AGENDA
MIDDLESEX-LONDON BOARD OF HEALTH

Thursday, July 20, 2023 at 7 p.m.
Microsoft Teams (Virtual)

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

Matthew Newton-Reid (Chair)
Michael Steele (Vice-Chair)
Peter Cuddy
Aina DeViet
Skylar Franke
Tino Kasi
Michael McGuire
Selomon Menghsha
Michelle Smibert
Dr. Alexander Summers (Medical Officer of Health, ex-officio member)
Emily Williams (Chief Executive Officer, ex-officio member)

SECRETARY

Emily Williams

TREASURER

Emily Williams

DISCLOSURE OF CONFLICTS OF INTEREST

APPROVAL OF AGENDA

MINUTES

Approve: May 18, 2023 – Board of Health meeting

Receive: May 18, 2023 – Performance Appraisal Committee meeting

Item #	Delegation	Recommendation	Information	Report Name and Number	Link to Additional Information	Overview and Lead
Correspondence						
1			**X**	June and July Correspondence		To receive the following items for information: a) Honourable Senator Patrick Brazeau - *Letter to New Democratic Party of Canada regarding Bill S-254* b) City of Hamilton Public Health Services - *Declarations of Emergency in the Areas of Homelessness, Mental Health, and Opioid Overdoses and Poisoning* c) Public Health Sudbury & Districts - *Saving Lives Through Lifejacket and Personal Flotation Device Legislation* d) Peterborough Public Health – *2024 Budget* e) Public Health Sudbury & Districts - *Letter of Support for Improved Indoor Air Quality in Public Settings* f) June and July 2023 Middlesex-London Board of Health External Landscape g) Algoma Public Health - *Letter of Support for Bill S-254, an Act to amend the Food and Drug Act (warning labels on alcoholic beverages)* h) Public Health Sudbury & Districts - *Letter of Support for Bill S-254, an Act to amend the Food and Drug Act (warning labels on alcoholic beverages)* i) Association of Local Public Health Agencies - *Annual Report for 2023* j) Association of Local Public Health Agencies - *2023 Resolutions* k) Simcoe Muskoka District Health Unit - *2024 Simcoe Muskoka District Health Unit Budget*

						l) Public Health Sudbury & Districts - *Public Health Funding* m) Public Health Sudbury & Districts - *Bill 103, Smoke-Free Ontario Amendment Act (Vaping is not for Kids), 2023* n) Simcoe Muskoka District Health Unit - *2023-24 Strategic Plan* o) Haliburton, Kawartha, Pine Ridge District Health Unit - *2024 Budget* p) Porcupine Health Unit - *Request for Air Quality Monitoring Stations in the Porcupine Health Unit region* q) Association of Ontario Public Health Business Administrators - *Call for Sustained Funding* Response Correspondence from the May 18, 2023 Board of Health Meeting: • Notice of Intent - Consultation on Potential Amendments to the Cannabis Regulations – May 18, 2023 • Letter of Support - Health Canada's Policy Update on Restricting Advertising of Food and Beverages to Children – June 9, 2023
Reports and Agenda Items						
2		**X**	**X**	Governance Committee Meeting Summary (Verbal)	[July 20, 2023 Agenda]	To provide an update from the July 20, 2023 Governance Committee meeting. Lead: Committee Chair Michelle Smibert
3			**X**	Government of Canada's Public Consultation on Single Use Plastic Waste (Report No. 41-23)	[Appendix A]	To provide information on a submission made to Environment and Climate Change Canada on plastics within the tobacco and vapour product industry. Leads: Dr. Alexander Summers, Medical Officer of Health and Linda Stobo, Manager, Substance Use Program Team

4		**X**	**X**	Concerns Regarding Modernizing the Alcohol Marketplace and Product Sales (Report No. 42-23)	Appendix A	To provide information on concerns regarding the expansion of the alcohol market in Ontario and to request endorsement from the Board of Health to share information about the public health risks associated with alcohol marketplace expansion. Leads: Dr. Alexander Summers, Medical Officer of Health and Linda Stobo, Manager, Substance Use Program Team
5			**X**	MLHU Employment Systems Review Update: Employment Equity and Recruitment Policy (Report No. 43-23)	Appendix A	To provide the Board of Health an update on the Employment Systems Review (Employment Equity and Recruitment Policy). Leads: Emily Williams, Chief Executive Officer, Cynthia Bos, Manager, Human Resources and Janet Roukema, Human Resources Specialist, Diversity and Inclusion
6			**X**	Current Public Health Issues (Verbal)		To provide an update on current public health issues in the Middlesex-London region. Lead: Dr. Alexander Summers, Medical Officer of Health
7			**X**	Medical Officer of Health Activity Report for May and June (Report No. 44-23)	London Free Press Op-Ed: Summers: London homeless crisis demands pandemic-like response	To provide an update on external and internal meetings attended by the Medical Officer of Health since the last Board of Health meeting. Lead: Dr. Alexander Summers, Medical Officer of Health
8			**X**	Chief Executive Officer Activity Report for May and June (Report No. 45-23)		To provide an update on external and internal meetings attended by the Chief Executive Officer since the last Board of Health meeting. Lead: Emily Williams, Chief Executive Officer

9		X	X	2024 Budget Projection (Report No. 46-23)		To provide the Board of Health information on budget projections for 2024 and to request endorsement of a letter to the Ministry of Health advocating for sustained funding for public health. Leads: Emily Williams, Chief Executive Officer, Dr. Alexander Summers, Medical Officer of Health, and David Jansseune, Assistant Director, Finance
10	X	X	X	2022 Draft Financial Statements (Report No. 47-23)	Appendix A Appendix B	To seek approval from the Board of Health to approve the 2022 Financial Statements. Leads: Emily Williams, Chief Executive Officer, David Jansseune, Assistant Director, Finance, Lisa Kenny, Comptroller, Katie DenBok, Partner, Audit (KPMG) and Dale Percival, Senior Manager, Audit (KPMG)

OTHER BUSINESS

The next meeting of the Middlesex-London Board of Health is Thursday, August 17, 2023 at 7 p.m.

CONFIDENTIAL

The Middlesex-London Board of Health will move into a confidential session to approve previous confidential Board of Health minutes and to discuss matters which pertain to one or more of the following, as per section 239(2) of the *Municipal Act, 2001, S.O. 2001, c. 25*:

(a) the security of the property of the municipality or local board;

(b) personal matters about an identifiable individual, including municipal or local board employees;

(c) a proposed or pending acquisition or disposition of land by the municipality or local board;

(d) labour relations or employee negotiations;

(e) litigation or potential litigation, including matters before administrative tribunals, affecting the municipality or local board;

(f) advice that is subject to solicitor-client privilege, including communications necessary for that purpose;

(g) a matter in respect of which a council, board, committee or other body may hold a closed meeting under another Act;

(h) information explicitly supplied in confidence to the municipality or local board by Canada, a province or territory or a Crown agency of any of them;

(i) a trade secret or scientific, technical, commercial, financial or labour relations information, supplied in confidence to the municipality or local board, which, if disclosed, could reasonably be expected to prejudice significantly the competitive position or interfere significantly with the contractual or other negotiations of a person, group of persons, or organization;

(j) a trade secret or scientific, technical, commercial or financial information that belongs to the municipality or local board and has monetary value or potential monetary value; or

(k) a position, plan, procedure, criteria or instruction to be applied to any negotiations carried on or to be carried on by or on behalf of the municipality or local board.

ADJOURNMENT

PUBLIC SESSION – MINUTES
MIDDLESEX-LONDON BOARD OF HEALTH

Thursday, May 18, 2023 at 7 p.m.
Microsoft Teams (Virtual)

MEMBERS PRESENT:	Matthew Newton-Reid (Chair) Selomon Menghsha (arrived at 7:03 p.m.) Skylar Franke (exited at 7:45 p.m.) Michelle Smibert Aina DeViet Tino Kasi (arrived at 7:10 p.m.) Michael McGuire Emily Williams, Chief Executive Officer (ex-officio) Dr. Alexander Summers, Medical Officer of Health (ex-officio)
REGRETS:	Michael Steele Peter Cuddy
OTHERS PRESENT:	Stephanie Egelton, Executive Assistant to the Board of Health (recorder) Sarah Maaten, Acting Director, Office of the Medical Officer of Health Mary Lou Albanese, Director, Environmental Health and Infectious Disease Jennifer Proulx, Acting Director, Healthy Start David Jansseune, Assistant Director, Finance Linda Stobo, Manager, Substance Use Program Team Abby Dafoe, Public Health Dietician Claire Bilik, Public Health Dietician Donna Kosmack, Manager, Oral Health Warren Dallin, Manager, Procurement and Operations Dan Flaherty, Manager, Communications Alex Tyml, Online Communications Coordinator Cynthia Bos, Manager, Human Resources

Chair Matthew Newton-Reid called the meeting to order at **7:01 p.m.**

DISCLOSURES OF CONFLICT OF INTEREST

Chair Newton-Reid inquired if there were any disclosures of conflicts of interest. None were declared.

APPROVAL OF AGENDA

It was moved by **M. McGuire, seconded by M. Smibert,** *that the **AGENDA** of the May 18, 2023 Board of Health meeting be approved.*

Carried

APPROVAL OF MINUTES

It was moved by **A. DeViet, seconded by S. Franke,** *that the **MINUTES** of the April 20, 2023 Board of Health meeting be approved.*

Carried

It was moved by **M. Smibert, seconded by S. Franke,** *that the **MINUTES** of the April 20, 2023 Governance Committee meeting be received.*

Carried

It was moved by **M. Smibert, seconded by S. Franke,** *that the **MINUTES** of the May 11, 2023 Finance and Facilities Committee meeting be received.*

Carried

NEW BUSINESS

Finance and Facilities Committee Meeting Summary from May 11, 2023 (Report No. 32-23)

Secretary and Treasurer Emily Williams provided an update on reports heard at the May 11, 2023 Finance and Facilities Committee meeting.

E. Williams noted that there were four (4) reports presented to the Committee for the Board's consideration. It was further noted that the next Finance and Facilities Committee meeting is in August. The June meeting has been cancelled due to challenges with staffing resources with the auditors.

It was moved by **M. McGuire, seconded by S. Franke,** *that the Board of Health:*

1) *Receive Report No. 06-23FFC re: Vector-Borne Disease Program: Contract Extension;*
2) *Approve extension of the existing contract for the Vector Borne Disease Program, Part A - Larval Mosquito Surveillance & Control, to Canadian Centre for Mosquito Management (CCMM) Inc. in the amount of $89,460 (before taxes) and $4,008 (before taxes) for supply of mosquito larvicide;*
3) *Approve extension of the existing contract for the Vector Borne Disease Program, Part B - Mosquito Identification and Viral Testing, to Entomogen Inc. in the amount of $21,025 (before taxes);*
4) *Receive Report No. 07-23FFC re: "2023 Q1 Financial Update and Factual Certificate" for information;*
5) *Receive Report No. 08-23FFC re: "Insurance Policies" for information; and*
6) *Receive Report No. 09-23FFC: "Employee and Family Assistance Program (EFAP) Services Contract Extension" for information.*

Carried

2023-24 MLHU Provisional Plan (Report No. 33-23)

Emily Williams, Chief Executive Officer and Dr. Alexander Summers, Medical Officer of Health presented the 2023-24 MLHU Provisional Plan.

E. Williams provided background on the Provisional Plan to date:

- The previous Board of Health approved the Provisional Plan to complete a two-year provisional plan and with current priority areas (November 2022). It was noted that capacity for a fulsome plan in 2022 remained limited.
- The 2021-22 Provisional Plan is being updated with a new 2023-24 Provisional Plan that provides interim strategic direction over the next two years until a full strategic plan can be completed.
- The strategic directions required a refresh, as they focused on COVID-19 recovery. The strategic goals (Client and Community Confidence, Program Excellence, Employee Engagement and Learning, and Organizational Excellence still resonate with strategic work underway at the Health Unit and are being carried over to the 2023-24 Provisional Plan per the Board's previous direction.
- To date, staff have been informed at the weekly Town Hall on the Provisional Plan process, the Strategy, Planning and Performance Team provided Senior Leadership Team a draft Provisional Plan for review, the Management Leadership Team was consulted, and the Marketing Coordinator created graphics for the draft Provisional Plan.

- As the Health Unit continues to be in COVID-19 recovery, the provisional plan is an opportunity to reflect on core public health work as we re-emerge from pandemic deployments to build a solid foundation for a full strategic plan. This includes:
  - Reprioritizing relationships with key partners from equity deserving groups;
  - Understanding what we (the Health Unit) does and do it well;
  - Supporting our staff well-being and their recovery; and
  - Clearly outline how we make effective decisions and follow through with them.

The next steps are:
- Get feedback from the Board on the drafted Provisional Plan;
- Receive approval and endorsement from the Board on the Provisional Plan;
- Communicate the approved Provisional Plan to all staff; and
- Update our website with the updated Provisional Plan.

Dr. Summers introduced the draft 2023-23 MLHU Provisional Plan. Dr. Summers noted that this process is not a fulsome strategic planning process – this will occur in the future during the five-year strategic plan.

Dr. Summers explained the definitions of the Provisional Plan:
- Goal: Where we want to go;
- Direction: The path we are taking to get there;
- Initiative: How we plan to move us forward along that path; and
- Tactics: The specific activities and projects to make progress on the initiatives.

Further, Dr. Summers provided an overview of the goals and directions within the 2023-24 Provisional Plan as referenced in Appendix A of the report:

<u>Client and Community Confidence</u>

Goal: We have strong relationships with our partners and are trusted by our community.

Directions:
- Facilitate meaningful and trusting relationships with prioritized equity-deserving groups, specifically Black and Indigenous communities; and
- Develop and adopt a partner engagement framework.

<u>Program Excellence</u>

Goal: Our public health programs are effective, grounded in evidence and equity.

Direction: Define what we do and do it well.

<u>Employee Engagement and Learning</u>

Goal: Our staff and leaders have the skills and capacity to do their jobs well, and their wellbeing is supported.

Directions:
- Develop and implement strategies to support staff mental health and wellbeing, including addressing systemic factors contributing to burn out; and
- Develop and implement comprehensive training, learning and development, and professional development opportunities for staff and leaders.

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Organizational Excellence

Goal: We make effective decisions, and we do what we say we are going to do.

Directions:
- Clarify who makes decisions and how those decisions are made; and
- Develop and initiate an organizational quality management system.

Dr. Summers noted that within the draft Provisional Plan, there is detail on how the organization will be moving along its directional path, which includes tactics and initiatives. It was noted that some of this work overlaps. Further, some work continues with ongoing implementation of the Taking Action for Reconciliation Plan (TAFR) and the Anti-Black Racism Plan (ABRP), in addition to prioritizing equity, diversity and inclusion.

Board Member Tino Kasi inquired if the Health Unit having policies in place with respect to equity and diversity in the workplace specific to leadership positions in the organization, and if related goals have specifically been considered for racialized individuals.

E. Williams noted that the Senior Leadership Team has recently approved organizational targets for improving diversity within workforce. Additionally, the Health Unit conducted a workforce census as a baseline assessment which was compared to the most recent Canadian census to establish targets. It was also noted that under the Client and Community Confidence section of the draft Provisional Plan, the Health Unit has been implementing recommendations (88 in total) from the Employment Systems Review, specifically related to improving Human Resources policies and procedures to support diversity, equity and inclusion. Recruitment tools have also been reviewed with the lens of diversity, equity and inclusion to consider equivalent experience as a proxy for education requirements, and with standardized interview tools with documented scoring to remove bias. E. Williams noted that staff would be pleased to bring a report to a future Board of Health meeting on the Employment Equity Policy and organizational targets.

T. Kasi further inquired if the Health Unit's leadership is mirroring the diverse population in which they serve (specifically racialized groups) and if this goal could be included in the Provisional Plan.

E. Williams noted that the current leadership complement does not reflect the levels of diversity in the London-Middlesex area, and this is one of the targets included in the Employment Equity Policy. Further, the Provisional Plan can be amended specifically under the "Organizational Excellence" section to include how the Health Unit is prioritizing employment equity.

It was moved by **S. Franke, seconded by M. Smibert,** *that the Board of Health:*
1) *Receive Report No. 33-23 re: "2023-24 MLHU Provisional Plan" for information; and*
2) *Provide feedback on the 2023-24 Provisional Plan (Appendix A) as appended to this report.*

Carried

Public Consultation on Potential Amendments to Federal Cannabis Regulations (Report No. 34-23)

Dr. Summers introduced Linda Stobo, Manager, Substance Use Program Team to present the report on consultations for amendments to federal cannabis regulations.

L. Stobo noted that on March 25, 2023, Health Canada released a Notice of Intent seeking public input on potential amendments to the Cannabis Regulations under the federal *Cannabis Act* to reduce regulatory burden while still maintaining the controls in place to address public health and safety risks. Health Canada is considering potential amendments that would reduce duplication within the legal requirements and reduce administrative and regulatory burdens where possible, while continuing to meet public health and safety objectives in the Act.

Health Unit staff from the Southwest Region collaborated on a set of recommendations that align with the public health approach to cannabis legalization, including increased access to a strictly regulated product while removing commercial influence to protect youth, eliminating the illicit market, and increasing public safety. These recommendations are with the Board for consideration as Appendix A.

L. Stobo summarized the recommendations in the draft submission, which correspond to three of the five priority areas that fall within the public health domain for which Health Canada has requested feedback:

- Priority Area 3: Production requirements for cannabis products;
- Priority Area 4: Packaging and labelling requirements for cannabis products; and,
- Priority Area 5: Record keeping and reporting for cannabis license holders.

It was moved by **A. DeViet, seconded by S. Franke,** *that the Board of Health:*

1) *Receive Report No. 34-23, re: "Public Consultation on Potential Amendments to Federal Cannabis Regulations" for information; and*
2) *Endorse and submit feedback prepared by Middlesex-London Health Unit staff, attached as Appendix A, to the Health Canada's Controlled Substances and Cannabis Branch on potential amendments to regulations under the Cannabis Act.*

Carried

Support for Health Canada's Policy Update on Restricting Advertising of Food and Beverages to Children (Report No. 35-23)

Dr. Summers introduced Abby Dafoe and Claire Bilik, Public Health Dieticians to present the report on Health Canada's Policy Update on Restricting Advertising of Food and Beverages to Children.

C. Bilik provided an overview of the current situation with food and beverage advertising to children. Children and youth are vulnerable and constantly exposed to the advertising of the food and beverage industry. This exposure typically increases as children grow into teens and have more screen time, especially online. The food industry appeals to children and youth using cartoons, celebrities, popular music, slang, and sports to market their products. Children are targeted because they are unable to critically assess advertisement messages, can influence family spending, and provide an opportunity to establish brand loyalty at a young age. Youth are also vulnerable to marketing due to their cognitive and emotional development, peer pressure, high levels of exposure to advertising, and increased independent purchasing power. Exposure to food and beverage advertising influences children and youths' food preferences, purchase requests and consumption patterns, which negatively impacts their health and wellbeing.

C. Bilik further provided a brief history on the *Food and Drugs Act* as it relates to this report:

- In 2015, Bill S-228, *An Act to amend the Food and Drugs Act* (prohibiting food and beverage marketing directed at children), was introduced and passed by the Senate and the House of Commons; however, it was not called to a final vote in 2019.
- In 2016, Health Canada released their Healthy Eating Strategy which included a commitment to restricting food and beverage advertising to children.
- In November 2021, Bill C-252, An Act to amend the Food and Drugs Act (prohibition of food and beverage marketing directed at children) was introduced.
- In April 2023, Bill C-252 was adopted by the Standing Committee on Health and was presented to the House of Commons on April 26, 2023. Health Canada released a policy update, indicating intention to amend the Food and Drug Regulations to "restrict advertising to children under the age of 13 of foods that contribute to excess intakes of sodium, sugars and saturated fat… focusing on television and digital media first". Health Canada is accepting comments until June 12, 2023, which are proposed in a letter of support.

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C. Bilik added that the Canadian Children's Food and Beverage Advertising Initiative set voluntary standards for the food industry to follow, however, this voluntary approach has not been effective at reducing food and beverage advertising to children.

A. Dafoe provided the recommendations proposed to the Board to be provided to Health Canada in the form of a letter of support:

- Increasing the age to under 18 for restricting commercial advertising; and
- Expanding restrictions to all advertising types such as celebrity and character endorsements as indicated in Bill C-252.

It was moved by **A. DeViet, seconded by M. Smibert,** *that the Board of Health:*

1) *Receive Report No. 35-23 re: "Support for Health Canada's policy update on restricting advertising of food and beverages to children";*
2) *Submit a letter on behalf of the MLHU Board of Health in support of Health Canada's recent policy update on restricting the commercial advertising of food and beverages to children along with these additional measures:*
    - *Increasing the age to under 18 for restricting commercial advertising;*
    - *Expanding restrictions to all advertising types such as celebrity and character endorsements as indicated in Bill C-252.*

Carried

Chair Newton-Reid noted that before proceeding with the meeting, that the Board must formally approve the provisional plan as amended based on feedback provided by Board Member T. Kasi to include the Health Unit's commitment to employment equity, under the "Organizational Excellence" section and to direct staff to bring a future report to the Board of Health on implementation of the Employment Equity Policy and employment targets.

It was moved by **T. Kasi, seconded by S. Menghsha,** *that the Board of Health:*

1) *Direct staff to provide a report to a future Board of Health meeting regarding implementation of the Middlesex-London Health Unit's Employment Equity Policy and related employment targets; and*
2) *Approve the 2023-24 Middlesex-London Health Unit Provisional Plan as amended.*

Carried

MLHU Strathroy Dental Clinic – May 2023 Update (Report No. 36-23)

E. Williams introduced Warren Dallin, Manager, Procurement and Operations to present the update on the MLHU Strathroy Dental Clinic.

W. Dallin provided a brief update on the Strathroy Dental Clinic build located at the Shops on Sydenham in Strathroy. The build for the dental clinic is proceeding as planned, with the project team working to continue to address matters that arise and working with the selected vendors (CCS Construction and Henry Schein). The dental clinic's expected construction completion date is May 31, dental equipment installation on June 9, and an expected clinic opening date in late June.

W. Dallin noted that the capital budget for the project (funds given to the Health Unit from the Ministry of Health) is currently $1,050,000, which is currently carrying a surplus.

It was moved by **M. McGuire, seconded by M. Smibert,** *that the Board of Health receive Report No. 36-23, re: "MLHU Strathroy Dental Clinic – May 2023 Update" for information.*

Carried

MLHU's Seniors' Dental Care Program - Partnerships (Report No. 37-23)

Dr. Summers introduced Donna Kosmack, Manager, Oral Health to provide an update on current partnerships within the Seniors' Dental Care program at the Health Unit.

D. Kosmack highlighted the work of the Oral Health team and partners with the Ontario Seniors' Dental program to address large wait times being experienced in the community. The new dental clinic in Strathroy will be operational in June and will assist with the wait times in the County of Middlesex.

D. Kosmack noted that the Ontario Seniors' Dental Program was launched before the COVID-19 pandemic. The pandemic caused dental services provincially to be paused, and public health dental services to be paused longer due to Oral Health staff being redeployed to support the pandemic response. The program interest and uptake as a result was higher than anticipated and has a lengthy waiting list. The Health Unit works with two (2) partners for community dental services – the Wright Clinic and the Southwest Ontario Aboriginal Health Access Centre (SOAHAC). These partners see clients of the Health Unit and the Health Unit provides funds for these services. The Health Unit has positive relationships with these partners, and Oral Health staff attend these clinics to support Health Unit clients on Mondays and Wednesdays.

D. Kosmack noted further that there have been higher volumes of clients needing emergency dental care than usual. The Health Unit has relationships with a few general dentists who assist when appointments are not available at the dental clinic, which ensures clients can be seen and diverted away from the hospital system.

It was moved by **A. DeViet, seconded by T. Kasi,** *that the Board of Health receive Report No. 37-23, re: MLHU's Seniors' Dental Care Program - Partnerships for information.*

Carried

Current Public Health Issues (Verbal)

Dr. Alexander Summers, Medical Officer of Health provided a verbal update on current public health issues within the region.

World Health Organization Announcements

On May 5, 2023, the Director General of the World Health Organization (WHO) declared that the COVID-19 virus no longer constitutes a public health emergency of international concern. This means that COVID-19 is now endemic and will continue to be present in the community as a seasonal respiratory illness with periods of high and low risk. Dr. Summers noted that getting regular COVID-19 vaccination boosters and masking when recommended is the best form of protection.

Further, on May 11, 2023, the Director General also determined that MPox (formerly Monkeypox) no longer constitutes a public health emergency of international concern. Outbreaks in Middlesex-London decreased towards the end of 2022. It is recommended that MPox surveillance efforts are integrated into existing health unit programs to address future outbreaks. Vaccination for MPox continues to be available.

Immunization of School Pupils Act

Work under the *Immunization of School Pupils Act* continues to be underway at the Health Unit. Through six cohorts, notices were sent out to students and their families regarding receiving necessary vaccinations to be in compliance or having an exemption form on file.

- May 2022 - August 2022: 41,000 information letters were mailed
- September 2022 - May 15, 2023: 35,567 information letters were mailed and over 35,000 immunization records were entered
- Suspension Rounds 1 – 6: 21,549 suspension letters were mailed resulting in 5,750 suspensions

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- Suspension Round 7 (May 25 suspension date): 287 suspension letters were mailed, and suspensions are to be determined
- Suspensions outstanding: Round 5 = 40; Round 6 =187

Public education has been provided to students and parents through letters, the Health Unit website, and social media on how to update vaccination records and receive missing vaccinations. The Health Unit held 17 vaccination "catch up" clinics within the community between September 2022 and May 2023. These clinics saw 8,144 students and 16,651 vaccinations were administered.

Health and Homelessness – Whole of Community System Response
Homelessness has doubled in the region and there are substantial impacts to those who are unhoused. The Whole of Community System Response is comprised of leaders from community partners, using a people centric and housing-first model. Hubs around the community will be created with different referral pathways for clients and are intended to provide wraparound supports and assist with the transition to housing. This is an entry point of a continuum of housing supports for clients, one where they choose where they need to be. Agencies from across the health and social services field have come together to build values, principles and commitment to a systems-level approach.

The Strategy and Accountability framework has been finalized, and meetings are being held to work further on implementation. Participating organizations will sign off on commitment letters and a Terms of Reference will be finalized. Discussions in May will be focused on 24/7 hub design, supportive housing units and models of care, and an encampment strategy.

MLHU in the News
Dr. Summers highlighted current news articles involving the Health Unit since the last Board meeting. Topics reported on by local media outlets included:

- Social Assistance Rates and Food Insecurity
- WHO's declaration ending the COVID-19 public health emergency
- MLHU inspection reports of restaurants on Western University Campus

Chair Newton-Reid inquired on the reason for media interest on food premises at Western. Dr. Summers noted that there were no specific concerns, and the media outlet (Western Gazette) was looking for a greater understanding on the inspection process. Dr. Summers added that during the inspection process of food premises, infractions may be identified and rectified, and the premises would pass inspection. Public Health Inspectors take an educational approach to food premises in the community regarding enforcement when possible.

It was moved by **M. Smibert, seconded by S. Menghsha,** *that the Board of Health receive the verbal report re: "Current Public Health Issues" for information.*

Carried

Medical Officer of Health Activity Report for April (Report No. 38-23)

Dr. Summers presented the Medical Officer of Health activity report for April.

It was moved by **M. McGuire, seconded by T. Kasi,** *that the Board of Health receive Report No. 38-23 re: "Medical Officer of Health Activity Report for April" for information.*

Carried

Chief Executive Officer Activity Report for April (Report No. 39-23)

E. Williams presented the Chief Executive Officer activity report for April.

It was moved by **T. Kasi, seconded A. DeViet,** *that the Board of Health receive Report No. 39-23 re: "Chief Executive Officer Activity Report for April" for information.*

Carried

CORRESPONDENCE

It was moved by **T. Kasi, seconded by M. Smibert,** *that the Board of Health receive the following items for information:*

a) City of Hamilton Public Health Services re: 2023 PHS Annual Service Plan & Budget Submission; Support for Sufficient, Stable and Sustained Funding for Local Public Health Agencies
b) May 2023 Middlesex-London Board of Health External Landscape
c) Public Health Sudbury & Districts re: Support for the 2022 Annual Report of the Chief Medical Officer of Health for Ontario
d) Association of Local Public Health Agencies re: Ontario Public Health Nursing Leaders Recommendations

Carried

OTHER BUSINESS

The next meeting of the Middlesex-London Board of Health is on Thursday, June 15, 2023, at 6 p.m.

CONFIDENTIAL

At **8:08 p.m.,** it was moved by **M. Smibert, seconded by M. McGuire,** *that the Board of Health will move in-camera to consider matters regarding labour relations or employee negotiations, personal matters about an identifiable individual, including Board employees, advice that is subject to solicitor-client privilege, including communications necessary for that purpose, litigation or potential litigation, including matters before administrative tribunals, affecting the municipality or local board and to approve previous confidential Board of Health minutes.*

Carried

At **8:25 p.m.,** it was moved by **M. Smibert, seconded by M. McGuire,** *that the Board of Health return to public session from closed session.*

Carried

ADJOURNMENT

At **8:25 p.m.,** it was moved by **A. DeViet, seconded by S. Menghsha,** *that the Board of Health adjourn the meeting.*

Carried

MATTHEW NEWTON-REID
Chair

EMILY WILLIAMS
Secretary

DRAFT

PUBLIC SESSION – MINUTES
MIDDLESEX-LONDON BOARD OF HEALTH
PERFORMANCE APPRAISAL COMMITTEE

Thursday, May 18, 2023 at 6 p.m.
Microsoft Teams

MEMBERS PRESENT: Michelle Smibert (Chair)
Matthew Newton-Reid
Aina DeViet
Tino Kasi

OTHERS PRESENT: Stephanie Egelton, Executive Assistant to the Board of Health (recorder)
Marc Lacoursiere, President, The Achievement Centre

REGRETS: Dr. Alexander Summers, Medical Officer of Health (ex-officio)
Emily Williams, Chief Executive Officer (ex-officio)
Michael Steele

At **5:58 p.m.,** Chair Michelle Smibert called the meeting to order.

