(33,367)	-7.7%	888,728		870,954	$ (17,774)	-2.0%	Higher spending in salaries ($24,637), overtime ($5,464), benefits ($2,025) and program supplies ($12,314) were partly offset by lower spending in travel $5,882, staff development $1,360, equipment costs $2,272 and other program costs $1,560.

MIDDLESEX-LONDON HEALTH UNIT
NET BUDGET VARIANCE SUMMARY
As at June 30, 2021

	2021 YTD ACTUAL (NET)	COVID RECLASS	2021 YTD RESTATED (NET)	2021 YTD BUDGET (NET)	VARIANCE (OVER) / UNDER	% VARIANCE	DECEMBER FORECAST	FUNDING ADJUSTMENTS	2021 ANNUAL NET BUDGET	ANNUAL SURPLUS / (DEFICIT)	% VARIANCE	Comment / Explanation
Total Office of the Medical Officer of Health	***$ 1,399,741***	***$ 52,480***	***$ 1,452,221***	***$ 1,424,235***	***$ (27,986)***	***-2.0%***	***$ 2,861,275***		***$ 2,848,470***	***$ (12,805)***	-0.4%	
Healthy Organization												
Office of the Director	$ 223,338	$ 17	$ 223,355	$ 181,684	$ (41,671)	-22.9%	$ 374,467		$ 363,368	$ (11,099)		Unplanned salaries ($68,314) and benefits ($6,144) for CEO were partly offset by lower spending for travel $7,773, staff development $8,758 and professional services $15,806.
Finance	272,660	731	273,390	189,185	(84,206)	-44.5%	400,797		378,369	$ (22,428)		Higher salaries ($60,929) and benefits ($8,124) due to unplanned staff increases coupled with unplanned overtime ($13,991) and additional program supplies ($580).
Human Resources	$ 343,133	$ 9,066	$ 352,199	$ 376,750	24,550	6.5%	740,421		753,499	$ 13,078		Lower than planned salaries $8,906, benefits $9,750 and professional services $5,125.
Information Technology	628,219	5,816	634,035	657,363	23,328	3.5%	1,302,299		1,314,725	$ 12,426		Higher than planned salaries ($12,805), computer equipment charges ($14,388) and cell phone costs ($7,880) are more than offset by lower spending for IT consulting $50,407, telecom charges $5,079 and computer supplies $2,020.
Privacy Risk & Governance	$ 15,536	$ 804	$ 16,340	$ 78,520	62,180	79.2%	123,917		157,039	$ 33,122		Lower spending in salaries $49,200, benefits $11,816 due to gapping coupled with underspending for program supplies $1,229.
Procurement & Operations	127,369	264	127,633	96,984	(30,650)	-31.6%	210,294		193,968	$ (16,326)	-8.4%	Higher than planned salaries ($30,311).
Program Planning & Evaluation	$ 205,989	$ 122,898	$ 328,887	$ 442,805	113,918	25.7%	824,927		885,610	$ 60,683	6.9%	Lower spending in salaries $92,626 and benefits $22,869 due to staffing gap for program evaluator and manager and lower spending for program supplies $3,598 partly offset by higher professional fees ($5,450).
Strategic Projects	59,675	52,970	112,645	141,830	29,185	20.6%	268,112		283,660	$ 15,548		Favourable variance in salaries $22,735, benefits $5,006, program supplies $457 and other program costs $640.
Total Healthy Organization	***$ 1,875,919***	***$ 192,566***	***$ 2,068,485***	***$ 2,165,119***	***$ 96,634***	***4.5%***	***$ 4,245,234***		***$ 4,330,238***	***$ 85,004***	2.0%	
General Expenses & Revenues	1,599,905	-	1,599,905	1,399,721	(200,184)	-14.3%	***$ 2,799,441***		***$ 2,799,441***	$ -	0.0%	General expenses have been adjusted to remove $146,134 of leasehold fit-up costs that will be capitalized. Higher operating costs include higher than anticipated benefits administration costs ($73,538), higher occupancy costs ($117,883) in part due to timing of recognition of insurance costs and higher security costs, other program costs ($9,349) and lower than planned misc. revenues ($7,182). These costs are partly offset by lower than planned spending for program supplies $4,630 and Board of Health expenses $6,666.
Total Expenditures Before Expected Gapping	**$ 27,643,759**	**$ (0)**	**$ 27,643,759**	**$ 32,058,052**	**$ 4,414,292**	**13.8%**	**$ 59,109,006**	**$ (3,858,909)**	**$ 64,225,388**	**$ 1,257,473**	2.0%	
Less: Expected Agency Gapping Budget				(628,736)	(628,736)		-		(1,257,473)	$ (1,257,473)		
TOTAL BOARD OF HEALTH EXPENDITURES	**$ 27,643,759**	**$ (0)**	**$ 27,643,759**	**$ 31,429,316**	**$ 3,785,556**	**12.0%**	**$ 59,109,006**	**$ (3,858,909)**	**$ 62,967,915**	**$ 0**	**0.0%**	

Middlesex-London Health Unit
FACTUAL CERTIFICATE

To: Members of the Board of Health, Middlesex-London Health Unit

The undersigned hereby certify that, to the best of their knowledge, information and belief after due inquiry, as at June 30, 2021:

1. The Middlesex-London Health Unit is in compliance, as required by law, with all statutes and regulations relating to the withholding and/or payment of governmental remittances, including, without limiting the generality of the foregoing, the following:
    - All payroll deductions at source, including Employment Insurance, Canada Pension Plan and Income Tax;
    - Ontario Employer Health Tax; and
    - Federal Harmonized Sales Tax (HST).

   Further, staff believe that all necessary policies and procedures are in place to ensure that all future payments of such amounts will be made in a timely manner.

2. The Middlesex-London Health Unit has remitted to the Ontario Municipal Employees Retirement System (OMERS) all funds deducted from employees along with all employer contributions for these purposes.

3. The Middlesex-London Health Unit is in compliance with all applicable Health and Safety legislation.

4. The Middlesex-London Health Unit is in compliance with applicable Pay Equity legislation.

5. The Middlesex-London Health Unit has not substantially changed any of its accounting policies or principles since December 8, 2016.

6. The Middlesex-London Health Unit reconciles its bank accounts regularly and no unexpected activity has been found.

7. The Middlesex-London Health Unit has filed all information requests within appropriate deadlines.

8. The Middlesex-London Health Unit is in compliance with the requirements of the Charities Act, and the return for 2020 has been filed.

9. The Middlesex-London Health Unit has been named in a complaint to the Human Rights Tribunal of Ontario by a former student. The hearing has been completed and a decision to dismiss has been rendered that found no violation of human rights. The individual filed an Application to Divisional Court for a Judicial Review which was dismissed, the individual is now seeking motion for leave to appeal. MLHU has also been named in a second complaint to the Human Rights Tribunal of Ontario by the same individual. This application is in respect to the recruitment of three management positions for which he was not selected for an interview.

10. The Middlesex-London Health Unit has been named in a legal action with respect to ‘Cali Nails’ or ‘the numbered company that operated Cali Nails’ for damages arising from the Order to close for Infection Prevention and Control (IPAC) infractions, and the publication of the associated Closure Order. The claim alleges that, as the Order to close and the associated public notice that the IPAC

infractions could lead to blood borne infections, this directly led to the drop in its business and the closure of the salon. Ultimately damages are being sought as a result.

11. The Middlesex-London Health Unit is fulfilling its obligations by providing services in accordance with our funding agreements, the Health Protection & Promotion Act, the Ontario Public Health Standards, and as reported to the Board of Health through reports including but not limited to:
    - Quarterly Financial Updates;
    - Annual Audited Financial Statements;
    - Annual Reporting on the Accountability Indicators;
    - Annual Service Plans; and
    - Information and Information Summary Reports.

Dated at London, Ontario this 16th day of September, 2021

Dr. Christopher Mackie	Emily Williams
Medical Officer of Health	Interim CEO

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 38-21

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health
Emily Williams, Chief Executive Officer (Interim)

DATE: 2021 September 16

Feedback on Proposed Regulations for Supplemented Foods

Recommendation

It is recommended that the Board of Health:

1. ***Receive Report No. 38-21"Feedback on Proposed Regulations for Supplemented Foods" for information; and,***
2. ***Direct the Medical Officer of Health to send a letter to Health Canada, responding to the public health concerns associated with these amendments, attached as Appendix A.***

Key Points

- The proposed regulatory framework may lead to greater availability and marketing of supplemented foods, which include energy drinks, potentially leading to health risks for vulnerable populations such as children/youth and pregnant women.
- The availability and promotion of supplemented food products within the food supply does not align with Canada's Dietary Guidelines.
- A comprehensive strategy is needed to mitigate the health risks potentially associated with the proposed regulatory changes.

Public Health Considerations for Proposed Amendments to Supplemented Foods Regulations

Health Canada has recently proposed amendments to Food and Drug regulations for Supplemented Foods. Supplemented foods are defined in the legislation as "prepackaged foods containing one or more added supplemental ingredients, which are vitamins, mineral nutrients, amino acids, or other ingredients (e.g., caffeine, herbal extracts), which have historically been marketed for the purpose of providing specific physiological or health effects". A few examples of popular supplemented foods include energy drinks or other foods with caffeine added and protein bars.

These amendments have been proposed, according to Health Canada, in order "to provide a predictable regulatory environment for supplemented foods that continues to protect the health and safety of Canadians, while also allowing industry to bring new and innovative products to market." However, there are number of public health concerns arising from these proposed changes.

The regulatory proposal points out the research showing children and young adults 12 – 30 years of age represent the largest proportion of caffeinated energy drink users, and that these drinks may be more likely to affect children and adolescents than they do adults. But in the current approach, a cautionary statement indicating that those aged 14-17 "should not consume" such products, **is not required** on the label. Furthermore, the amendments appear to reduce barriers for the food industry to gain market approval for

supplemented food products, including the potential for accelerated approval timelines, which could lead to greater access by children and youth to products such as energy drinks.

Canada's Dietary Guidelines, released by Health Canada in 2019, outline that processed or prepared foods and beverages high in sodium, free sugars, or saturated fat, undermine healthy eating and should not be consumed regularly. The possibility of increased availability and consumption of supplemented food products, as a result of these amendments, most being high in these ingredients of health concern, contradicts Health Canada's own dietary guidance.

In order to address the health risks of increased marketing and access to some supplemented food products, policy and program measures are needed, including additional restrictions on marketing to children and youth as well as clear language at point-of-purchase.

In summary, the MLHU response, attached as Appendix A, to the proposed amendments includes the following recommendations:

- Revise the proposed front of package symbols and wording to convey a cautionary, "warning" message;
- Develop a communication campaign to educate consumers, especially vulnerable populations, on the potential risks of the proposed regulatory changes;
- Develop an evidence-informed, comprehensive strategy that establishes policy and program measures to mitigate the possible negative health and environmental impacts of the proposed regulations; and
- Establish a transparent and comprehensive process to collect and synthesize data and research evidence on the health risks associated with consuming supplemental ingredients and supplemented food products.

This report was prepared by the Healthy Living division.

Christopher Mackie, MD, MHSc, CCFP, FRCPC
Medical Officer of Health

Emily Williams, BScN, RN, MBA
Chief Executive Officer (Interim)

(Response Deadline Sept 24, 2021)

Office of Legislative and Regulatory Modernization
Policy, Planning and International Affairs Directorate
Health Products and Food Branch
Health Canada
Holland Cross, Tower A, Suite 14, Ground Floor
11 Holland Avenue
Ottawa, Ontario
K1A 0K9 (Address locator: 3000A)
Via e-mail to: hc.lrm.consultations-mlr.sc@canada.ca

Re: Feedback on Proposed Regulations for Supplemented Foods (Canada Gazette, Part 1, Volume 155, Number 26: Regulations Amending the Food and Drug Regulations - Supplemented Foods)

Dear Sir or Madam:

Thank you for the opportunity to provide feedback on the proposed amendments to the Food and Drug Regulations (FDR) regarding supplemented foods (SF) and supplemental ingredients (SI).

The development of a framework for regulating supplemented food products is of public health significance, and therefore, the Middlesex London Health Unit (MLHU) has prioritized a response for this important subject. Nutrition is a modifiable risk factor for the prevention of chronic disease and plays a significant role in an individual's overall physical and mental health throughout their lifespan.

MLHU acknowledges Health Canada's efforts to apply a risk-based approach in developing the proposed regulatory amendments. We also recognize that a streamlined framework for regulating supplemented foods has advantages (e.g., logistically, operationally) - both for the federal government as the body responsible for market approval of such products, and for the food industry.

However, while the proposed regulations include some potential strengths in terms of reducing regulatory barriers, MLHU recommends that the proposed framework be very carefully considered given the lack of evidence in support of health benefits for Supplemented Food (SF) products and the growing evidence of health risks of certain SF products. Our concerns are described in the attached.

The Middlesex London Health Unit looks forward to continuing to work in partnership with federal regulators in addressing the health concerns associated with 'supplemented' food products. For more information or to discuss further, please do not hesitate to contact myself or Donna Kosmack, Program Manager, Chronic Disease Prevention and Tobacco Control at (519) 663-5317 ext. 2302.