DISCLOSURES OF CONFLICT OF INTEREST

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

APPROVAL OF AGENDA

It was moved by **A. DeViet, seconded by M. Reid,** *that the **AGENDA** for the May 18, 2023 Performance Appraisal Committee meeting be approved.*

Carried

APPROVAL OF MINUTES

It was moved **T. Kasi, seconded by M. Reid,** *that the **MINUTES** of the March 16, 2023 Performance Appraisal Committee meeting be approved.*

Carried

CONFIDENTIAL

At **6 p.m.,** it was moved by **M. Reid, seconded by A. DeViet,** *that the Board of Health (Performance Appraisal Committee) will move in-camera to consider matters regarding personal matters about identifiable individuals, including municipal or local board employees and matters regarding labour relations or employee negotiations.*

Carried

At **6:31 p.m.,** it was moved by **M. Reid, seconded by T. Kasi,** *that the Performance Appraisal Committee return to public session from closed session.*

Carried

OTHER BUSINESS

The next meeting of the Performance Appraisal Committee is on Thursday, July 20 at 6 p.m.

ADJOURNMENT

At **6:31 p.m.**, it was moved by **M. Reid, seconded by A. DeViet,** *that the meeting be adjourned.*

Carried

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MICHELLE SMIBERT	**MATTHEW NEWTON-REID**
Committee Chair	**Board Chair**

DRAFT

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 41-23

TO: Chair and Members of the Board of Health

FROM: Dr. Alexander Summers, Medical Officer of Health
Emily Williams, Chief Executive Officer

DATE: 2023 July 20

GOVERNMENT OF CANADA'S PUBLIC CONSULTATION ON SINGLE USE PLASTIC WASTE

Recommendation

It is recommended that the Board of Health receive Report No. 41-23 re: "Government of Canada's Public Consultation on Single Use Plastic Waste" for information.

Key Points

- On November 23, 2018, the Canadian Council of Ministers of the Environment implemented the Canada-wide Strategy on Zero Plastic Waste to improve waste collection, enhance value recovery, and prevent and remove plastic pollution throughout the entire lifecycle of plastics.
- The Government of Canada was seeking public input on a regulatory framework that would serve as the starting point for the proposed *Recycled Content and Labelling for Plastic Products Regulations* and the federal plastics registry.
- The Middlesex-London Health Unit staff prepared and submitted feedback, attached as Appendix A, by the deadline of May 18, 2023, providing comments that pertain to the utilization of plastics within the commercial tobacco and vapour product industries.

Background

On June 9, 2018, during Canada's 2018 G7 Presidency, a significant milestone was achieved as Canada, alongside France, Germany, Italy, the United Kingdom, and the European Union, adopted the Ocean Plastics Charter. This global commitment aims to tackle plastic pollution and promote responsible plastic use, efficient recycling, and sustainable design. In November 2018, Canada implemented its Strategy on Zero Plastic Waste. The federal, provincial, and territorial governments adopted a Canada-wide Action Plan with two phases: Phase 1 (2019) focuses on improving plastic circularity and implementing systemic changes, while Phase 2 (2020) targets reducing plastic pollution and promoting global cooperation. On April 18, 2023, the Canadian Government launched consultations on a regulatory framework for the proposed *Recycled Content and Labelling for Plastic Products Regulations*. They also released a technical paper outlining the reporting requirements for the federal plastics registry, as part of their commitment to move towards zero plastic waste.

Plastic Pollution from the Commercial Tobacco and Vapour Product Industry

Commercial tobacco product waste consistently ranks among the highest contributors to litter, making up approximately 30 to 40% of all global litter (World Health Organization, 2022). During the Great Canadian Shoreline Clean Up of 2019, cigarette butts alone accounted for 42% of all collected litter (Physicians for a Smoke-Free Canada (PSC, 2022). In Canada alone, approximately 15, 000 tonnes of cigarette waste are generated annually, with the environmental impact further amplified by the volume of plastic waste from the 24 billion cigarette filters used per year in Canada (PSC, 2022). These littered cigarette butts, containing single-use plastic filters and toxic chemicals, pose substantial harm to the environment. The non-biodegradable cellulose-acetate filters persist as microplastics, causing severe damage to aquatic ecosystems.

Vapour products, particularly disposable e-cigarettes with non-recyclable components and single-use plastic reservoirs, contribute to environmental concerns. The popularity of disposable vapes has led to increased littering of vaping waste, potentially releasing chemical contaminants. In 2019, 90 million vaping pods were sold in Canada, and improper disposal in landfill sites or on the ground as litter is common.

Summary of Key Recommendations

The development of comprehensive policies aimed at reducing plastic waste in Canada is an opportunity to collectively address both environmental and human health concerns. Drawing upon the objectives of the World Health Organization's Framework Convention on Tobacco Control, of which Canada is signed party, the Middlesex-London Health Unit's submission, attached as Appendix A, focuses on the utilization of plastics within the commercial tobacco and vapour product industries. The Middlesex-London Health Unit's comments include the following recommendations:

- Ban the manufacturing of cigarettes with single-use plastic filters and prohibit the manufacturing and sale of single-use vapes and plastic components for vapour products.
- Implement a new standard that would mandate manufacturers to exclusively produce vapour products comprised of reusable materials to reduce waste and promote sustainability.
- Implement Extended Producer Responsibility (EPR) programs for the commercial tobacco and vapour industries, ensuring they bear the costs of take-back initiatives and incentives to prevent product waste from polluting the environment.
- Require commercial tobacco and vapour product industries to report data on plastics diversion by the end of 2024. Phase out single-use plastic components in both products and packaging through a federally imposed requirement.
- Include single-use plastic cigarette butt filters in a comprehensive ban of single use plastics.
- Introduce standardized disposal labelling in Canada, like the European Union, to provide consumers with information on how to safely dispose vaping products.
- As a signed party to the World Health Organization's Framework Convention on Tobacco Control and in compliance with Article 5.3, exclude the tobacco and vapour product industries from stakeholder consultations due to their conflict of interest.

The Canadian government's strategy to regulate single-use plastic production and waste is a crucial milestone in tackling climate change. Upstream strategies that will facilitate transformative changes at the manufacturing level in concert with efforts to address post-consumer waste are required.

This report was submitted by the Healthy Living Division.

Dr. Alexander Summers, MD, MPH, CCFP, FRCPC
Medical Officer of Health

Emily Williams, BScN, RN, MBA, CHE
Chief Executive Officer

May 16, 2023

ATTN: Tracey Spack
Director
Plastics Regulatory Affairs Division
Environment and Climate Change Canada
351 Saint-Joseph Boulevard
Gatineau QC, K1A 0H3
Email: plastiques-plastics@ec.gc.ca

RE: Middlesex-London Health Unit Submission - Single Use Plastic Waste

INTRODUCTION

The Middlesex-London Health Unit is pleased to offer insights on the Canadian government's strategy to regulate single-use plastic production and waste, recognizing it as a crucial milestone in tackling climate change. With the goal of achieving Canada's target of zero plastic waste, the Canadian Government's prioritization of upstream strategies that will facilitate transformative changes at the manufacturer level is required. These measures are crucial for reducing environmental impacts, complementing efforts to address post-consumer waste. The development of comprehensive policies aimed at reducing plastic waste in Canada presents a significant opportunity to collectively address both environmental and public health concerns. By integrating two crucial domains, we can foster approaches that effectively mitigate both human and environmental harm. Drawing inspiration from the Framework Convention on Tobacco Control and its identified objectives, we can formulate strategies that contribute to minimizing adverse impacts on both humans and the environment. The following comments specifically pertain to the utilization of plastics within the commercial tobacco and vapour product industries.

We recommend that the Canadian government ban the manufacturing of cigarettes with single-use plastic filters and prohibit the production and sale of single-use vapes and plastic components for vapour products. By implementing a new product standard that mandates vapour product manufacturers to exclusively produce reusable items, the government can demonstrate environmental responsibility in addressing urgent environmental concerns. These actions will effectively reduce waste and promote sustainability.

Moreover, it is essential to mandate Extended Producer Responsibility (EPR) programs for the commercial tobacco and vapour industries, ensuring they bear the costs of take-back initiatives and incentives to prevent product waste from polluting the environment. By shifting the burden of product disposal management from taxpayers and municipal governments to the producers themselves, the considerable expenses associated with post-consumer waste can be mitigated. This approach not only promotes financial fairness but also encourages producers to take proactive measures in minimizing waste and preserving the environment.

Federal Plastics Registry

We endorse the goals of the Federal Plastics Registry, valuing its transparency and the potential to expand and include other industries in the EPR programs. We emphasize the importance of assigning greater responsibility to manufacturers rather than retailers in the producer hierarchical

approach. Additionally, it is vital to consider the inclusion of online retailers within Canada in the registry, including those who import plastic products into the country.

Numerous jurisdictions have either implemented or are considering the adoption of EPR programs, including methods like municipal litter abatement fees and waste charges on products. San Francisco introduced a cigarette litter abatement fee of $0.85 per pack in 2009, while Korea implemented a waste charge on cigarettes and e-cigarettes back in 1996 (PSC, 2022). In New York State, legislation has been passed for collecting and recycling cigarettes butts through a deposit and refund system, although it is yet to be signed into law (PSC, 2022). The European Union (EU) has adopted an EU plastics strategy with a directive mandating producers to cover costs for awareness-raising, litter clean-up, data gathering, reporting, and waste collection (PSC, 2022). The strategy also requires markings on product packages to inform consumers about plastic content, appropriate disposal methods, and the environmental consequences of litter. EU member states such as Ireland and Spain have implemented EPR Program components as of January 2023.

It is recommended that tobacco and vapour product companies be included within an EPR program. In addition to their inclusion, it is recommended that tobacco and vapour product companies be legally required to report their data on plastics diversion by the end of 2024. Furthermore, it is recommended that tobacco and vapour product companies phase out single-use plastic components in both their products and their packaging through a federally imposed requirement. This decisive action is essential for reducing their detrimental impact on the environment, as well as safeguarding human and aquatic health.

Tobacco Product Litter

Tobacco product waste consistently ranks among the highest contributors to global litter, comprising an estimated 30 to 40% of all litter (WHO, 2022). In the Great Canadian Shoreline Clean Up of 2019, cigarette butts accounted for 42% of all collected litter (PSC, 2022). In Canada alone, approximately 15,000 tonnes of cigarette waste are generated annually (PSC, 2022). The sheer volume of plastic waste from cigarettes, including the 24 billion filters used per year in Canada, magnifies the environmental impact, even with a small percentage of improperly discarded cigarette butts (PSC, 2022). Littered cigarette butts, comprised of single-use plastic filters and toxic chemicals, pose significant harm to the environment (PSC, 2022). Plastic cellulose-acetate filters are resistant to biodegradation and persist in the environment as microplastics, inflicting severe damage on the aquatic ecosystem (Beutel et al., 2021).

A significant majority of Canadians, with two-thirds of those polled in 2021, are in favour of including single-use plastic cigarette butt filters in a comprehensive plastics ban in Canada (Oceana Canada, 2021).

Vapour Product Litter

Most vapour products feature common plastic components such as a case and an e-liquid reservoir. While there is variation in terms of reusability, a considerable number of these devices are not recyclable, and numerous models utilize single-use plastic reservoirs, often referred to as “pods”. The rise in popularity of non-reusable, one-piece “disposable” e-cigarettes can be attributed to their affordability (Beutel et al., 2021).

Although limited studies exist on the prevalence of vapour product waste in the environment, it is highly likely that the surge in usage has corresponded with an increase in littering of vapour product waste, leading to the release of chemical contaminants (Beutel et al., 2021). In Canada, the sale of 90 million vaping pods was recorded in 2019, with vaping rates continuing to rise (PSC, 2022). Recognizing the potential environmental impact, regulatory bodies such as the U.S. Environmental Protection Agency and other environmental agencies classify vapour product cartridges contaminated with nicotine as hazardous waste (PSC, 2022).

In our local Middlesex-London region, it has been confirmed that vapes are not being properly disposed of through electronic or hazardous waste management channels, but instead end up in landfills. This unfortunate practice contributes to a significant environmental impact caused by vapour product waste in our community. Compounding the issue is the escalating youth vaping epidemic. According to the 2021-2022 Canadian Student Tobacco, Alcohol and Drugs Survey (CSTADS) results, 29% of students in grades 7 to 12 have ever tried an e-cigarette (with nicotine, without nicotine, and/or with an unknown content). Furthermore, 24% of students in grades 10 to 12 reported using an e-cigarette in the past month (CSTADS, 2021-2022). Within the Middlesex-London region, Public Health Nurses and Tobacco Enforcement Officers (TEOs) observe frequent vape use among youth in both elementary and secondary schools. During inspections, numerous empty single-use pods are frequently found scattered as litter on the ground. Among youth who vape, TEOs estimate that approximately 75-85% use disposable pods, which are either discarded in the garbage or discarded as litter. Considering that a youth who vapes may use a disposable pod every 1 to 3 days and the popularity of low cost, disposable e-cigarettes is increasing, vapour products' contributions to single use plastic waste should not be underestimated.

Recyclability Labelling

To assist consumers in proper disposal practices, incorporating precise information on product labels, even those that are non-recyclable, would be considered a judicious approach. The introduction of standardized disposal labelling in Canada, akin to the specifications implemented in the European Union, is recommended. While recyclability may differ across the country, it is essential to gather information on commonly recyclable materials and products across all jurisdictions to establish a foundation for standardization. By facilitating clear and consistent disposal guidance, we can empower consumers to make informed choices and enhance waste management practices nationwide.

In the process of determining the feasibility of recyclability labeling, it is crucial to prioritize consultation with the relevant industries; however, we propose the following considerations to guide those consultations:

- In alignment and compliance with the guidelines of the Framework Convention on Tobacco Control, it is recommended that tobacco and vapour product industries be excluded from stakeholder consultations;
- In accordance with article 18 of the Framework Convention on Tobacco Control, the Government of Canada as a signed party, is obligated to protect the environment and health of persons regarding the cultivation and manufacturing of commercial tobacco products; and,
- The potential issue of "greenwashing" by industries when establishing compliance and reporting mechanisms exists and may require mitigation strategies.

We express our gratitude for the opportunity to contribute our insights to these vital policies that will safeguard the well-being of Canadians and the environment in the years ahead.

Sincerely,

Dr. Alexander Summers, MD, MPH, CCFP, FRCPC
Medical Officer of Health

References

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MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 42-23

TO: Chair and Members of the Board of Health

FROM: Dr. Alexander Summers, Medical Officer of Health
Emily Williams, Chief Executive Officer

DATE: 2023 July 20

CONCERNS REGARDING MODERNIZING THE ALCOHOL MARKETPLACE AND PRODUCT SALES

Recommendation

It is recommended that the Board of Health:

1) ***Receive Report No. 42-23, re: "Concerns Regarding Modernizing the Alcohol Marketplace and Product Sales" for information; and***
2) ***Endorse the Ontario Public Health Association's (OPHA) letter, attached as Appendix A, to share information about the public health risks associated with alcohol marketplace expansion and evidence-informed policies to mitigate alcohol-related harms with the Ontario Ministries of Finance and Health.***

Key Points

- The Ontario government continues to explore ways to modernize and expand the alcohol market in Ontario which will make alcohol increasingly accessible.
- In 2018/2019, 30% of Middlesex-London residents aged 12 years and older were drinking alcohol above what is considered a low-risk level.
- Research confirms that increased alcohol availability leads to increased alcohol consumption and alcohol-related health and social harms.
- The OPHA has submitted a letter, attached as Appendix A, to the Ministry of Health and the Ministry of Finance to share information about the public health risks associated with alcohol marketplace expansion and evidence-informed policies to mitigate alcohol-related harms.

Background

The Ontario government continues to explore ways to modernize and expand the alcohol market, which will make alcohol increasingly accessible including:

- Expanding sales of beverage alcohol to more than 270 new retail outlets across Ontario since 2018.
- Permanently allowing licensed restaurants and bars to include alcohol with food as part of a takeout or delivery order.
- Freezing the basic beer tax rates that were set to be indexed to inflation.
- Permanently extending hours of operation for alcohol retail store locations.
- Campaigning for alcohol to be sold in convenience stores.

While the government's stated goal is to "expand choice and convenience for consumers while giving businesses more opportunities", the public health consequences of continued increases to alcohol access

must be considered. Decades of research substantiate that increased alcohol availability leads to increased alcohol consumption, which results in increased alcohol-related harms. Furthermore, these harms are disproportionately felt by populations experiencing health inequities, also known as the alcohol paradox.

Alcohol Use and Consequences

We have a culture of drinking in Canada where alcohol consumption has become normalized. Alcohol is used to celebrate, commiserate, cope, and can even be seen as a rite of passage. As such, alcohol is the most commonly used drug in our community with 80% of our Middlesex-London residents, aged 12 years and older, identifying themselves as current drinkers (i.e., had 1 or more drinks in the past 12 months) and 30% are drinking alcohol above what is considered a low-risk level (i.e., had 3 or more drinks in the past 7 days) based on the new Canadian Guidance on Alcohol and Health (Public Health Ontario (PHO) Snapshot, 2018-19). Of those reporting alcohol consumption above the low-risk levels in Middlesex-London, 15% report moderate risk drinking (3-6 drinks in the last week) and 15% report increasingly high-risk drinking levels (7 or more drinks in the last week) (PHO Snapshot, 2018-19).

Alcohol accounts for a significant number of injuries, illnesses, and deaths each year. In 2020, there were 6,202 deaths and 319,580 emergency room & hospital visits in Ontario related to alcohol (Canadian Alcohol Policy Evaluation, 2023). Alcohol has been classified as a type 1 carcinogen by the International Agency for Research on Cancer since 1988 and has been causally related to 7 types of cancer (Canadian Centre for Substance Use and Addiction (CCSA), 2023). Unfortunately, a large portion of Canadians are not aware of this fact putting many lives at risk given there are an estimated 7,000 cancer deaths due to alcohol consumption each year in Canada (CCSA, 2023). In addition to the human costs related to alcohol, there are significant financial implications. In 2020, alcohol cost Ontario taxpayers $7.109 billion in direct (e.g., healthcare and enforcement) and indirect (e.g., lost productivity) costs. Despite perceptions that alcohol is a large revenue generator for the province, in 2020-21, alcohol only produced $5.162 billion in returns for the province of Ontario, creating a $1.947 billion deficit for the province (CAPE, 2023).

Best Practice Alcohol Policies

Recently, the OPHA sent a letter, attached as Appendix A, to the Ministries of Health and Finance to share information about the public health risks associated with alcohol marketplace and product sale expansion. Additionally, OPHA highlighted five essential policy measures to decrease alcohol harms to Ontarians:

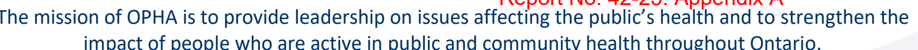
1. Reduce retail density, especially in low socio-economic status (SES) neighbourhoods.
2. Maintain or decrease hours of sale, with no exceptions.
3. Strengthen Ontario's alcohol pricing policies including taxation, minimum pricing, or other means.
4. Stop further privatization of alcohol sales.
5. Apply a whole of government, health-in-all-policies approach to alcohol modernization.

OPHA's Alcohol Policy Working Group, of which the Middlesex-London Health Unit is an active member, works collaboratively to communicate support for the maintenance and strengthening of alcohol policies and to increase awareness of health harms associated with alcohol consumption. By endorsing the OPHA letter, the Middlesex-London Board of Health is communicating the need to consider the public health consequences of continued increases to alcohol access and the importance of reducing alcohol-related harms.

This report was submitted by the Healthy Living Division and the Office of the Medical Officer of Health.

Dr. Alexander Summers, MD, MPH, CCFP, FRCPC
Medical Officer of Health

Emily Williams, BScN, RN, MBA, CHE
Chief Executive Officer



The mission of OPHA is to provide leadership on issues affecting the public's health and to strengthen the impact of people who are active in public and community health throughout Ontario.

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Constituent Societies

Alliance for Healthier Communities (AHC)

Association of Public Health Epidemiologists in Ontario (APHEO)

Association of Supervisors of Public Health Inspectors of Ontario (ASPHIO)

Canadian Institute of Public Health Inspectors - Ontario Branch (CIPHI-O)

Community Health Nurses' Initiatives Group (RNAO)

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Ontario Association of Public Health Nursing Leaders (OAPHNL)

Ontario Dietitians in Public Health (ODPH)

Ontario Public Health Libraries Association (OPHLA)

Charitable Registration Number 11924 8771 RR0001

Minister Peter Bethlenfalvy, Ministry of Finance of Ontario
Minister Sylvia Jones, Minister of Health
Sent by email to: peter.bethlenfalvy@ontario.ca and sylvia.jones@ontario.ca

May 31, 2023

Dear Minister Bethlenfalvy and Minister Jones,

Re: Modernizing alcohol marketplace and product sales

On behalf of the leaders and members of the Ontario Public Health Association (OPHA), we are writing to you to express our serious concerns about the impact that increasing alcohol availability and affordability will have on the health of Ontarians. We were recently invited to participate in closed door consultations by the Ministry of Finance, but were unable to given that the non-disclosure agreement would have prevented us from letting our members know about our participation or the kinds of input we would provide. Given that the government is conducting consultations regarding potential continued "modernization" of the alcohol marketplace, we are writing to highlight the inevitable consequences of illnesses, deaths and social harms to our citizens that will follow with increased sales and consumption of alcohol in Ontario. We implore the Government of Ontario to not increase access, availability or affordability of alcohol in light of the evidence below.

Research and real world evidence shows that when alcohol becomes more available and cheap, the following increases: street/domestic violence, chronic diseases, sexually transmitted infections, road crashes, youth drinking and injury (1) and suicide. (2,3) Along with increased costs from healthcare, lost productivity, criminal justice and other direct costs also increase. (4)

OPHA recommends that the government implement the following policy measures to mitigate these harms:

1. Reduce retail density, especially in low socio-economic status (SES) neighbourhoods.
2. Maintain or decrease hours of sale, with no exceptions.
3. Strengthen Ontario's alcohol pricing policies including taxation, minimum pricing or other means.
4. Stop further privatization of alcohol sales.
5. Apply a whole of government, health-in-all-policies approach to alcohol modernization.

The final report on Canada's Guidance on Alcohol and Health states that alcohol contributed to 18,000 deaths in Canada in 2017. (5) The evidence overwhelmingly proves that less is better when it comes to drinking alcohol. (5) Alcohol consumption causes 200 health and injury conditions, (6) and is identified by the World Health Organization (WHO) as a class 1 carcinogen in the same class as tobacco smoke and asbestos. (7) Most Canadians are not aware of this fact, which is concerning given that there are 7,000 cancer deaths due to alcohol consumption each year in Canada. (5) Not only does alcohol cause a high burden of disease, it also has significant social and economic consequences. Furthermore, impairment by alcohol is strongly associated with increased risk of unintentional injuries, violence and other second-hand effects, which impacts not only those consuming alcohol but also persons who have not decided to drink alcohol, including children. (5)

While the cost and harms of tobacco are decreasing for the first time, alcohol costs and harms are increasing. In Canada, the per-person healthcare costs attributable to alcohol rose from $117 to $165, increasing by 40.5% between 2007 and 2020, compared to tobacco, the per-person healthcare costs decreased from $167 to $143 during the same time. This fact helps create context to policy decisions being made; while tobacco has had increasing restrictions placed on it, such as increased taxes, product labelling and advertising bans/restrictions, alcohol has no such policies. The current alcohol policies are staying stagnant or being dismantled. (8)

We are asking for the government to strengthen its policy on alcohol. We must implement high standards to protect the people of Ontario from the harms alcohol contributes to and to ensure the businesses that perpetuate these harms do not obtain commercial gains or profits at the expense of Ontarians' health.

1. **OPHA recommends reducing retail density, especially in low socio-economic status (SES) neighbourhoods.**

Restrict the number and location of alcohol outlets to reduce alcohol related problems, and/or enable municipalities to do so. Proof of strong effectiveness and a large breadth of research exist to support this fact. (1) Changes involving increased access through a greater number of alcohol outlets, such as permitting sales in supermarkets, influence both alcohol consumption and harm. (1) This is concerning, being that Ontario increased access in 2015, where the number of locations authorized to sell beer increased by 450 stores. (9) Since that time, the government has expanded sales of beverage alcohol further to more than 270 new retail outlets across Ontario since 2018, including 191 LCBO convenience outlets and 87 grocery stores. (10)

Research shows that once Ontario started selling alcohol in grocery stores in 2015, there were over 24,000 more alcohol related emergency room visits than in the two years before. (11) Alcohol availability in the province increased by 22% between 2007 and 2017. (12) Changes to rules that made it easier to buy alcohol during the COVID-19 pandemic have become permanent and have increased alcohol availability. (13)

A recent analysis using the Cancer Risk Factors Atlas of Ontario documented that in Toronto, higher alcohol intake was found in areas where residents lived within 500 m of off-premise alcohol retailers, compared with areas with retailers over 1 kilometre away. Regardless of neighbourhood socio-economic status, access to off-premise alcohol retailers was related to excess alcohol consumption in Toronto neighbourhoods. (14) Despite what this analysis found, a health equity lens should be applied in alcohol policy changes as people of lower socio-economic status and other priority groups (e.g., youth) (1,15) are typically disproportionately affected by policies that increase alcohol access in their neighbourhoods. (1,16)

The CAPE report cards are a research project that provides assessments of provincial, territorial and the federal governments in Canada implementing policies proven to reduce harms due to alcohol. (17) Ontario's report card was recently (December 2022) downgraded to an F for this alcohol policy area. The previous report cautions against expansion of alcohol availability in corner stores and more grocery outlets. (17) The current report advises the following for alcohol availability:

- Strengthen and reduce existing density limits for off-premise outlets and introduce density limits for on-premise establishments. (17)
- Introduce placement limits for all premises (17)
- Prohibit on-premise alcohol takeout. (17)
- Prohibit alcohol home delivery from all premises. (17)

2. OPHA recommends maintaining or decreasing hours of sale, with no exceptions.

Similar to the Centre for Addiction and Mental Health, OPHA has concerns around increasing hours of sale. (18) Extensions of as little as one to two hours have been observed to result in increased harms. (19) (20) Extended hours of sale attract a younger drinking crowd and result in higher blood alcohol content (BAC) levels for males. (21) Controls on retail hours and days of sale have been shown to be effective in reducing consumption and alcohol-related harms (22) and evidence suggests a potential direct effect of policies that regulate alcohol sales times in the prevention of heavy drinking, injuries, motor vehicle incidents, alcohol-related hospitalizations, assaults, homicides and violent crime. (23,22,24,25)

Furthermore, research for on-premise outlets (e.g., licensed establishments) show that extended hours of alcohol service are associated with increased alcohol consumption and increased alcohol-related harms. (1) (17) Evidence indicates a higher risk of ambulance calls for trauma in areas with highest density of on-premise licensed alcohol establishments (26) with alcohol-related violence most likely occurring between 22:00 and 2:00 hours. (27) It has also been suggested that emergency calls for injury and intoxication may be reduced by limiting the hours of operation of licensed alcohol establishments. (26)

In Germany, banning sale of alcohol between 10 pm and 5 am in retail settings resulted in a significant decrease in alcohol-related hospitalizations among adolescents and young adults, as well as hospitalizations due to violent assault. (28)

The 2023 CAPE report card rated Ontario with an F for this alcohol policy area and recommended the following:

- Reduce and legislate maximum trading hours allowed per week.
- Implement the following hours of sale: 11 am to 8 pm for off-premise and 11 am to 1 am for on-premise with no extensions. (2)

3. OPHA recommends strengthening Ontario's alcohol pricing policies.

Alcohol pricing policy is a highly cost-effective intervention which is underutilized by governments. Decades of international and Canadian research show that raising the price of alcohol is one of the most cost-effective approaches for reducing consumption and thereby alcohol-related health and social harms. This is done through policy actions such as excise taxes, minimum pricing, and regularly adjusting alcohol prices for inflation. (2) Another innovative action would be to implement a dedicated, earmarked, or surcharged tax on alcohol to help cover the health and social costs. (29)

There have been eight meta-analyses that have systematically reviewed the results of applicable econometric studies. It was consistently reported in all eight reviews that a price increase leads to decreases in consumption. (1) This can also be corroborated by research on tobacco pricing, which has the same mechanism of action, only for a different substance. (30) Higher prices on alcohol encourages less consumption by drinkers and hinders non-drinkers to start drinking. (1)

The above was demonstrated in British Columbia where a 10 per cent increase in minimum alcohol prices was associated with a 32 per cent drop in alcohol-related deaths. (31) In Saskatchewan, a 10 per cent increase in minimum prices significantly reduced consumption of all types of alcoholic beverages by almost 8.5 per cent, thereby decreasing harms as well. (1,32) A recent major international study found that, on average, a 1 per cent increase in overall alcohol prices was associated with a 0.5 per cent reduction in alcohol use and resulted in increases in both industry profits and government revenues. (33)

Pricing controls have been demonstrated to be particularly effective for susceptible populations, such as young people, and heavy drinkers. (1,15) For young people, a price increase leads to reduced rates of suicide, traffic injuries and sexually transmitted diseases with the opposite effect with price decrease. (1) Alcohol harms that are typically attributed to long term heavy drinking are also found to change in response to tax changes. (1) Generally, research proposes that alcohol taxes have a greater fiscal impact on lower income people than those with higher income. (1)

It has been identified that corporations, such as those involved with Big Alcohol, create narratives to interfere with policy decisions. This practice is referred to as **argument-based discursive strategies**, where corporations, for example, stress the crucial role that the industry plays in the economy, or promote industry-preferred solutions such as education and voluntary initiatives. (34) It is not surprising then that the story created around increasing alcohol prices is that it will have negative impacts on the economy and employment.