Sincerely,

Comments on the Proposed Regulations for Supplemented Foods

While there are some advantages to the proposed regulatory framework, MLHU has the following **key** concerns as they pertain to protecting and promoting population health:

1. **The proposed regulatory framework may lead to an increase in the availability of supplemented food products in the food supply which in turn, may pose risks to the health of the public, particularly to vulnerable population groups.**
    - As noted in the regulatory proposal, the supplemental ingredients used to develop supplemented food products, can pose a risk to health if they are overconsumed by the general population or consumed by populations who may be more vulnerable to their health impacts (e.g., pregnant women, children, youth). For example:
        - The regulatory proposal discusses the research which indicates that male children and young adults 12 – 30 years of age represent the largest proportion of caffeinated energy drink users, and that these drinks may be more likely to affect children and adolescents than they do adults.
        - Health Canada has previously indicated that *"in some cases, one energy drink could have more caffeine than the safe daily intake for many children and teens".*
        - The Expert Panel previously convened by Health Canada reported a number of concerns related to the health impacts of caffeinated energy drink consumption, and recommended a range of related measures to protect the health of consumers. This includes the panel recommendations that energy drinks be designated and named as "stimulant drug containing drinks", and that they require a label indicating that such products are not recommended for children and adolescents under the age of 18 years.
    - As outlined in the objectives of the regulatory proposal, the proposed framework *"provides flexibility to adapt to new evidence related to supplemented foods and supplemental ingredients, thus supporting innovation in the food industry*".
        - Compared to the current approach (i.e., Temporary Market Authorizations), the proposed amendments appear to reduce barriers for the food industry to gain market approval for supplemented food products, including the potential for accelerated approval timelines. As such, industry may be encouraged to develop a wider variety of supplemented food products than what is currently available in the market.
        - An increased and wider variety of supplemented food products on the market over the long-term has the potential to increase public consumption of supplemented food products, including an increase in 'mixing' of supplemental ingredients (i.e., from intake of various types of supplemented products). This, in turn, may lead to an increase in adverse health effects within the population and in vulnerable populations when the supplemental ingredients consumed are associated with potential health risks.
    - The 'supplemented' and 'supplemental' terminology used in the proposed regulatory framework and any related consumer-facing language (e.g., on product labels, in marketing and advertising) may create a '*health halo'* effect for supplemented food products. The terminology may be misleading and/or misinterpreted by consumers, given the potential for a perceived association with health products such as vitamin and mineral supplements. As such, consumers may be encouraged to consume more of these products (i.e., through a '*health halo'* effect) and

may be less likely to understand the risks associated with consuming certain supplemented food products.

2. **The availability and promotion of supplemented food products within the food supply does not align with Canada's Dietary Guidelines.**
    - Canada's Dietary Guidelines outline that processed or prepared foods and beverages that contribute to excess sodium, free sugars, or saturated fat, undermine healthy eating and should not be consumed regularly.
        - Supplemented foods are **prepackaged** foods containing one or more supplemental ingredients, many of which fall under the umbrella of processed or prepared foods/beverages.
        - Increased availability and consumption of supplemented food products may come at the expense of consumption of the foods and beverages promoted within Canada's Dietary Guidelines (i.e., vegetables, fruit, whole grains, protein foods and water).
        - Including the term 'supplemented' (e.g. in the supplemented food facts table, on the Supplemented Food Caution Identifier) on the label of supplemented foods, may lead consumers to overestimate the healthfulness of those foods (i.e., the '*health halo effect*'). This is of particular concern given the fact that many of the foods in the List of Permitted Supplemented Food Categories are foods that Canada's Dietary Guidelines indicate should not be consumed regularly (e.g., sugary drinks such as soft drinks, juice, sports and energy drinks, and confectioneries such as candies, candy bars and chocolate).
    - Canada's Dietary Guidelines include consideration of the environmental implications of food choices and eating patterns; including the way that food is produced, processed, distributed, and consumed.
        - Supplemented food products are prepackaged products which may have negative environmental impacts given that they are highly processed and require packaging (e.g., wrappers, bottles) which may be harmful to the environment.

3. **The proposed regulatory framework is not accompanied by a comprehensive strategy to mitigate the health risks that may be associated with the proposed regulatory changes.**
    - While a risk-based approach was considered in the regulatory proposal development process, a full range of policy and program measures appears to be needed (e.g., additional restrictions on marketing/promotion, restrictions at point-of-purchase) to mitigate the health risks that may be associated with an increased availability of supplemented food products on the market over the long-term.
    - This is of particular concern for vulnerable populations (e.g., children and youth) who may be more susceptible to negative health effects from consumption of supplemented food products.
        - This includes youth aged 14-17 who are part of the age range (12 to 30 years of age) representing the largest proportion of caffeinated energy drink users, but for whom there may be fewer conditions and restrictions for industry to adhere to. For example, a cautionary statement indicating that those aged 14-17 "should not consume" such products, is not required on the label. As outlined in the regulatory proposal, the current approach places the onus on consumers aged 14 and above to interpret the

label and *"understand their caffeine consumption and manage within their recommended limits".*

Given the above key concerns, **Middlesex London Health Unit recommends the following**, for your consideration:

1. **Restrict use of the terms 'supplemented' and 'supplemental' in consumer-facing language (e.g., on product labels, through marketing and advertising).** This recommendation aligns with a risk-based approach to regulating supplemented food products in a manner that protects the health of consumers, including vulnerable populations. For example:
    - **Revise the language for the proposed Supplemented Food Caution Identifier (SFCI) symbol.** More specifically, replace the term 'supplemented' with language that conveys caution (e.g., 'warning') and makes specific reference to the cautionary statements on the other portion of the label for more information. The term 'supplemented' (along with an exclamation mark) may be not be interpreted by consumers as cautionary in nature and may not sufficiently warn consumers of the health risks associated with consuming the product. The SCFI symbol should use clear consumer-friendly language (e.g., "warning", "caution") to indicate risk and direct them to the cautionary statements on the other portion of the label to read more.

2. **Develop a communication campaign and related products to educate the public regarding the regulatory changes, including messaging pertaining to:**
    - a consumer-friendly overview of the regulatory changes.
    - how 'supplemented foods' and 'supplemental ingredients' are defined, with examples of such products.
    - the potential health risks associated with overconsumption of supplemented food products by the general population and of consumption among vulnerable populations, with specific examples (e.g., the risks of consumption of caffeinated energy drinks among children and youth).
    - how to identify supplemented food products in the market and interpret any applicable cautionary statements and warnings (e.g., how to look for and interpret the supplemented food caution identifier on the label).
    - the importance for Canadians to limit their consumption of processed/prepared food products, including supplemented food products, as per Canada's Food Guide and Canada's Dietary Guidelines.
    - that while supplemented foods may be promoted by the food industry as having physiological or health effects, individuals need not consume them in order to meet their dietary/nutritional requirements (i.e., but rather to follow the recommendations outlined in Canada's Food Guide).
    - the process for the public to report on adverse health effects or events due to the consumption of a supplemented food product, with strong consideration for inclusion of this information on the label of supplemented food products.

3. **Develop an evidence-informed, comprehensive strategy that establishes a range of policy and program measures to mitigate the possible negative health and environmental impacts of the proposed regulations, including consideration of:**
    - Limits on the number and variety of supplemented food products a company may develop within a specific time frame to mitigate potential increased availability of supplemented foods.
    - Restrictions on the types of products that can be formulated and available on the market to ensure that vulnerable groups (e.g., children and youth) are not targeted directly or indirectly through the product development and formulation phases. For example:
        - Restrictions on the use of 'kid/youth-friendly' flavours (e.g., 'cotton candy').
        - Restrictions on adding supplemental ingredients to products that are consumed more regularly by vulnerable populations such as children and youth (e.g., candies, certain beverages such as juice).
    - Conditions and restrictions on supplemented foods (e.g., 'do not consume' cautionary statements) for youth 14 – 17 years of age for products that may pose risk to their health (e.g., caffeinated energy drinks); similar to the considerations made to develop the conditions and restrictions required for children and youth under 14 years of age and also in consideration of the previously noted Expert Panel recommendations pertaining to caffeinated energy drinks.
    - Restrictions on marketing and promotion of supplemented foods that directly or indirectly target vulnerable populations such as children and youth up to 18 years of age. For example:
        - Restrictions related to sampling of products at any location where vulnerable populations (e.g., children and youth under 18 years of age) congregate, and/or locations where certain activities such as the provision of alcohol or engagement in high-intensity activities could further increase health risks when combined with the consumption of supplemented food products (e.g., caffeinated energy drinks).
        - Restrictions pertaining to branding, events and/or sponsorship.
    - Restrictions on sales at the point-of-purchase when there is the potential to mitigate health risks for vulnerable populations (e.g., prohibitions on sales of caffeinated energy drinks to children and youth under 18 years or age, restrictions related to product placement/location in stores and on shelves).

4. **Establish a transparent and comprehensive process to regularly gather and synthesize data and research evidence on the health risks associated with consuming supplemental ingredients and supplemented food products. Use such findings to inform, review and market approvals of supplemented food products and any ongoing amendments to the supplemented food regulations in the FDR.**
    - A comprehensive process to regularly review and synthesize data (including incident report data) and research evidence should be in place to inform product review/approvals and ongoing regulatory amendments in order to protect the health and safety of consumers. Findings from this process should be communicated to health officials and the public on an ongoing basis.
        - While recognizing that industry-driven data/evidence is relevant and informative, this process must also integrate data/evidence from unbiased, non-industry sources. This includes data and research that is neither collected/conducted, nor funded, by the food industry. Using unbiased forms of data/evidence in addition to incident report data to

inform approvals and regulatory amendments is required to protect the health and safety of consumers.

- A transparent and thorough process for reporting and investigating adverse incidents (i.e., adverse health effects) associated with the consumption of supplemented food products should be put in place. This process should be adequately communicated to the public and be integrated into the regulatory framework, where applicable (e.g., requirements for product labels to include adverse event reporting information).

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 39-21

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health
Emily Williams, Chief Executive Officer (Interim)

DATE: 2021 September 16

SUBMISSION TO HEALTH CANADA'S CONSULTATION ON THE PROPOSED VAPING PRODUCTS' FLAVOUR REGULATIONS AND ORDER

Recommendation

It is recommended that Report No. 39-21 re: "Submission to Health Canada's Consultation on the Proposed Vaping Products' Flavour Regulations and Order" be received for information.

Key Points

- Most young people prefer flavoured vapour products, and in many instances, flavours are responsible for recruiting new young vapers. Using vapour products is not safe and presents additional risks for young people during the final stages of brain development.
- In Ontario, the Association of Local Public Health Agencies (alPHa) has adopted a resolution calling for federal and provincial action on e-cigarettes. The resolution was sponsored by the Middlesex-London Board of Health and urges governments of Ontario and Canada to enact policy measures based on recommendations by the Council of Chief Medical Officers of Health.
- Health Canada sought input on the proposed Order Amending Schedules 2 and 3 to the *Tobacco and Vaping Products Act* and the proposed Standards for Vaping Products' Sensory Attributes Regulations to address the rapid uptick in vaping and to reduce harms from vapour product use; the Health Unit's submission is attached as Appendix A.

Background

Widespread availability and an abundance of flavours of vaping products in Canada has increased vaping rates among youth at an alarming rate. In a 2019 study by Hammond et.al. showed a 74% increase in vaping among Canadian youth from 2017 to 2019. The percentage of youth who reported using a vapour product within the last 30 days increased from 8.4% to 14.6%.

Results from the 2018-19 Canadian Student Tobacco, Alcohol and Drugs Survey (CSTADS) show e-cigarette prevalence rates among Canadian grade 7 to 12 students have doubled from 10% in 2016-17 to 20% in 2018-19. Nicotine is harmful to youth as it can alter their brain development and affect their memory and concentration.

For Young People, It's all about the Flavour

The 2020-2021 Youth and Young Adults Vaping Project, (YYAVP) found that 92% of young people used a flavoured vaping product at initiation and 90% continued to vape flavoured products. Among young people, mint/menthol was the second most popular flavour, while tobacco was the least favourite flavour. Additionally, it has been found that adolescents consider the flavour of vaping products to be the most

important factor when considering using the product. Therefore, a flavour restriction should include mint and menthol flavours, as they have been shown to make vapour products more appealing to young people.

Gateway Drug

In addition to a gateway to nicotine addiction, vaping may increase the risk of subsequent cigarette initiation. In a paper published in 2019, Berry, et. al. found that young people who use e-cigarettes are four times more likely to smoke tobacco cigarettes. Similarly, a study published in 2020 found that individuals who used vapour products were five times more likely to become regular cigarette smokers in a years' time as compared to non-vapour product users.

This is concerning as young people who transition to smoking regular combustible cigarettes, or become dual users are then being exposed to the added chemicals found in combustible cigarettes as well as the carcinogens from the combustion.

Opportunity for Protective Policy Measures through Federal Regulation

The availability of flavours in vapour products have posed significant challenges in Public Health efforts to halt vapour product uptake, especially by young people. Health Canada and the Ontario Ministry of Health should be commended for their work thus far to address vaping, but additional regulations are required. As such, the health unit has responded to Health Canada's request for comments on proposed changes to the Order Amending Schedules 2 and 3 to the *Tobacco and Vaping Products Act* and the proposed Standards for Vaping Products' Sensory Attributes Regulations, attached as Appendix A. Additionally, further references are found in Appendix B.

This report was prepared by the Healthy Living Division.

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September 2, 2021

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Dear Sir or Madame;

The Middlesex-London Health Unit welcomes the opportunity to provide comments on Health Canada's proposed vaping products flavour regulations and order and shares Health Canada's concerns about the widespread use of vaping among Canadian youth. High vaping rates in Canada are putting young people at risk of nicotine addiction and the harms associated with vaping.

The Middlesex-London Health Unit applauds Health Canada for its diligence in regulating vaping product promotion, packaging and labelling, and most recently for placing a maximum nicotine concentration of 20 mg/ml for any vaping product marketed in Canada.

We agree with Health Canada's proposal to further restrict vaping product flavours. With a few modifications, we support Health Canada moving forward with Option 5, a three-pronged approach that would restrict flavoured vaping products to tobacco and mint/menthol only by:

- Prohibiting most flavouring ingredients, and all sugars and sweeteners in vaping products;
- Further restricting the promotion of flavours; and
- Prescribing sensory attributes standards.

However, in order to stem the epidemic of youth vaping in our nation and protect those most likely to uptake the use of vapour products, regulations need to be strengthened. The Middlesex London Health Unit recommends Health Canada take the following actions as outlined below:

Recommendation: Health Canada should further strengthen Option 5 by amending Schedule 2 in order to restrict flavouring ingredients that impart mint, menthol, or mint/menthol flavours, banning their promotion, and prohibiting products that confer sensory attributes typical of mint/menthol.

Recommendation: Health Canada should continuously monitor emerging evidence on the harms of flavouring agents, regularly update the list of prohibited ingredients, and commit to the frequent sampling and testing of vaping products for the presence of prohibited ingredients.

Recommendation: Health Canada should extend the outlined restrictions that would prevent the attractive promotion of flavoured vaping products to the promotion of mint/menthol.

Recommendation: Given the popularity of mint/menthol and non-tobacco flavours among young people, Health Canada should prescribe standards to ensure that all vaping products only bring to the user the smell, taste and chem-esthetic sensations typical of tobacco. Health Canada should continuously assess products against the sensory attribute standards prescribed using a trained sensory panel to ensure that products sold in the market limit users' perceptual experience to one typical of tobacco only.

Recommendation: Health Canada should take a strong stance on implementing compliance measures through active monitoring across the supply chain, testing of products for prohibited ingredients, and establishing a trained sensory panel. Health Canada should also remain vigilant and monitor the threat of cross-jurisdictional purchasing of flavoured vaping products through online retailers and manufacturers.

The proposed regulations along with the recommended improvements we have suggested will help to prevent youth, young adults and non-smokers from initiating vapour product use. The Middlesex-London Health Unit looks forward to continuing to work in partnership with our federal public health partners to address this emerging public health issue of significant concern. For more information or to discuss further, please do not hesitate to contact me or Donna Kosmack, Program Manager for Chronic Disease Prevention and Tobacco Control at (519) 663-5317 ext. 2302.

Sincerely,

Christopher Mackie, MD, MHSc, CCFP, FRCPC
Medical Officer of Health

Attachment

Comments on the Proposed Vaping Products' Flavour Regulations

Importance of flavours in driving vaping behaviour in youth

- The nation-wide prevalence of vaping among students (grade 7-12) has doubled, rising from 10% in 2016-2017 to 20.2% in 2018-2019.[1,2]
- Youth are also vaping more frequently and one in every three students has tried an e-cigarette.[1,2]
- Vaping products are cheap, widely accessible, and attractive – young people are being enticed with over 7,700 flavours.[3]
- Flavours are consistently cited as a primary reason young people begin vaping and continue to vape.[4–6]
- A Heart & Stroke funded study, the *2020-2021 Youth and Young Adult Vaping Project (YYAV)*, found that 92% of young people used a flavoured vaping product at initiation, and 90% continued to vape flavoured products.[7]
- Among young people, mint/menthol was the second most popular flavour reported while tobacco was least popular – only 1% of those surveyed used a tobacco flavoured e-liquid at initiation and presently.[7]
- In contrast, adults (especially smokers) had a greater preference for tobacco flavoured vaping products.[6]
- Data from the 2019 Canadian Tobacco and Nicotine Survey (CTNS) found that 22% of adults 25 years or older used tobacco flavoured vaping products most often.[8]
- This increased to 41% for adults 45 years or older.[8]
- Exposure to nicotine through vaping devices can damage young brains, affecting mood, memory and concentration.[9–12]
- Vaping in young people is also associated with an increased odds of subsequent tobacco smoking,[13,14] emphasizing the need for a comprehensive approach to address youth vaping.
- Globally, several jurisdictions have taken action to restrict the availability of flavoured vaping products to dissuade youth use, including Netherlands, Finland, and the U.S. states of California, New York, New Jersey, Massachusetts, and Rhode Island. In Canada, Nova Scotia, Prince Edward Island, and Nunavut have complete flavours restrictions, excluding tobacco flavours.

Popularity of mint/menthol among youth and young adults

- Flavours are a top reported positive aspect of vaping among young vapers,[7] and nearly half (44%) of Canadian youth surveyed in the 2020-2021 YYAV study said they would quit vaping if they could not purchase flavoured vaping products.[7]
- A systematic review by Zare et al. (2018) found that adolescents consider the flavour of vaping products to be the most important factor when trying e-cigarettes and that vaping initiation is more likely to occur with fruit, sweet, menthol and cherry flavoured products.[6]

- In one study of nearly 3,400 students, the use of non-traditional flavoured vaping products (versus tobacco only, or mint and menthol) among adolescents was associated with continued use and greater puffing frequency.[15]
- This was also observed in a second study of 1,800 high school students in Philadelphia, where initial use of flavoured vaping products (except tobacco or unflavoured products) was associated with a progression to current vaping after 18 months.[16]
- When non-traditional flavours are restricted, but mint and menthol remain on the market, young people shift their purchasing and consumption preferences toward mint and menthol flavoured vaping products.[17,18]
- In Canada, 90,000 youth vapers prefer mint/menthol flavours and would continue to be influence to vape if mint/menthol is not included in the flavour restrictions.[1,7]
- Canadian data also indicated that youth and young adult women have a higher preference for mint/menthol as their present flavour,[7] and exempting mint/menthol flavours from the proposed restrictions may disproportionately impact young women.[7]

Flavouring ingredients and their associated health risks

- Heating e-liquids to high temperatures can produce toxic aerosols that may damage cells of the mouth, nose, lungs, and blood vessels in the human body.[20–25]
- In one study, the addition of sucralose, a sweetener, enhanced the formation of toxic compounds known as aldehydes, in e-cigarette vapour.[26] When the chemical composition of flavoured versus unflavoured aerosols was compared, more aldehydes were formed in the aerosols of flavoured e-liquids.[20]
- An Ontario study tested 166 different e-liquids and found that sweet e-liquids had a greater number of flavouring chemicals compared to tobacco and menthol flavoured e-liquids.[27] Benzyl alcohol, benzaldehyde, and vanillin were among the chemicals identified in the samples tested that posed a risk of inhalation toxicity.[27]
- The long-term consequences of inhalation or exposure to these compounds are currently unknown.

Restricting the promotion of flavours

- Despite industry claims that flavoured vaping products are not being advertised in a youth-appealing way, evidence suggests the opposite. In one study, 255 Californian youth were presented with eight random advertisements for fruit-, dessert-, alcohol- and coffee-flavoured vaping products. A majority of those surveyed felt the sweet flavours were targeted to a younger audience, this was especially true for the “Cupcake man” flavour.[28]
- The Ontario Tobacco Research Unit (OTRU) collected samples of flavoured vaping products from online Canadian vape stores in 2019 and found several examples of flavoured vaping products with attractive packaging, design elements, names and descriptors with youth-appeal.[29]

Prescribing sensory attribute standards

- The proposed regulations would mandate that a flavoured vaping product or its emissions forgo sensory attributes that result in a sensory perception (smell or taste) that is not typical of tobacco or mint/menthol. This is an innovative way to regulate the availability of flavoured vaping products and restrict manufacturers' ability to make products with a highly pleasant smell or taste.
- Youth have a strong innate preference for sweetness that tapers off with age.[30–32] This is concerning because fruit and confectionary flavours contain sugars and sweeteners and are very popular among youth.
- Sugars and sweeteners can increase the appeal of vaping products by enhancing perceived sweetness and smoothness.[33]
- Sensory attributes like sweetness, smoothness, and even familiarity are linked to higher liking and appeal ratings, especially among young people.[33,34] Furthermore, flavouring ingredients and additives are extremely effective at masking the bitterness and harshness of nicotine.[33,34]
- Attenuated bitterness and harshness makes high nicotine vaping significantly more tolerable in youth and is also associated with higher liking and appeal ratings.[33]
- Mint and menthol remain popular among young people and possess their own sensory-enhancing effects. Mint is familiar to youth and menthol can attenuate the bitterness and harshness of nicotine, enhancing the appeal and tolerability of high nicotine vaping as well.[33,35]
- Recent evidence among young ice-flavour (menthol-fruit) users indicated that menthol contributed a "cooling" sensory attribute that could additively increase the appeal of high-nicotine vaping, the risk for frequent vaping, nicotine dependence, and poly-tobacco product use.[35]
- Ice-flavour users were more likely to report using combustible cigarettes in the past 30 days, report vaping dependence and initiation at an earlier age, and engage in more vaping episodes per day compared to users of fruit or confectionary flavours.[35]

Flavours and smoking cessation

- Although it is argued that a comprehensive flavour ban could reduce the appeal of e-cigarettes among some adult smokers,[36] the evidence is inconclusive on whether having a large variety of flavours contributes to smoking cessation.[37–39]
- Data from the U.S. Population Assessment of Tobacco and Health (PATH) Study indicated that adults who used sweet or mint/menthol flavours (vs tobacco flavours) were less likely to abstain from smoking and/or vaping.[40] The two-year follow-up found that 44% of exclusive e-cigarette users continued vaping while 60% of dual users returned to exclusive cigarette smoking, 26% continued dual use, and only 5% transitioned to exclusive e-cigarette use.[40]
- E-cigarettes are not medically approved cessation devices and while some clinical studies show they may be effective cessation aids when paired with counselling in controlled environments, most larger populations studies find e-cigarettes to be ineffective.[41]

- Factors other than flavours, such as the motivation or intention to quit smoking, are important for cessation and can also influence consumer behaviour. A California study of adult vapers revealed that when presented with a hypothetical flavour ban (excluding tobacco), adults who were motivated to quit smoking using e-cigarettes were significantly more likely to continue purchasing and using available vaping products compared to users who vaped for other reasons.[42]
- An interview of U.S. adults who successfully quit smoking and vaping found they recommended smokers to use tobacco flavours to transition away from cigarettes and suggested that having fewer flavours in the market could make it less overwhelming for smokers turning to e-cigarettes for cessation.[43,44]
- A comprehensive flavour ban that includes mint/menthol would still give adult smokers access to a range of tobacco flavours, ensuring that e-cigarettes maintain their potential for smoking cessation.
- Youth and young adults primarily use vaping products for reasons other than cessation[8,45–50] and flavours are a top reported positive aspect of vaping among youth.[7]
- The fact that most youth who vape are never-smokers is concerning. In 2019, 74% of youth aged 15-19 who reported vaping in the past 30 days were never-smokers compared to 41% of young adults aged 20-24 and 14% of adults 25 and older.[8]
- Flavours entice youth to start vaping[7], exposing them to the harms of nicotine addiction. The earlier in childhood an individual uses nicotine, the stronger the addiction and the harder it is to quit.[51,52]
- Vaping is a gateway to nicotine addiction and may increase the risk of subsequent cigarette initiation.[30]
- Regular e-cigarette users may be five-times more likely than non-e-cigarette users to become regular smokers in the absence of any tobacco use history.[7,53]

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MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 40-21

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health
Emily Williams, Chief Executive Officer (Interim)

DATE: 2021 September 16

DIVERSITY AND INCLUSION ASSESSMENT: MLHU WORKFORCE CENSUS

Recommendation

It is recommended that the Board of Health:

1) ***Receive Report No. 40-21 re: "Diversity and Inclusion Assessment: MLHU Workforce Census" for information;***
2) ***Endorse the recommendations within the Workforce Census Report for implementation at the Middlesex-London Health Unit.***

Key Points

- The Diversity and Inclusion Assessment has two deliverables - an Employment Systems Review (ESR) and a Workforce Census – to provide recommendations to ensure all employees have a safe and inclusive workplace experience and that employees reflect diversity in the community.
- The Workforce Census provides an analysis of the demographic makeup of MLHU's workforce in comparison to the Middlesex-London community to assess whether MLHU's workforce is representative of and reflects the community, as well as 12 recommendations for implementation.

Background

The Diversity and Inclusion Assessment consists of two components: 1) Employment Systems Review, and 2) Workforce Census. The Diversity and Inclusion Assessment was originally planned to be completed by 2019, however was delayed due to the proposed public health restructuring and the COVID-19 pandemic. The Employment Systems Review was completed in May 2021 (Report No. 24-21).