This narrative has been challenged with the argument that if people buy less alcohol, they will spend more money on other goods, which will create jobs elsewhere in the economy. (29) It is also wise to be cautious when relying on employment estimates from the alcohol industry research stating how many jobs are involved with alcohol production - similar industries have exaggerated these estimates in the past. Research for the World Bank revealed that numbers reported to be employed by the tobacco industry were three times the actual number of FTEs. (29)

The 2023 CAPE report card rated an F for this alcohol policy area, and recommended improvement through the following:

- Increase minimum prices to a price per standard drink (e.g. 17.05 mL pure alcohol) of at least $2.04* for alcohol sold at off-premise stores and $4.07* for alcohol sold at on-premise establishments, after taxes (*2023 price). (17)
- Include on-premise alcohol and beer sold off-premise to automatic indexation. (17)
- Set minimum prices by ethanol content (e.g. $/L ethanol). (17)
- Tax alcohol at a higher rate than consumer goods, update general alcohol prices yearly to reflect Ontario specific inflation rates, and increase alcohol sales taxes. (17)
- Set off-premise minimum retail markups to be at least 100% of the landed cost across all beverage types and set on-premise markups at or above the off-premise retail price. (17)

The World Health Organization has a resource tool on alcohol taxation and pricing policies to inform the above actions. (29)

4. OPHA recommends against further privatization of alcohol sales.

Government retail monopolies are an effective way to limit alcohol consumption and harm at the population level. (1,2) Proof of strong effectiveness and a large breadth of research exist to support this fact. (1) In Canadian jurisdictions where government retail monopolies have been dismantled and partial or full privatization have been introduced, increases in alcohol consumption and harms have been observed. (2) With governmental monopolies, the priority can be given to public health and public safety goals rather than a focus on profits and increasing sales. Not only does government monopolies on alcohol support population health it also provides governments with a means of income. (1)

In Sweden, modelling was done to predict the potential impact of privatizing Sweden's alcohol monopoly, along with other policy impacts. Stockwell et al. (2018) estimated that privatization could lead to increases in consumption of between 20% and 31% and in mortality of up to 80%. (1) Evidence from Finland demonstrates that removing even a single beverage from government monopoly control can have dramatic impacts. (1) The positive effects of re-monopolization cannot be ignored as well. Re-monopolization is associated with a decrease in alcohol-related harms including suicides, falls and motor vehicle collisions. (2)

The 2023 CAPE report card rated an F for this alcohol policy area for the province and recommended that Ontario:

- Maintain the present network of government-owned and government-run LCBO retail stores with a mandate to protect health and safety. (17)
- Ensure that new legislation/regulations do not further privatize alcohol sales (e.g. convenience stores, more grocery stores and big box stores). (17)

5. OPHA recommends applying a whole of government, health-in-all-policies approach to alcohol modernization.

Bring all government ministries together when developing new public policy or making changes to existing policies to ensure health and safety implications are considered. Establish baselines, monitor, measure and review the impact of changes to alcohol policy to other government priorities and goals. To illustrate, policing costs were ranked as the second biggest cost caused by alcohol at 11.1% of the total costs of alcohol. (35) The Ontario Government is increasing police funding to deal with violent crime, as quoted by Premier Ford: "As crime continues to rise in communities across Ontario, we're taking action to get more boots on the ground…to address crime and keep people safe." (Twitter) If the Ontario Government is looking to decrease crime, increasing access to alcohol would be in direct opposition to this goal. (36,37) Having better collaboration and understanding among Ministry areas would help with aligning goals and decrease competing priorities.

In summary, the Ontario Public Health Association recommends the following:

1. Reduce retail density, especially in low socio-economic status (SES) neighbourhoods.
2. Maintain or decrease hours of sale, with no exceptions.
3. Strengthen Ontario's alcohol pricing policies including taxation, minimum pricing or other means.
4. Stop further privatization of alcohol sales.
5. Apply a whole of government, health-in-all-policies approach to alcohol modernization.

The people of Ontario deserve communities that support, not undermine their health and well-being. When it comes to alcohol sales, the government must forego the objectives of "expanding choice and convenience for consumers" in favour of the health of Ontarians. The majority of the public does not yet recognize or know the extent of the harms that alcohol causes (38), and the government has an obligation to protect people. OPHA has previously provided the government with the information needed to make informed and balanced decisions regarding alcohol policy and we trust that the enclosed information and our recommendations will end further "modernization" of the alcohol market.

Government spending to meet the growing costs from alcohol-related harms is not sustainable. Industry interests support greater access and increased consumption. The Government of Ontario's legacy can be one that puts the health of Ontarians first, and over the interests of industry. We urge the government to work across ministries and in close collaboration with employers, healthcare providers and community stakeholders to strengthen alcohol policies or at least prevent further erosion. We would welcome the opportunity to meet with you and/or your ministries to discuss our recommendations further and the government's move towards progressive alcohol control policies.

Sincerely,

John Atkinson
Executive Director

Cc: Dr. Kieran Moore, Chief Medical Officer of Health
Fausto Iannialice, Director, Alcohol Policy and Strategic Initiatives Branch
Dr. Eileen DeVilla, Chair, Council of Medical Officers of Health (COMOH)

More about the Ontario Public Health Association

OPHA has established a strong record of success as the voice of public health in Ontario. We are a member-based, not-for-profit association that has been advancing the public health agenda since 1949. OPHA provides leadership on issues affecting the public's health and strengthens the impact of those who are active in public and community health throughout Ontario. OPHA does this through a variety of means including advocacy, capacity building, research and knowledge exchange. Our membership represents many disciplines from across multiple sectors.

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MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 43-23

TO: Chair and Members of the Board of Health

FROM: Emily Williams, Chief Executive Officer
Dr. Alexander Summers, Medical Officer of Health

DATE: 2023 July 20

MLHU EMPLOYMENT SYSTEMS REVIEW UPDATE: EMPLOYMENT EQUITY AND RECRUITMENT POLICY

Recommendation

It is recommended that the Board of Health receive Report No. 43-23 re: "MLHU Employment Systems Review Update: Employment Equity and Recruitment Policy" for information.

Key Points

- The Employment Equity Policy was approved and released to all staff in October 2022.
- Targets and Benchmarks to improve diversity in the workforce at the MLHU as required under the Employment Equity Policy have been established.
- The Recruitment Policy and Procedure was launched and released to all staff in June 2023, which supports reducing bias in hiring to achieve employment equity targets.
- Workforce demographics from the Workplace Census survey at MLHU are outlined in Appendix A.

Background

Turner Consulting Group Inc. delivered the Employment System Review (ESR) as part of the Diversity and Inclusion Assessment in March 2021. In May 2021, the Board of Health committed to the systemic, coordinated, comprehensive and sustained implementation of the ESR. At that time, it was recommended that the 88 recommendations be prioritized, and that a plan for implementation would be led by the Human Resources (HR) Team in close collaboration with the Health Equity and Reconciliation Team (HEART), and that the Senior Leadership Team (SLT) would ensure appropriate resourcing and prioritization of the implementation of approved recommendations. In 2022, an investment was approved for a Diversity and Inclusion Specialist as part of the HR team, which has been a critical driver for this important work. Over the course of the last 6 months, significant work has progressed in the areas of the Employment Equity Policy and Procedures, along with the release of the updated Recruitment Policy and Procedures.

Progress on ESR Recommendation Implementation and Prioritization

The Employment Equity Policy and Procedure includes the establishment of, "targets based on the workforce analysis to achieve reasonable progress towards equitable representation of Designated Groups (Indigenous people, Black and other racialized groups, women, persons with disability, LGBTQ2+ people, and newcomers). The targets will be approved by SLT and will be communicated to all employees". The HR, HEART, Strategy, Planning and Performance (SPP) and Population Health and Assessment and Surveillance (PHAS) teams collaborated on setting the targets and benchmarks using census data, other relevant population data, industry standards, and historical and predicted turnover rates.

Table 1 in Appendix A summarizes the 2021 MLHU demographics obtained via the Workplace Census survey, the targets that were developed, and the benchmark data based on the Middlesex London census area. The Workplace Census indicates the MLHU respondents identified as 82% White/European, 14% racialized, <2% North American Indigenous, and 2% preferred not to answer. When analyzing the results within various occupational groups at the Health Unit (Table 2, Appendix A), the percentage of racialized Public Health Program Staff and Administrative and Support Staff is 20% and 21% respectively. The Nursing and Leadership groups had the least amount of racial diversity with 9% and 8% respectively. Using data from the 2021 Canada Census and Our Health Counts (OHC), 75% of the population in Middlesex London identify as White/European, 20% as racialized, and 5% as North American Indigenous. These figures establish the benchmark that the MLHU workforce ideally would reflect in the long-term, mindful that this demographic picture is changing annually. Understanding that the Health Unit operates within societal structural obstacles, and that the procedural changes that are being implemented in the updated Recruitment Policy and Procedure and through other initiatives will take time to impact the MLHU workforce racial demographics, interim targets have been established to provide measures by which to monitor progress. The Employment Equity targets approved by SLT are: 79% White/European, 18% racialized, and 3% North American Indigenous representation among the MLHU employees by 2025.

The Workplace Census looked at other measures of diversity as well. It found that the MLHU staff report similar levels of disability as the general population. When considering religious diversity, gender identity and sexual orientation, there were no significant differences compared to that of the general population, although like racial identity, there were segments of Health Unit staff that preferred not to answer these questions. Creating and maintaining an equitable and inclusive environment where staff feel safe to answer all questions in the Workplace Census Survey is an underlying goal of all the ESR recommendations.

While the Employment Equity Policy and Procedures formalize MLHU's commitment to an equitable and diverse workplace, the revision and implementation of the Recruitment Policy and Procedures is how the MLHU processes support that commitment. The ESR had 42 recommendations related to Recruitment that have been met through policy and procedure changes released on June 9th, which include:

- a rigorous review of the qualifications, posting, screening and interview tools in a recruitment planning meeting for each hiring process, including consideration of education equivalencies for appropriate positions;
- a structured approach to interviewing to ensure questions asked to have a direct connection to qualifications;
- including an objective guide on required responses within all interview tools; and
- introducing consensus scoring of candidates.

These and other measures serve to broaden the candidate pool to better reflect the demographics of the area the MLHU serves, and to minimize bias in the selection process. The updated Recruitment Policy and Procedure has been well-received by leaders and union partners, and was also reviewed prior to implementation by the Equity, Diversity, and Inclusion Advisory Committee to obtain feedback.

Risks to Achieving Employment Equity Targets

The size of the organization and potential funding constraints in the next several years could impact the number of actual new hires joining the MLHU. The ability to meet these targets will be further impacted by the racial make-up of the qualified applicant pool, as well as collective agreement limitations that continue to heavily weight seniority in selection processes. With respect to improving diversity within the Health Unit Nursing complement, there remain several 'over-hired' (above base budget) nursing staff. Depending on the racial identity of these staff, it may be difficult to achieve increased diversity in this occupational group as these extra positions are absorbed via attrition.

Given the challenges in recruiting leadership talent across the health sector, the MLHU is committed to developing leadership talent within the organization. The introduction of the Potential Leaders Development Program, which includes opportunities for leadership training for front line staff, supports this objective, and Employment Equity will be considered in selection decisions. It is recognized that this may therefore take some time to see the increase in diversity in this occupational group.

Next Steps

Leaders have been providing teams with a presentation, prepared and supported by the HR Specialist, Diversity & Inclusion, explaining the development and establishment of the targets. Employees will have the opportunity to ask questions about the process. Once all teams have received this presentation, it will be presented in a Town Hall to all staff in late July.

The outstanding recruitment and other ESR recommendations will be addressed in the coming months. Auditing, monitoring, and making necessary adjustments to the application of the Recruitment Policy and Procedure will be important next steps in meeting the Employment Equity targets.

The next ESR and Workplace Census Survey is scheduled to be completed in 2025 and will provide the MLHU with data by which to determine progress in achieving the targets set. In the event the targets are not achieved, an analysis report will include recommendations for actions in the following cycle for consideration and approval by the SLT. The analysis report and approved action items (if applicable) will be provided to the Board of Health at that time.

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

EWilliams

Emily Williams, BScN, RN, MBA, CHE
Chief Executive Officer

Dr. Alexander Summers, MD, MPH, CCFP, FRCPC
Medical Officer of Health

Table 1: Indigenous and Racialized Population, Permanent Full-time and Part-time Employees

Indigenous and Racialized Population, Permanent Full-time and Part-time Employees			
	Permanent FT & PT Employees	Goal/Target	Benchmark
	%	%	%
North American Indigenous	<2%	3%	5%
Racialized	14%	18%	20%
White/European	82%	79%	75%
Prefer not to answer	2%		
TOTAL	100%	100%	100%

Table 2: Representation of the Equity Seeking Groups by Occupation, Permanent Full-time and Part-time Employees

Representation of the Equity Seeking Groups by Occupation, Permanent Full-time and Part-time Employees	
	Indigenous and Racialized People
Nurses	9%
Public Health Program Staff	20%
Administrative and Support Staff	21%
Leadership Staff	8%
Average	14%
Goal	**20%**
# of new staff to meet goal	8

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 44-23

TO: Chair and Members of the Board of Health

FROM: Dr. Alexander Summers, Medical Officer of Health

DATE: 2023 July 20

MEDICAL OFFICER OF HEALTH ACTIVITY REPORT FOR MAY AND JUNE

Recommendation

It is recommended that the Board of Health receive Report No. 44-23, re: Medical Officer of Health Activity Report for May and June for information.

The following report highlights activities of the Medical Officer of Health for the period of May 1, 2023 – July 8, 2023.

The Medical Officer of Health provides oversight of all public health programs at the Middlesex-London Health Unit, and co-chairs the Senior Leadership Team. The Medical Officer of Health participates in a wide range of external and internal meetings, along with liaising with community partners and municipal and provincial stakeholders.

The Medical Officer of Health, along with other team members, continues to host a weekly Middlesex-London Health Unit (MLHU) Staff Town Hall.

The Medical Officer of Health also participated in the following meetings:

Client and Community Impact – *These meeting(s) reflect the MOH's representation of the Health Unit in the community:*

May 2 Participated in a case conference with the Health Services and Review Board regarding an *Immunization of School Pupils* appeal.

May 3 Presented at the 36th Annual Geriatric Medicine Refresher Day, organized by Western University St. Joseph's Health Care.

May 4 Hosted Matthew Meyer and Amber Alpaugh-Bishop from the Middlesex-London Ontario Health Team.

Participated in a call to discuss MLHU participation with the Queens University's Public Health and Preventive Medicine residency program.

May 5 Participated in a call to discuss designing a wholistic needs screener with London Health Sciences Centre.

May 8 Attended a COMOH Executive Update meeting.

Participated in a meeting with Dr. Joanne Kearon and Dr. Emily Groot from the Northern Ontario School of Medicine regarding clinical training.

May 11 Attended a Strategy and Accountability meeting as part of the Whole of Community Response Plan.

May 12 Attended the monthly COMOH Executive meeting.

Interview with Mike Stubbs, AM980 CFPL regarding the World Health Organization announcement that the COVID-19 global public emergency has ended.

Interviews with Angela McInnes and Colin Butler, CBC News London, regarding the Board of Health letter to the provincial government regarding social assistance rates and food affordability.

May 16 Participated in the provincial Public Health Sector Coordination Table meeting.

Attended a COMOH Executive Update meeting.

Attended the YMCA Women of Excellence Gala.

May 17 Attended a meeting of the Infectious Disease Training Program Committee meeting.

May 18 Met with a medical student to discuss specialization in public health and preventive medicine.

May 23 With Dr. Joanne Kearon, participated in a meeting to discuss a public health and preventive medicine residency at Western University.

May 24 Participated in a call to discuss MLHU participation with the Queens University's Public Health and Preventive Medicine residency program.

May 25 Attended the monthly Middlesex-London Ontario Health Team Coordinating Council meeting.

Met with Lynne Livingston, Manager, City of London.

May 26 Presented at the McMaster University Academic Half Day.

Participated in a call with Dr. Natalie Bocking, Medical Officer of Health, Haliburton, Kawartha, Pine Ridge District Health Unit.

Met with a medical student to discuss specialization in public health and preventive medicine.

May 31 Attended the London-Middlesex Primary Care Alliance/MLHU/Middlesex-London Ontario Health Team Vaccination Discussion meeting.

Participated in the Public Health Leadership Table meeting, organized by the Office of the Chief Medical Officer of Health.

June 1 Toured Mission Services' Quinton Warner House.

June 5 Met with leadership from the Regional HIV/AIDS Connection.

June 6 Attended COMOH Working Group meeting.

June 8 & 9 Attended the Urban Public Health Network meeting in Halifax, Nova Scotia.

June 12 & 14 Attended the Association of Local Public Health Agencies' Annual General meeting.

June 15 Chaired the Healthy Living divisional leadership meeting.

June 19 Attended the monthly Southwest Medical Officer of Health/Associate Medical Officer of Health meeting.

With Emily Williams, CEO, met with staff from Hon. Monte McNaughton's office to discuss the MLHU Strathroy Dental Clinic and its grand opening.

June 20 Presented the Healthcare Provider Webinar.

With Dr. Joanne Kearon, participated in a meeting to discuss a public health and preventive medicine residency at Western University.

June 21 Participated at the Indigenous Solidarity Day event at the Wortley Green, representing MLHU.

Met with Lynne Livingston, Manager, City of London.

June 22 Participated in the Middlesex County Warden's Charity Golf Tournament.

June 23 Participated in a call with Dr. Mehdi Aloosh, Medical Officer of Health, Windsor-Essex County Health Unit.

June 26 Participated in the grand opening ceremony of the MLHU Strathroy Dental Clinic.

June 27 Interview with Amanda Margison, CBC London, regarding the special air quality statement in effect for the Middlesex-London region.

Participated in a stakeholder interview with Alison Locker, Manager, Population Health Assessment and Surveillance for the Canadian Urban Substance Surveillance Project.

June 28 Participated in an Infectious Disease Residency Training Program Committee Meeting.

July 5 Met with leadership from the Regional HIV/AIDS Connection regarding the Needle Syringe Program.

July 7 Interview with Pat Maloney, London Free Press, regarding the current COVID-19 status in London and Middlesex County.

July 8 Published an opinion editorial in the London Free Press, titled "London homeless crisis demands pandemic-like response."

Employee Engagement and Learning – *These meeting(s) reflect on how the MOH influences the Health Unit's organizational capacity, climate and culture and the contributions made to enable engaged and empowered staff; thoughtful and responsive leadership and organizational structures that support decision-making, innovation and learning:*

May 1 Participated in a meeting regarding revising medical directives and processes for immunoglobulin.

Participated in a meeting regarding a revised model for the COVID-19 vaccination clinics.

May 2 Participated in a meeting regarding the operationalization of a Management Operating System.

May 3 Attended a meeting to discuss revising agency orientation at MLHU.

May 4 Chaired the Healthy Living divisional leadership meeting.

May 8 Participated in a meeting regarding the centralized ordering project for MLHU.

Attended a meeting to finalize MLHU's STI strategy.

May 11 Attended a Provisional Planning Sponsor check-in meeting.

Attended a SDOH Project Sponsor meeting.

May 12 Attended a meeting regarding a project on clinical process improvements involving students from Fanshawe College.

May 16 Attended the monthly Population Health Assessment and Surveillance Team leadership meeting.

May 17 Attended a project kick-off meeting for the project on clinical process improvements involving students from Fanshawe College.

May 18 Attended the monthly surveillance meeting.

Chaired the Healthy Living divisional leadership meeting.

May 24 Attended the Public Health Foundation divisional leadership meeting.

May 26 Participated in a meeting regarding case and contact management for HIV.

Participated in a meeting regarding determining common interventions.

Participated in an update meeting regarding a revised model for the COVID-19 vaccination clinics.

May 29 Chaired the meeting of the First Nations Communities Working Group.

May 31 Participated in a meeting regarding determining common interventions.

June 1 Chaired the Healthy Living divisional leadership meeting.

June 6 Orientated and met with Infectious Disease Resident.

June 16 Orientated and met with Infectious Disease Resident and Public Health Resident.

June 19 Attended a meeting to finalize the agency STI strategy.

June 23 Participated in the Staff Summer Social.

June 28 With Emily Williams, CEO, facilitated a meeting with Cynthia Bos, Manager, Human Resources to discuss daily program operations.

Attended the Social Determinants of Health Project Sponsor Meeting.

Attended the Steering Committee Meeting for the Intervention Description/Indicator Development Project.

July 4 Orientated and met with Infectious Disease Resident.

Orientated and met with Pre-clerkship Medical Student.

With Emily Williams, CEO, facilitated a meeting with Sarah Webb, Manager, Community Outreach and Clinical Supports to discuss daily program operations.

July 6 With Emily Williams, CEO, facilitated a meeting with Andrew Powell, Manager, Safe Water, Rabies, and Vector Borne Diseases to discuss daily program operations.

With Emily Williams, CEO, facilitated a meeting with Ronda Manning, Manager, Early Years Community Health Promotion to discuss daily program operations.

Attended the Healthy Living Division Leadership meeting.

July 7 With Emily Williams, CEO, facilitated a meeting with Dave Pavletic, Manager, Food Safety and Healthy Environments to discuss daily program operations.

Personal Development – *These meeting(s) reflect on how the MOH develops their leadership, skills and growth to define their vision and goals for the Health Unit.*

May 9 Participated in an Infectious Diseases Journal Club regarding Doxycycline PEP for STI prevention.

May 10 Attended the 31st Annual Clinical Day in Family Medicine.

May 17 Participated in the fifth LEADS training session.

June 12 & 14 Attended the Association of Local Public Health Agencies' Annual Conference.

June 16 Participated in career day with Public Health and Preventative Medicine Residents at University of Toronto.

June 20 Participated in the PHO Rounds, Mpox: Outbreak, Response, and Vaccine Effectiveness.

Governance – *This meeting(s) reflect on how the MOH influences the alignment of management methods and systems to ensure appropriate structures and resources are in place to achieve the HU's mission and vision. This also reflects on the MOH's responsibility for actions, decision and policies that impact the HUs ability to achieve the requirements as set out under the strategic plan, the Ontario Public Health Organizational Standards (OPHOS), other funder requirements and direction provided by the Board of Health:*

May 9	Attended the monthly Board of Health agenda review and executive meetings.
May 11	Attended the May Finance and Facilities Committee meeting.
May 17	Attended the monthly one-on-one meeting with the Board Chair.
	Attended a COMOH Public Health Priorities Forum meeting.
May 18	Attended the May Board of Health meeting.
May 30	Attended an MOH/CEO Budget Discussion meeting.
June 5	Attended the Executive Meeting with the Board Chair, Vice-Chair and Chief Executive Officer.
June 19	Attended the monthly one-on-one meeting with the Board Chair.

This report was prepared by the Medical Officer of Health.

Alexander T. Summers

Dr. Alexander Summers, MD, MPH, CCFP, FRCPC
Medical Officer of Health

MIDDLESEX-LONDON HEALTH UNIT

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 45-23

TO: Chair and Members of the Board of Health

FROM: Emily Williams, Chief Executive Officer

DATE: 20 July 2023

CHIEF EXECUTIVE OFFICER ACTIVITY REPORT FOR MAY AND JUNE

Recommendation

It is recommended that the Board of Health receive Report No. 45-23, re: Chief Executive Officer Activity Report for May and June for information.

The following report highlights activities of the Chief Executive Officer (CEO) for the period of May 1, 2023 – July 8, 2023. The CEO was on vacation from May 19 – May 29.

Standing meetings include weekly Healthy Organization leadership team meetings, SLT (Senior Leadership Team) meetings, MLT (MLHU Leadership Team) meetings, Virtual Staff Town Hall meetings, bi-weekly R3 meetings, and weekly check ins with the Healthy Organization managers and the MOH.

The CEO also attended the following meetings:

Client and Community Impact – *These meeting(s) reflect the CEO's representation of the Health Unit in the community:*

May 2 The CEO met with Carl Bernat, Vice President of CCS Engineering & Construction Inc. to discuss matters related to the Strathroy Dental construction project.

May 9 The CEO attended the Breakfast of Champions, hosted by St. Joseph's Health Foundation and CMHA Thames Valley Addiction and Mental Health Services, a fundraiser in support of Mental Health Awareness.

May 31 The CEO attended the Strategy and Accountability table meeting organized by the City of London as part of the Health and Homelessness work.

June 6 The CEO attended a meeting to discuss London Health Sciences Centre's (LHSC) Master Plan.

June 15 The CEO attended the Strategy and Accountability Table meeting of the Health and Homelessness work organized by the City of London.

June 21 The CEO attended the Indigenous Solidarity Day event in Wortley Village.

June 22 The CEO attended the Middlesex London Ontario Health Team (MLOHT) Coordinating Council Meeting.

June 26 The CEO, with the Board of Health Chair, and Medical Officer of Health, attended the opening of the Strathroy Dental Clinic.

Employee Engagement and Learning – *These meeting(s) reflect on how the CEO influences the Health Unit's organizational capacity, climate and culture and the contributions made to enable engaged and empowered staff; thoughtful and responsive leadership and organizational structures that support decision-making, innovation and learning:*

May 1 The CEO offered welcome greetings to new staff at the Health Unit orientation session.

May 4 The CEO participated in the Employment Systems Review (ESR) Steering committee Meeting.

The CEO, along with the Medical Officer of Health, Director, Environmental Health and Infectious Diseases (EHID), met to discuss centralized ordering of clinical supplies.

May 11 The CEO attended the monthly Provisional Planning Sponsor meeting.

The CEO attended a confidential legal meeting.

The CEO participated in the ESR Project Team Meeting.

May 12 The CEO, along with the Medical Officer of Health and Director, EHID, met with Mike Kadour regarding a potential project at the Health Unit working with Healthcare Administration students from Fanshawe.

May 16 The CEO attended the Public Health Sector Coordination Table meeting organized by the Office of the Chief Medical Officer of Health.

May 18 The CEO attended the quarterly update meeting with Stronghold.

May 18 The CEO met with the Chief Nursing Officer to co-create the implementation plan for model of care review at the Health Unit.

May 29 The CEO attended a meeting related to confidential HR matters.

June 1 The CEO attended a meeting related to confidential legal matters.

The CEO, along with the Medical Officer of Health, Environmental Health and Infectious diseases (EHID), Assistant Director, Finance, Manager, Sexual Health, and Medical Resident met to discuss the Needle Syringe Program in collaboration with Regional HIV/AIDS Connection.

June 6 The CEO attended a meeting regarding confidential HR matters.

June 19 The CEO attended a meeting related to confidential HR matters.

The CEO participated in the Employment Systems Review (ESR) Steering Committee Meeting.

June 21 The CEO, with the Medical Officer of Health, participated in discussions to fill the Acting Director of Healthy Living position.

June 22 The CEO met to discuss professional development with a member of staff.

The CEO, with the Medical Officer of Health, participated in discussions to fill the Acting Director or Health Living position.

June 23 The CEO, with the Medical Officer of Health, participated in discussions to fill the Acting Director of Healthy Living position.

The CEO attended the second annual MLHU Staff Day Social, organized by the BeWell Committee.

June 26 The CEO participated in the Equity, Diversity, and Inclusion (EDI) committee meeting.

June 27 The CEO attended the BeWell Committee meeting to discuss a change to the organization's Corporate Social Responsibility policy.

June 28 The CEO, along with the Medical Officer of Health met with the manager, Human Resources (HR) to participate in "A day in the Life of My Team" to better understand the day-to-day workings of the HR team.

June 29 The CEO attended a meet and greet with Strong Hold to meet the new parent company's CEO.

July 4 The CEO, along with the Medical Officer of Health met with the manager, Community Outreach and Clinical Support to participate in "A day in the Life of My Team" to better understand the day-to-day workings of the Community Outreach and Clinical Support teams.

July 6 The CEO attended the Community Health Promotion team meeting to participate in discussions related to the Provisional Plan.

The CEO, along with the Medical Officer of Health met with the manager, Safe Water, Rabies, and Vector Born Disease to participate in "A Day in the Life of My Team" to better understand the day-to-day working of the Safe Water, Rabies and Vector Born Disease team.

The CEO, along with the Medical Officer of Health met with the manager, Early Years Community Health Promotion (EYCHP) to participate in "A Day in the Life of My Team" to better understand the day-to-day workings of EYCHP.

July 7 The CEO met with Stephanie Jackson from London Health Sciences Centre (LHSC) for mentorship.

The CEO, along with the Medical Officer of Health met with the manager, Food Safety and Healthy Environment to participate in "A Day in the Life of My Team" to better understand the day-to-day workings of the Food Safety and Health Environment team.

Personal Development – *These meeting(s) reflect on how the CEO develops their leadership, skills and growth to define their vision and goals for the Health Unit.*

May 8 The CEO attended training related to self-assessment of Myers Briggs Type Indicator.

June 7 The CEO chaired the McCormick Care Board Quality Committee Meeting.

June 8 The CEO attended the McCormick Care Board Executive Committee Meeting.

June 26 The CEO met with a representative from The Achievement Centre to debrief the recently completed performance appraisal surveys.

June 27 The CEO attended the McCormick Care Board of Directors Meeting and the Annual General Meeting.

Governance – *This meeting(s) reflect on how the CEO influences the alignment of management methods and systems to ensure appropriate structures and resources are in place to achieve the HU's mission and vision. This also reflects on the CEO's responsibility for actions, decision and policies that impact the HUs ability to achieve the requirements as set out under the strategic plan, the Ontario Public Health Organizational Standards (OPHOS), other funder requirements and direction provided by the Board of Health:*

May 1 The CEO met with the CEO of Southwestern Public Health, to review issues of common interest.

May 4 The CEO, along with the Medical Officer of Health, Manager, Human Resources, Director, Public Health Foundations met to discuss the MLHU Agency Orientation Program.

The CEO attended a meeting with the Ministry of Health Funding and Oversight program to learn about funding updates.

The CEO, along with the Manager, Human Resources, met with AON, the health and benefits broker for the Health Unit, to conduct annual planning.

May 5 The CEO attended a half-day meeting with four other CEO's in public health to discuss issues of common interest and share learning and strategies.

May 8 The CEO attended a meeting with other MOH's and CEO's from across the province to discuss budget planning for 2024.

May 9 The CEO attended the May Board of Health agenda review and Executive Meeting.

May 10 The CEO attended the Public Health Foundations divisional leadership meeting to discuss the strategic plan, the Management Operating System and upcoming meetings with the MOH.

May 11 The CEO attended the May Finance and Facilities Committee Meeting.

May 12 The CEO, along with the Manager, HR, met with the HR Coordinator Learning Systems and Performance Management to review progress on the electronic performance appraisal tool for leaders, as part of the Joy in Work initiative action plan.

May 19 The CEO attended a meeting with other MOH's and CEO's from across the province to discuss budget planning for 2024.

May 29 The CEO attended the Strathroy Dental Project Steering Committee meeting.

May 30 The CEO met with the Manager, Health Equity, to review the organization's strategy related to Corporate Social Responsibility.

The CEO attended a meeting with other MOH's and CEO's from across the province to discuss budget planning for 2024.

May 31 The CEO, with the Healthy Organization Division leadership team, met to review the strategic plan and update the divisional workplan with new priorities for 2023-2024.

June 1 The CEO attended a meeting with the Ministry of Health Funding and Oversight program to learn about funding updates.

The CEO met with the City of London for a follow-up meeting to discuss the accessibility review.

June 5 The CEO, along with Board Chair Newton-Reid, and the Medical Officer of Health met to review the alPHa resolutions.

June 6 The CEO, along with the Medical Officer of Health, and Assistant Director, Finance met to review the 2023 budget.

June 8 The CEO attended the monthly Provisional Planning Sponsor meeting.

The CEO chaired the Public Health Roles Advisory Workgroup meeting, providing an update on the job description project.

June 9 The CEO attended a meeting with other MOH's and CEO's from across the province to discuss budget planning for 2024.

June 12 The CEO attended the alPHa conference and Annual General Meeting June 12-13.

June 14 The CEO attended a meeting in-person with MOH's and CEO's from across the province to discuss budget planning for 2024.

June 19 The CEO, with the Medical Officer of Health, attended a meeting with two of MPP Monte McNaughton's staff regarding the opening of the Seniors Dental Clinic in Strathroy.

The CEO attended the Strathroy Dental Project Steering Committee meeting.

The CEO attended a School Health Team meeting to provide updates on the 2023-2024 Provisional Plan.

June 23 The CEO attended the Multi-Year Budget Implementation and City Council's Strategic Plan Implementation meeting organized by the City of London.

June 28 The CEO met with CUPE and HR regarding a confidential HR matter.

This report was prepared by the Chief Executive Officer.

EWilliams

Emily Williams, BScN, RN, MBA, CHE
Chief Executive Officer

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 46-23

TO: Chair and Members of the Board of Health

FROM: Emily Williams, Chief Executive Officer
Dr. Alexander Summers, Medical Officer of Health

DATE: 2023 July 20

2024 BUDGET PROJECTION

Recommendation

It is recommended that the Board of Health:
1) ***Receive Report No. 46-23 re: "2024 Budget Projection" for information;***
2) ***Direct staff to submit relevant business cases via the City of London Multi-year Budgeting Process, including one to reflect the loss of mitigation funding, and one to request an inflation-related increase;***
3) ***Direct staff to submit information to the County of Middlesex to support the 2024 budgeting process, to reflect the loss of mitigation funding, and to request for an inflation-related increase; and***
4) ***Draft a letter of advocacy for stable and sufficient funding for local Public Health and direct it to the Minister of Health and the Premier of Ontario.***

Key Points
- The current projections for the Middlesex London Health Unit 2024 budget indicate a significant shortfall.
- The Ministry of Health is signaling the end of several one-time funding sources in 2024, including Mitigation funding, School Focused Nurses Initiative funding, and COVID-19 Extraordinary Expense funding.
- The 2023 budget process included zero-based budgeting for both General Expenses and staffing levels across the agency, and no further savings are available via this approach.
- Many health units in the province have submitted letters of advocacy for stable and sufficient funding for local Public Health to the Minister of Health and the Premier of Ontario, and staff are recommending a similar letter be drafted from the MLHU Board of Health.

Background

The Middlesex London Health Unit (MLHU) receives funding for programs deemed 'Mandatory' as outlined by the Ontario Public Health Standards (OPHS) from the Province of Ontario, the City of London, and the County of Middlesex. Funding from the Ministry of Health (MoH) has typically been provided in three categories: cost-shared with the Municipalities; 100% funded; and one-time (or temporary) funded.

Mitigation Funding
In 2019, the cost-shared funding model was planned to be changed from a 75:25 split with the Municipalities to a 70:30 split, however, significant concerns were raised, and one-time 'Mitigation' funding was provided to ease the burden on the Municipalities. In 2020, 2021, 2022 and 2023 one-time 'Mitigation' funding in the amount of $1,361,300 was provided to the MLHU. The Ministry of Health is signalling an end to Mitigation funding beginning in 2024.

One-Time Funding
Notable one-time funding that has been provided to the MLHU the last several years includes the School Focused Nurses Initiative (SFNI), and COVID-19 Extraordinary Expense funding, which has enabled the MLHU to implement a comprehensive and successful response to the COVID-19 pandemic. Although the pandemic has ended, COVID-19 remains an indefinite risk to the population, requiring ongoing local public health response and resources. COVID-19 has recently been added to the list of Diseases of Public Health Significance (DOPHS), requiring public health staff to provide active Case and Contact/Outbreak Management. Additionally, significant infection prevention and control (IPAC) support and consultation is required for a myriad of settings including healthcare setting, long-term care and retirement homes, and congregate care settings. As well, Public Health Units (PHUs) across the province are anticipating the receipt of a 'Vaccine Planning Template' from the MoH, requiring each agency to outline its plan to provide COVID-19 vaccine, along with the Influenza vaccine, and those captured under the Immunization of School Pupils Act (ISPA). At this time, the Ministry of Health is signalling an end to one-time COVID-19 Extraordinary Expense funding beginning in 2024, as well as one-time SFNI funding in June 2023.

Base Funding
In 2022, the MoH provided a 1% increase in base funding (the combination of cost-shared and 100% funded program funding), the first increase to base funding since 2018. The contributions to the cost-shared budget from the City of London remained stable from 2010-2019 at $6.1M annually, with the first increase of approximately $600,000 requested in 2020 to address inflationary pressures amidst frozen funding from the province. The COVID-19 pandemic required significant redeployment of staff, and the increased amount was returned to the City, in keeping with historic practices of returning surplus funds to the Municipality at year end. Total refunds to the City of London from the MLHU between 2010 and 2021 totalled $3.8M. Similarly, contributions to the cost-shared budget from the County of Middlesex remained consistent between 2010 and 2020 at $1.2M annually, with the first increase requested in 2020 in the amount of approximately $122,000. Surplus funds were also historically returned to the County, with total refunds between 2010 and 2021 totaling $725,000. Inflationary pressures impacting base funding include labour contracts with unionized staff and corporate expense inflation.

'Gapping' Budget
In order to submit a balanced budget, and to account for employee turnover with associated vacancies, and unspent program funds, the MLHU has historically included a planned 'gapping' line in the budget. Pre-pandemic gapping budget was typically between $900K and $1.2M annually, however, in 2023 this number increased to $1,539,315.

2023 Budget
The base funding for the Middlesex London Health Unit for 2023 remains unknown, with a zero percent increase in provincial funding used for planning assumptions, and no increase in funding requested from either Municipality. Mitigation funding, continuation of School Focused Nursing Initiative funding (to June 30, 2023), and availability of COVID-19 Extraordinary funds have been confirmed for 2023. Modified zero-based budgeting was undertaken during the 2023 budgeting process, yielding a significant decrease in general expenses of $537,000, which is not repeatable. Workforce planning (to assist with forecasting) was introduced, and subsequent review in the first quarter of the year identified the need for several corrections in staffing allocations and program funding that will be included in the 2024 budget.

2024 Budget Projections

As noted above, for the 2024 Budget year, the MoH is signaling an end to Mitigation funding, School Focused Nurses Initiative funding, and COVID-19 Extraordinary funding. Acknowledging the ongoing risk of COVID-19 and the subsequent increase local public health work, the Infectious Disease Control and Vaccine Preventable Disease teams have estimated associated workload and staffing required, which will need to be absorbed in the MLHU Base Budget. Inflationary pressures continue, including contractual obligations for salary increases and corporate expenses. There is also a need to decrease the 'gapping' budget, given the resumption of most programs and services, and a decrease in employee turnover. These factors combine to indicate a significant shortfall in the 2024 budget for the MLHU.

Current Activities

Meetings have been set up with all local Members of Provincial Parliament (MPP) over the summer for the Board Chair, Medical Officer of Health (MOH) and the Chief Executive Officer (CEO). Delegations have also been requested at the upcoming Association of Municipalities of Ontario (AMO) meeting in August. Many Boards of Health (BOH), as well as the Association of Local Public Health Agencies (alPHa) and the Association of Public Health Business Administrators (AOPHBA) have written letters to the Minister of Health and the Premier of Ontario, advocating for stable and sufficient public health funding, and it is recommended that the MLHU BOH do the same.

Next Steps

The City of London and the County of Middlesex Finance Administrators have been kept apprised of the risk with respect to the Mitigation Funding, as well as the COVID-19 Extraordinary Expense funding over the past several years. The City of London's multi-year budget process is underway with a draft budget submission for the MLHU due by August 15th. This includes several business case submissions, including an 'Assessment Growth' application which enables the MLHU to request additional funding in support of increased activities directly tied to the growth in the population and accompanying housing and industry expansion in London. There is also a 'Legislative' business case, which provides an opportunity to request additional funding that is a result of changes in legislation or funding models. The discontinuation of Mitigation funding falls in this category, and it is recommended that staff submit a business case given the timing of the City budget process, which could later be retracted if Mitigation funds are received. The 'Base Funding' business case includes the opportunity to submit inflation-related increases, and it is recommended that staff also request an inflationary increase. The County budget process does not launch until the beginning of 2024; however, it is recommended that communication be shared with respect to Mitigation funding and the need for an inflationary increase.

Advocacy via the MPPs, alPHa, AOPHBA, and at AMO will include an overview of the financial pressures facing the MLHU. Staff will be notified of the challenge and the plan for advocacy via a Town Hall, followed by updates from their leaders to hear updates and ask questions.

This report was prepared by the Chief Executive Officer.

EWilliams

Emily Williams, BScN, RN, MBA, CHE
Chief Executive Officer

Alexander T. Summers

Dr. Alexander Summers, MD, MPH, CCFP, FRCPC
Medical Officer of Health

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 47-23

TO: Chair and Members of the Board of Health

FROM: Emily Williams, Chief Executive Officer
Dr. Alexander Summers, Medical Officer of Health

DATE: 2023 July 20

2022 DRAFT FINANCIAL STATEMENTS

Recommendation

It is recommended that the Board of Health review and approve the audited Financial Statements for the Middlesex-London Health Unit for the year ending December 31, 2022.

Key Points

- The reports of the Financial Statements (Appendix A) and Audit Findings Report (Appendix B) for the twelve months ending December 31, 2022 are attached.
- Preparation of the financial statements is the responsibility of MHLU's management. The financial statements have been prepared in compliance with legislation and the Canadian Public Sector Accounting Standards (PSAS).
- A summary of significant accounting policies is provided in note 1 to the financial statements.

Financial Overview

This report provides an overview of the financial information found in both the Statement of Financial Position and the Statement of Operations and Accumulated Surplus. The Statement of Financial Position can be found on page 5 of the draft financial statements (Appendix A). As at December 31 of 2022, the Health Unit had approximately $12.3 million in cash and near-cash financial assets to offset its $12.1 million in short-term financial liabilities.

As of this date, total financial liabilities were $19.2 million and included the following:

Short-Term Liabilities ($12.1 million) (often paid during the next operating year):

1) $5.0 million in amounts owing to the Province of Ontario
2) $0.6 million in amounts owing to the City of London
3) $0.1 million in amounts owing to the County of Middlesex
4) $0.9 million in unpaid accounts payable and accrued liabilities
5) $4.2 million in deferred revenue
6) $1.3 million in accrued wages and benefits

Bank Indebtedness

7) $3.8 million in demand instalment loan

Long-Term Liabilities (often extending past the next operating year):

8) $3.2 million present value of employee future benefits liability

With regard to the $3.2 million present value of employee future benefits liability, this is the estimated current amount required to fund all future costs associated with providing post-retirement benefits. This liability is currently unfunded; however, each year an estimated amount required for the current year is appropriated from surplus. Detail related to this liability is outlined in Note 2, page 13.

The Non-Financial Assets, which total $7.2 million, include the net book value of the Health Unit's tangible capital assets, such as leasehold improvements, computer systems, and prepaid expenses. Note 6, page 16 outlines a schedule of changes to the tangible capital assets during the year.

The last amount listed on the Statement of Financial Position is the Health Unit's accumulated surplus. This represents the net financial and physical resources available to provide future services. The details of what items make up this balance can be found in the draft financial statements on Note 9, page 18.

The Statement of Operations and Accumulated Surplus, which details the Health Unit's revenues and expenditures for 2022 is found on page 6 of the financial statements. Total revenue of $56.8 million is comprised of $56.0 million (98.5%) in grant revenue from four sources: the Province of Ontario ($47 million or 84% of grant revenue, the Government of Canada ($0.3 million or 0.5%), the Corporation of the City of London ($7.3 million or 13.0%) and the Corporation of the County of Middlesex ($1.4 million or 2.5%). The remaining $0.8 million (1.4% of total revenue) comes from program revenue and other off-set revenues.

The revenues provide for cash and non-cash expenditures of $57.1 million. The majority of the expenditures are salaries and benefits, which total $45.7 million (80%). The remaining $11.3 million (20%) consists of professional services (5.1%), rent and maintenance (5.8%), materials and supplies (5.7%), charge for amortization of tangible capital assets (1.4%), travel (0.2%), and other expenses (1.8%).

Audit Findings Report

KPMG's Audit Findings Report is included as Appendix B. A common practice in presenting the report is for the Auditor Team to meet in private with Board Members, excluding all MLHU staff.

Katie DenBok, Partner and Dale Percival, Senior Manager, KPMG LLP, will be present at the July 20 Board of Health meeting to address any questions regarding this report.

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

Emily Williams, BScN, RN, MBA, CHE Chief Executive Officer	Dr. Alexander Summers, MD, MPH, CCFP, FRCPC Medical Officer of Health

Financial Statements of

MIDDLESEX-LONDON HEALTH UNIT

And Independent Auditors' Report thereon

Year ended December 31, 2022

Draft

MIDDLESEX-LONDON HEALTH UNIT

Financial Statements
Year ended December 31, 2022

Financial Statements

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Statement of Operations and Accumulated Surplus 6

Statement of Change in Net Debt 7

Statement of Cash Flows 8

Notes to Financial Statements 9-20

Draft

MIDDLESEX-LONDON HEALTH UNIT

Financial Statements
Year ended December 31, 2022

Management's Responsibility for the Financial Statements

The accompanying financial statements of the Middlesex-London Health Unit ("Health Unit") are the responsibility of the Health Unit's management and have been prepared in compliance with legislation, and in accordance with Canadian public sector accounting standards for local governments established by the Public Sector Accounting Board of the Chartered Professional Accountants of Canada. A summary of the significant accounting policies is described in Note 1 to the financial statements. The preparation of financial statements necessarily involves the use of estimates based on management's judgment, particularly when transactions affecting the current accounting period cannot be finalized with certainty until future periods.

The Health Unit's management maintains a system of internal controls designed to provide reasonable assurance that assets are safeguarded, transactions are properly authorized and recorded in compliance with legislative and regulatory requirements, and reliable financial information is available on a timely basis for preparation of the financial statements. These systems are monitored and evaluated by management.

The Finance & Facilities Committee meets with management and the external auditors to review the financial statements and discuss any significant financial reporting or internal control matters prior to their approval of the financial statements.

The financial statements have been audited by KPMG LLP, independent external auditors appointed by the Health Unit's Board of Health, through the City of London. The accompanying Independent Auditors' Report outlines their responsibilities, the scope of their examination and their opinion on the Health Unit's financial statements.

Emily Williams, BScN, RN, MBA, CHE
Chief Executive Officer

David Jansseune, CPA, CMA
Assistant Director, Finance

Matthew Newton-Reid, Chair
Board of Health

Draft

INDEPENDENT AUDITORS' REPORT

To the Chair and Members, Middlesex-London Board of Health

Opinion

We have audited the financial statements of Middlesex-London Health Unit (the "Health Unit"), which comprise:

- the statement of financial position as at December 31, 2022
- the statement of operations and accumulated surplus for the year then ended
- the statement of change in net debt for the year then ended
- the statement of cash flows for the year then ended
- and notes to the financial statements, including a summary of significant accounting policies

(Hereinafter referred to as the "financial statements").

In our opinion, the accompanying financial statements present fairly, in all material respects, the financial position of the Health Unit as at December 31, 2022, and its results of operations and its cash flows for the year then ended in accordance with Canadian public sector accounting standards.

Basis for Opinion

We conducted our audit in accordance with Canadian generally accepted auditing standards. Our responsibilities under those standards are further described in the "***Auditors' Responsibilities for the Audit of the Financial Statements***" section of our auditors' report.

We are independent of the Health Unit in accordance with the ethical requirements that are relevant to our audit of the financial statements in Canada, and we have fulfilled our other ethical responsibilities in accordance with these requirements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Responsibilities of Management and Those Charged with Governance for the Financial Statements

Management is responsible for the preparation and fair presentation of the financial statements in accordance with Canadian public sector accounting standards and for such internal control as management determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, management is responsible for assessing the Health Unit's ability to continue as a going concern, disclosing as applicable, matters related to going concern and using the going concern basis of accounting unless management either intends to liquidate the Health Unit or to cease operations, or has no realistic alternative but to do so.

Those charged with governance are responsible for overseeing the Health Unit's financial reporting process.

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Auditors' Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditors' report that includes our opinion.

Reasonable assurance is a high level of assurance but is not a guarantee that an audit conducted in accordance with Canadian generally accepted auditing standards will always detect a material misstatement when it exists.

Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

As part of an audit in accordance with Canadian generally accepted auditing standards, we exercise professional judgment and maintain professional skepticism throughout the audit.

We also:

- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for our opinion.

  The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.

- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Health Unit's internal control.

- Evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by management.

- Conclude on the appropriateness of management's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the Health Unit's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our auditors' report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify our opinion. Our conclusions are based on the audit evidence obtained up to the date of our auditors' report. However, future events or conditions may cause the Health Unit to cease to continue as a going concern.

- Evaluate the overall presentation, structure and content of the financial statements, including the disclosures, and whether the financial statements represent the underlying transactions and events in a manner that achieves fair presentation.

- Communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that we identify during our audit.

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Chartered Professional Accountants, Licensed Public Accountants

July 2023

London, Canada

MIDDLESEX-LONDON HEALTH UNIT

Statement of Financial Position
December 31, 2022, with comparative information for 2021

		2022		2021
Financial Assets				
Cash	$	4,181,797	$	10,481,078
Accounts receivable		1,195,023		764,281
Grants receivable		6,910,975		2,480,606
		12,287,795		13,725,965
Financial Liabilities				
Accounts payable and accrued liabilities		851,182		1,510,746
Deferred revenue		4,213,229		2,905,137
Demand loan (note 5)		3,840,625		4,026,743
Due to Province of Ontario		5,005,768		4,383,914
Due to The Corporation of the City of London		611,898		2,189,701
Due to The Corporation of the County of Middlesex		116,552		121,949
Accrued wages and benefits		1,329,494		2,714,699
Employee future benefits (note 2)		3,220,100		3,057,800
		19,188,849		20,910,689
Net Debt		(6,901,054)		(7,184,724)
Non-Financial Assets				
Tangible capital assets (note 6)		6,996,281		7,524,760
Prepaid expenses		211,326		209,881
		7,207,607		7,734,641
Commitments (note 7)				
Contingencies (note 8)				
Accumulated surplus (note 9)	$	306,553	$	549,917

The accompanying notes are an integral part of these financial statements.

Draft

MIDDLESEX-LONDON HEALTH UNIT

Statement of Operations and Accumulated Surplus

Year ended December 31, 2022, with comparative information for 2021

	2022 Budget	2022	2021
Revenue:			
Grants:			
Ministry of Health	$ 52,642,573	$ 44,444,190	$ 50,589,571
The Corporation of the City of London	7,344,798	7,344,798	6,095,059
Ministry of Children and Youth Services	2,483,313	2,536,257	2,538,604
The Corporation of the County of Middlesex	1,404,859	1,404,859	1,160,961
Government of Canada	291,227	291,223	370,667
	64,166,770	56,021,327	60,754,862
Other:			
Property search fees	5,000	1,916	3,500
Family planning	157,000	70,366	82,737
City of London Tobacco Reinforcement	415,798	296,975	182,206
Other income (note 10)	565,440	454,627	425,009
	1,143,238	823,884	693,452
Total Revenue	65,310,008	56,845,211	61,448,314
Expenditures:			
Salaries:			
Public Health Nurses	11,878,169	13,324,247	12,426,386
Other salaries	14,693,651	10,006,491	13,786,815
Administrative staff	11,548,085	10,766,146	11,337,651
Public Health Inspectors	3,208,548	2,663,999	2,444,933
Dental staff	1,206,191	1,102,004	704,311
Medical Officers of Health	581,622	419,248	610,193
	43,116,266	38,282,135	41,310,289
Other Operating:			
Benefits	9,393,150	7,443,304	7,322,256
Professional services	3,890,960	2,905,417	4,089,278
Rent and maintenance	2,861,574	3,286,234	2,869,385
Other expenses (note 11)	933,923	1,007,827	1,127,707
Materials and supplies	2,271,538	3,264,552	3,915,687
Amortization expense	2,420,566	779,188	789,355
Travel	422,031	119,918	280,851
	21,193,742	18,806,440	20,394,519
Total Expenditures	65,310,008	57,088,574	61,704,808
Annual deficit	-	(243,364)	(256,494)
Accumulated surplus, beginning of year	549,917	549,917	806,411
Accumulated surplus, end of year	$ 549,917	$ 306,553	$ 549,917

The accompanying notes are an integral part of these financial statements.

Draft

MIDDLESEX-LONDON HEALTH UNIT

Statement of Change in Net Debt

Year ended December 31, 2022, with comparative information for 2021

	2022	2021
Annual deficit	$ (243,364)	$ (256,494)
Acquisition of tangible capital assets, net	(250,710)	(260,608)
Amortization of tangible capital assets	779,189	789,355
	285,115	272,253
Acquisition of prepaid expenses	(211,326)	(209,881)
Use of prepaid expenses	209,881	222,809
	(1,445)	12,928
Change in net debt	283,671	285,181
Net debt, beginning of year	(7,184,724)	(7,469,905)
Net debt, end of year	$(6,901,054)	$(7,184,724)

The accompanying notes are an integral part of these financial statements.

Draft

MIDDLESEX-LONDON HEALTH UNIT

Statement of Cash Flows

December 31, 2022, with comparative information for 2021

	2022	2021
Cash provided by (used in):		
Operating activities:		
Annual deficit	$ (243,364)	$ (256,494)
Items not involving cash:		
Amortization expense	779,189	789,355
Change in employee future benefits	162,300	175,500
Changes in non-cash assets and liabilities:		
Accounts receivable	(430,742)	(311,955)
Grants receivable	(4,430,369)	3,003,604
Prepaid expenses	(1,445)	12,928
Due to Province of Ontario	621,854	3,018,918
Due to Government of Canada	-	(53)
Due to The Corporation of the City of London	611,898	2,189,701
Due to The Corporation of the County of Middlesex	(5,397)	121,949
Accounts payable and accrued liabilities	(2,849,265)	356,303
Deferred revenue	1,308,093	895,945
Accrued wages and benefits	(1,385,205)	887,161
Net change in cash from operating activities	(5,862,452)	10,882,862
Financing Activities:		
Repayment of demand loan	(186,118)	(173,257)
Net change in cash from financing activities	(186,118)	(173,257)
Capital activities:		
Acquisition of tangible capital assets	(250,710)	(260,608)
Net change in cash from capital activities	(250,710)	(260,608)
Net change in cash	(6,299,280)	10,448,997
Cash, beginning of year	10,481,078	32,081
Cash, end of year	$ 4,181,797	$ 10,481,078

The accompanying notes are an integral part of these financial statements.

Draft

MIDDLESEX-LONDON HEALTH UNIT

The Middlesex-London Health Unit (the "Health Unit") is a joint local board of the municipalities of The Corporation of the City of London and The Corporation of the County of Middlesex that was created on January 1, 1972. The Health Unit provides programs which promote healthy and active living throughout the participating municipalities.

1. Significant accounting policies:

The financial statements of the Health Unit are prepared by management in accordance with Canadian public sector accounting standards as recommended by the Public Sector Accounting Board ("PSAB") of the Chartered Professional Accountants of Canada. Significant accounting policies adopted by the Middlesex-London Health Unit are as follows:

(a) Basis of presentation:

The financial statements reflect the assets, liabilities, revenue and expenditures of the reporting entity. The reporting entity is comprised of all programs funded by the Government of Canada, the Province of Ontario, The Corporation of the City of London, and The Corporation of the County of Middlesex. It also includes other programs that the Board of Health may offer from time to time with special grants and/or donations from other sources.

Inter-departmental transactions and balances have been eliminated.

(b) Basis of accounting:

Sources of financing and expenditures are reported on the accrual basis of accounting with the exception of donations, which are included in the statement of operations as received.

The accrual basis of accounting recognizes revenues as they become available and measurable; expenditures are recognized as they are incurred and measurable as a result of receipt of services and the creation of a legal obligation to pay.

The operations of the Health Unit are funded by government transfers from the Government of Canada, Province of Ontario, The Corporation of the City of London and The Corporation of the County of Middlesex. Government transfers are recognized in the financial statements as revenue in the period in which events giving rise to the transfer occur, providing the transfers are authorized, any eligibility criteria have been met and reasonable estimates of the amounts can be made. Government transfers not received at year end are recorded as grants receivable due from the related funding organization in the statement of financial position.

Funding amounts in excess of actual expenditures incurred during the year are repayable and are reflected as liabilities due to the related funding organization in the statement of financial position.

Draft

1. Significant accounting policies (continued):

(c) Employee future benefits:

(i) The Health Unit provides certain employee benefits which will require funding in future periods. These benefits include sick leave, life insurance, extended health and dental benefits for early retirees.

The cost of sick leave, life insurance, extended health and dental benefits are actuarially determined using management's best estimate of salary escalation, accumulated sick days at retirement, insurance and health care cost trends, long term inflation rates and discount rates.

(ii) The cost of multi-employer defined benefit pension plan, namely the Ontario Municipal Employees Retirement System (OMERS) pensions, are the employer's contributions due to the plan in the period. As this is a multi-employer plan, no liability is recorded on the Health Unit's financial statements.

(d) Non-financial assets:

Non-financial assets are not available to discharge existing liabilities and are held for use in the provision of services. They have useful lives that extend beyond the current year and are not intended for sale in the ordinary course of operations.

(i) Tangible capital assets

Tangible capital assets are recorded at cost which includes amounts that are directly attributed to acquisition, construction, development or betterment of the asset. The cost, less residual value of the tangible capital assets, are amortized on a straight-line basis over the estimated useful lives as follows:

Asset	Useful Life - Years
Leasehold Improvements	5 - 20
Computer Systems	4
Motor Vehicles	5
Furniture & Equipment	7

Assets under construction are not amortized until the asset is available for productive use.

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1. Significant accounting policies (continued):

(d) Non-financial assets (continued):

(ii) Contributions of tangible capital assets

Tangible capital assets received as contributions are recorded at their fair market value at the date of receipt and are recorded as revenue.

(iii) Leased tangible capital assets

Leases which transfer substantially all the benefits and risks incidental to ownership of property are accounted for as leased tangible capital assets. All other leases are accounted for as operating leases and the related payment are charged to expense as incurred.