The Middlesex-London Health Unit has had an intentional focus on health equity and reducing health inequities through public health action for close to a decade. As part of its commitment to health equity, it is essential that MLHU demonstrates organizational leadership in understanding and addressing diversity and inclusion within the workplace. This Assessment was initiated to identify recommendations for steps MLHU could take to ensure that all employees have the same opportunities for a safe and inclusive workplace experience, and that the workforce composition would better reflect the diversity of the community served. In August 2020, MLHU contracted Turner Consulting Group Inc. to conduct the Assessment.

Workforce Census

After the Employment Systems Review (ESR), the second deliverable of the Diversity and Inclusion Assessment was the Workforce Census. The goals of the Workforce Census include the following:

- Assessing the current demographic makeup of MLHU employees;

- Looking at the representation of employees in various demographic groups, including disability, religion/faith, Indigenous identity, racial identity, gender identity, and sexual orientation;
- Evaluating the level of diversity of the MLHU workforce compared with that of residents living in the Middlesex-London community.

The consultant developed an online census survey of thirteen questions that was completed by MLHU staff at all levels, positions, roles, and disciplines. With an overall response rate of 84% for permanent full-time and part-time employees, the results were then analyzed by the consultant's team and compared with the demographic context of the Middlesex-London community to assess whether MLHU's workforce is representative of the community.

Results

A comprehensive report was provided by the consultant (see Appendix A), outlining the purpose, methodology and responses of the workforce census, along with the demographic context and analysis of the workforce demographics. The report also provides a list of recommendations and next steps.

Workforce analysis focused on the following demographic areas:

- Disability
- Indigeneity and Racial Identity
- Religion/Faith
- Gender/Gender Identity
- Sexual Orientation
- Age and Years of Service of Racialized and White Employees
- Occupation
- Casual and Temporary Employees

In total, twelve recommendations were identified for implementation at MLHU (see Appendix B).

Next Steps & Conclusion

As the role of the consultants comes to an end with this assessment, it is critical that MLHU remain committed to the implementation of the Workforce Census recommendations. An implementation plan will be developed, and recommendations will be prioritized appropriately. Some recommendations will begin to be implemented in 2021, while others will take longer to fully realize. The development of the implementation plan will be led by the Health Equity and Indigenous Reconciliation Team, in collaboration with the Human Resources Team, the internal Advisory Committee, and relevant teams across the health unit. The Senior Leadership Team will ensure appropriate resourcing and prioritization of the implementation of approved recommendations. It is crucial to have an ongoing commitment from the Board of Health, MLHU's Leadership Team, and all MLHU employees to the implementation of the recommendations. This will help create an equity-oriented and inclusive workplace which will support everyone at MLHU to be their best self and will, ultimately, enhance public health outcomes.

This report was prepared by the Health Equity and Indigenous Reconciliation Team.

Christopher Mackie, MD, MHSc, CCFP, FRCPC
Medical Officer of Health

Emily Williams, BScN, RN, MBA
Chief Executive Officer (Interim)

TURNER CONSULTING GROUP

July 2021

DIVERSITY & INCLUSION ASSESSMENT

PART 2 Workforce Census

MIDDLESEX-LONDON HEALTH UNIT

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EXECUTIVE SUMMARY

This is the first Workforce Census conducted by the Middlesex-London Health Unit (MLHU, the Health Unit). It was designed to help the Health Unit understand the diversity of its workforce and to answer the following key questions:

- What is the current demographic makeup of Health Unit employees?
- What is the representation of employees in various demographic groups, including disability, religion/faith, Indigenous identity, racial identity, gender identity, and sexual orientation?
- How does the diversity of the Health Unit workforce compare with that of residents living in Middlesex-London?

The survey consisted of 13 questions and took respondents less than 10 minutes to complete. Census Week was designated as April 23 to 30, 2021. Staff were also given time at the weekly townhall meeting on both April 23 and 30 to complete the census.

An overall response rate of 84% was achieved for permanent full-time and part-time staff.

THE DEMOGRAPHIC CONTEXT

Middlesex-London is a growing community, with more people, jobs, and services expected to come to the region in the coming years. Adding to this growth are housing prices in Toronto, leading many people to move farther away from the city in search of affordable housing. This growth will be further fuelled by the COVID-19 pandemic, with Toronto experiencing a record population loss during the pandemic as more people move away from the city in response to work-from-home options becoming increasingly available.

The Census of Canada data shows that the Indigenous and racialized communities within Middlesex-London are growing at a faster rate than the overall population and therefore will constitute an increasingly larger proportion of the Middlesex-London community. Between 2006 and 2016, the Indigenous population grew by 69%, from 6,580 to 11,145 individuals, increasing from 1.6% of the community to 2.4%. During that same period, the racialized population grew by 56%, from 48,915 to 76,460 individuals, growing from 12% of the population to 17%.

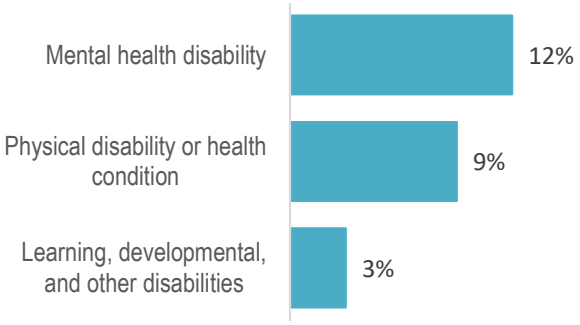
PERSONS WITH DISABILITIES

A person with a disability is defined as someone with a long-term or recurring physical, mental, sensory, psychiatric, or learning challenge.

20% of survey respondents reported having a disability similar to their representation in the external labour market.

12% reported a mental health disability, while 9% of survey respondents reported having a physical disability or health condition. In addition, about 3% of all survey respondents reported having a learning, developmental, or other type of disability.

Type of Disability, Permanent Full-Time and Part-Time Employees, Workforce Census.

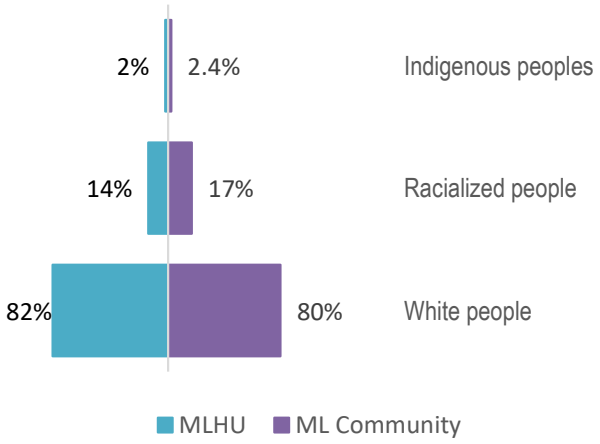


INDIGENOUS PEOPLES & RACIALIZED PEOPLE

Compared with their representation in the population of Middlesex-London, Indigenous peoples are slightly underrepresented in the MLHU workforce — fewer than 2% of employees who responded to the survey identify as Indigenous compared with 2.4% of the residents of Middlesex-London.

Similarly, racialized people are underrepresented in the MLHU workforce — 14% of survey respondents identified as racialized, compared with 17% of the residents of Middlesex-London.

Indigenous Peoples and Racialized People, Permanent Full-Time and Part-Time Employees, Workforce Census.



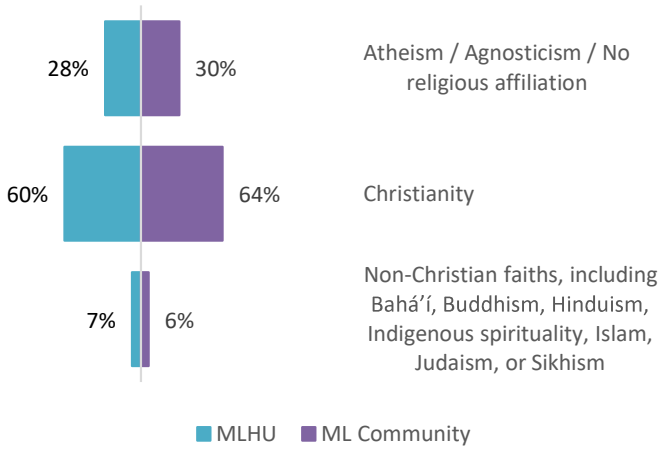
RELIGION/FAITH

Compared with the religious diversity of Middlesex-London, a similar proportion of MLHU employees reported being atheist, agnostic, or having no religious affiliation (28% of survey respondents versus 30%).

A slightly smaller proportion (60%) of MLHU employees reported being affiliated with Christianity compared with the proportion of Middlesex-London residents who identified that way (64%).

A similarly small proportion (7%) of MLHU employees identified with a non-Christian religion (e.g., Bahá'í, Buddhism, Hinduism, Indigenous spirituality, Islam, Judaism, or Sikhism) compared with the proportion of the community served that identified that way (6%).

Religion/Faith, Permanent Full-Time and Part-Time Employees, Workforce Census.



GENDER/GENDER IDENTITY

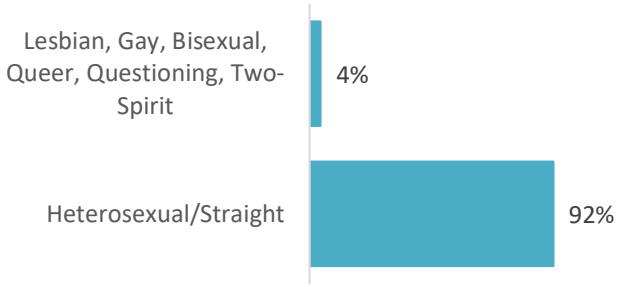
The vast majority of employees are women (82%), while 15% are men. This reflects the ongoing predominance of women in occupations that have been traditionally female-dominated, including public health nurses (the larges occupational group), and other public health professionals, such as dietitians and health promoters. While the survey gave employees the option of identifying as gender diverse, transgender, and Two-Spirit, none identified as such. An additional 3% (6 people) chose not to answer this question.

SEXUAL ORIENTATION

About 4% of respondents indicated that they identify as lesbian, gay, bisexual, queer, questioning, or Two-Spirit, while 92% identify as heterosexual. Four percent of employees chose not to answer this question.

The Census of Canada does not ask questions about sexual orientation.

Sexual Orientation, Permanent Full-Time and Part-Time Employees, Workforce Census.



ADDITIONAL ANALYSIS

Additional analysis of the data shows that:

- 54% of racialized employees had fewer than 5 years of service with the Health Unit, compared with 28% of White employees.
- Racialized employees have a younger age profile than their White counterparts. 38% percent of racialized employees and 19% of White employees are under the age of 35; 51% of racialized employees and 56% of White employees are aged 35 to 54; and 6% of racialized employees and 21% of White employees are aged 55 and older.
- Racialized employees represent 9% of public health nurses, far below their 28% representation among all nurses in Ontario. Furthermore, racialized people represent only 8% of leadership staff.
- While they represent 82% of all employees, women constitute only 64% of those in leadership positions.
- Persons with disabilities are well represented among all occupational groups, other than in leadership positions.
- While racialized employees represent 14% of permanent employees, they represent 27% of temporary and casual employees. They represent 36% of the COVID-19 staff hired and 33% of the administrative and support staff. In addition, 50% of the temporary and casual non-unionized administrative and support staff are racialized.
- All of the equity-seeking groups have a higher representation among casual and temporary employees compared with their representation among the permanent full-time workforce, except persons with disabilities. For Indigenous and racialized employees, their representation in temporary positions is double that of their representation in permanent positions. For those who identify as LGBTQ2S+, their representation is over three times their representation in permanent positions.

RECOMMENDATIONS

Based on these findings, the following recommendations have been made:

Recommendation 1: It is recommended that MLHU continue to work with unions to strengthen protocols to appropriately accommodate employees, which may mean accommodating employees across bargaining units and reviewing existing collective agreement language to addresses this point.

Recommendation 2: It is recommended that the Health Unit continue to provide supervisors and managers with access to training to ensure that they understand their legal obligations and are appropriately accommodating employees with disabilities.

Recommendation 3: It is recommended that MLHU continue to educate employees about mental health, with a focus on reducing stigma around mental health, increasing supports to employees, and equipping managers to support and accommodate employees.

Recommendation 4: It is recommended that the Health Unit undertake intentional and measurable efforts to increase the representation of Indigenous peoples and racialized people in its workforce.

Recommendation 5: It is recommended that MLHU explore the allocation of entry-level positions, including student positions, specifically for Indigenous peoples and racialized people.

Recommendation 6: It is recommended that Employee Resource Groups be created for Indigenous and racialized employees to allow them to provide input into MLHU actions intended to create more diverse and inclusive work environments.

Recommendation 7: It is recommended that the Health Unit ensure that managers are aware of their legal duty to provide religious accommodation to employees and what that means (e.g., time off for religious observance, accommodation of dietary restrictions, shift scheduling, and scheduling of meetings).

Recommendation 8: It is recommended that MLHU continue to offer multifaith prayer spaces and that MLHU conduct a survey of employees to ensure that these spaces are located in areas that are accessible to the employees who need it and that the locations and procedures to access these spaces are communicated to new and existing employees.

Recommendation 9: It is recommended that strategies be developed to create a more welcoming and positive workplace for employees regardless of gender identity and gender expression.

Recommendation 10: It is recommended that MLHU undertake a positive space campaign that includes delivering training and making resources available to assist managers, supervisors, and employees with creating safe and welcoming environments for those who identify as LGBTQ2S+.