(e) Use of estimates:

The preparation of the Health Unit's financial statements requires management to make estimates and assumptions that affect the reporting amounts of assets and liabilities, the disclosure of contingent assets and liabilities at the date of the financial statements, and the reported amounts of revenues and expenses during the period. Significant estimates include assumptions used in estimating provisions for accrued liabilities, and in performing actuarial valuations of post-employment benefits.

In addition, the Health Unit's implementation of the Public Sector Accounting Handbook PS3150 has required management to make estimates of the useful lives of tangible capital assets.

Actual results could differ from these estimates.

(f) Future accounting pronouncements:

These standards and amendments were not yet effective for the year ending December 31, 2022, and have therefore not been applied in preparing these financial statements. Management is currently assessing the impact of the following accounting standards updates on the future financial statements.

(i) Asset Retirement Obligations

PS 3280, Asset Retirement Obligations, addresses the recognition, measurement, presentation and disclosure of legal obligations associated with the retirement of tangible capital assets in productive use. This standard is effective for fiscal years beginning on or after April 1, 2022 (the Health Unit's December 31, 2023 year end).

(ii) Financial Statement Presentation

PS 1201, Financial Statement Presentation requires entities to present a new statement of remeasurement gains and losses separate from the statement of operations and accumulated surplus. This new statement includes unrealized gains and losses arising from remeasurement of financial instruments and items denominated in foreign currencies and any other comprehensive income that arises when a government includes the results of government business enterprises and partnerships. This standard is effective for fiscal years

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(f) Future accounting pronouncements (continued):

beginning on or after April 1,2022 and applies when PS 3450, Financial Instruments, and PS 2601, Foreign Currency Translation, are adopted (the Health Unit's December 31, 2023 year-end).

(iii) Financial Instruments

PS 3450, Financial Instruments, establishes the standards on accounting for and reporting all types of financial instruments including derivatives. This standard is effective for fiscal periods beginning on or after April 1, 2022 (the Health Unit's December 31, 2023 year-end).

(iv) Foreign Currency Translation

PS 2601, Foreign Currency Translation, establishes the standards on accounting for and reporting transactions that are denominated in a foreign currency. This standard is effective for fiscal periods beginning on or after April 1, 2022 (the Health Unit's December 31, 2023 year-end). Earlier adoption is permitted. A public sector entity adopting this standard must also adopt the new financial instruments standard.

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2. Employee future benefits:

The Health Unit pays certain life insurance benefits on behalf of the retired employees as well as extended health and dental benefits for early retirees to age sixty-five. The Health Unit recognizes these post-retirement costs in the period in which the employees render services. The most recent actuarial valuation was performed as at December 31, 2020.

	2022	2021
Accrued employee future benefit obligations	$ 3,394,800	$ 3,277,000
Unamortized net actuarial loss	(174,700)	(219,200)
Employee future benefits liability as of December 31	$ 3,220,100	$ 3,057,800

Retirement and other employee future benefit expenses included in the benefits in the statement of operations consist of the following:

	2022	2021
Current year benefit cost	$ 223,800	$ 209,000
Interest on accrued benefit obligation	101,900	103,200
Amortization of net actuarial loss	44,500	38,300
Total benefit cost	$ 370,200	$ 350,500

Benefits paid during the year were $207,900 (2021 - $175,000).

Draft

2. Employee future benefits (continued):

The main actuarial assumptions employed for the valuation are as follows:

(i) Discount rate:

The obligation as at December 31, 2022, of the present value of future liabilities and the expense for the year ended December 31, 2022, are determined using a discount rate of 3.00% and 3.00% respectively (2021 – 3.00%).

(ii) Medical costs:

Prescription drug costs are assumed to increase at the rate of 4.7% per year (2021 – 4.5%) varying over 19 years to an ultimate rate of 4.0%. Other Medical costs are assumed to increase at a rate of 4.8% per year (2021 - 4.6%), varying over 19 years to an ultimate rate of 4.0%. Vision costs are assumed to increase at a rate of 0% per year.

(iii) Dental costs:

Dental costs are assumed to increase at the rate of 5.1% per year (2021 – 4.9%), varying over 19 years to an ultimate rate of 4.0%.

3. Pension agreement:

The Health Unit contributes to the OMERS which is a multi-employer plan, on behalf of 386 members. The plan is a defined benefit plan which specifies the amount of the retirement benefit to be received by the employees based on the length of service and rates of pay.

During 2022, the plan required employers to contribute 9.0% of employee earnings up to the year's maximum pensionable earnings and 14.6% thereafter. The Health Unit contributed $2,257,274 (2021 - $2,101,187) to the OMERS pension plan on behalf of its employees during the year ended December 31, 2022.

The last available report for the OMERS plan was on December 31, 2022. At that time, the plan reported a $6.7 billion actuarial deficit (2021 - $3.1 billion), based on actuarial liabilities for $130.3 billion (2021 - $120.8 billion) and actuarial assets for $123.6 billion (2021 - $117.7 billion). If actuarial surpluses are not available to offset the existing deficit and subsidize future contributions, increases in contributions will be required in the future.

4. Bank Indebtedness:

In 2021, to better manage daily cash flows, the Health Unit entered into a $8 million demand revolving line of credit, available by way of overdraft. Interest on amounts drawn is calculated at prime rate less 0.75% per annum. No amount was outstanding under the line of credit as at year end or as at the previous year end.

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5. Demand Loan:

In 2020, the Health Unit entered a loan agreement for a $4.2 million demand instalment loan with an amortization period of 20 years to finance the fit-up and relocation costs related to the move to Citi Plaza. The loan was subsequently converted into two non-revolving amortizing instalment loans, with $3,050,000 established as a fixed rate instalment loan, and the remaining $1,150,000 established as a floating rate instalment loan. The fixed rate of interest on the first loan is 1.915% per annum over a term of 5 years and is being repaid by monthly blended payments of principal and interest of $15,307. The interest rate on the second loan is calculated at prime rate less 0.75% per annum and shall be repaid by monthly principal payments of $4,792. All amounts under the demand loans are repayable immediately on demand by the bank.

Principal payments are due as follows:

2023	$ 188,603
2024	191,135
2025 (Renewable in 2025)	3,460,887
	$3,840,625

Draft

MIDDLESEX-LONDON HEALTH UNIT

Notes to Financial Statements (continued)
Year ended December 31, 2022

6. Tangible Capital Assets:

Cost	Balance at December 31, 2021	Additions	Disposals / Transfers	Balance at December 31, 2022
Leasehold Improvements – 20 years	$6,756,703	$ -	$ -	$ 6,756,703
Computer Systems	1,555,619	192,333	-	1,747,952
Furniture & Equipment	1,204,590	58,377	-	1,262,967
Total	$ 9,516,912	$ 250,710	$ -	$ 9,767,622

Accumulated amortization	Balance at December 31, 2021	Amortization expense	Disposals / Transfers	Balance at December 31, 2022
Leasehold Improvements – 20 years	$ 471,922	334,181	$ -	$ 806,103
Computer Systems	920,867	300,707	-	1,221,574
Furniture & Equipment	599,363	144,301	-	743,664
Total	$ 1,992,152	$ 779,189	$ -	$ 2,771,341

	Net book value December 31, 2021	Net book value December 31, 2022
Leasehold Improvements – 20 years	$ 6,284,781	$ 5,950,600
Computer Systems	634,751	526,378
Furniture & Equipment	605,226	519,303
Total	$ 7,524,760	$ 6,996,281

Draft

MIDDLESEX-LONDON HEALTH UNIT

Notes to Financial Statements (continued)
Year ended December 31, 2022

6. Tangible Capital Assets (continued):

Cost	Balance at December 31, 2020	Additions	Disposals / Transfers	Balance at December 31, 2021
Leasehold Improvements – 20 years	$6,610,569	$ 146,134	$ -	$ 6,756,703
Computer Systems	1,461,274	94,345	-	1,555,619
Furniture & Equipment	1,184,461	20,129	-	1,204,590
Total	$ 9,256,304	$ 260,608	$ -	$ 9,516,912

Accumulated amortization	Balance at December 31, 2020	Amortization expense	Disposals / Transfers	Balance at December 31, 2021
Leasehold Improvements – 20 years	$ 137,740	334,182	$ -	$ 471,922
Computer Systems	614,528	306,339	-	920,867
Furniture & Equipment	450,529	148,834	-	599,363
Total	$ 1,202,797	$ 789,355	$ -	$ 1,992,152

	Net book value December 31, 2020	Net book value December 31, 2021
Leasehold Improvements – 20 years	$ 6,472,829	$ 6,284,781
Computer Systems	846,746	634,751
Furniture & Equipment	733,932	605,226
Total	$ 8,053,507	$ 7,524,760

Draft

MIDDLESEX-LONDON HEALTH UNIT

Notes to Financial Statements (continued)
Year ended December 31, 2022

7. Commitments:

The Health Unit is committed under operating leases for office equipment and rental property.

Future minimum payments to expiry are as follows:

2023	$ 821,520
2024	720,831
2025	747,149
2026	730,658
2027	730,658
Thereafter (Remaining term of Lease)	$ 10,139,603

8. Contingencies:

From time to time, the Health Unit is subject to claims and other lawsuits that arise in the ordinary course of business, some of which may seek damages in substantial amounts. These claims may be covered by the Health Unit's insurance. Liability for these claims and lawsuits are recorded to the extent that the probability of a loss is likely, and it is estimable.

9. Accumulated Surplus:

Accumulated surplus consists of individual fund surplus and reserves as follows:

	2022	2021
Surpluses:		
Invested in tangible capital assets	$ 6,996,281	$ 7,524,760
Net transfer to surplus	194,920	(66,378)
Unfunded:		
Demand loan	(3,840,625)	(4,026,743)
Post-employment benefits	(3,220,100)	(3,057,800)
Total surplus	130,477	373,839
Reserves set aside by the Board:		
Employment costs	176,077	176,077
Total reserves	176,077	176,077
Accumulated surplus	$ 306,553	$ 549,917

Draft

10. Other income:

The following revenues are presented as other income in the statement of operations:

	2022 Budget	2022	2021
Charitable donations	$189,992	$ 234,635	$ 142,806
OHIP billings	173,483	147,060	130,397
Miscellaneous	168,863	67,852	126,925
Food handler training	4,116	4,770	3,094
Vaccines	28,986	310	21,787
	$ 565,440	$ 454,627	$ 425,009

11. Other expenses:

The following expenditures are presented as other expenses in the statement of operations:

	2022 Budget	2022	2021
Communications	$ 211,981	$ 229,813	$ 219,536
Health promotion/advertising	187,792	214,952	194,485
Miscellaneous	133,544	45,791	138,303
Postage and courier	23,197	97,495	24,024
Printing	191,912	75,274	198,752
Staff development	74,577	201,447	77,235
Capital funding - SOAHAC	-	-	160,500
Insurance	110,919	143,055	114,872
	$ 933,923	$ 1,007,827	$ 1,127,707

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12. Financial Risks:

(a) Interest rate risk

The Health Unit has debt with variable interest rates based on prime plus a margin. As a result, the Health Unit is exposed to interest rate risk due to fluctuations in the prime rate.

Middlesex-London Health Unit

Audit Findings Report for the year ended December 31, 2022

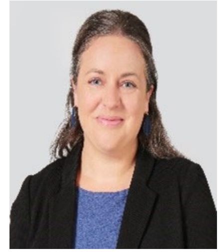
KPMG LLP

Prepared as of July 3, 2023 for the meeting on July 20, 2023

kpmg.ca/audit

KPMG contacts

Key contacts in connection with this engagement



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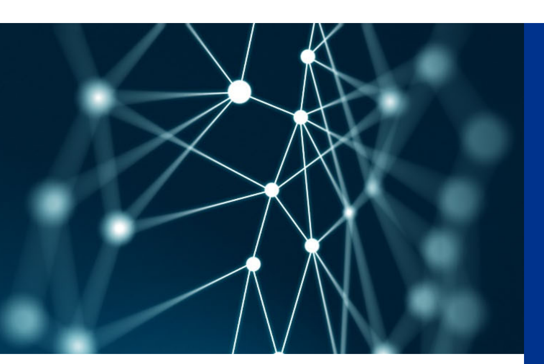


4 Audit highlights

Status of the audit

Uncorrected audit misstatements

Control deficiencies

Additional matters

Audit quality

Appendices

Digital use information

This Audit Findings Report is also available as a “hyper-linked” PDF document.

If you are reading in electronic form (e.g. In “Adobe Reader” or “Board Books”), clicking on the home symbol on the top right corner will bring you back to this slide.

Click on any item in the table of contents to navigate to that section.

The purpose of this report is to assist you, as a member of the Board, in your review of the results of our audit of the financial statements as at and for the period ended December 31, 2022. This report is intended solely for the information and use of Management, and the Board of Directors and should not be used for any other purpose or any other party. KPMG shall have no responsibility or liability for loss or damages or claims, if any, to or by any third party as this report has not been prepared for, and is not intended for, and should not be used by, any third party or for any other purpose.

Audit highlights

Status of the audit

We have completed the audit of the financial statements ("financial statements"), with the exception of certain remaining outstanding procedures, which are highlighted on slide 5 of this report.

Uncorrected audit misstatements

Professional standards require that we request of management that all identified audit misstatements be corrected. We have already made this request of management. See slides 6.

Significant unusual transactions

No matters to report.

Audit risks and results – significant risks

The presumed fraud risk from revenue recognition has been rebutted as it is not considered applicable to Middlesex-London Health Unit where performance is not measured based on revenue or profits.

No matters to report based on procedures performed to address the presumed fraud risk from management override of controls.

Corrected audit misstatements

No matters to report.

Control deficiencies

We did not identify any control deficiencies that we determined to be significant deficiencies in internal control over financial reporting. See slide 8 for certain required communications regarding control deficiencies.

Materiality

Materiality of $1,080,000 (2021 - $1,177,000) was determined based on preliminary total expenses, resulting in an audit posting threshold of $54,000 (2021 - $58,850). A threshold of $216,000 has been used for reclassification misstatements in the current year.

Status of the audit

As of July 3, 2023 we have completed the audit of the financial statements, with the exception of certain remaining procedures, which include:

- Journal entry testing
- Review of lease commitment schedule
- Final review and documentation of audit file
- Receipt of the signed management representation letter
- Completing our discussions with the Board of Directors, and
- Obtaining evidence of the Board of Directors' approval of the financial statements

We will update the Board of Directors, and not solely the Chair, on significant matters, if any, arising from the completion of the audit, including the completion of the above procedures.

Our auditor's report will be dated upon the completion of <u>any</u> remaining procedures.

Uncorrected audit misstatements

Uncorrected audit misstatements include financial presentation and disclosure omissions.

Impact of uncorrected audit misstatements – Not material to the financial statements

The management representation letter includes the Summary of Uncorrected Audit Misstatements, which discloses the impact of all uncorrected misstatements considered to be other than clearly trivial. Based on both qualitative and quantitative considerations, management have decided not to correct certain misstatements and represented to us that the misstatements —individually and in the aggregate—are, in their judgment, not material to the financial statements. This management representation is included in the management representation letter.

We concur with management's representation that the uncorrected misstatements are not material to the financial statements. Accordingly, the uncorrected misstatements have no effect on our auditor's report.

Below is a summary of the impact of the uncorrected misstatement:

Other revenue – disclosure misstatement

We noted that there was a change in the grouping of elements making up other revenue in the notes to the financial statement. This did not result in a change in the overall other revenue amount

Control deficiencies

Consideration of internal control over financial reporting (ICFR)

In planning and performing our audit, we considered ICFR relevant to the Entity's preparation of the financial statements in order to design audit procedures that are appropriate in the circumstances for the purpose of expressing an opinion on the financial statements, but not for the purpose of expressing an opinion on ICFR.

Our understanding of internal control over financial reporting was for the limited purpose described above and was not designed to identify all control deficiencies that might be significant deficiencies. The matters being reported are limited to those deficiencies that we have identified during the audit that we have concluded are of sufficient importance to merit being reported to those charged with governance.

Our awareness of control deficiencies varies with each audit and is influenced by the nature, timing, and extent of audit procedures performed, as well as other factors. Had we performed more extensive procedures on internal control over financial reporting, we might have identified more significant deficiencies to be reported or concluded that some of the reported significant deficiencies need not, in fact, have been reported.

A deficiency in internal control over financial reporting

A deficiency exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent or detect misstatements on a timely basis. A deficiency in design exists when (a) a control necessary to meet the control objective is missing or (b) an existing control is not properly designed so that, even if the control operates as designed, the control objective would not be met. A deficiency in operation exists when a properly designed control does not operate as designed, or when the person performing the control does not possess the necessary authority or competence to perform the control effectively.

Significant deficiencies in internal control over financial reporting

A significant deficiency in internal control over financial reporting is a deficiency, or combination of deficiencies, in internal control that, in the auditor's professional judgment, is of sufficient importance to merit the attention of those charged with governance.

Other financial reporting matters

We also highlight the following:

Financial statement presentation - form, arrangement, and content

No matters to report.

Concerns regarding application of new accounting pronouncements

See details in appendices relating to upcoming changes in Public Sector Accounting Standards. Disclosure has been included in the financial statements (Note 1(k)) on those changes that are likely to have an impact on Middlesex-London Health Unit. No concerns noted.

Significant qualitative aspects of financial statement presentation and disclosure

No matters to report.

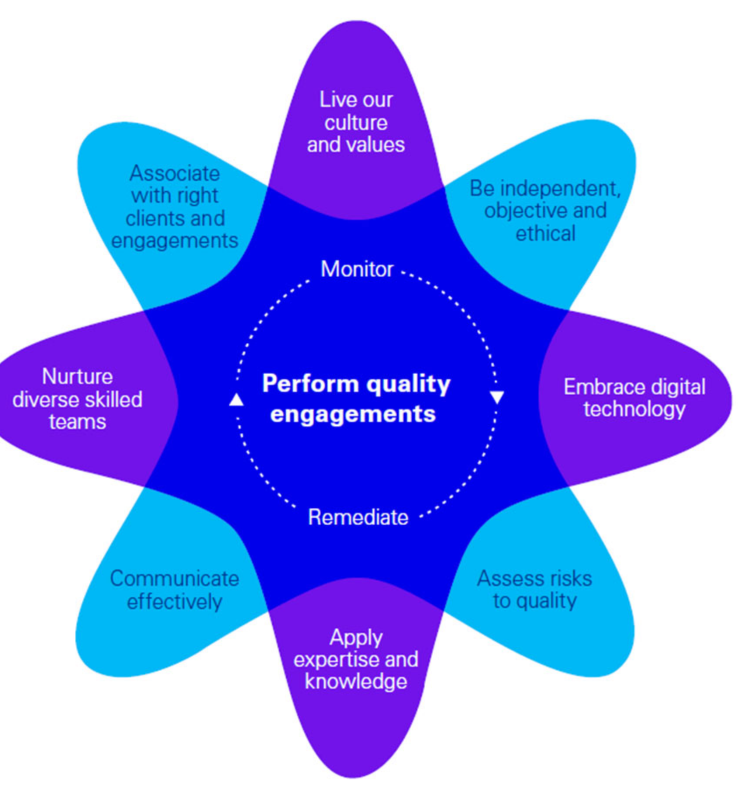
Audit quality: How do we deliver audit quality?

Quality essentially means doing the right thing and remains our highest priority. Our **Global Quality Framework** outlines how we deliver quality and how every partner and staff member contributes to its delivery.

Perform quality engagement sits at the core along with our commitment to continually monitor and remediate to fulfil on our quality drivers.

Our **quality value drivers** are the cornerstones to our approach underpinned by the **supporting drivers** and give clear direction to encourage the right behaviours in delivering audit quality.

KPMG 2022 Audit Quality and Transparency Report



We define 'audit quality' as being the outcome when:

- audits are **executed consistently**, in line with the requirements and intent of **applicable professional standards** within a strong **system of quality controls;** and
- all of our related activities are undertaken in an environment of the utmost level of **objectivity, independence, ethics** and **integrity.**

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Audit and assurance insights

Appendix: Other required communications

Engagement terms

A copy of the engagement letter and any subsequent amendments has been provided to the Management.

CPAB communication protocol

The reports available through the following links were published by the Canadian Public Accountability Board to inform Audit Committees and other stakeholders about the results of quality inspections conducted over the past year:

- CPAB Audit Quality Insights Report: 2021 Annual Inspections Results
- CPAB Audit Quality Insights Report: 2022 Interim Inspections Results
- The 2022 Annual Inspection Results will be available in March 2023

Appendix: Management representation letter

KPMG LLP
Chartered Accountants
1400-14- Fullarton Street
London, Ontario
N6A 5P2

July 20, 2023

Ladies and Gentlemen:

We are writing at your request to confirm our understanding that your audit was for the purpose of expressing an opinion on the financial statements (hereinafter referred to as "financial statements") of Middlesex-London Health Unit ("the Entity") as at and for the period ended December 31, 2023.

General:

We confirm that the representations we make in this letter are in accordance with the definitions as set out in **Attachment I** to this letter.

We also confirm that, to the best of our knowledge and belief, having made such inquiries as we considered necessary for the purpose of appropriately informing ourselves:

Responsibilities:

1) We have fulfilled our responsibilities, as set out in the terms of the engagement letter dated January 1, 2023 for:

   a) the preparation and fair presentation of the financial statements and believe that these financial statements have been prepared and present fairly in accordance with the relevant financial reporting framework.

   b) providing you with all information of which we are aware that is relevant to the preparation of the financial statements ("relevant information"), such as financial records, documentation and other matters, including:

      (i) the names of all related parties and information regarding all relationships and transactions with related parties;

      (ii) the complete minutes of meetings, or summaries of actions of recent meetings for which minutes have not yet been prepared, of shareholders, board of directors and committees of the board of directors that may affect the financial statements. All significant actions are included in such summaries.

   c) providing you with unrestricted access to such relevant information.

   d) providing you with complete responses to all enquiries made by you during the engagement.

   e) providing you with additional information that you may request from us for the purpose of the engagement.

   f) providing you with unrestricted access to persons within the Entity from whom you determined it necessary to obtain audit evidence.

   g) such internal control as we determined is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error. We also acknowledge and understand that we are responsible for the design, implementation and maintenance of internal control to prevent and detect fraud.

   h) ensuring that all transactions have been recorded in the accounting records and are reflected in the financial statements.

i) ensuring that internal auditors providing direct assistance to you, if any, were instructed to follow your instructions and that we, and others within the entity, did not intervene in the work the internal auditors performed for you.

Internal control over financial reporting:

2) We have communicated to you all deficiencies in the design and implementation or maintenance of internal control over financial reporting of which we are aware.

Fraud & non-compliance with laws and regulations:

3) We have disclosed to you:

   a) the results of our assessment of the risk that the financial statements may be materially misstated as a result of fraud.

   b) all information in relation to fraud or suspected fraud that we are aware of that involves:

      — management;

      — employees who have significant roles in internal control over financial reporting; or

      — others

   where such fraud or suspected fraud could have a material effect on the financial statements.

   c) all information in relation to allegations of fraud, or suspected fraud, affecting the financial statements, communicated by employees, former employees, analysts, regulators, or others.

   d) all known instances of non-compliance or suspected non-compliance with laws and regulations, including all aspects of contractual agreements, whose effects should be considered when preparing financial statements.

   e) all known actual or possible litigation and claims whose effects should be considered when preparing the financial statements.

Subsequent events:

4) All events subsequent to the date of the financial statements and for which the relevant financial reporting framework requires adjustment or disclosure in the financial statements have been adjusted or disclosed.

Related parties:

5) We have disclosed to you the identity of the Entity's related parties.

6) We have disclosed to you all the related party relationships and transactions/balances of which we are aware.

7) All related party relationships and transactions/balances have been appropriately accounted for and disclosed in accordance with the relevant financial reporting framework.

Estimates:

8) The methods, the data and the significant assumptions used in making accounting estimates, and their related disclosures are appropriate to achieve recognition, measurement or disclosure that is reasonable in the context of the applicable financial reporting framework.

Going concern:

9) We have provided you with all information relevant to the use of the going concern assumption in the financial statements.

10) We confirm that we are not aware of material uncertainties related to events or conditions that may cast significant doubt upon the Entity's ability to continue as a going concern.

Non-SEC registrants or non-reporting issuers:

11) We confirm that the Entity is not a Canadian reporting issuer (as defined under any applicable Canadian securities act) and is not a United States Securities and Exchange Commission ("SEC") Issuer (as defined by the Sarbanes-Oxley Act of 2002). We also confirm that the financial statements of the Entity will not be included in the group financial statements of a Canadian reporting issuer audited by KPMG or an SEC Issuer audited by any member of the KPMG organization.

Yours very truly,

MIDDLESEX-LONDON HEALTH UNIT

____

David Jansseune, Assistant Director of Finance

Attachment I – Definitions

Materiality

Certain representations in this letter are described as being limited to matters that are material.

Information is material if omitting, misstating or obscuring it could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

Judgments about materiality are made in light of surrounding circumstances, and are affected by perception of the needs of, or the characteristics of, the users of the financial statements and, the size or nature of a misstatement, or a combination of both while also considering the entity's own circumstances.

Fraud & error

Fraudulent financial reporting involves intentional misstatements including omissions of amounts or disclosures in financial statements to deceive financial statement users.

Misappropriation of assets involves the theft of an entity's assets. It is often accompanied by false or misleading records or documents in order to conceal the fact that the assets are missing or have been pledged without proper authorization.

An error is an unintentional misstatement in financial statements, including the omission of an amount or a disclosure.

Related parties

In accordance with Accounting Standards for Not-for-Profit Organizations a *related party* is defined as:

- Related parties exist when one party has the ability to exercise, directly or indirectly, control, joint control or significant influence over the other. Two or more parties are related when they are subject to common control, joint control or common significant influence. Two not-for-profit organizations are related parties if one has an economic interest in the other. Related parties also include management and immediate family members.

In accordance with Accounting Standards for Not-for-Profit Organizations a *related party transaction* is defined as:

- A related party transaction is a transfer of economic resources or obligations between related parties, or the provision of services by one party to a related party, regardless of whether any consideration is exchanged. The parties to the transaction are related prior to the transaction. When the relationship arises as a result of the transaction, the transaction is not one between related parties.

Appendix: Upcoming changes to accounting standards

Standard	Summary and implications

Asset retirement obligations	• The new standard PS 3280 *Asset retirement obligations* is effective for fiscal years beginning on or after April 1, 2022.
	• The new standard addresses the recognition, measurement, presentation and disclosure of legal obligations associated with retirement of tangible capital assets. Retirement costs will be recognized as an integral cost of owning and operating tangible capital assets.
	• The asset retirement obligations ("ARO") standard will require the public sector entity to record a liability related to future costs of any legal obligations to be incurred upon retirement of any controlled tangible capital assets ("TCA"). The amount of the initial liability will be added to the historical cost of the asset and amortized over its useful life if the asset is in productive use.
	• As a result of the new standard, the public sector entity will:
	  • Consider how the additional liability will impact net debt, as a new liability will be recognized with no corresponding increase in a financial asset;
	  • Carefully review legal agreements, senior government directives and legislation in relation to all controlled TCA to determine if any legal obligations exist with respect to asset retirements;
	  • Begin considering the potential effects on the organization as soon as possible to coordinate with resources outside the finance department to identify ARO and obtain information to estimate the value of potential ARO to avoid unexpected issues.

Appendix: Upcoming changes to accounting standards

Standard	Summary and implications
Financial instruments and foreign currency translation	• The new standards PS 3450 *Financial instruments*, PS 2601 *Foreign currency translation*, PS 1201 *Financial statement presentation* and PS 3041 *Portfolio investments* are effective for fiscal years beginning on or after April 1, 2022. • Equity instruments quoted in an active market and free-standing derivatives are to be carried at fair value. All other financial instruments, including bonds, can be carried at cost or fair value depending on the public sector entity's choice and this choice must be made on initial recognition of the financial instrument and is irrevocable. • Hedge accounting is not permitted. • A new statement, the Statement of Remeasurement Gains and Losses, will be included in the financial statements. Unrealized gains and losses incurred on fair value accounted financial instruments will be presented in this statement. Realized gains and losses will continue to be presented in the statement of operations. • PS 3450 *Financial instruments* was amended subsequent to its initial release to include various federal government narrow-scope amendments.
Revenue	• The new standard PS 3400 *Revenue* is effective for fiscal years beginning on or after April 1, 2023. • The new standard establishes a single framework to categorize revenue to enhance the consistency of revenue recognition and its measurement. • The standard notes that in the case of revenue arising from an exchange transaction, a public sector entity must ensure the recognition of revenue aligns with the satisfaction of related performance obligations. • The standard notes that unilateral revenue arises when no performance obligations are present, and recognition occurs when there is authority to record the revenue and an event has happened that gives the public sector entity the right to the revenue.

Appendix: Upcoming changes to accounting standards

Standard	Summary and implications
Purchased Intangibles	• The new Public Sector Guideline 8 *Purchased intangibles* is effective for fiscal years beginning on or after April 1, 2023 with earlier adoption permitted. • The guideline allows public sector entities to recognize intangibles purchased through an exchange transaction. The definition of an asset, the general recognition criteria and GAAP hierarchy are used to account for purchased intangibles. • Narrow scope amendments were made to PS 1000 *Financial statement concepts* to remove the prohibition to recognize purchased intangibles and to PS 1201 *Financial statement presentation* to remove the requirement to disclose purchased intangibles not recognized. • The guideline can be applied retroactively or prospectively.
Public Private Partnerships	• The new standard PS 3160 *Public private partnerships* is effective for fiscal years beginning on or after April 1, 2023. • The standard includes new requirements for the recognition, measurement and classification of infrastructure procured through a public private partnership. • The standard notes that recognition of infrastructure by the public sector entity would occur when it controls the purpose and use of the infrastructure, when it controls access and the price, if any, charged for use, and it controls any significant interest accumulated in the infrastructure when the public private partnership ends. • The public sector entity recognizes a liability when it needs to pay cash or non-cash consideration to the private sector partner for the infrastructure. • The infrastructure would be valued at cost, which represents fair value at the date of recognition with a liability of the same amount if one exists. Cost would be measured in reference to the public private partnership process and agreement, or by discounting the expected cash flows by a discount rate that reflects the time value of money and risks specific to the project. • The standard can be applied retroactively or prospectively.