Recommendation 11: It is recommended that MLHU focus on hiring more Indigenous and racialized people into positions of public health nurses.

Recommendation 12: It is recommended that MLHU launch a follow-up Workforce Census in 4 to 5 years to determine the success of the implementation of the recommendations outlined in this report and to increase the survey response rates for groups where response rates were low. In this next census, it is also recommended that MLHU adopt outreach strategies to reach the employees who did not respond to the 2021 census.

PART A: INTRODUCTION

1. Background

The Diversity and Inclusion Assessment is a key part of Middlesex-London Health Unit's (MLHU, the Health Unit) ongoing commitment to health equity. The assessment consists of two parts: an Employment Systems Review (ESR) and a Workforce Census. The ESR was completed in early May 2021. The Workforce Census is summarized in this report.

The results of the ESR and Workforce Census will enable MLHU to develop an Equity, Diversity, and Inclusion Action Plan that will not only help to ensure that the employees of the Health Unit better reflect the diverse community served but will also support all employees to contribute their best to the organization.

The goals of the Diversity and Inclusion Assessment are to:

- Understand the composition of the current workforce and how employees self-identify
- Inform the revision, enhancement, and/or development of current and future policies and practices in order to foster an equity-oriented and inclusive workplace culture
- Identify and respond to the experiences and expectations of diverse groups within the workplace with respect to inclusion, access, equity, engagement, and eliminating discriminatory practices
- Inform efforts to further develop an equity-oriented and inclusive workplace culture that prevents and responds to the existence of discrimination and oppression to engage, encourage, and support all employees to realize their full potential in the workplace, and
- Identify potential recommendations to address the identified issues.

Turner Consulting Group Inc. was contracted in December 2018 to conduct this Diversity and Inclusion Assessment. This work was delayed in 2019 because of uncertainty surrounding the potential merging of health units by the provincial government. It was delayed again in early 2020 because of the onset of the COVID-19 pandemic.

The Workforce Census collects specific demographic data on employees to establish a baseline for the diversity of the Health Unit's workforce, compared with the diversity of the community served, and to increase employees' sense of inclusion.

The census will provide the data to support evidence-based decision making. By better understanding who its employees are, the Health Unit will be able to identify gaps in

representation, enabling it to create programs, priorities, and resources to foster the growth of a more diverse workforce and an inclusive workplace for all employees.

Collecting and analyzing data that identifies people on the basis of race, disability, sexual orientation, and other identities is permitted, and in fact encouraged, by the Ontario *Human Rights Code* (the Code). The Ontario Human Rights Commission (OHRC) has found that "data collection can play a useful and often essential role in creating strong human rights and human resources strategies for organizations."[1]

The focus of a workforce census is on assessing the representation of the groups identified by the 1984 Royal Commission on Equality in Employment as experiencing persistent and systemic discrimination in employment, namely women, racialized people (or visible minorities), Indigenous peoples, and persons with disabilities. More recently, members of the LGBTQ2S+[2] community have also been identified as a group that experiences systemic barriers in employment. As such, this group, along with those who practice non-Christian religions, is also included in the equity efforts of many organizations. Employees who belong to these groups are collectively referred to throughout this report as "Indigenous peoples and members of the equity-seeking groups."

The OHRC notes that collecting and analyzing workforce data can be an effective and often essential tool for assessing whether people's rights under the Code are being or might potentially be infringed. Where underrepresentation exists or barriers to hiring and advancement have been identified, organizations have a duty to take corrective action to make sure that the Code is not being breached and will not be breached in the future.[3]

The OHRC requires that the data be collected in a way that follows accepted data collection techniques and abides by privacy and other applicable legislation. The OHRC also requires that the data be collected for a purpose that is consistent with the Code, such as:[4]

- Monitoring and evaluating potential discrimination
- Identifying and removing systemic barriers
- Lessening or preventing disadvantage, and

[1] Ontario Human Rights Commission. (2009, November 26). *Count me in! Collecting human rights-based data*. http://www.ohrc.on.ca/en/count-me-collecting-human-rights-based-data

[2] This is a shortened acronym that incorporates anatomical sex, sexual orientation, and gender identity and is meant to refer to the entire lesbian, gay, bisexual, trans, queer, questioning, intersex, pansexual, Two-Spirit, and asexual communities, otherwise referred to as LGBTQQIP2SAA.

[3] Ontario Human Rights Commission. (2009, November 26). *Count me in! Collecting human rights-based data*. http://www.ohrc.on.ca/en/count-me-collecting-human-rights-based-data/2-when-collecting-data-good-idea

[4] Ibid.

- Promoting substantial equity for people identified by Code grounds.

The key questions to be answered by this Workforce Census are the following:

- What is the current demographic makeup of Health Unit employees?
- What is the representation of employees in various demographic groups, including disability, religion/faith, Indigenous identity, racial identity, gender identity, and sexual orientation?
- How does the diversity of the Health Unit workforce compare with that of the residents living in Middlesex-London?

2. The Demographic Context

Middlesex-London is a growing community, with more people, jobs, and services expected to come to the region in the coming years. This increase has been fueled by rising housing prices in Toronto, with many people moving farther away from the city in search of affordable housing. This growth will be further fuelled by the COVID-19 pandemic, with Toronto experiencing a record population loss as more people move away from the city in response to work-from-home options becoming increasingly available.

Fuelled largely by immigration, Ontario's racialized population is growing at a faster rate than the provincial population and is making up an increasingly larger proportion of the provincial population. The same is true of the racialized population in the Middlesex-London community.

Table 1. Rate of Population Growth, Indigenous, Racialized, and Total Population (2006–2016).

	Indigenous Population			Racialized Population			Total Population	
Year	#	% of Population	Rate of Growth Since 2006	#	% of Population	Rate of Growth Since 2006	#	Rate of Growth Since 2006
ONTARIO								
2006	242,490	1.8%		2,745,200	21%	—	12,851,821	—
2016	374,395	2.8%		3,885,585	29%	42%	13,448,494	5%
MIDDLESEX-LONDON HEALTH UNIT COMMUNITY								
2006	6,580	1.6%	—	48,915	12%	—	422,333	—
2016	11,145	2.4%	69%	76,460	17%	56%	455,526	8%
Source: Statistics Canada, Census of Canada, 2006, 2016.								

As Table 1 shows, between 2006 and 2016 the racialized population in Ontario grew by 42% (from 2,745,200 to 3,885,585), while the population of the province grew by only 5% (from 12,851,821 to 13,448,494). As such, the racialized population increased from 21% of Ontario's population in 2006 to 29% of the provincial population in 2016.

The table also shows that Middlesex-London is growing at a faster rate than the provincial population overall; Middlesex-London grew by 8% between 2006 and 2016, while the provincial population grew by only 5% during this time.

Furthermore, Middlesex-London's racialized population grew by 56%, from 48,915 to 76,460 individuals, growing from 12% of the population in 2006 to 17% in 2016.

During that same period, Middlesex-London's Indigenous population grew by 69%, from 6,580 to 11,145 individuals, increasing from 1.6% of the community to 2.4%.

Because of Statistics Canada's persistent undercounting of the Indigenous population, MLHU also conducted a community-drive survey for Indigenous peoples in London.[5] The Our Health Counts London study found that there are more than twice the number of Indigenous people in London than was estimated by Statistics Canada (22,673 and 29,361).

The Indigenous community has been identified as one of the fastest-growing populations in Canada. Statistics Canada also projects that the racialized population will continue to grow at a faster rate than the general population, resulting in racialized people representing a larger proportion of the population over the coming years. While the growth of the racialized population will be fueled largely by immigration, a growing proportion of racialized people are Canadian-born. In 2011, about 31% of racialized people in Canada were born here.[6]

Statistics Canada projections show that the provincial population will approach 18 million by 2036, with the racialized population increasing to 48% of the population.[7] No projections on the growth of Middlesex-London's racialized population are available.

3. The Workforce Census

3.1 The Survey

This work was led and supported by the Health Equity and Indigenous Reconciliation Team. The Diversity and Inclusion Advisory Committee, consisting of staff from various divisions and levels of the organization, including representatives from both unions, also provided input into the census questions and reviewed and provided input into the draft report.

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[5] Southwest Ontario Aboriginal Health Access Centre. (n.d.). *Our Health Counts London*. https://soahac.on.ca/our-health-counts/

[6] Statistics Canada. (2016, September 15). *Immigration and ethnocultural diversity in Canada*. https://www12.statcan.gc.ca/nhs-enm/2011/as-sa/99-010-x/99-010-x2011001-eng.cfm

[7] Statistics Canada. (2017, January 25). *Immigration and diversity: Population projections for Canada and its regions, 2011 to 2036*. https://www.statcan.gc.ca/pub/91-551-x/91-551-x2017001-eng.htm

The census questions were designed to focus on the groups that experience systemic and persistent disadvantage in the labour market. The questions were designed to allow for a direct comparison of the composition of the Health Unit's workforce to the 2016 Statistics Canada Census data and other relevant data sources.

Additional data on age, length of service, occupation, and type of employment was collected to assist in the analysis of the demographic data and thus identify any barriers to hiring and advancement within the organization.

The survey consisted of 13 questions and took respondents less than 10 minutes to complete. The completion of the Workforce Census was voluntary, and participants could choose not to participate in the census in its entirety. If they chose to participate in the census, they were able to opt out of answering any of the questions by selecting the response "I prefer not to answer." Employees were also able to exit the survey at any time.

3.2 Privacy Protections

An online survey service provider (Survey Monkey) was used to host the online census and capture the data. Survey Monkey encrypts all data in transit and provides a high level of security for the storage of the data. Furthermore, only authorized employees from Turner Consulting Group Inc. were able to access the data on password-protected computers.

Additional steps also have been taken to ensure that individual employees cannot be identified in this report. First, smaller work units have been grouped with other units. Where fewer than 10 employees identified as belonging to a particular identity group, the data has been grouped with other categories. For example, because a small number of people responded that they practise various non-Christian faiths such as Bahá'í, Buddhism, Hinduism, Indigenous spirituality, Islam, Judaism, or Sikhism, they have been grouped into one category.

3.3 Administration of the Survey

A high survey response rate is critical to painting an accurate picture of the diversity of the workforce — the more employees who complete the survey, the more accurate the snapshot will be.

Key to a high survey response rate is how the survey is administered. The goal of the survey administration strategy is to ensure that all employees know about and are able to complete the survey. Critical to achieving this goal is a communications strategy that informs all employees about the census, addresses their concerns, and encourages them to participate in this important organizational initiative. As such, a communications strategy

was developed to ensure that all MLHU employees were informed about the census prior to its launch and could have their questions about the census answered.

Employees were informed about the census using various communication tools before and after the launch of the census. Emails were sent to all staff to introduce the census, and reminder emails were sent to encourage them to complete the census. The census was announced through an email sent by the Chief Nursing Officer. One reminder was email sent by the Medical Officer of Health and another by the Chief Nursing Officer. The Manager, Health Equity and Indigenous Reconciliation also sent emails to the managers to remind them to encourage participation within their teams. In addition, two townhall meetings were used to remind staff of the census. The consultant attended one of the townhall meetings to provide staff with an overview presentation of the census.

The emails also provided staff with the link to the Diversity and Inclusion Assessment website, hosted by the consultant, which provided further information on the census, answered frequently asked questions, and provided information on how employee privacy and confidentiality would be maintained.

In addition, posters were printed and distributed for display at MLHU's primary offices to announce the census initiative, the date of the census, and the website employees could visit for further information. As nearly all employees were working from home because of the pandemic, electronic communication was prioritized.

Census Week was designated as April 23 to 30, 2021. On that day, an email was sent from the Chief Nursing Officer, and the lead of this project, to all employees with a link to the online survey. Staff were also given time at the weekly townhall meeting on both April 23 and 30 to complete the census.

3.4 Analyzing the Data

Preparation and analysis of the data occurred in three stages: data vetting, data entry, and data analysis.

Data vetting and recoding are important steps that ensure that the data collected through the census can be analyzed. Data vetting involved reviewing answers to the census questions and ensuring that the information provided was sufficiently accurate. If someone wrote in a response to a question that fit into a preestablished category, the answer was recoded into the correct category. For example, if they wrote in "Catholic" in response to the question about faith or religion, the answer was categorized as Christian.

The goal of the census was to identify areas of underrepresentation for Indigenous peoples and members of the equity-seeking groups and any potential barriers to their hiring and advancement. As such, areas of underrepresentation are identified and recommendations made for where the Health Unit should focus its attention. However, the recommended actions have not been prioritized in this report. Instead, MLHU should consider the recommendations from this report and those in the ESR report, along with available resources, related activities, and strategies, in order to prioritize them and develop an implementation plan. So, while the consultants have analyzed the data to identify what the issues are and how they can be addressed, it is up to MLHU to determine the specific actions to be taken and when these actions will be implemented.

In our analysis, we also comment on the proportion of survey respondents who chose not to answer a particular question. These responses give potential insight into the perspectives of those with marginalized versus dominant identities. First, those with marginalized identities may have chosen not to answer particular questions because of fear of disclosure. In this context, marginalized identities can include those with hidden identities, such as people who identify as LGBTQ2S+, have a non-evident disability, identify as Indigenous, or practise a non-Christian religion. They may choose not to self-identify as belonging to a particular group out of fear that disclosure could have negative repercussions on their current and future job prospects within the organization.

In addition, employees may be part of the dominant group and may have misunderstandings about the purpose of the census (e.g., I'm going to lose my job if I don't identify with a marginalized identity). They may also feel offended that they are asked to identify their race, gender identity, sexual orientation, and so on. As such, high rates of refusing to answer particular questions are noted, as this information provides the Health Unit with insight as to where additional education about workplace equity, diversity, and inclusion may be needed.

3.5 Retaining the Data

This survey represents a snapshot of the composition of the organization as of April 2021. The database will be retained by Turner Consulting Group for 1 year following the completion of this report, which gives the Health Unit the opportunity to request any additional analyses of the data. At the end of the 1-year period, the database will be deleted.

4. Survey and Response Rates

4.1 Survey Rate

Section A of the Workforce Census asked employees whether they wished to participate in the census. If they chose not to participate, employees were given the opportunity to share why.

While participating in the survey was voluntary, all employees were asked to complete this section of the census to allow MLHU to determine the extent to which all employees received the census and were provided with the opportunity to complete it. This question also provides an opportunity to better understand why employees might have chosen not to participate in the census.

The survey rate represents the number of employees who confirmed that they received the survey, whether or not they completed it. The goal was to achieve a survey rate of 100%, meaning that all employees knew about and indicated that they had the opportunity to complete the survey. Unfortunately, we are unable to account for the employees who received the survey, chose not to participate, but also chose not to return the paper survey or chose not to indicate their non-participation on the online survey.

The formula for calculating the survey rate is as follows:

$$\text{Survey rate} = \frac{\text{Number of employees that completed Section A whether or not they participated in the census}}{\text{Total number of MLHU employees}} \times 100$$

The survey was administered to all Health Unit employees. Of the Health Unit's total of 671 permanent, temporary, and casual employees, 493 indicated that they received and were given the opportunity to participate in the census. This is a survey rate of 73%. Of those who received the survey, 6 (1%) indicated that they did not want to participate.

4.2 Response Rate

The response rate is the proportion of employees who chose to participate in the survey by answering at least one of the questions. The Canadian Human Rights Commission has identified that a survey response rate of 80% provides a more accurate reflection of the composition of an organization's workforce.

The response rate was calculated as follows:

$$\text{Response rate} = \frac{\text{Number of employees who participated in the survey by answering at least one question}}{\text{Total number of MLHU employees}} \times 100$$

As Table 2 shows, the response rate for Health Unit employees varies greatly by employment type, from a low of 21% for permanent casual employees to a high of 86% for permanent full-time employees.

Table 2. Response Rate by Employment Type, Workforce Census.

Employment Type	Total Employees #	Survey Respondents #	Response Rate %
Permanent full-time	236	204	86%
Permanent part-time	23	14	61%
Permanent casual	19	4	21%
Temporary (full-time, part-time, casual, and student or volunteer)	393	223	57%
Prefer not to respond	—	4	—
TOTAL	**671**	**449**	**67%**

The differences in response rate by employment type reflect the fact that some groups of employees are inherently harder to communicate with and engage, including employees who don't have daily access to a computer as well as casual employees who may only work a few hours a week.

Given the low response rate for permanent casual and temporary employees, the focus of this analysis is the permanent full-time and part-time employees, who had an overall response rate of 84%.

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PART B: SUMMARY OF THE DATA

5. Demographic Overview

5.1 Disability

The Workforce Census asked employees to identify whether they have a disability, and if so, to specify the type of disability.

The survey described a person with a disability as someone with a long-term or recurring physical, mental, sensory, psychiatric, or learning challenge. Examples of disabilities include:

- Learning disability (e.g., dyslexia, ADHD, etc.)
- Mental health disability (e.g., depression, bipolar, anxiety, PTSD, etc.)
- Physical disability or health condition (e.g., vision loss (uncorrected by glasses), hearing loss (uncorrected by a hearing aid), speech difficulties, mobility issues, chronic pain, epilepsy, amputation, multiple sclerosis, etc.)
- Developmental disability (e.g., autism spectrum disorder, brain injury, cerebral palsy, spina bifida, etc.), and
- Any other disability affecting the ability to work and/or to perform activities of daily living.

As shown in Table 3, 20% of survey respondents reported having a disability, while 75% reported that they do not and 5% chose not to answer this question.

Table 3. Persons with Disabilities, Permanent Full-Time and Part-Time Employees, Workforce Census.

	Permanent Full-Time and Part-Time Employees	
	#	%
Person with a disability	43	20%
Person without a disability	163	75%
Prefer not to answer	10	5%
TOTAL	**216**	**100%**

The 2017 Canadian Survey on Disability (CSD) is a national survey of Canadians aged 15 and over whose everyday activities are limited because of a long-term condition or health-related problem.[8] The CSD provides comprehensive data on persons with disabilities, including information on disability types and severity, employment profiles, income,

[8] 2016 Statistics Canada Census data on disability is not available, as this question is not asked in the Census. Instead, special surveys are conducted periodically to assess the extent to which Canadians experience disability.

education, and other disability-specific information. The CSD definition of disability includes anyone who reported being limited in their daily activities owing to a long-term condition or health problem.[9] The CSD provides data at the national and provincial levels, but not at the city level. As such, data specific to the prevalence of disability in the Middlesex-London population is not available.

The CSD found that 20% of Ontario's working-age population (25 to 64 years) reported having a disability.[10] As such, the proportion of survey respondents with a disability (20%) is comparable to the proportion within the provincial working-age population.

Individuals who identified that they had a disability were then asked to specify the type of disability. As employees may have more than one disability, survey respondents were able to check all that apply.

Employees' responses indicate that mental health and physical disabilities are the most common type of disability experienced by MLHU employees — 12% reported a mental health disability, while 9% of survey respondents reported having a physical disability or health condition. In addition, about 3% of all survey respondents reported having a learning, developmental, or other type of disability.

Table 4. Persons with Disabilities, Type of Disability, Permanent Full-Time and Part-Time Employees, Workforce Census.

Type of Disability	Permanent Full-Time and Part-Time Employees	
	#	%*
Mental health disability	25	12%
Physical disability or health condition	19	9%
Learning, developmental, and other disabilities	7	3%
Prefer not to answer	1	0.5%
Total reporting a disability	**43**	**20%**
TOTAL	**216**	**—**
*Individual percentages add up to more than 21% owing to multiple responses.		

Implications and Recommendations

With 20% of survey respondents reporting some form of disability, the Health Unit must ensure that both managers and employees understand MLHU's legal obligation to provide accommodation under the Ontario *Human Rights Code.* It is also important to ensure that unions are aware of their obligations, as they have a duty to assist in an employer's

[9] Morris, S., Fawcett, G., Brisebois, & Hughes, J. (2018, November 28). *A demographic, employment and income profile of Canadians with disabilities aged 15 years and over, 2017.* Statistics Canada. https://www150.statcan.gc.ca/n1/pub/89-654-x/89-654-x2018002-eng.htm

[10] Statistics Canada. (2012). *Canadian* Survey *on Disability, 2012*. http://www.statcan.gc.ca/pub/89-654-x/89-654-x2015001-eng.htm

attempts to accommodate employees. Case law has made it clear that when an employee is unable to fulfill the duties of their position, the search for alternatives must be extensive, including, as a last resort, looking for accommodation outside the bargaining unit. The Supreme Court of Canada has held that a union has a duty to cooperate with an employer's accommodation attempts, even if it means going outside the terms of the collective agreement.[11]

In addition, with reports of mental health disability outnumbering those of physical disability, the Health Unit may want to consider strengthening efforts to reduce stigma around mental health, increasing supports to employees, equipping managers to support employees, and creating a more welcoming and inclusive work environment.

Recommendation 1: It is recommended that MLHU continue to work with unions to strengthen protocols to appropriately accommodate employees, which may mean accommodating employees across bargaining units and reviewing existing collective agreement language to address this point.

Recommendation 2: It is recommended that the Health Unit continue to provide supervisors and managers with access to training to ensure that they understand their legal obligations and are appropriately accommodating employees with disabilities.

Recommendation 3: It is recommended that MLHU continue to educate employees on mental health, with a focus on reducing stigma around mental health, increasing supports to employees, and equipping managers to support and accommodate employees.

5.2 Indigeneity and Racial Identity

The survey asked employees to respond to two questions about whether they identify as being of North American Indigenous ancestry and the race with which they identify, regardless of place of birth or ethnicity.

Table 5 provides the responses in the categories of North American Indigenous, White/European, and racialized. Because of their small numbers, the racial subgroups have been grouped together under the category of racialized.

[11] Anand, G. (n.d.). *The boundaries of the duty to accommodate: How far does an employer have to go?* Canadian Association of Counsel to Employers. CACE 5th Annual Conference. https://businessdocbox.com/Human_Resources/69589195-By-gita-anand-miller-thomson-llp-with-the-assistance-of-adrienne-campbell.html

Table 5. Indigenous and Racialized Population, Permanent Full-Time and Part-Time Employees, Workforce Census.			
	Permanent Full-Time and Part-Time Employees		Middlesex-London Health Unit (2016 Census) [12]
	#	%	%
North American Indigenous	<5	<2%	2.4%
White/European	177	82%	80%
Racialized	31	14%	17%
Prefer not to answer	4	2%	—
TOTAL	**216**	**100%**	**100%**

Compared with their representation in the population of Middlesex-London, Indigenous peoples are slightly underrepresented in the MLHU workforce — fewer than 2% of employees who responded to the survey identify as Indigenous compared with 2.4% of the residents of Middlesex-London.

Similarly, racialized people are underrepresented in the MLHU workforce — 14% of survey respondents identified as racialized, compared with 17% of the residents of Middlesex-London. This is a gap of 6 individuals.

By contrast, 82% of survey respondents identified as White, which is slightly higher than their representation of 80% of the residents of Middlesex-London.

Implications and Recommendations

This data shows that MLHU needs to do more to increase the representation of Indigenous and racialized employees to reflect the diversity in the community served.

Recommendation 4: It is recommended that the Health Unit undertake intentional and measurable efforts to increase the representation of Indigenous peoples and racialized people in its workforce.

Recommendation 5: It is recommended that MLHU explore the allocation of entry-level positions, including student positions, specifically for Indigenous peoples and racialized people.

Recommendation 6: It is recommended that Employee Resource Groups be created for Indigenous and racialized employees to provide input into MLHU actions intended to create more diverse and inclusive work environments.

[12] Statistics Canada. (2016). *Community profile*.

5.3 Religion/Faith

The Workforce Census asked MLHU employees to identify which faith, religion, or belief group they identify with.

Table 6. Religion or Faith Group, Permanent Full-Time and Part-Time Employees, Workforce Census.

	Permanent Full-Time and Part-Time Employees		Middlesex-London Health Unit (2011 National Household Survey) [13]
Religion/Faith Group	**#**	**%**	**%**
Atheism / Agnosticism / No religious affiliation	61	28%	30%
Christianity	129	60%	64%
Non-Christian faiths, including Bahá'í, Buddhism, Hinduism, Indigenous spirituality, Islam, Judaism, or Sikhism	14	7%	6%
Prefer not to answer	11	5%	—
TOTAL	**215**	**100%**	**100%**

Compared with the religious diversity of Middlesex-London, a similar proportion of MLHU employees reported being atheist, agnostic, or having no religious affiliation (28% of survey respondents versus 30%). A slightly smaller proportion (60%) of MLHU employees reported being affiliated with Christianity compared with the proportion of Middlesex-London residents who identified that way (64%). A similarly small proportion (7%) of MLHU employees identified with a non-Christian religion (e.g., Bahá'í, Buddhism, Hinduism, Indigenous spirituality, Islam, Judaism, or Sikhism) compared with the proportion of the community served that identified that way (6%).

Of all the demographic questions, this question had the highest non-response rate — 5% of survey respondents chose not to identity their religion or faith.

Implications and Recommendations

In 2011,[14] most Canadians reported some religious affiliation. However, over time, the Census shows that there have been dramatic changes to the religious affiliation reported

[13] Statistics Canada. (2011). *Community profile*. https://www12.statcan.gc.ca/nhs-enm/2011/dp-pd/prof/details/page.cfm?Lang=E&Geo1=HR&Code1=3544&Data=Count&SearchText=middlesex&SearchType=Begins&SearchPR=01&A1=All&B1=All&Custom=&TABID=1

2011 National Household Survey data is used here, as religion is asked on the Canadian Census every 10 years. As such, data from the 2016 Census is not available. Note also that in 2011 the Government of Canada replaced the Census with a National Household Survey. The Census was reinstated for 2016.

[14] The Census asks questions on religion every 10 years. As such, the 2011 National Household Survey provides the most recent data available.

as well as an increase in the proportion of the population that reports no religious affiliation. Immigration continues to gradually change the religious diversity within Canada. As the country of origin of immigrants has shifted, so too has the religious composition of the Canadian population.

As such, the trend toward increasing religious diversity will continue for decades to come. While data specific to the Middlesex-London community is not available, Statistics Canada projections show that the proportion of people who report having no religion will increase to 35% in 2036, while the proportion of those affiliated with non-Christian religions could almost double by 2036 to between 13% and 16% of Canada's population.[15] Muslims are expected to make up half of this group.