Appendix: Upcoming changes to accounting standards

Standard	Summary and implications
Concepts Underlying Financial Performance	• The revised conceptual framework is effective for fiscal years beginning on or after April 1, 2026 with earlier adoption permitted. • The framework provides the core concepts and objectives underlying Canadian public sector accounting standards. • The ten chapter conceptual framework defines and elaborates on the characteristics of public sector entities and their financial reporting objectives. Additional information is provided about financial statement objectives, qualitative characteristics and elements. General recognition and measurement criteria, and presentation concepts are introduced.

Financial Statement Presentation	• The proposed section PS 1202 *Financial statement presentation* will replace the current section PS 1201 *Financial statement presentation*. PS 1202 *Financial statement presentation* will apply to fiscal years beginning on or after April 1, 2026 to coincide with the adoption of the revised conceptual framework. Early adoption will be permitted.
	• The proposed section includes the following:
	  • Relocation of the net debt indicator to its own statement called the statement of net financial assets/liabilities, with the calculation of net debt refined to ensure its original meaning is retained.
	  • Separating liabilities into financial liabilities and non-financial liabilities.
	  • Restructuring the statement of financial position to present total assets followed by total liabilities.
	  • Changes to common terminology used in the financial statements, including re-naming accumulated surplus (deficit) to net assets (liabilities).
	  • Removal of the statement of remeasurement gains (losses) with the information instead included on a new statement called the statement of changes in net assets (liabilities). This new statement would present the changes in each component of net assets (liabilities), including a new component called “accumulated other”.
	  • A new provision whereby an entity can use an amended budget in certain circumstances.
	  • Inclusion of disclosures related to risks and uncertainties that could affect the entity’s financial position.
	• The Public Sector Accounting Board is currently deliberating on feedback received on exposure drafts related to the reporting model.

Appendix: Upcoming changes to accounting standards

Standard	Summary and implications
Employee benefits	• The Public Sector Accounting Board has initiated a review of sections PS 3250 *Retirement benefits* and PS 3255 *Post-employment benefits, compensated absences and termination benefits*. • The intention is to use principles from International Public Sector Accounting Standard 39 *Employee benefits* as a starting point to develop the Canadian standard. • Given the complexity of issues involved and potential implications of any changes that may arise from the review of the existing guidance, the new standards will be implemented in a multi-release strategy. The first standard will provide foundational guidance. Subsequent standards will provide additional guidance on current and emerging issues. • The proposed section PS 3251 *Employee benefits* will replace the current sections PS 3250 *Retirement benefits* and PS 3255 *Post-employment benefits, compensated absences and termination benefits*. It will apply to fiscal years beginning on or after April 1, 2026. Early adoption will be permitted and guidance applied retroactively. • This proposed section would result in public sector entities recognizing the impact of revaluations of the net defined benefit liability (asset) immediately on the statement of financial position. Organizations would also assess the funding status of their post-employment benefit plans to determine the appropriate rate for discounting post-employment benefit obligations. • The Public Sector Accounting Board is in the process of evaluating comments received from stakeholders on the exposure draft.
Government not-for-profit strategy	• The Public Sector Accounting Board has approved its government not-for-profit ("GNFP") strategy implementation plan. • The approved strategy option is to incorporate the PS 4200 series of standards with potential customizations into public sector accounting standards. This means reviewing the existing PS 4200 series of standards to determine if they should be retained and added to public sector accounting standards. Incorporating the updated or amended PS 4200 series standards in public sector accounting standards would make the guidance available to any public sector entity. Accounting and/or reporting customizations may be permitted if there are substantive and distinct accountabilities that warrant modification from public sector accounting standards.

Appendix: Newly effective changes to auditing standards

CAS 315 (Revised) Identifying and Assessing the Risks of Material Misstatement has been revised, reorganized and modernized in response to challenges and issues with the previous standard. It aims to promote consistency in application, improve scalability, reduce complexity, support a more robust risk assessment and incorporate enhanced guidance material to respond to the evolving environment, including in relation to information technology. Conforming and consequential amendments have been made to other International Standards on Auditing.

Affects both preparers of financial statements and auditors

Applies to audits of financial statements for periods beginning on or after 15 December 2021

See here for more information from CPA Canada

We design and perform risk assessment procedures to obtain an understanding of the:

- entity and its environment;
- applicable financial reporting framework; and
- entity's system of internal control.

The audit evidence obtained from this understanding provides a basis for:

- identifying and assessing the risks of material misstatement, whether due to fraud or error; and
- the design of audit procedures that are responsive to the assessed risks of material misstatement.

Appendix: Newly effective changes to auditing standards

Key change	Impact on the audit team	Impact on management
Overall, a more robust risk identification and assessment process, including: • New requirement to take into account how, and the degree to which, 'inherent risk factors' affect the susceptibility of relevant assertions to misstatement • New concept of significant classes of transactions, account balances and disclosures and relevant assertions to help us to identify and assess the risks of material misstatement • New requirement to separately assess inherent risk and control risk for each risk of material misstatement • Revised definition of significant risk for those risks which are close to the upper end of the spectrum of inherent risk	When assessing inherent risk for identified risks of material misstatement, we consider the degree to which inherent risk factors (such as complexity, subjectivity, uncertainty, change, susceptibility to management bias) affect the susceptibility of assertions to misstatement. We use the concept of the spectrum of inherent risk to assist us in making a judgement, based on the likelihood and magnitude of a possible misstatement, on a range from higher to lower, when assessing risks of material misstatement The changes may affect our assessments of the risks of material misstatement and the design of our planned audit procedures to respond to identified risks of material misstatement. If we do not plan to test the operating effectiveness of controls, the risk of material misstatement is the same as the assessment of inherent risk.	If the effect of this consideration is that our assessment of the risks of material misstatement is higher, then our audit approach may increase the number of controls tested and/or the extent of that testing, and/or our substantive procedures will be designed to be responsive to the higher risk. We may perform different audit procedures and request different information compared to previous audits, as part of a more focused response to the effects identified inherent risk factors have on the assessed risks of material misstatement.

Appendix: Newly effective changes to auditing standards

Key change	Impact on the audit team	Impact on management
Overall, a more robust risk identification and assessment process, including evaluating whether the audit evidence obtained from risk assessment procedures provides an appropriate basis to identify and assess the risks of material misstatement	When making this evaluation, we consider all audit evidence obtained, whether corroborative or contradictory to management assertions. If we conclude the audit evidence obtained does not provide an appropriate basis, then we perform additional risk assessment procedures until audit evidence has been obtained to provide such a basis.	In certain circumstances, we may perform additional risk assessment procedures, which may include further inquires of management, analytical procedures, inspection and/or observation.
Overall, a more robust risk identification and assessment process, including performing a 'stand back' at the end of the risk assessment process	We evaluate whether our determination that certain material classes of transactions, account balances or disclosures have no identified risks of material misstatement remains appropriate.	In certain circumstances, this evaluation may result in the identification of additional risks of material misstatement, which will require us to perform additional audit work to respond to these risks.

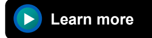
Appendix: Newly effective changes to auditing standards

Key change	Impact on the audit team	Impact on management
Modernized to recognize the evolving environment, including in relation to IT	New requirement to understand the extent to which the business model integrates the use of IT. When obtaining an understanding of the IT environment, including IT applications and supporting IT infrastructure, it has been clarified that we also understand the IT processes and personnel involved in those processes relevant to the audit. Based on the identified controls we plan to evaluate, we are required to identify the: • IT applications and other aspects of the IT environment relevant to those controls • related risks arising from the use of IT and the entity's general IT controls that address them. Examples of risks that may arise from the use of IT include unauthorized access or program changes, inappropriate data changes, risks from the use of external or internal service providers for certain aspects of the entity's IT environment or cybersecurity risks.	We will expand our risk assessment procedures and are likely to engage more extensively with your IT and other relevant personnel when obtaining an understanding of the entity's use of IT, the IT environment and potential risks arising from IT. This might require increased involvement of IT audit professionals. Changes in the entity's use of IT and/or the IT environment may require increased audit effort to understand those changes and affect our assessment of the risks of material misstatement and audit response. Risks arising from the use of IT and our evaluation of general IT controls may affect our control risk assessments, and decisions about whether we test the operating effectiveness of controls for the purpose of placing reliance on them or obtain more audit evidence from substantive procedures. They may also affect our strategy for testing information that is produced by, or involves, the entity's IT applications.
Enhanced requirements relating to exercising professional skepticism	New requirement to design and perform risk assessment procedures in a manner that is not biased toward obtaining audit evidence that may be corroborative or toward excluding audit evidence that may be contradictory. Strengthened documentation requirements to demonstrate the exercise of professional scepticism.	We may make changes to the nature, timing and extent of our risk assessment procedures, such as our inquires of management, the activities we observe or the accounting records we inspect.

Appendix: Newly effective changes to auditing standards

Key change	Impact on the audit team	Impact on management
Clarification of which controls need to be identified for the purpose of evaluating the design and implementation of a control	We will evaluate the design and implementation of controls that address risks of material misstatement at the assertion level as follows: • Controls that address a significant risk. • Controls over journal entries, including non-standard journal entries. • Other controls we consider appropriate to evaluate to enable us to identify and assess risks of material misstatement and design our audit procedures	We may identify new or different controls that we plan to evaluate the design and implementation of, and possibly test the operating effectiveness to determine if we can place reliance on them. We may also identify risks arising from IT relating to the controls we plan to evaluate, which may result in the identification of general IT controls that we also need to evaluate and possibly test whether they are operating effectively. This may require increased involvement of IT audit specialists.

Appendix: Insights to enhance your business



We have the unique opportunity as your auditors to perform a deeper dive to better understand your business processes that are relevant to financial reporting.

Lean in Audit

Lean in Audit™ is KPMG's award-winning methodology that offers a new way of looking at processes and engaging people within your finance function and organization through the audit.

By incorporating Lean process analysis techniques into our audit procedures, we can enhance our understanding of your business processes that are relevant to financial reporting and provide you with new and pragmatic insights to improve your processes and controls.

Clients like you have seen immediate benefits such as improved quality, reduced rework, shorter processing times and increased employee engagement.

We look forward to discussing how we can use this approach for your audit going forward.

How it works

Standard Audit	Typical process and how it's audited	
Lean in Audit™	Applying a Lean lens to perform walkthroughs and improve Audit quality and minimize risks and redundant steps	
How Lean in Audit helps businesses improve processes	Make the process more streamlined and efficient for all	

Value: what customers want **(maximize)**

Necessary: required activities **(minimize)**

Redundant: non-essential activities **(remove)**

Process controls

Key controls tested

Appendix: Audit and assurance insights

Our latest thinking on the issues that matter most to Audit Committees, board of directors and management.

KPMG Audit & Assurance Insights
Curated research and insights for audit committees and boards.

Board Leadership Centre
Leading insights to help board members maximize boardroom opportunities

Current Developments
Series of quarterly publications for Canadian businesses including Spotlight on IFRS, Canadian Securities & Auditing Matters and US Outlook reports.

Audit Committee Guide – Canadian Edition
A practical guide providing insight into current challenges and leading practices shaping audit committee effectiveness in Canada.

Accelerate 2023
The key issues driving the audit committee agenda in 2023.

Momentum
A quarterly newsletter with the latest thought-leadership from KPMG's subject matter leaders across Canada and valuable audit resources for clients.

KPMG Climate Change Financial Reporting Resource Centre
Our climate change resource centre provides insights to help you identify the potential financial statement impacts to your business.

IFRS Breaking News
A monthly Canadian newsletter that provides the latest insights on international financial reporting standards and IASB activities.

kpmg.ca

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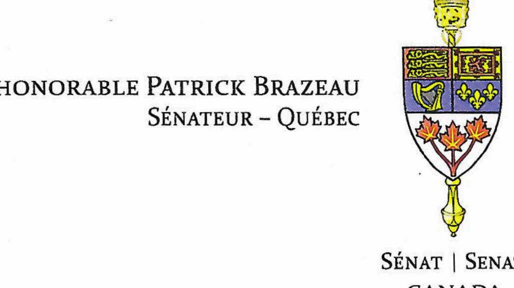
KPMG member firms around the world have 227,000 professionals, in 145 countries.

Correspondence A



L'HONORABLE PATRICK BRAZEAU
SÉNATEUR – QUÉBEC

THE HONOURABLE PATRICK BRAZEAU
SENATOR – QUEBEC

SÉNAT | SENATE
CANADA

May 9, 2023

National Director Anne McGrath
New Democratic Party of Canada
300 - 279 Laurier West
Ottawa, Ontario K1P 5J9

Dear Ms. McGrath:

I am writing to you today to express my concerns regarding the lack of awareness among Canadians about the direct link between alcohol consumption and cancer. The evidence is indisputable that alcohol is a class one carcinogen, causing at least 7 fatal cancers. Despite this fact, 80% of Canadians consume alcohol regularly, yet only 1 in 4 are aware of its cancer-causing properties. This is largely due to the powerful and well-financed alcohol lobby that has successfully kept Canadians in the dark about the risks associated with alcohol consumption.

To address this issue, I have introduced Bill S-254 (https://www.parl.ca/legisinfo/en/bill/44-1/s-254), which mandates the honest labeling of alcoholic beverages. This bill is about the health of Canadians and their right to know about the risks associated with alcohol consumption so that they can make better-informed decisions about their health.

I want to emphasize that my bill is not about the social impacts of alcohol, or the costs associated with them, but rather about ensuring that Canadians are fully informed about the risks associated with alcohol consumption. I believe that this is a serious issue that requires immediate attention from elected politicians for the benefit of Canadians, not the alcohol industry, which has been given too much leeway for far too long.

I would like to know your party's position on honest labeling and your plans regarding alcohol policy in general. I appreciate your time and look forward to hearing from you soon.

Sincerely,

ÉDIFICES DU PARLEMENT | PARLIAMENT BUILDINGS • OTTAWA, ONTARIO K1A 0A4
613-995-8625 • 1-800-267-7362 @SENATORBRAZEAU • PATRICK.BRAZEAU@SEN.PARL.GC.CA

Correspondence A

CC: Canadian Cancer Society
Canadian Public Health Association
Timiskaming Drug & Alcohol Strategy Steering Committee
Peterborough Public Health
Middlesex-London Health Unit
Association of Local Public Health Agencies
Ontario Public Health Association
Simcoe Muskoka District Health Unit
Canadian Alcohol Use Disorder Society
Queens Community Health Board
Toronto Public Health
Fraser Health
Southeastern Community Health Board
Dartmouth Community Health Board
Durham Region Health Department
Vancouver Coastal Health

Le 9 mai 2023

Madame Anne McGrath,
Directrice nationale du Nouveau Parti démocratique du Canada,
300-279, rue Laurier Ouest,
Ottawa (Ontario) K1P 5J9

Chère Madame McGrath,

Je vous écris aujourd'hui pour exprimer mes préoccupations concernant le manque de sensibilisation des Canadiens au lien direct entre la consommation d'alcool et le cancer. Les preuves sont indéniables que l'alcool est un cancérogène de classe un, causant au moins 7 cancers mortels. Malgré ce fait, 80 % des Canadiens consomment régulièrement de l'alcool, mais seulement 1 sur 4 sont conscients de ses propriétés cancérogènes. Cela est largement dû au puissant et bien financé lobby de l'alcool qui a réuss à maintenir les Canadiens dans l'ignorance des risques associés à la consommation d'alcool.

Pour aborder ce problème, j'ai présenté le projet de loi S-254,(https://www.parl.ca/legisinfo/fr/projet-de-loi/44-1/s-254) qui exige l'étiquetage honnête des boissons alcoolisées. Ce projet de loi concerne la santé des Canadiens et leur droit de connaître les risques associés à la consommation d'alcool afin qu'il puissent prendre des décisions plus éclairées sur leur santé.

L'HONORABLE PATRICK BRAZEAU
SÉNATEUR – QUÉBEC

THE HONOURABLE PATRICK BRAZEAU
SENATOR – QUEBEC

Je tiens à souligner que mon projet de loi ne concerne pas les impacts sociaux de l'alcool ou les coûts qui y sont associés, mais plutôt à veiller à ce que les Canadiens soient pleinement informés des risques associés à la consommation d'alcool. Je crois que c'est un problème grave qui nécessite une attention immédiate de la part des politiciens élus pour le bénéfice des Canadiens, et non de l'industrie de l'alcool, qui a été trop tolérée pendant trop longtemps.

Je voudrais connaître la position de votre parti sur l'étiquetage honnête et vos projets en matière de politique de l'alcool en général. Je vous remercie de votre temps et j'attends votre réponse avec impatience.

Sincèrement,

CC : Société canadienne du cancer
Association Canadienne de Santé publique
Stratégie contre les drogues et l'alcool du Timiskaming (SDAT)
Santé publique de Peterborough
Bureau de Santé Middlesex-London
Association des agences de santé publique locales
L'Association pur la santé publique de l'Ontario
Unité de santé du district de Simcoe Muskoka
Société canadienne des troubles liés à l'utilisation d'alcool
Conseil de santé communautaire de Queens
Santé publique Toronto
Santé Fraser
Conseil de santé communautaire du Sud-Est
Conseil de santé communautaire de Dartmouth
Département de santé de la région de Durham
Santé côtière de Vancouver

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OFFICE OF THE MAYOR
CITY OF HAMILTON

The Honourable Sylvia Jones, M.P.P.
Minister of Health
Ministry of Health
5th floor
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Toronto, ON M7A 1Z8
Sylvia.jones@pc.ola.org

The Honourable Michael A. Tibollo, M.P.P.
Associate Minister of Mental Health and Addictions
Ministry of Health
Frost South
6th Floor
7 Queens Park Circle
Toronto, ON M7A 1Y7
Michael.tibolloco@pc.ola.org

May 11, 2023

Subject: Declarations of Emergency in the Areas of Homelessness, Mental Health and Opioid Overdoses/Poisoning

Dear Minister Jones and Minister Tibollo,

At the April 12, 2023 Hamilton City Council meeting, a motion was passed declaring an emergency of Homelessness, Mental Health, and Opioid Overdoses/Poisoning. In adherence with this motion, I am writing to you today to request that the Provincial Government act on the eight measures proposed by the Association of Local Public Health Agencies". These specific measures include:

1. Creation of a multi-sectoral task force to guide the development of a robust provincial opioid response plan that will ensure necessary resourcing, policy change, and health and social system coordination;

2. Expanding access to evidence informed harm reduction programs and practices including lifting the provincial cap of 21 Consumption and Treatment Service (CTS) Sites, funding Urgent Public Health Needs Sites (UPHNS) and scaling up safer supply options

3. Revision of the current CTS model to address the growing trends of opioid poisoning amongst those who are using inhalation methods;

4. Expanding access to opioid agonist therapy for opioid use disorder through a range of settings (e.g. mobile outreach, primary care, emergency departments, Rapid Access to Addiction Medicine Clinics), and a variety of medication options;

5. Providing a long-term financial commitment to create more affordable and supportive housing for people in need, including people with substance use disorders;

6. Addressing the structural stigma and harms that discriminate against people who use drugs, through provincial support and advocacy to the Federal government to decriminalize personal use and possession of substances and ensure increased investments in health and social services at all levels;

7. Increasing investments in evidence-informed substance use prevention and mental health promotion initiatives that provide foundational support for the health, safety and well-being of individuals, families, and neighbourhoods, beginning from early childhood; and

8. Funding additional and dedicated positions for public health to support the critical coordination and leadership of local opioid and substance abuse strategies."

As with other municipalities throughout Ontario, the impact of the drug toxicity crisis continues to have a significant impact on our community. Between January 2023 and April 2023, Hamilton Paramedic Services responded to 336 incidents related to suspect opioid overdoses, with three out of the four months surpassing previous monthly totals. Furthermore, 52 suspect drug-related deaths have occurred this year as of April 12, not only representing lives cut short but also untold grief for the loved ones of these individuals and the broader community.

Hamilton continues to coordinate a local response with health and social service providers to address this public health crisis by leveraging local expertise and resources. While these local efforts continue, further response and collaboration is needed at all levels of government. The eight measures recommended by the Association of Local Public Health Agencies would provide a range of interventions to best support individuals based on their needs, and reflect the ongoing serious harms present in our community related to the toxic drug supply. For example, investing in the necessary support and prevention initiatives for our children and youth would promote mental health and work to prevent substance use. Increasing the number of CTS sites would help save lives by increasing

the number of places to safely consume substances in our community, while facilitating access to treatment options. As this complex issue transcends municipal boundaries, the Province is best situated to act decisively in order meet these goals through their capacity, resources, and leadership.

We firmly believe that one of the necessary responses to the ongoing drug toxicity crisis is to action the above eight items. However, Hamilton cannot accomplish this undertaking alone and Provincial leadership is needed to ensure success. The Hamilton Public Health Services team is more than agreeable to meet with your staff to tackle this task head-on and thereby continue to ensure that Ontario is a place where all its residents can be healthy, prosperous and reach their fullest potential throughout life.

Yours Sincerely,

Andrea Horwath

Mayor

City of Hamilton

CC:
Hon. Doug Ford, Premier and Minister of Intergovernmental Affairs

Hon. Peter Bethlenfalvy, Minister of Finance
Hon. Steve Clark, Minister of Municipal Affairs and Housing
Hon. Doug Downey, Attorney General
Hon. Michael Parsa, Minister of Children, Community and Social Services

Dr. Kieran Moore, Chief Medical Officer of Health

Hon. Neil Lumsden, MPP Hamilton East – Stoney Creek
Donna Skelly, MPP Flamborough – Glanbrook
Monique Taylor, MPP Hamilton Mountain
Sandy Shaw, MPP Hamilton West – Ancaster – Dundas
Sarah Jama, MPP Hamilton Centre

Association of Local Public Health Agencies
Council of Ontario Medical Officers of Health
Ontario Boards of Health
Ontario Health
Ontario Public Health Association

May 16, 2022

VIA ELECTRONIC MAIL

The Honourable Doug Ford
Premier of Ontario
Legislative Building, Queen's Park
Toronto ON M7A 1A1

Dear Premier Ford:

Re: Bill 93, Joshua's Law (Lifejackets for Life), 2023

On behalf of the Board of Health for Public Health Sudbury & Districts, I am writing to convey the Board's support for Bill 93 Joshua's Law (Lifejackets for Life), 2023 which recently passed second reading.

The matter of boating safety and drowning prevention is of great interest to the Board of Health for Public Health Sudbury & Districts. On September 22, 2022, we advised your office of the Board's resolution to request the Government of Ontario to enact legislation requiring all individuals in a pleasure boat to wear a lifejacket or PFD.

Over the 10-year period from 2012 to 2021, 2147 Ontarians (65 Sudbury and districts) had emergency department visits that resulted from a drowning or submersion injury related to watercraft and, over the last 10 years of available death data (2009-2018), 198 Ontarians (8 Sudbury and districts) died of a drowning or submersion injury related to watercraft. The Board of Health is aware that of the nationally reported boating deaths from 2013 to 2017 for which data were available, 79% were not wearing a lifejacket or personal floatation device (PFD). Not wearing a lifejacket is the most common behavioural risk factor associated with boating drownings across the lifespan. In Canadian drowning deaths from 2013 to 2017 for which PFD data were available, 87% of 15–34-year-olds, 75% of 35–64-year-olds, and 80% of 65+ year olds were not wearing lifejackets. Not wearing lifejackets continues to be identified as the most common risk factor in drowning deaths beyond childhood.

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Bill 93 is an important first step to saving lives. Public Health will continue to strongly advocate for the Government of Ontario to enact legislation requiring all individuals to wear a personal flotation device (PFD) or lifejacket while on a pleasure boat that is underway, or while being towed behind a pleasure boat using recreational water equipment.

Thank you for your attention on this important issue.

Sincerely,

René Lapierre
Chair, Board of Health

cc: Honourable C. Mulroney, Minister of Transportation
Honourable S. Jones, Minister of Health
Jamie West, Member of Provincial Parliament, Sudbury
France Gélinas, Member of Provincial Parliament, Nickel Belt
Michael Mantha, Member of Provincial Parliament, Algoma-Manitoulin
Viviane Lapointe, Member of Parliament, Sudbury
Marc Serré, Member of Parliament, Nickel Belt
Carol Hugues, Member of Parliament, Algoma-Manitoulin-Kapuskasing
Association of Local Public Health Agencies
All Ontario Boards of Health

Correspondence D

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May 19, 2023

The Honourable Sylvia Jones
Deputy Premier of Ontario
Minister of Health
sylvia.jones@ontario.ca

Re: Peterborough Public Health 2024 Budget

Dear Minister Jones:

The PPH Board of Health (BOH) recently met with our Members of Provincial Parliament and representatives from the City of Peterborough, the County of Peterborough, Curve Lake First Nation, and Hiawatha First Nation to discuss our shared concerns surrounding the financial challenges facing public health.

We recognize that it is still early in the budget process, and that the 2023 provincial budget implementation is still progressing. However, because of the breadth of uncertainties and financial risks facing public health in our region, we wanted the opportunity to discuss our current and forthcoming challenges. We are grateful for the engagement of MPPs Piccini, Scott and Smith, and appreciate their thoughtful reflections and willingness to follow up on concerns from local funders.

The BOH is proud to work with provincial and local funding partners to deliver public health services to our region. The provincial role in public health funding has been essential throughout the COVID-19 pandemic, and we are appreciative of the support we have received from your Government through one-time extraordinary funding to ensure the most effective response possible.

From previous communication from PPH, and other local public health agencies, you will likely be aware that there are longstanding challenges with the sustainability of public health funding in Ontario. PPH has worked to maximize efficiencies in operations, and for years now has seen funding agreements fall short of inflationary increases. We have now reached a point where we cannot continue to deliver critical public health services with the funding we receive.

There are three significant financial concerns facing public health in 2024:

1. PPH, like other sectors, must account for cost increasing at an average rate of 2-3% per year just to maintain the same level of programming. In 2023, the approved PPH cost-shared budget increased by 1.94%, as we continue to be careful stewards of public funds, while maintaining needed services. Yet provincial funding increases have not kept pace. Will your government ensure adequate continued base funding increases to, at minimum, maintain existing service levels?

2. COVID-19 funding has been extended for 2023; however, we are uncertain whether this will continue beyond the current year. This uncertainty undermines our ability to retain the human health resources required to maintain a proportionate response to the ongoing threat of COVID-19. It also further erodes our ability to ensure readiness for future threats to population health, as has been prioritized

by Ontario's Chief Medical Officer of Health in his 2022 Annual Report. Will your government continue to ensure PPH is funded at a level to adequately maintain a proportionate COVID-19 contact tracing and vaccination response, and ensure readiness for future threats to population health?

3. The Province of Ontario moved from a 75/25 to a 70/30 funding split; however, mitigation funding has delayed this download to municipalities. Will your government reverse the decision to move to a 70/30 funding split and maintain that additional contribution to public health? If not, will you consider supporting phasing this in over multiple years to ensure that this download can be effectively managed by local funders?

We continue to value our partnership with the Province of Ontario on advancing public health issues in this community. The COVID-19 pandemic and the aforementioned Ontario CMOH 2022 Annual Report have highlighted the need to ensure the stability of public health funding for continued response to COVID-19 and future health threats, which may be just around the corner. The work of public health extends further to improving the health and prosperity of our community.

In the City, County, Curve Lake First Nation and Hiawatha First Nation, further loss of public health programs will mean that businesses cannot operate safely, people cannot access important public health services, and health and economic development throughout our region will suffer. Without addressing these acute funding issues our community may experience:

- Diminished capacity to respond to and manage disease outbreaks in Long-Term Care, risking the lives of elderly and medically fragile residents;
- Negative economic consequences for over 1,500 local businesses and significant risks to public safety as food premises and small drinking water systems are left uninspected or face delayed openings;
- Reduced ability to vaccinate school-aged children against infectious diseases and screen for urgent oral health issues, undermining lifelong health and opportunities for future employment.

The pandemic has taught us that healthy communities and economies cannot exist without healthy people. With all that we have learned over the past three years, we seek your support and investment to ensure a strengthened and resilient public health system without creating undue strain on local funders.

We look forward to hearing from you.