The Census data shows that most residents of Middlesex-London (64%) are affiliated with Christianity. The number of residents who belong to other religions — including Bahá'í, Buddhism, Hinduism, Indigenous spirituality, Islam, Judaism, or Sikhism — is growing. Collectively, these religious groups account for more than 1 in 10 Canadians (11%) as of 2011, up from 4% in 1981.[16] In Middlesex-London, residents who reported an affiliation with a non-Christian faith represented 6% of the population.

The Census also shows an increase in the number of people who reported that they have no religious affiliation. Before 1971, fewer than 1% of Canadians reported no religious affiliation. In the 2011 National Household Survey, 30% of Middlesex-London residents reported no religious affiliation. It should be noted that those who reported no religious affiliation are not necessarily absent of spiritual beliefs. Instead, they may not identify with a particular religious group. In fact, 80% of Canadians say that they believe in God.[17]

The growing number of employees who report being affiliated with non-Christian religions raises the need for the Health Unit to ensure that religious accommodation is provided, which goes beyond the policy of giving days off for religious observance to include dress, prayer space, and adjusted shifts.

Recommendation 7: It is recommended that the Health Unit ensure that managers are aware of their legal duty to provide religious accommodation to employees and what that

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[15] Morency, J., Malenfant, E. C., & MacIsaac. (2017, January 25). *Immigration and diversity: Population projections for Canada and its regions, 2011 to 2036.* https://www150.statcan.gc.ca/n1/pub/91-551-x/91-551-x2017001-eng.htm

[16] Pew Research Center. (2013, June 27). *Canada's changing religious landscape.* http://www.pewforum.org/2013/06/27/canadas-changing-religious-landscape/

[17] Baha, S. A. (2015). The spirituality of atheist and "no religion" individuals in the millennial generation: Developing new research approaches for a new form of spirituality. *The Arbutus Review*, *6*(1): 63–75.

means (e.g., time off for religious observance, accommodation of dietary restrictions, shift scheduling, and scheduling of meetings).

Recommendation 8: It is recommended that MLHU continue to offer multifaith prayer spaces and that MLHU conduct a survey of employees to ensure that these spaces are located in areas that are accessible to the employees who need it and that the locations and procedures to access these spaces are communicated to new and existing employees.

5.4 Gender / Gender Identity

The Workforce Census asked employees to identify their gender identity. Gender identity is a person's internal and individual experience of gender, which may not correspond to their biological sex assigned at birth.

As Table 7 shows, the vast majority of employees are women (82%), while 15% are men. This reflects the ongoing predominance of women in occupations that are traditionally female-dominated, including public health nurses (the larges occupational group) and other public health professionals, such as dietitians and health promoters.

Table 7. Gender / Gender Identity, Permanent Full-Time and Part-Time Employees, Workforce Census.

	Permanent Full-Time and Part-Time Employees		Middlesex-London Health Unit (2016 Census)[18]
Gender	**#**	**%**	**%**
Woman	176	82%	51%
Man	32	15%	49%
Gender Diverse / Transgender / Two-Spirit	—	—	—
Prefer not to answer	6	3%	—
TOTAL	**214**	**100%**	**—**

While the survey gave employees the option of identifying as gender diverse, transgender, and Two-Spirit, none identified as such. An additional 3% (6 people) chose not to answer this question.

While the 2016 Census of Canada collected data on gender, it did not allow Canadians to identify a gender other than "woman" or "man." As such, no Census data is available on Canadians who identify as gender diverse or transgender.[19]

[18] Statistics Canada. (2016). *Community profile*.

[19] The 2021 Census will be the first time that transgender Canadians are counted.

Implications and Recommendations

While no survey respondents reported that they identify as gender diverse, transgender, or Two-Spirit, it is important to ensure that the workplace is welcoming and inclusive of existing employees who identify this way and simply chose not to self-identify on the survey, as well as future gender-diverse employees.

Recommendation 9: It is recommended that strategies be developed to create a more welcoming and positive workplace for employees regardless of gender identity and gender expression.

5.5 Sexual Orientation

The census asked employees to identify their sexual orientation. It provided the options of bisexual, gay, heterosexual/straight, lesbian, queer, questioning, and Two-Spirit. If a survey respondent did not identify with one of these sexual orientations, employees were able to write in their sexual orientation.

Table 8. Sexual Orientation, Permanent Full-Time and Part-Time Employees, Workforce Census.

	Permanent Full-Time and Part-Time Employees	
Sexual Orientation	**#**	**%**
Lesbian, Gay, Bisexual, Queer, Questioning, Two-Spirit	9	4%
Heterosexual/Straight	196	92%
Prefer not to answer	9	4%
TOTAL	**214**	**100%**

Because the number of people who reported that they identify as lesbian, gay, bisexual, queer, questioning, or Two-Spirit was small, their responses are grouped into one category. About 4% of respondents indicated that they identify as lesbian, gay, bisexual, queer, questioning, or Two-Spirit, while 92% identify as heterosexual. Four percent of employees chose not to answer this question.

The Census of Canada does not ask questions about sexual orientation. As such, we must rely on other population surveys for an estimate of the LGBTQ2S+ population. One estimate comes from the 2014 Canadian Community Health Survey (CCHS), which was the first Statistics Canada survey to include a question on sexual orientation.[20] The CCHS found that 3% of Canadians aged 18 to 59 self-identified as gay, lesbian, or bisexual (1.7% self-identified as gay or lesbian and 1.3% as bisexual).[21] This survey also employed a conservative approach to measuring sexual orientation, asking only whether a person was

[20] This survey resulted in limited provincial estimates and does not provide estimates for cities.

[21] Statistics Canada. (2015). *Canadian Community Health Survey, 2014*. https://www.statcan.gc.ca/eng/dai/smr08/2015/smr08_203_2015

gay, lesbian, or bisexual. Therefore, it likely underestimates the representation of those who do not identify as heterosexual.

Another estimate of the size of the LGBTQ2S+ population comes from a 2012 Forum Research poll, which found that 5% of Canadians aged 18 and over identify as lesbian, gay, bisexual, or transgender.[22] Again, given the limited categories, this poll likely also underestimates the representation of those who do not identify as heterosexual.

Studies in other countries, which worded questions differently, estimate a gay, lesbian, and bisexual population of between 1.5% and 7%.[23] One 2011 study found that approximately 3.5% of the U.S. population is gay, lesbian, or bisexual and 0.3% is transgender.[24]

Using these estimates, survey respondents who identify as LGBTQ2S+ appear to be well represented in the MLHU workforce.

Implications and Recommendations

Given that the question on sexual orientation had one of the highest non-response rates (4%), there may be employees who either don't feel safe disclosing their identity or who are heterosexual and don't feel comfortable answering this question.

Recommendation 10: It is recommended that MLHU undertake a positive space campaign that includes delivering training and making resources available to assist managers, supervisors, and employees with creating safe and welcoming environments for those who identify as LGBTQ2S+.

6. Additional Analysis

6.1 Age and Years of Service of Racialized and White Employees

Graph 1 compares the years of service of racialized and White employees.

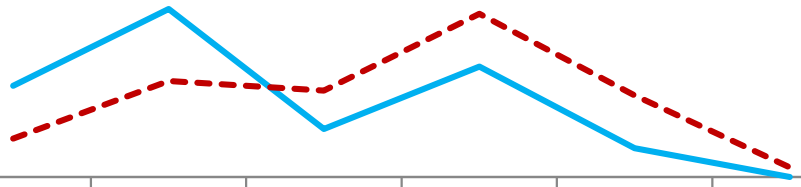
The data shows that 54% of racialized employees had fewer than 5 years of service with the Health Unit, compared with 28% of White employees. This data suggests that increased hiring of racialized employees took place in the past 5 years. It may also indicate that racialized staff hired more than 5 years ago have not remained with the organization.

[22] Carlson, K. B. (2012, July 6). The true north LGBT: New poll reveals landscape of gay Canada. *National Post*. http://news.nationalpost.com/news/canada/the-true-north-lgbt-new-poll-reveals-landscape-of-gay-canada

[23] Rogers, S. (2010). *Gay Britain: Inside the ONS statistics.* The Guardian, DataBlog. http://www.guardian.co.uk/news/datablog/2010/sep/23/gay-britain-ons

[24] Gates, Gary J. (2011). *How many people are lesbian, gay, bisexual, and transgender?* The Williams Institute. https://www.schoolnewsnetwork.org/attachments/Gates-How-Many-People-LGBT-Apr-2011.pdf

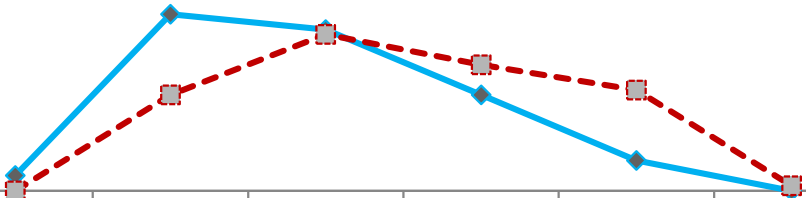
Graph 1. Years of Service, Racialized and White Employees, Permanent Full-Time and Part-Time Employees, Workforce Census.



	Less than 1 year	1 to 5 years	6 to 10 years	11 to 20 years	21 to 30 years	30+
Racialized employees	19%	35%	10%	23%	6%	0%
White employees	8%	20%	18%	34%	17%	2%

Graph 2 shows that racialized employees have a younger age profile than their White counterparts. Thirty-eight percent of racialized employees and 19% of White employees are under the age of 35; 51% of racialized employees and 56% of White employees are aged 35 to 54; and 6% of racialized employees and 21% of White employees are aged 55 and older.

Graph 2. Age, Racialized and White Employees, Permanent Full-Time and Part-Time Employees, Workforce Census.



	Under 24	25 to 34	35 to 44	45 to 54	55 to 64	65+
Racialized employees	3%	35%	32%	19%	6%	0%
White employees	0%	19%	31%	25%	20%	1%

The data suggests that while the Health Unit has been doing more to hire racialized employees in the past 5 years, more needs to be done to increase the representation of racialized people in the MLHU workforce to better reflect the population served. Furthermore, MLHU needs to ensure that it creates work environments that are inclusive, respectful, and responsive to the needs of people from diverse backgrounds. This will ensure that MLHU not only recruits employees from diverse backgrounds, but also retains them.

6.2 Occupation

Also important to this analysis is the diversity within the various occupational groups.

Table 9. Representation of the Equity-Seeking Groups by Occupation, Permanent Full-Time and Part-Time Employees, Workforce Census.

	Women	Racialized People	LGBTQ2S+	Persons with Disabilities
Public Health Program Staff: Public Health Nurse, Community Health Nursing Specialist, Immunizer (nurse)	99%	9%	6%	23%
Public Health Program Staff: Dental Assistant, Dental Hygienist, Dietitian, Epidemiologist, Program Evaluator, Family Home Visitor, Health Promoter, Public Health Inspector, Tobacco Enforcement Officer, Test Shopper, Vector-Borne Disease Coordinator and/or Field Technician, Librarian, Outreach Worker, Physician	75%	20%	3%	20%
Public Health Program Staff:* Contact Tracer, Contact Tracer Lead, Case Investigator Lead, Immunizer (non-nurse), Screener, Greeter/Navigator, Reconstitutioner, Post-Vaccination Staff	—	—	—	—
Administrative and Support Staff: Administrative Assistant, Data Analyst, Clinical Team Assistant, Program Assistant, IT staff (e.g., Network / Telecommunications Analyst, Desktop / Applications Analyst), Corporate Trainer, Online Communications Coordinator, Client Service Representative, Receiving and Operations Coordinator, Marketing Coordinator	76%	21%	—	24%
Administrative and Support Staff: Finance Staff, Non-Union Human Resource Staff, Executive Assistant, Senior Executive Assistant	83%	—	—	25%
Leadership Staff: Chief Executive Officer, Medical Officer of Health, Associate Medical Officer of Health, Chief Nursing Officer, Director, Senior Manager, Manager, Supervisor	64%	8%	—	11%
	82%	**14%**	**3%**	**20%**

*Only a small number of permanent employees indicated that they work in this occupational group. As such, no analysis has been conducted for this occupational group.

Among permanent employees, women represent nearly all nurses and a smaller proportion of the other occupational groups. Most notable is that while they represent 82% of all employees, women constitute only 64% of those in leadership positions.

Racialized employees represent 14% of all employees; they make up 20% of non-nursing public health program staff and 21% of unionized administrative and support staff. However, they represent only 9% of public health nurses. This is far below their 28% representation among all nurses in Ontario. Furthermore, racialized people represent only 8% of leadership staff.

Those who identify as LGBTQ2S+ appear to be employed only among permanent public health staff.

Persons with disabilities are well represented among all occupational groups, other than leadership positions. While it is unknown what contributes to this high representation in these occupations, job demands that lead to illness or injury may be a contributor. Additionally, while it is also unknown why there is low representation in leadership positions, the current societal model of leadership, which does not lend itself to accommodations, may be a contributor.

Because of the small number of Indigenous employees, they have not been included in this analysis by occupation.

Recommendation 11: It is recommended that MLHU focus on hiring more Indigenous and racialized people into public health nurse positions.