Miigwech,

Original signed by

Councillor Kathryn Wilson
Chair, Board of Health

/ag

cc: The Hon. Doug Ford, Premier of Ontario
Local Councils
Local MPPs
The Association of Local Public Health Agencies
Ontario Boards of Health

May 30, 2023

VIA ELECTRONIC MAIL

Honourable Jean-Yves Duclos
Minister of Health, Canada
House of Commons
hcminister.ministresc@hc-sc.gc.ca

Honourable Dominic LeBlanc
Minister of Intergovernmental Affairs, Infrastructure and Communities, Canada
iga.minister-ministre.aig@pco-bcp.gc.ca

Honourable Sylvia Jones
Minister of Health, Ontario
sylvia.jones@ontario.ca

Honourable Steve Clark
Minister of Municipal Affairs and Housing, Ontario
minister.mah@ontario.ca

Dear Honourable Ministers:

Re: Support for Improved Indoor Air Quality in Public Settings

I am pleased to share with you Public Health Sudbury & Districts' Board of Health motion in support Peterborough Public Health's calls to the Federal and Provincial ministers for resources and policy leavers to improve indoor air quality in public settings. At its meeting on April 20, 2023, the Board of Health carried the following resolution #17-23:

> *WHEREAS the virus that causes COVID-19 (SARS-CoV2), as well as other respiratory viruses, are spread principally through respiratory droplets and aerosols; and*
>
> *WHEREAS ventilation can affect how well respiratory droplets and aerosols are removed from an area. As noted by the Ontario Science Table, "aerosols play a role in the transmission of SARS-CoV-2, especially in poorly ventilated indoor areas"; and*
>
> *WHEREAS Canada's Chief Science Advisor recommends that owners and operators of indoor public facilities "scale-up and monitor effective prevention*

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interventions, such as improving ventilation in schools, workplaces and public places as part of a first line of prevention of SARS-CoV2 infection and other respiratory/airborne pathogens";

THEREFORE BE IT RESOLVED THAT the Board of Health for Public Health Sudbury & Districts endorse the letters dated March 3, 2023, from Peterborough Public Health to federal and provincial ministers calling for investments and policy levers to improve indoor air quality in public settings such that health is further protected for all; and

FURTHER THAT this resolution be shared with relevant federal and provincial government ministers, area members of parliament and provincial parliament, the Chief Medical Officer of Health, and Ontario boards of health.

Poor indoor air quality poses an environmental health risk that disproportionately impacts vulnerable Canadians. Therefore, as the Chair of our Board of Health, I request that the Provincial government implement a stepwise approach though amendments to the Ontario Building Code, requiring improved air quality standards in new construction; and that the Federal and Provincial governments identify, fund, and implement strategies such as grants, tax breaks, and other incentives, that assist owners to improve indoor air quality in all public settings.

Sincerely,

René Lapierre
Chair, Board of Health

cc: Carol Hughes, Member of Parliament, Algoma-Manitoulin-Kapuskasing
Marc Serré, Member of Parliament, Nickel Belt
Viviane Lapointe, Member of Parliament, Sudbury
Michael Mantha, Member of Provincial Parliament, Algoma-Manitoulin-Kapuskasing
France Gélinas, Member of Provincial Parliament, Nickel Belt
Jamie West, Member of Provincial Parliament, Sudbury
Dr. Kieran Moore, Chief Medical Officer of Health
Loretta Ryan, Executive Director, Association of Local Public Health Agencies
All Ontario Boards of Health

Middlesex-London Board of Health
External Landscape Review – June and July 2023

The purpose of this briefing note is to inform MLHU Board of Health members about what is happening in the world of public health and impacts to the work of the MLHU and Board. This includes governance and legislative changes, news from other local public units, external reports on important public health matters, learning opportunities and MLHU events. **Please note that items listed on this correspondence are to inform Board members and are not necessarily an endorsement.**

Local Public Health News

New permanent Niagara Region Medical Officer of Health appointed

After an extensive recruitment process, Niagara Regional Council, as Niagara's Board of Health, is pleased to share the appointment of **Dr. Azim Kasmani** as permanent Medical Officer of Health and Commissioner of Public Health and Emergency Services for Niagara Region. Dr. Kasmani began his new role as Medical Officer of Health on May 28.

To view the full media release, please visit Niagara Region's website.

Impact to MLHU Board of Health
The Board supports collaboration and connection with other public health units in the province and encourages MLHU's Medical Officer of Health to work with other Medical Officers of Health as necessary for advocacy and idea sharing.

New Associate Medical Officer of Health, City of Hamilton

Dr. Brendan Lew is the incoming Associate Medical Officer of Health for the City of Hamilton. Dr. Lew's first day with the City will be July 1, 2023. Dr. Lew received his Medical Degree in 2018 from McMaster University, as well as his Master of Public Health in 2022. He completed his residency training at McMaster University and was certified by the Royal College of Physicians and Surgeons as a Public Health and Preventive Medicine specialist in June 2023.

Impact to MLHU Board of Health
The Board supports collaboration and connection with other public health units in the province and encourages MLHU's Medical Officer of Health to work with other Associate/Medical Officers of Health as necessary for advocacy and idea sharing.

National, Provincial and Local Public Health Advocacy

Ontario Investing in Provincewide Homelessness Prevention

On May 25, 2023, the Ontario government is investing nearly $770,000 to help the Canadian Alliance to End Homelessness (CAEH) work with communities to connect people experiencing or at risk of homelessness with the local services and supports they need.

The CAEH will use the funding to provide ongoing support to Ontario's 47 service managers – who deliver support services and homelessness prevention programs in local communities – so they can maintain and improve local by-name lists. The by-name lists help service managers understand the extent of homelessness in their communities and improve access to resources as soon as they are available. This includes housing assistance, such as supportive housing or rent supplements, and services like Ontario Works or health care.

To view the full media release, please visit the Ontario (Municipal Affairs and Housing) Newsroom online.

Impact to MLHU Board of Health
The Middlesex-London Health Unit has been partnering with the City of London and other community agencies to support integrated housing and care hubs in Middlesex and London. With more financial support, housing hubs can see more resources to expend necessary services.

Mental Health Services and Programs with, and for, Black Communities

On June 5, 2023, Public Health Ontario released a report (rapid review) on Mental Health Services and Programs with, and for, Black Communities in Ontario. The aim was to review documentation on mental health services for Black communities and summarize their structures, service type, practices, and any available evaluation.

This rapid review addresses the following: what are the characteristics of current mental health services and programs focused on Black communities and what are reported impacts of those services and programs?

To view the full report, visit Public Health Ontario's website.

Impact to MLHU Board of Health
The Board of Health supports activities and work under the Health Unit's Provisional Strategic Plan and the Anti-Black Racism Plan. The Provisional Strategic Plan under the sections Client and Community Confidence, and Organizational Excellence outline strategic ways the organization can include equity subject matter. The ABRP has identified 45 recommendations, which are focused on addressing and eliminating anti-Black racism from public health programs and services in London and Middlesex County.

Canada to become first country in the world to require health warnings on individual cigarettes

On May 31, 2023 during World No Tobacco Day, the Honourable Carolyn Bennett, Minister for Mental Health and Addictions and Associate Minister of Health, announced that Canada will soon require that health warnings be printed directly on individual cigarettes — becoming the first country in the world to take this approach.

The new Tobacco Products Appearance, Packaging and Labelling Regulations will be part of the Government of Canada's continued efforts to help adults who smoke to quit, to protect youth and non-tobacco users from nicotine addiction, and to further reduce the appeal of tobacco. In addition, the regulations will support Canada's Tobacco Strategy and its target of reaching less than 5% tobacco use by 2035.

These regulations will come into force on August 1, 2023 and will be implemented through a phased approach that will see most measures on the Canadian market within the year.

To view the full media release, please visit the Government of Canada Newsroom online.

Impact to MLHU Board of Health
On September 15, 2022, the Middlesex-London Board of Health received Report 51-22: Feedback on Proposed Tobacco Product Labelling Requirements Under the Tobacco and Vaping Products Act. This report advised the Board on a submission that was sent to Health Canada to provide feedback and recommendations on labeling requirements for tobacco and vaping products. The feedback was collated by Health Canada and final guidelines (supported by the Health Unit) were released.

2023 alPHa Annual General Meeting & Conference

From June 12-14, 2023, representation from public health units and Boards of Health met in Toronto for the Association of Local Public Health Agencies' Annual General Meeting in Conference. MLHU was represented by Chair Newton-Reid, Vice-Chair Steele, Chief Executive Officer, Emily Williams and Medical Officer of Health, Dr. Alex Summers.

Topic areas included:

- Constitutional Amendment on Voting Delegates Allocation
- Toward a Renewed Smoking and Nicotine Strategy in Ontario
- Improving Indoor Air Quality to Prevent Infections and Promote Respiratory Health
- Ending Underhousing and Homelessness in Ontario
- Monitoring Food Affordability in Ontario and Inadequacy of Social Assistance Rates
- Advocating for a National School Food Program in Canada

To review resolutions supported, please visit alPHa's website.

Impact to MLHU Board of Health
Delegates at the 2023 alPHa Annual General Meeting and Conference (including those from MLHU) supported resolutions which coincide with the Ontario Public Health Standards and program obligations under the *Health Protection and Promotion Act.*

Strong Mayor Powers Expanded to Mayors in 26 Municipalities

On June 16, 2023, the Ontario Government announced that strong mayor powers would be expanded to 26 municipalities, which includes the City of London effective July 1, 2023. *Strong Mayors, Building Homes Act, 2022* provide specific powers and duties to the Mayor and include:

- The Mayor can establish, dissolve, appoint members and assign functions;
- The Mayor can propose housing-related bylaws and pass them with support of one-third of councillors, override council approval of by-laws;
- Administration powers such as appointing a Chief Administrative Officer, hire or dismiss certain heads of the organizational structure, determining organization structure and direct staff;
- For the municipal budget:
  - The Mayor may present a proposed City budget no later than February 1.
  - City Council has 30 days to amend the proposed budget after the Mayor presents it or may choose to shorten this period.
  - The Mayor may veto Council amendments up to 10 days after Council adopts the amendment or may choose to shorten this period.
  - If the Mayor does not exercise his veto the amended budget is deemed adopted. Council may override the Mayor's veto with a 2/3 vote up to 15 days later in which case the amended budget is deemed adopted.
  - If Council does not exercise an override of the Mayor's veto the proposed budget is deemed adopted.

To view the full media release, please visit the Ontario (Municipal Affairs and Housing) Newsroom online.

Impact to MLHU Board of Health
As one of the municipal partners (City of London) now has designated "strong mayor powers", decisions that our municipal partners make can impact Board of Health decisions (especially wit budgetary matters). It is important for the Board of Health to be aware of these legislative impacts as a local governing board.

Correspondence F

<u>MLHU News</u>

Photo taken by Middlesex-London Health Unit Communications

Middlesex-London Health Unit opens new dental office in Strathroy

On June 26, 2023, the Middlesex-London Health Unit with support from the Ministry of Health held their grand opening event to celebrate the opening of the Strathroy Dental Clinic. The Middlesex-London Health Unit opened its new dental services office in Strathroy this morning, significantly increasing the agency's capacity to deliver routine dental services to low-income seniors and children under the age of 17 who come from low-income families. The Health Unit currently offers these services through the dental clinic at its Citi Plaza offices in downtown London; however, demand has surpassed expectations, resulting in several months of delay between when a patient books their appointment and when they are seen by a dentist.

Located in The Shops on Sydenham, the new dental services office was made possible through a $1.05 million capital-funding grant from the Ontario Ministry of Health. Construction of the new space was completed by CCS Contractors, which won the contract after a competitive bid process.

To see the full media release and learn more about the dental clinic, visit our website.

Impact to MLHU Board of Health
The Board has been receiving updates for over 1 year on the funding received by the Health Unit for the Seniors' Dental Clinic. The Board acknowledges that services for low cost dental services is necessary to create healthy communities, especially in the rural areas of the Health Unit's jurisdiction.

Correspondence G

www.algomapublichealth.com

June 8, 2023

Via Email

Honourable Jean -Yves Duclos
Minister of Health, Canada
House of Commons
Ottawa, ON K1A 0A6
Jean-yves.duclos@parl.gc.ca

Dear Honourable Minister Duclos:

Re: Support for Bill S-254, an Act to amend the Food and Drug Act (warning labels on alcoholic beverages)

On April 26, 2023, the Board of Health for Algoma Public Health (APH), the local public health agency for the District of Algoma in Ontario, received information on alcohol-related harms and the newly released Canada's Guidance on Alcohol and Health, which outlines the current evidence linking alcohol to many health conditions and aims to help people make informed decisions about their alcohol consumption. At this time, a motion was passed to endorse Bill S-254 – An Act to Amend the Food and Drug Act (Warning Labels on Alcoholic Beverages), which calls on the federal government of Canada to implement alcohol warning labels.(1)

The Board of Health for Algoma Public Health is asking the federal government to express support for Bill S-254, by implementing alcohol warning labels that:
1. Indicate the volume that constitutes a standard drink; and
2. Detail the number of standard drinks in the beverage container; and
3. Display health messages regarding the relationship between the number of standard drinks consumed and health outcomes, including the risk of cancer.

More than 75% of Canadians report consuming alcohol, and only 28% of Canadians are aware of the linkage between alcohol and cancer.(2) When asked if warning labels on alcoholic beverages would change behaviour, two-thirds of those surveyed said they would decrease their consumption with this knowledge.(2) In Algoma, over 1 in 4 residents drink heavily and breast and colorectal cancers are more frequently diagnosed, compared to Ontario.(3) APH's Board of Health is committed to influencing the development and implementation of healthy policies and programs related to alcohol and other drugs, with a goal of reducing harms associated with substance use.

Bill S-254 aligns with the recent call to action in Canada's Guidance on Alcohol and Health, regarding mandatory labelling on alcoholic beverages, including the number of standard drinks in a container, risk levels from Canada's Guidance on Alcohol and Health, and health warnings.[1] In Canada, tobacco and cannabis products, two other legally regulated substances, are already subject to mandatory warning labels under the Tobacco and Vaping Products and Cannabis Acts, which have been found to be among the most direct and prominent means of communicating with smokers.[4] In the same way that packaging and health warnings on tobacco products were used as part of a broader public health approach to reducing tobacco-related harms, labels on alcoholic beverages can help people make informed choices about their alcohol consumption, and raise awareness of alcohol-related harms.

We ask for your support of Bill S-254 and the implementation of federally mandated labels on all alcohol containers sold in Canada, to better inform Canadians about the health risks of alcohol. This is especially important given that the majority of Canadians are unaware that alcohol is classified by the World Health Organization (WHO) as a Class 1 carcinogen and is a cause of 7 different types of cancer, including breast and colon.[5]

Thank you for your consideration in advocating for improved health of Canadians.

Sally Hagman

Sally Hagman
Chair, Board of Health,

cc: Dr. J. Loo, Medical Officer of Health and CEO for Algoma Public Health
The Honorable Senator Patrick Brazeau
Local Councils
Local MPs
The Association of Local Public Health Agencies
Ontario Boards of Health

June 6, 2023

VIA ELECTRONIC MAIL

Honourable Jean-Yves Duclos
Minister of Health, Canada
House of Commons
Ottawa, ON K1A 0A6

Dear Honourable Jean-Yves Duclos:

Re: Bill S-254 – An Act to amend the Food and Drugs Act (warning label on alcoholic beverages)

The link between alcohol and chronic disease, injury, and death is a significant public health concern.

> *WHEREAS alcohol is a well-established risk factor for premature death and injury due to unintentional injuries, violence, cancer, liver disease, heart disease, and high blood pressure; and*
>
> *WHEREAS the Canadian Center on Substance Use and Addiction released new guidelines and information in January 2023 about alcohol consumption and health; and*
>
> *WHEREAS within the Public Health Sudbury & District's catchment area, only 37% of adults report that they are aware that consumption of alcohol every day may increase their risk of cancer; and*
>
> *WHEREAS Public Health Sudbury & Districts has elevated and increasing rates of heavy drinking (27.9% PHSD in 2019/2020, compared with 15.6% for the province); and*
>
> *WHEREAS the Ontario Public Health Association and multiple Ontario boards of health in Ontario are writing in support of Senator Brazeau's Bill S-254 – An Act to amend the Food and Drugs Act (warning label on alcoholic beverages), which, if passed, would require the industry to*

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Chapleau
34 rue Birch Street
Box / Boîte 485
Chapleau ON P0M 1K0
t: 705.860.9200
f: 705.864.0820

toll-free / sans frais
1.866.522.9200

phsd.ca

include informative labels on alcoholic bottles discussing health risks and standard drink size;

THEREFORE BE IT RESOLVED THAT the Board of Health for Public Health Sudbury & Districts similarly convey its support for federally mandated health risk labels on all alcohol containers sold in Canada and urge members of parliament and senators to support Bill S-254.

Based on new guidelines published by the Canadian Centre on Substance Use and Addiction, *Canada's Guidance on Alcohol and Health*, the health risks associated with alcohol consumption are better known. However, given current perceptions and routine promotions of alcohol consumption within popular culture, a gap exists between the populations' understanding of the associated health risks and alcohol consumption behaviours. A review of data in the area served by the Board of Health for Public Health Sudbury & Districts points to an evident gap in this understanding.

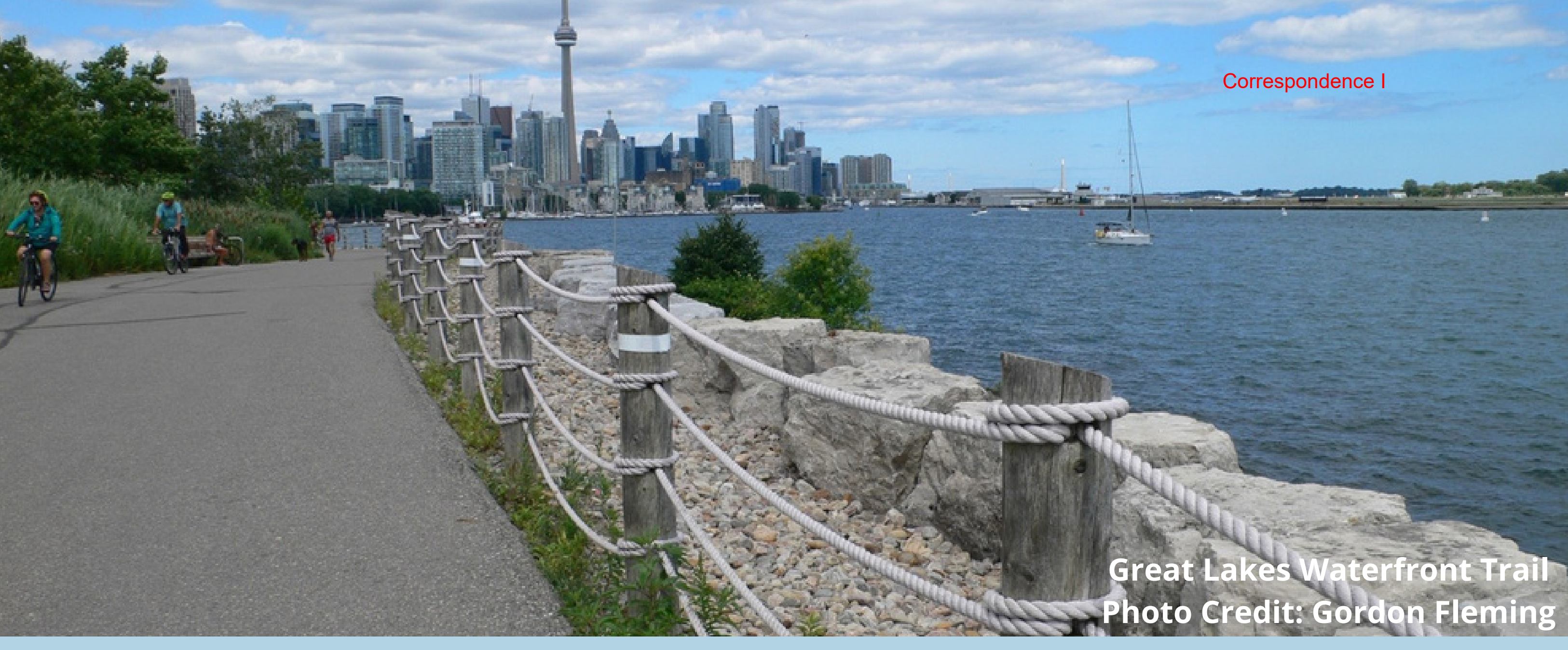
The Board of Health plays a key role in advocating for the best interests of those who live in Sudbury and districts. Alcohol warning labels, including information about standard drink sizes, empower individuals to make informed decisions about their alcohol consumption and their health.

We thank you for your attention to this important health promoting initiative. We ask that you support Senator Brazeau's call through Bill S-254 to implement alcohol labelling to ensure Canadians make informed decisions about their alcohol consumption and their health.

Sincerely,

René Lapierre
Chair, Board of Health

cc: Patrick Brazeau, Senator
Donald Plett, Senator
Raymonde Saint-Germain, Senator
Scott Tannas, Senator
Jane Cordy, Senator
Marc Gold, Senator
Carolyn Bennett, Minister of Mental Health and Addictions, Government of Canada
France Gélinas, Member of Provincial Parliament, Nickel Belt
Jamie West, Member of Provincial Parliament, Sudbury
Michael Mantha, Member of Provincial Parliament, Algoma-Manitoulin
Dr. Kieran Moore, Medical Officer of Health, Government of Ontario
Loretta Ryan, Executive Director, Association of Local Public Health Agencies
Dr. Theresa Tam, Chief Public Health Officer of Canada
All Ontario Boards of Health



Annual Report 2022-2023

President & Executive Director Report

Correspondence L

The Association of Local Public Health Agencies (alPHa) is the collective voice of Ontario's local public health agencies. The Association continues to offer active and outstanding support to its members by providing Ontario's Boards of Health, Medical Officers of Health, and Affiliate organizations with a strong and unified voice on issues that affect local public health. Each of Ontario's 34 local Boards of Health is a current member in good standing, and this is essential for alPHa's continued strength and unity.

Over the past year, alPHa has continually profiled the importance of public health's upstream focus on prevention, communicated the key role local public health plays in communities, and reinforced the extraordinary value of the work carried out every day by Ontario's public health professionals. The common thread of public health's value was strong throughout alPHa's work in 2022-2023, by highlighting the need for the full resumption of routine public health programs and services, in addition to ongoing duties related to the pandemic response.

Guided by its Strategic Plan, alPHa has been active in creating submissions, reports, and other communication tools as a foundation for advocacy on behalf of its members for a stable, sustainable, resilient, and locally based public health system in Ontario. Highlights of alPHa's work for 2022-2023 include:

- Creation of public policy submissions and advancement of alPHa Resolutions on key public health issues. These were supported by the development of additional communication tools including Public Health Matters infographics and videos. Widely shared, these demonstrate the value and return on investment that local public health provides. These resources are useful for our members and in meetings with local councillors, MPPs, and other important stakeholders.

- Successfully launching the BOH Orientation Manual and BOH Governance Toolkit. These are complimented by the ever-growing BOH Shared Resources webpage that support the Board of Health members and are an excellent resource for all of alPHa's members.

- Continuing to provide relevant and timely member-focused information to local public health agencies through e-mail, website, social media, and newsletters. *Information Break*, in particular, is a sharable resource that functions as a monthly portal to public health news, association activities, and events.

· Effectively positioned alPHa to be the voice of Ontario's public health system by holding more than 50 meetings of alPHa's Board, BOH Section, COMOH Section, Affiliates, and their respective Executive Committees.

A major component of alPHa's success in 2022-2023 has been based on relationships that alPHa has built and nurtured over the years with key stakeholders and decision-makers. It is an extensive list that, to name a few, includes Ontario's Ministry of Health, Ontario's Chief Medical Officer of Health, Public Health Ontario, Ontario Health, Association of Municipalities of Ontario, and the Ontario Medical Association. Forging these strong alliances supports the aims of public health and has ensured thait alPHa's Board of Directors, Boards of Health (BOH) Section, Council of Medical Officers of Health (COMOH) Section and Affiliate members are the voice of local public health. In keeping with this, alPHa members actively represented the local public health system at a variety of key public health tables and other important meetings. alPHa was also pleased to co-host and present at The Ontario Public Health Convention 2023 (TOPHC), participate in panels at the AMO 2022 AGM/Conference, present at the Northwestern Ontario Municipal Association (NOMA) 2023 AGM/Conference, participate in the Ontario Chronic Disease Prevention Alliance event at Queen's Park in February 2023, and many other external events.

President & Executive Director Report

Correspondence I

In 2022-2023, alPHa provided important opportunities for the collective voice of Ontario's public health system to assemble. alPHa continued to attract high-profile speakers to its symposiums, conferences, and events, which this past year included the 2023 Winter Symposium, a special conference for Executive and Administrative Assistants and two 'Road to Mental Readiness' workshops, for the COMOH Section in November 2022 and for the BOH Section and Affiliate members in February 2023. In addition, alPHa relaunched the Fitness Challenge in the month of May as the Workplace Health and Wellness Month and is dedicating additional resources to support the physical and mental health of our members.

alPHa's 2023 AGM, plenary sessions, and Section meetings are taking place in Toronto from June 12 to 14, 2023. These are the first in-person events in over three years. While the event is planned and hosted by alPHa, it couldn't be done without Toronto Public Health co-hosting and support from the University of Toronto's Dalla Lana School of Public Health and the Temerty Faculty of Medicine.

The success of alPHa for 2022-2023 is built not only on the support of you, its members, it requires a dedicated and unified governance board, complemented by the tremendous work and services provided by alPHa staff. The alPHa Board continues to give the Association a uniquely qualified and unified leadership voice for Ontario's local public health system. alPHa is fortunate to have Board members who volunteer and are passionate about public health – thank you to each and everyone. alPHa recognizes and understands the challenges facing our members. Guided by its Strategic Plan, alPHa will continue to work tirelessly leading with one, unified voice representing the public health system across its member constituents in its commitment to influence Ontario's decision-makers to ensure a robust local public health system with ample resources to protect the entire population's health.

Thank you to everyone who contributed to and supported alPHa this past year. We are pleased to share this report with Ontario's public health leaders and look forward to continuing to work together to foster a stronger local public health system in Ontario.

Sincerely,

Trudy Sachowski
President

Loretta Ryan
Executive Director

Financial Statements

The following financial information represents alPHa's audited statements as completed by Chaplin & Co. LLP, Chartered Professional Accountants, for the year ended March 31, 2023. A complete audited report can be obtained from alPHa.

Allocation Report
For the year ended March 31, 2023

Revenue	
Membership fees, grants and sponsorships	$ 501,990
Conferences	114,593
Project funding	39,284
Interest and other funding	13,053
	669,020
Expenses	
Salaries and benefits	378,084
Conferences, meetings, and travel	17,662
Project expenses	44,894
Office and program expenses	79,012
	519,652
	$149,368

Financial Statements cont'd

The following financial information represents alPHa's audited statements as completed by Chaplin & Co. LLP, Chartered Professional Accountants, for the year ended March 31, 2023. A complete audited report can be obtained from alPHa.

Balance Sheet as at March 31, 2023

Assets	
Current	
Cash	$126,863
Short-term investments	437,017
Accounts receivable	11,192
Prepaid expenses	4,691
	581,843
Capital assets	2,080
	581,843
Liabilities	
Current	
Accounts payable & accrued liabilities	
Deferred revenue	$ 26,182
	26,182
Net assets	555,661
	$ 581,843

Our Members

Ontario's 34 public health units and their boards are active members of alPHa.

Algoma Public Health

Brant County Health Unit

Chatham-Kent Public Health

Durham Region Health Department

Eastern Ontario Health Unit

Grey Bruce Health Unit

Haldimand-Norfolk Health Unit

Haliburton, Kawartha, Pine Ridge District Health Unit

Halton Region Health Department

City of Hamilton Public Health Services

Hastings Prince Edward Public Health

Huron Perth Public Health

Kingston, Frontenac, Lennox & Addington Public Health

Lambton Public Health

Leeds, Grenville and Lanark District Health Unit

Middlesex-London Health Unit

Niagara Region Public Health

North Bay Parry Sound District Health Unit

Northwestern Health Unit

Ottawa Public Health

Peel Public Health

Peterborough Public Health

Porcupine Health Unit

Public Health Sudbury & Districts

Renfrew County & District Health Unit

Simcoe Muskoka District Health Unit

Southwestern Public Health

Thunder Bay District Health Unit

Timiskaming Health Unit

Toronto Public Health

Region of Waterloo, Public Health

Wellington-Dufferin-Guelph Public Health

Windsor-Essex County Health Unit

York Region Public Health

Members of the alPHa Board of Directors 2022-2023

Executive Committee	
President/BOH Representative, North West Region	Trudy Sachowski
Vice President/ COMOH Representative, Central Region	Dr. Charles Gardner
Past President/COMOH, ex officio	Dr. Paul Roumeliotis
Treasurer/BOH Representative, East Region	Wess Garrod
COMOH Section Chair / COMOH Representative, Toronto	Dr. Eileen de Villa
BOH Section Chair/ BOH Representative, South West Region	Carmen McGregor
Affiliate Executive Representative/ AOPHBA	Cynthia St. John
Members at Large	
BOH Representative, Central West Region	Maureen Wilson
BOH Representative, North East Region	René Lapierre
BOH Representative, Central East Region	Bob Chapman
BOH Representative, Toronto	Anu Sriskandarajah
COMOH Representative, South West Region	Dr. Alexander Summers
COMOH Representative, Central West Region	Dr. Hsiu-Li Wang
COMOH Representative, North Region	Dr. Lianne Catton
COMOH Representative, East Region	Dr. Vera Etches
Affiliate Representative, APHEO	Emma Tucker
Affiliate Representative, OAPHD	Paul Sharma
Affiliate Representative, HPO	Susan Stewart
Affiliate Representative, OPHNL	Jennifer Vickers-Manzin
Affiliate Representative, ASPHIO	Steven Rebellato
Affiliate Representative, ODPH	Carolyn Doris
Cross-Appointment (non-voting), OPHA	Kevin Churchill

Acknowledgments

Thank you to Toronto Public Health for co-hosting and the University of Toronto's Dalla Lana School of Public Health and the Temerty Faculty of Medicine for their generous support.

Our conference sponsors:

Land Acknowledgment

Gathering today, as members of the Association of Local Public Health Agencies, we acknowledge the actions of the Truth and Reconciliation Commission of Canada.