Table 9. Representation of the Equity-Seeking Groups by Occupation, Temporary and Casual Employees, Workforce Census.				
	Women	**Racialized People**	**LGBTQ2S+**	**Persons with Disabilities**
Public Health Program Staff: Public Health Nurse, Community Health Nursing Specialist, Immunizer (nurse)	93%	9%	7%	17%
Public Health Program Staff: Dental Assistant, Dental Hygienist, Dietitian, Epidemiologist, Program Evaluator, Family Home Visitor, Health Promoter, Public Health Inspector, Tobacco Enforcement Officer, Test Shopper, Vector-Borne Disease Coordinator and/or Field Technician, Librarian, Outreach Worker, Physician	75%	8%	8%	8%
Public Health Program Staff: Contact Tracer, Contact Tracer Lead, Case Investigator Lead, Immunizer (non-nurse), Screener, Greeter/Navigator, Reconstitutioner, Post-Vaccination Staff	73%	36%	8%	10%
Administrative and Support Staff: Administrative Assistant, Data Analyst, Clinical Team Assistant, Program Assistant, IT staff (e.g., Network / Telecommunications Analyst, Desktop / Applications Analyst), Corporate Trainer, Online Communications Coordinator, Client Service Representative, Receiving and Operations Coordinator, Marketing Coordinator	83%	33%	10%	14%
Administrative and Support Staff: Finance Staff, Non-Union Human Resource Staff, Executive Assistant, Senior Executive Assistant	75%	50%	17%	—
Leadership Staff: Chief Executive Officer, Medical Officer of Health, Associate Medical Officer of Health, Chief Nursing Officer, Director, Senior Manager, Manager, Supervisor	—	—	—	—
	69%	**27%**	**11%**	**13%**

Women constitute 69% of temporary and casual employees, 93% of public health nurses, and a smaller proportion of those in the other occupational groups.

While racialized employees represent 14% of permanent employees, they represent 27% of temporary and casual employees. They represent only 9% of public health nurses and 8% of other public health program staff. However, they represent 36% of the COVID-19 staff hired and 33% of the administrative and support staff. In addition, 50% of the temporary and casual non-unionized administrative and support staff are racialized.

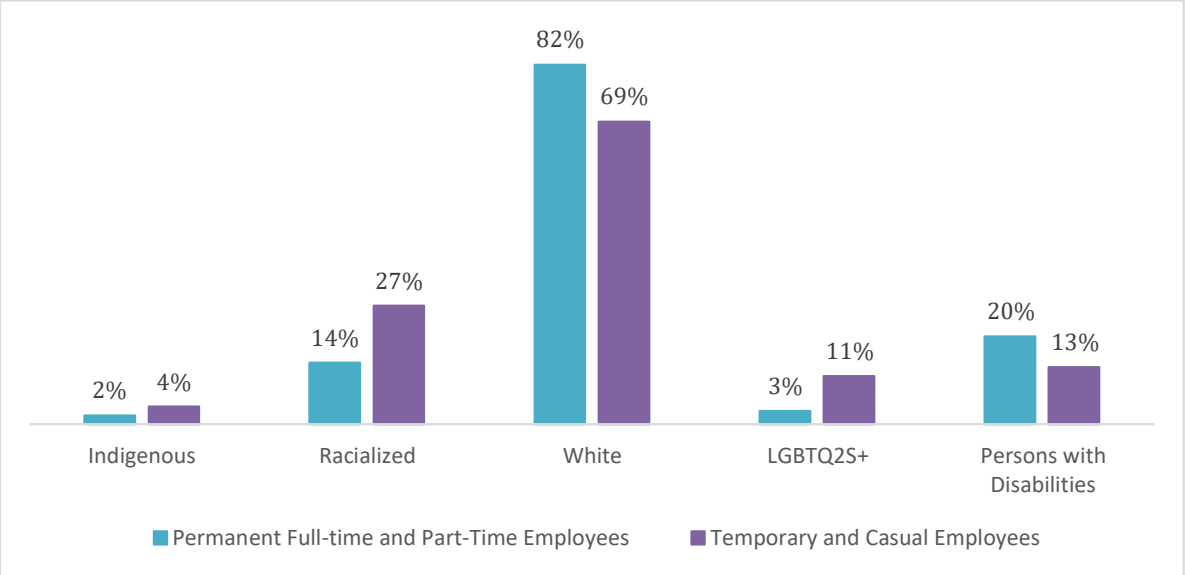
Among temporary and casual employees, those who identify as LGBTQ2S+ are better represented among all occupational groups (other than leadership staff).

A smaller proportion of persons with disabilities are employed on a temporary and casual basis (13%) than among permanent positions (20%); their representation is also lower in each occupational group for those who are temporary and casual as opposed to permanent employees.

6.3 Casual and Temporary Employees

Another important area of consideration is the overall increase in precarious employment in the labour market, with racialized people and Indigenous peoples less likely to be employed in full-time permanent positions. Their White counterparts therefore have a higher representation among permanent employees than among temporary and casual employees. In addition, those who identify as LGBTQ2S+ are also more likely to be employed on a temporary and casual basis.

Graph 3. Permanent Full-Time and Part-Time Versus Temporary Employees, Workforce Census.



Graph 3 compares the representation of various groups within casual, occasional, and temporary positions (both full time and part-time) relative to their representation among permanent employees. As the data shows, all the equity-seeking groups have a higher representation among casual and temporary employees than among the permanent full-time workforce, except persons with disabilities. For Indigenous and racialized employees, their representation in temporary positions is double that of their representation in

permanent positions. For those who identify as LGBTQ2S+, their representation is over three times their representation in permanent positions.

This data shows that the Health Unit has done a good job of hiring from a diverse pool of talent for a range of temporary and casual positions. While contract employment can lead to more stable employment, members of these groups tend to face barriers to moving into permanent positions.

Additional Recommendations

In addition to the recommendations made throughout this report, the following recommendation is made.

Recommendation 12: It is recommended that MLHU launch a follow-up Workforce Census in 4 to 5 years to determine the success of the implementation of the recommendations outlined in this report and to increase the survey response rates for groups where response rates were low. In this next census, it is also recommended that MLHU adopt outreach strategies to reach the employees who did not respond to the 2021 census.

MLHU Workforce Census 2021
RECOMMENDATIONS

Based on these findings, the following recommendations have been made:

Recommendation 1: It is recommended that MLHU continue to work with unions to strengthen protocols to appropriately accommodate employees, which may mean accommodating employees across bargaining units and reviewing existing collective agreement language to addresses this point.

Recommendation 2: It is recommended that the Health Unit continue to provide supervisors and managers with access to training to ensure that they understand their legal obligations and are appropriately accommodating employees with disabilities.

Recommendation 3: It is recommended that MLHU continue to educate employees about mental health, with a focus on reducing stigma around mental health, increasing supports to employees, and equipping managers to support and accommodate employees.

Recommendation 4: It is recommended that the Health Unit undertake intentional and measurable efforts to increase the representation of Indigenous peoples and racialized people in its workforce.

Recommendation 5: It is recommended that MLHU explore the allocation of entry-level positions, including student positions, specifically for Indigenous peoples and racialized people.

Recommendation 6: It is recommended that Employee Resource Groups be created for Indigenous and racialized employees to allow them to provide input into MLHU actions intended to create more diverse and inclusive work environments.

Recommendation 7: It is recommended that the Health Unit ensure that managers are aware of their legal duty to provide religious accommodation to employees and what that means (e.g., time off for religious observance, accommodation of dietary restrictions, shift scheduling, and scheduling of meetings).

Recommendation 8: It is recommended that MLHU continue to offer multifaith prayer spaces and that MLHU conduct a survey of employees to ensure that these spaces are located in areas that are accessible to the employees who need it and that the locations and procedures to access these spaces are communicated to new and existing employees.

Recommendation 9: It is recommended that strategies be developed to create a more welcoming and positive workplace for employees regardless of gender identity and gender expression.

Recommendation 10: It is recommended that MLHU undertake a positive space campaign that includes delivering training and making resources available to assist managers, supervisors, and employees with creating safe and welcoming environments for those who identify as LGBTQ2S+.

Recommendation 11: It is recommended that MLHU focus on hiring more Indigenous and racialized people into positions of public health nurses.

Recommendation 12: It is recommended that MLHU launch a follow-up Workforce Census in 4 to 5 years to determine the success of the implementation of the recommendations outlined in this report and to increase the survey response rates for groups where response rates were low. In this next census, it is also recommended that MLHU adopt outreach strategies to reach the employees who did not respond to the 2021 census.

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 41-21

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2021 September 16

MEDICAL OFFICER OF HEALTH ACTIVITY REPORT FOR AUGUST AND SEPTEMBER

Recommendation

It is recommended that the Board of Health receive Report No. 41-21 re: "Medical Officer of Health Activity Report for August and September" for information.

The following report presents activities of the Medical Officer of Health (MOH) for the period of July 1 – September 1, 2021.

To respond to the COVID pandemic, increased meetings and webinars were necessary to keep up with the ever-changing landscape. The MOH continued to participate in external and internal pandemic-related meetings. These included calls daily, every other day, or weekly with Middlesex County, the City of London, local health partners, the Association of Local Public Health Agencies (alPHa), the Ministry of Health, Ontario Health West, the Southwest LHIN, the Office of the Chief Medical Officer of Health, and Public Health Ontario. The MOH and Mayor Ed Holder hold bi-weekly COVID-19 virtual media briefings (Monday and Thursday), with the Warden of Middlesex County and a representative from London Health Sciences Centre attending once each week.

The MOH and the Associate Medical Officer of Health (AMOH), along with other team members, continue to host a weekly MLHU Staff Town Hall and present on many topics, including COVID-19.

The following events were also attended by the MOH:

July 2 Interview with Jennifer Bieman (London Free Press) on a local church outbreak

July 4 Participated in SW MOH/AMOH standing meeting (hosted by Windsor-Essex)

July 9 Interview with Jess Brady (Global News Radio, 980 CFPL) on Stage 3 reopening

July 12 Meeting with Minister of Education, Stephen Lecce on school reopening

July 13 Interview with Jennifer Bieman (London Free Press) on moving to the walk-in model at vaccination clinics
Participated in Science Table Working Session, with the Ontario COVID-19 Science Advisory Table

July 15 Participated in Science Table Working Session, with the Ontario COVID-19 Science Advisory Table
Participated in COMOH section meeting with the Chief Medical Officer of Health
Attended Finance and Facilities Committee and Board of Health meeting

July 29 Meeting with President Alan Shepard to discuss vaccination at Western University
Participated in COMOH section meeting with the Chief Medical Officer of Health

August 4 Meeting with Jenifer Dunn of London Abused Women's Centre to discuss statistics and domestic violence during the pandemic
Participated in Last Mile Regional Engagement Session with the Ministry of Health
Interview with Sophia Harris (CBC News) on Moderna supply expiring
Participated in Ultimate Canada Sports' Medical Working Group

August 6 Interview with Ashley Okwuosa (TVO) on local vaccination efforts

August 9 Meeting with President Peter Devlin to discuss vaccination at Fanshawe College

August 13 Meeting with Council of Universities to discuss vaccination in university settings
Interview with Jess Brady (Global News Radio, 980 CFPL) on 2009 age group vaccinations.

August 31 Attended Thames Valley District School Board Meeting with Dr. Joyce Lock (Southwestern Public Health) to discuss vaccination in students and staff.

September 1 Participated in Last Mile Regional Engagement Session with the Ministry of Health
Participated in telephone town hall (hosted by MPP Teresa Armstrong) on back-to-school with TVDSB Trustees Rahman and Pizzolato

This report was submitted by the Office of the Medical Officer of Health.

Christopher Mackie, MD, MHSc, CCFP, FRCPC
Medical Officer of Health

CORRESPONDENCE – September 2021

a) Date: August 6, 2021
Topic: Menu Labelling, Child Visual Health and Vision Screening, and Consumption and Treatment Services Compliance and Enforcement protocols
From: Peterborough Public Health
To: The Honourable Christine Elliott

Background:

On August 6, 2021, the Board of Health for Peterborough Public Health wrote to Minister Elliott to request that the Ministry of Health consider funding an increase to their cost-shared base budget to accommodate additional staff positions for the implementation of Menu Labelling, Child Visual Health and Vision Screening, and Consumption and Treatment Services Compliance and Enforcement protocols under the Ontario Public Health Standards. With the anticipated return to regular programs and services in the upcoming months and the ongoing demands of COVID-19 response there are concerns that mandated programs will not be adequately resourced.

Recommendation: Receive.

b) Date: August 15, 2021
Topic: Response to COVID-19 – June 2021 Update
From: Toronto Public Health
To: Toronto Members of Parliament, Members of Provincial Parliament and All Boards of Health

Background:

On August 15, 2021, Toronto City Council adopted a number of motions related to the Black Scientists' Task Force on Vaccine Equity as well as items related to the current COVID-19 response.

Recommendation: Receive.

c) Date: July 20, 2021
Topic: COVID-19 Recovery and Post Pandemic Funding
From: Southwestern Public Health
To: The Honourable Christine Elliott

Background:

On July 20, 2021, the Board of Health for Southwestern Public Health wrote to Minister Elliott requesting that the Ministry of Health commit to an extension of mitigation funding for the 2022 fiscal year as well as one-time funding for COVID-19 extraordinary expenses. It was also requested that the Ministry commit to increasing base-funding levels and multi-year funding

to accommodate increasing operating costs as well as restoring and returning programs to Ontario Public Health Standards requirement levels.

Recommendation: Receive.