In that spirit, we acknowledge that this meeting, the discussions, and decisions made here will take place on several traditional Indigenous territories across our province.

Today, this land is home to many diverse Indigenous people from across Turtle Island. We recognize their enduring presence.

We respectfully acknowledge each participant's traditional territory as we meet today. We are grateful to have the opportunity to work and live on this land.

480 University Avenue, Suite 300, Toronto, Ontario M5G 1V2
(416) 595-0006 | info@alphaweb.org | www.alphaweb.org
Follow us on Twitter @PHAgencies

Disposition of Resolutions 2023

Resolutions Session
2023 Annual General Meeting
Tuesday, June 13, 2023

Resolution #	Title	Sponsor	Page
A23-01	**Constitutional Amendment on Voting Delegates Allocation**	**alPHa Board of Directors**	**3**
CARRIED			
A23-02	**Toward a Renewed Smoking and Nicotine Strategy in Ontario**	**Simcoe Muskoka**	**5**
CARRIED AS AMENDED			
A23-03	**Improving Indoor Air Quality to Prevent Infections and Promote Respiratory Health**	**Peterborough Public Health / Niagara Region Public Health**	**24**
CARRIED			
A23-04	**Ending Underhousing and Homelessness in Ontario**	**alPHa Boards of Health Section**	**26**
CARRIED AS AMENDED			
A23-05	**Monitoring Food Affordability in Ontario and Inadequacy of Social Assistance Rates**	**Ontario Dietitians in Public Health**	**27**
CARRIED			
LATE RESOLUTIONS			
A23-06	**Advocating for a National School Food Program in Canada.**	**Kingston, Frontenac and Lennox & Addington Board of Health**	**31**
CARRIED			

RESOLUTION A23-01

TITLE: **Constitutional Amendment on Voting Delegates Allocation**

SPONSOR: **alPHa Board of Directors**

WHEREAS article 8.5 of the Constitution of the Association of Local Public Health Agencies specifies the total number of voting delegates based upon the population served by the member local official health agency as follows: *under 200,000* – **4**; *200,000 - 300,000* – **5**; *300,001 - 400,000* – **6**; *over 400,000* – **7**; *Toronto* **20**; and

WHEREAS the most recent change to this allocation was the passage of an amendment to the alPHa Constitution in 1998 to assign 20 delegates to the newly amalgamated City of Toronto, which incorporated former municipalities of East York, Etobicoke, North York, Scarborough and York; and

WHEREAS further amalgamations, public health unit mergers, and population growth have substantially altered the distribution and size of the population of Ontario since that time; and

WHEREAS the composition of the alPHa membership has changed substantially as a result, with the number of public health units reduced from 44 to a current total of 34; and

WHEREAS according to the 2021 Census, 34 public health units are serving over 3 million more Ontarians in total than 44 were serving in 1998; and

WHEREAS the data on population sorted by health region from the 2021 Canada Census of Population have been published; and

WHEREAS these data show that populations have changed sufficiently that four public health units have moved into a higher vote allocation category; and

WHEREAS these data show that populations have changed sufficiently that three public health units categorized in the "more than 400,000" allocation category now have populations in excess of 1 million;

NOW THEREFORE BE IT RESOLVED that the Association of Local Public Health Agencies approve the creation of a new allocation category, namely "Population More Than 1,000,000";

AND FURTHER that each member public health unit in this category be allocated a total of eight (8) voting delegates, as follows:

POPULATION VOTING DELEGATES

Under 200,000	4	Over 400,000	7
200,000 - 300,000	5	Over 1,000,000	8
300,001 - 400,000	6	Toronto	20

BACKGROUND – A23-1

Allocation of Votes: alPHa Resolutions

Health Unit	Population	Voting Delegates
TORONTO	2,794,356	**20**
POPULATION OVER 1,000,000		
Ottawa	1,017,449	**8**
Peel	1,451,022	
York	1,173,334	
POPULATION OVER 400,000		
Durham	696,992	**7**
Halton	596,637	
Hamilton	569,353	
Middlesex-London	500,563	
Niagara	477,941	
Simcoe-Muskoka	599,843	
Waterloo (587,165)	587,165	
Windsor Essex – moved up from >300K	422,860	
POPULATION OVER 300,000		
Wellington-Dufferin-Guelph	307,283	**6**
POPULATION OVER 200,000		
Eastern Ontario	210,276	**5**
Kingston, Frontenac, Lennox and Addington	206,962	
Southwestern	216,533	
Sudbury	202,431	
POPULATION UNDER 200,000		
Algoma	112,764	**4**
Brant	144,937	
Chatham-Kent	104,316	
Grey Bruce	174,301	
Haldimand-Norfolk	116,706	
Haliburton, Kawartha, Pine-Ridge	189,183	
Hastings-Prince Edward	171,450	
Huron Perth	142,931	
Lambton	128,154	
Leeds, Grenville and Lanark	179,830	
North Bay-Parry Sound	129,362	
Northwestern	77,338	
Peterborough	147,681	
Porcupine	81,188	
Renfrew	107,522	
Thunder Bay	152,885	
Timiskaming	32,394	

RESOLUTION A23-02

TITLE: **Toward a Renewed Smoking, Vaping, and Nicotine Strategy in Ontario**

SPONSOR: **Simcoe Muskoka District Health Unit (SMDHU)**

WHEREAS commercial tobacco use remains the leading preventable cause of death and disease in Ontario and Canada; and

WHEREAS the direct and indirect financial costs of tobacco smoking are substantial and were estimated at $7 billion in Cancer Care Ontario and Public Health Ontario's 2019 report The Burden of Chronic Diseases in Ontario; and

WHEREAS the prevalence of cigarette smoking among Ontarians aged 15 years and older in 2020 was 9.9%, amounting to 1,222,000 people; and

WHEREAS the commercial tobacco control landscape has become more complex with the rapid rise of vaping among youth, as well as the concerning prevalence of waterpipe and cannabis smoking; and

WHEREAS the membership previously carried resolution A21-1 proposing policy measures to address youth vaping for implementation at the provincial and federal levels, several of which have yet to be implemented; and

WHEREAS the membership previously carried resolution A17-5 recommending that the provincial tobacco control strategy be aligned with the tobacco endgame in Canada; and

WHEREAS Ontario and Canada have made great strides in commercial tobacco control in Ontario, which are now endangered by the lack of a provincial strategy and infrastructure to support its continuation; and

WHEREAS disproportionate commercial tobacco and nicotine use and associated health burdens exist among certain priority populations;

NOW THEREFORE BE IT RESOLVED that the Association of Local Public Health Agencies write to the Ontario Minister of Health recommending that a renewed and comprehensive smoking, vaping, and nicotine strategy be developed with the support of a multidisciplinary panel of experts, local public health, and people with lived experience;

AND FURTHER that the Association of Local Public Health Agencies recommend that, in the development of a target for such a provincial strategy, the expert panel examine the sufficiency and inclusiveness of Canada's Tobacco Strategy target of less than 5% commercial tobacco use by 2035 with respect to all nicotine delivery products;

AND FURTHER that the Association of Local Public Health Agencies recommend that the pursuit of health equity be foundational to such a provincial strategy;

AND FURTHER that a copy be sent to the Chief Medical Officer of Health of Ontario.

BACKGROUND:

TOWARD A RENEWED COMMERCIAL TOBACCO AND NICOTINE STRATEGY IN ONTARIO

1. Commercial Tobacco

Canada has made great strides in commercial tobacco[1] control, and Ontario has until recent years been a leader among our provinces and territories, having made tremendous progress in decreasing smoking rates and in turn the negative health outcomes of smoking. Smoking prevalence among Canadians and Ontarians 15 years and older have dropped from 25% and 23%, respectively, in 1999 down to around 10% in 2020.[1] This decrease is representative of a remarkable downward trend nationally and provincially that appear to be on track to reach the endgame goal of less than 5% tobacco use by 2035, a target adopted by the federal government in Canada's Tobacco Strategy[2] and previously recommended for adoption in Ontario[3]. The recent Report of the First Legislative Review of the *Tobacco and Vaping Products Act* elaborates on this trend, noting that "declines in the number of young persons who smoke played an important role in declining prevalence rates overall; smoking rates among Canadians aged 15-19 are currently at an all-time low."[4]

However, it is crucial to note that this progress was achieved over decades, with explicit commercial tobacco control strategies in place to guide tobacco control research, policy development, and policy implementation; all this work was also undergirded by a robust infrastructure. Recent examples of progress in the federal policy arena include the implementation of policies around plain and standardized packaging for commercial tobacco products and enhanced package health warnings, as well as a ban on flavours in cigarettes and most cigars. Provincially, Ontario has strengthened its commercial tobacco contraband measures.

While Canada retains a strategy, Ontario is now operating without one—and there is still much work to be done: Tobacco use remains the leading preventable cause of death and disability in Canada,[5,6] killing approximately 48,000 Canadians each year,[2] of which nearly 17,000 are Ontarians.[7] The Ontario Public Health Standards' *Tobacco, Vapour and Smoke Guideline, 2021* states that "[e]very day tobacco kills more Ontarians than alcohol, illegal drugs, accidents, suicides and homicides combined. People who use tobacco are more likely to go to the hospital and stay longer. They are also likely to die younger."[8] The economic burden is similarly immense: While updated data on the economic burden of tobacco use is needed, 2017 data indicated health care costs of $6.1 billion and overall costs of $12.3 billion nationally.[9] In Ontario, a separate report determined the overall annual economic burden of tobacco smoking to be around $7 billion, exceeding that of alcohol consumption, physical inactivity, or unhealthy eating, taken separately.[10]

2. Vaping

The landscape of commercial tobacco and nicotine products has become more complex with the advent of vaping products containing nicotine, which includes electronic cigarettes (e-cigarettes), the primary users of which are youth. Vaping is the "act of inhaling and exhaling an aerosol produced by a vaping product, such as an electronic cigarette."[11] Most vaping devices use electrical power from a battery to heat a liquid solution to produce an aerosol that is breathed in by the user through the mouthpiece. Most vaping liquids contain nicotine, the levels of which range from very low to more than what is found in a typical tobacco cigarette, together with flavouring compounds that are dissolved in a liquid mixture

[1] Commercial tobacco is distinct from traditional or ceremonial use of tobacco by Indigenous peoples. In the implementation and enforcement of the *Smoke-Free Ontario Act, 2017*, the Ministry of Health protects the use of tobacco by Indigenous peoples and communities when used for traditional or ceremonial purposes.

composed typically of propylene glycol and/or glycerol (i.e., vegetable glycerin).[11] Some vaping liquids also contain cannabis.[12]

National data from 2021 indicates that 13% of adolescents aged 15 to 19 years and 17% of young adults aged 20 to 24 years in Canada reported having vaped at least once during the 30-day period before the survey, compared with 4% of adults aged 25 or older.[13] Provincially, there has been a meteoric rise in youth vaping rates in recent years: According to the Ontario Student Drug and Health Survey, grade 7–12 students who reported used vaping products in the past year doubled from 11% in 2017 to 23% in 2019, with 13%—representing approximately 105,600 students—vaping weekly or daily.[14] These rates are particularly alarming among students in higher grades: The 2019 survey indicated that 35% of students in grade 12 vaped in the past year, of which 21% were vaping weekly or daily.[14] Moreover, among students who vaped in the past year, those who reported using a nicotine-containing product doubled from 28% in 2017 to 56% in 2019.[14] The more recent 2021 survey noted a decrease of past-year vaping among students to 15%. However, those who reported using a nicotine-containing product increased further to 84%, implying that the overall percentage of students vaping nicotine-containing products remained approximately the same as in 2019. There are several challenges to interpretation of the 2021 survey results. For example, the change to an online mode of questionnaire delivery for 2021 led to dramatically decreased response rates that may impact the provincial representativeness of the results.[15] The report also indicates that "because of the significant changes to the methodology in 2021, caution is warranted when comparing these estimates with those from previous OSDUHS cycles."[15] More broadly, both the COVID-19 pandemic as well as changes to the federal and provincial regulatory and policy environments since 2019 have likely impacted the prevalence of youth vaping; however, longitudinal assessments have been disrupted by the pandemic and therefore the extent of impacts is unknown. Further monitoring, data collection and evaluation is needed to understand the impact of these changes and events on adolescent vaping initiation, escalation, and overall prevalence.

Regardless of the method of delivery, the highly addictive effects of nicotine are fundamentally the same, and may have particularly insidious effects on the developing brains of youth.[16,17] Although vaping products have been advertised in part as a harm reduction and smoking cessation product that may reduce health risks and possibly save lives for people who smoke, with some evidence to support this claim,[18,19] there has been no discernible population-level change in smoking cessation rates since vaping products entered the market.[20] Therefore, any individual-level efficacy of vaping products as a smoking cessation tool does not appear to translate to population-level impact. Furthermore, the vast majority of uptake has been among youth without a smoking history. In fact, among those who reported having vaped in the past 30 days, a majority (61%) of youth aged 15 to 19 and more than one-quarter (27%) of young adults aged 20 to 24 had never tried a tobacco cigarette in their life, which suggests that the majority of youth are not using vaping devices to reduce or quit smoking.[13] Therefore, the current evidence around the benefits of vaping products for the purpose of smoking cessation, while still evolving, is not of relevance to youth. In contrast, the evidence to date around the harms of vaping is becoming increasingly clear; in particular, people who vape but do not smoke are on average around three times more likely than those who do not vape to initiate cigarette smoking,[21,22] lending credence to the concern of a gateway effect. Additional evidence of harms from vaping includes the following:

- A variety of substances known to be toxic, carcinogenic, or cause disease have been identified in vaping products.[23]
- Intentional or accidental exposure to nicotine e-liquids can lead to poisoning, which can be lethal, with a significant number of accidental poisonings occurring in children under the age of six.[21]
- Vaping can cause burns and injuries, which can be lethal.[21]
- Vaping can cause respiratory disease in the form of E-cigarette or Vaping Use-Associated Lung Injury (EVALI).[21]
- Vaping can lead to seizures.[21]

- Vaping products contribute to environmental waste.[21]

Moreover, there are differences between vaping and smoking dependence that may impact attempts to quit, including the greater variability in vaping products compared to cigarettes, the discreteness and convenience of vaping, and the greater social acceptability of vaping among youth.[24] To address the rise of vaping, Ontario has required retail registration with local public health units for sale of flavoured vaping products (except mint-menthol or tobacco flavours), restricted sale of flavoured products (except mint-menthol and tobacco flavours) to specialty vape stores, banned sale of vaping products in several public premises, and banned their use in most public premises, though with notable exceptions such as post-secondary institutions. There are also several promising local and regional campaigns such as "Not an Experiment"[25] aiming to raise awareness among youth, parents, and educators about the risks of vaping. However, more control measures and interventions, as well as evaluation of their effectiveness, are needed to protect youth from the harms of both vaping as well as all future commercial nicotine delivery products.

3. Waterpipe smoking

Also referred to as "shisha" or "hookah", waterpipe smoking involves smoking a heated tobacco or non-tobacco "herbal" product.[26] Its increase in prevalence globally may be explained in part by misconceptions of lesser harm relative to other forms of tobacco smoking, its social nature, and the availability of various flavours and nicotine-free products.[26] However, waterpipe smoking of both tobacco and non-tobacco products results in inhalation of various carcinogens and toxins, and results in similar negative health effects to cigarette smoking.[26] Moreover, while the *Smoke-Free Ontario Act, 2017* prohibits the use of tobacco in waterpipes in restaurants and bar patios, the use of non-tobacco products in waterpipes is still permitted, impacting not only waterpipe smokers but also the public through secondhand and thirdhand smoke.[26]

4. Cannabis smoking

Cannabis, which can be consumed by various means including smoking, vaping, and ingestion, refers to all products derived from the *Cannabis sativa* plant, and can consist of up to approximately 540 different chemical substances, among which the main psychoactive constituent is tetrahydrocannabinol (THC).[27] The federal *Cannabis Act* came into force in October 2018, resulting in legalization and regulation of production, distribution, sale, import, export, and possession of cannabis for adults of legal age.[28] The 2021 Canadian Cannabis Survey indicates that approximately 25% of Canadians have reported using cannabis in the past 12 months, of whom 74% reported smoking as one method of cannabis consumption.[12] In addition to an array of health effects associated with cannabis consumption, smoked cannabis in particular can increase risk of bronchitis, lung infections, and chronic cough.[29] The *Smoke-Free Ontario Act, 2017* prohibits the smoking of cannabis in enclosed workplaces, enclosed public places, and other designated places.

5. Ontario's commercial tobacco and nicotine control landscape

Despite concerted efforts through research and reports providing evidence-informed recommendations towards a "tobacco endgame" culminating in the *Smoke-Free Ontario Modernization* report in 2017,[3] there has been limited incorporation of these recommendations into the province's approach to commercial tobacco and nicotine control.[30] For example, actions to increase the cost of commercial tobacco products through tax and other pricing policies have been limited; Ontario continues to have the second lowest retail price and total tobacco tax for tobacco products in Canada.[31,32] Moreover, among the many programs and services that have been lost during the COVID-19 pandemic, commercial tobacco and nicotine prevention, protection, and cessation programs have been significantly impacted. Indeed, the

broader commercial tobacco control infrastructure in Ontario has declined substantially both before and during the pandemic, a decline that is closely tied to the loss of a provincial strategy. With the loss of the Smoke-Free Ontario Strategy, the following crucial infrastructure has been lost: the Smoking and Health Action Foundation, the Leave the Pack Behind program, the Youth Advocacy Training Institute as well as the associated youth advocacy programming, the Program Training and Consultation Centre, funding to public health units for youth and young adults as staff, Smokers' Helpline telephone counselling, Registered Nurses Association of Ontario special projects for tobacco control, Heart & Stroke Foundation of Ontario mass media campaigns, and provincial mass media campaigns. In addition, provincial funding has been reduced for monitoring, research, and evaluation, which has impacted the activities of organizations such as the Ontario Tobacco Research Unit. Funding from other sources such as NGOs has also been lost for organizations such as the Ontario Campaign for Action on Tobacco. Furthermore, many stakeholder engagement opportunities at the provincial level, such as through the Tobacco Control System Committee, the Youth Prevention Task Force, the Communications and Marketing Advisory Committee, the Protection and Enforcement Task Force, the Research and Evaluation Task Force, the Capacity Building and Training Task Force, and monthly calls between Tobacco Control Area Networks and Ministry staff, have been discontinued. Finally, organizations such as Public Health Ontario have had a reduced focus on commercial tobacco and nicotine as an inevitable consequence of the significant resources that have been committed to combatting the COVID-19 pandemic, although their recent re-engagement in this area is inspiring.

These setbacks are compounded by ongoing inequities in the health impacts of tobacco and nicotine use among certain populations. Smoking is a socioeconomically stratified behaviour, as evidenced by decreasing prevalence rates with increasing education.[33] Disproportionate commercial tobacco and nicotine use and associated health burdens exist among Indigenous populations, members of the LGBTQ2S+ community, low-income populations, people with less formal education, people working in certain occupations (e.g., trades), individuals with mental health needs, individuals who use other substances, and incarcerated individuals.[2,9,31,34] Moreover, while reaching less than 5% tobacco use by 2035 may be possible with current strategies, such a target on its own does not sufficiently address this disproportionate burden among these populations. When addressing such health inequities among Indigenous peoples, it is also important to take a culturally safe approach that distinguishes between commercial tobacco use and traditional or ceremonial use of tobacco.

6. Examining the policy options

In late 2022, the Simcoe Muskoka District Health Unit (SMDHU) performed a brief jurisdictional scan focusing on recently implemented commercial tobacco and nicotine control policies (see Appendix A) and explored the grey literature to both identify existing policies at the federal and provincial levels, as well as determine some of the priority areas for action for a renewed smoking and nicotine strategy. SMDHU also conducted a conversation with key informants, the key points of which were summarized through the lens of an adapted version of the World Health Organization's MPOWER framework[2] (see Appendix B).[36]

Given the relative recency of vaping as a phenomenon, evidence is emerging related to the effectiveness of interventions to reduce vaping[23,37–41] as well the cost-effectiveness of doing so.[42] Lessons learned from interventions used to combat commercial tobacco use may also be applied to address vaping.[40] However, evaluation will be needed to confirm effectiveness. There have already been a variety of effective

[2] The World Health Organization Framework Convention on Tobacco Control (FCTC) is a legally binding international health treaty on tobacco control, which 182 countries including Canada have ratified.[35] To help countries reduce demand for tobacco, the WHO developed the MPOWER measures: Monitor tobacco use and prevention policies; Protect people from tobacco smoke; Offer help to quit tobacco use; Warn about the dangers of tobacco; Enforce bans on tobacco advertising, promotion and sponsorship; and Raise taxes on tobacco.[36]

commercial tobacco and nicotine control interventions implemented in Ontario and other Canadian jurisdictions over the years, but a coordinated, comprehensive, multi-level, evidence-informed, and enduring strategy is needed to achieve the target of less than 5% tobacco use by 2035. Such a strategy would continue to be informed by evidence and focus on the traditional pillars of prevention, cessation, and protection, as well as industry denormalization and engagement of disproportionately impacted groups such as First Nations, Inuit and Métis (FNIM) organizations and communities.[3,9,34,43,44] However, for such a strategy to work, there must be provincial and federal commitments to strong regulations around all alternative methods of nicotine delivery. In particular, the Council of the Chief Medical Officers of Health has recommended a "broad regulatory approach to all alternative methods of nicotine delivery (i.e. other than tobacco products) that offers strong youth protection while allowing appropriate access for adult who smoke to products if they are proven effective in decreasing or stopping the use of all nicotine-containing products."[45]

7. Conclusion

Despite significant progress in commercial tobacco control, the health and economic burdens of tobacco-related disease in Canada remain unconscionably high. Moreover, vaping, waterpipe smoking, and cannabis smoking have added further complexity to the smoking and nicotine control landscape that risks undoing the tremendous progress that has been made. A coordinated, comprehensive, and enduring provincial smoking and nicotine control strategy is needed to save lives, protect young minds, reduce health inequities, and save money.

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Appendix A: Jurisdictional Scan of Tobacco and Nicotine Control Policies in Canada

Summary: A jurisdictional scan of Canadian federal, provincial, and territorial tobacco and nicotine control strategies was performed. An array of pre-existing documents[32,46–48] (environmental scans, briefing notes, etc.) produced by Physicians for a Smoke-Free Canada (PSC) cover similar objectives, and therefore constitute a major contribution to this scan. Overall, strategies have continued to focus on efforts surrounding the four pillars of prevention, cessation, protection and denormalization, with varying degrees of emphasis on each. However, the last few years have seen a deceleration in commercial tobacco control efforts, while vaping products have taken the spotlight, particularly following the amendment of the *Tobacco Act* in 2018 to become the *Tobacco and Vaping Products Act* (TVPA).

With respect to commercial tobacco control, the following recent changes have occurred at the federal, provincial, and/or territorial levels:

- plain and standardized packaging
- enhanced package health warnings
- ban on flavours in cigarettes and most cigars including menthol and cloves
- additional contraband measures in some jurisdictions

With respect to vaping control, the following recent changes have occurred at the federal, provincial, and/or territorial levels:

- taxes on vaping products
- retail licensing/registration
- minimum age restrictions
- requiring proof of age in stores
- display bans in stores
- restriction to sale in specialty vape stores
- bans on internet sales
- bans on incentives to retailers
- bans on non-tobacco flavours
- bans on various forms of advertisement
- restrictions on nicotine content
- health warnings

There are also plans at the federal level for implementing "reporting requirements that would require vaping product manufacturers to submit information to Health Canada about sales and ingredients used in vaping products."[4]

Limitations: While such a scan would be most useful if it summarized the implementation of the jurisdictional strategies that were identified (in addition to effects of implementation, technical feasibility, political viability, alignment with the Canadian regulatory landscape, etc.), the scan was largely limited to information that could be gleaned from web-based searches of the grey literature. Furthermore, jurisdictions outside of Canada such as New Zealand,[49] Australia,[50,51] Finland[52] and California[53] may provide further insights into tobacco and nicotine control, but were not covered in this scan.

Table A1: Jurisdictional Scan Results

F/P/T	Strategic Document	Alignment with Endgame Target[47] (less than 5% by 2035)	Recent Policy Implementation[4,32,44,46] (listed if not already implemented in Ontario)
Fed	Canada's Tobacco Strategy[2] (2018)	• Supports endgame goal of less than 5% by 2035. • Note: In 2020/2021, Health Canada changed its progress indicator from "percentage of Canadians (aged 15+) who have used any tobacco product in the last 30 days" to "Percentage of Canadians (aged 15+) who are current cigarette smokers."[54]	• Vaping products: ban on ads in stores (except age-restricted stores), display ban, ban on broadcast ads, ban on billboards/outdoor signs, ban on lifestyle ads, ban on sponsorships, ban on youth-appealing ads, health warnings / labelling requirements, restriction on nicotine content (max 20 mg/mL), excise tax, plan to ban all flavours except tobacco and mint-menthol, plan to impose vaping product reporting requirements, compliance and enforcement activities • Tobacco products: Plain and standardized packaging, enhanced package health warnings, ban on flavours in cigarettes and most cigars including menthol and cloves
BC	BC's Tobacco Control Strategy: targeting our efforts[55]	• No endorsement of endgame goal • BC's 2013 Guiding Framework for Public Health[56] targets a reduction of smoking to 10% by 2023. • In the 2018 report First to 5% by 2035[57], the Clean Air Coalition of BC recommended that BC be the first jurisdiction to achieve 5% by 2035, but there is no evidence of endorsement by government.	• Vaping products: tax, retail notification and reporting requirement, sale of flavoured products restricted to specialty vape stores, ban on sale and use in some public premises • Tobacco products: subsidized nicotine replacement therapy (NRT) to all residents, second highest level of overall taxation on cigarettes ($15.30 for a 20-pack), highly regarded stop-smoking service model, some exemplary practices in Indigenous stewardship
AB	Creating Tobacco-free Futures: Alberta's Strategy to Prevent and Reduce Tobacco Use 2012-2022[58]	• No endorsement of endgame goal • 10-year targets set for 2022: - Albertans ages 15 and over: 12 % - Albertans ages 12 to 19: 6% - Albertans ages 20 to 24: 20% - Pregnant women in Alberta: 11%	• Vaping products: ban on possession below minimum legal age, ban on sale in some public premises, ban on use in most public premises including outdoor cultural events

F/P/T	Strategic Document	Alignment with Endgame Target[47] (less than 5% by 2035)	Recent Policy Implementation[4,32,44,46] (listed if not already implemented in Ontario)
		- Reduce estimated per capita tobacco sales by 50 per cent to 745 units in 2022.	
SK	No strategic document identified. Public-facing Information available on their Tobacco and Vapour Products webpage.	• No endorsement of endgame goal • The Saskatchewan Coalition for Tobacco Reduction produced a report entitled Protecting our Future: Recommendations to reduce tobacco use in Saskatchewan, but this document does not appear to have been endorsement by government.	• Vaping products: tax, ban on sale and use in some public premises
MB	No strategic document identified. Public-facing information available on their Smoking, Vaping Control & Cessation webpage.	• No endorsement of endgame goal	• Vaping products: ban on sale and use in some public premises
ON	Smoke-Free Ontario: The Next Chapter - 2018[30] Note: This strategy was neither adopted nor implemented by the present government.	• No endorsement of endgame goal • Reduce smoking to 10% by 2023 • Reduce the number of smoking-related deaths by 5,000 each year. • Reduce exposure to the harmful effects of tobacco and the potentially harmful effects of other inhaled substances and emerging products (including medical cannabis).	• Vaping products: retail registration with local public health unit required for sale of flavoured products (not tobacco or mint-menthol), sale of flavoured products (except tobacco and menthol) restricted to specialty vape stores, ban on sale in several public premises, ban on use in most public premises (post-secondary institutions excluded) • Tobacco products: additional contraband measures
QC	Stratégie pour un Québec sans tabac 2020-2025[59] (see Appendix A for summary English translation)	• No endorsement of endgame goal • Reduce smoking to 10% by 2025.	• Vaping products: retail notification requirement, ban on internet sale and on incentives to vaping product retailers, ban on sale in most public premises, ban on use in many public premises • Tobacco products: subsidized nicotine replacement therapy (NRT) to all residents
NB	New Brunswick's Tobacco-Free	• **Supports endgame goal of less than 5% by 2035.**	• Vaping products: retail licensing/registration, ban on all

F/P/T	Strategic Document	Alignment with Endgame Target[47] (less than 5% by 2035)	Recent Policy Implementation[4,32,44,46] (listed if not already implemented in Ontario)
	Living Strategy: A Tobacco and Smoke-Free Province for All[60] (2019-2023) was produced by the NB Anti-Tobacco Coalition, funded by the Government of NB.		flavours except tobacco, ban on use in most public premises
NS	Moving toward a Tobacco-Free Nova Scotia: Comprehensive Tobacco Control Strategy for Nova Scotia[61] (2011) Public-facing information available on their Tobacco Free Nova Scotia webpage.	• No endorsement of endgame goal • Decrease tobacco use rates individuals aged 15-19 years to 10%, 20-24 years to 20%, and 25 years and older to 15%.	• Vaping products: retail licensing/registration, tax, ban on all flavours except tobacco, ban on sale and use in most public premises (post-secondary institutions included)
PEI	No strategic document specific to tobacco control identified. Tobacco control is addressed in PEI's Wellness Strategy[62] (2015-2018)	• No endorsement of endgame goal	• Vaping products: Sale restricted to age 21 years and above and only in specialty stores, ban on all flavours except tobacco, ban on sale in many public premises, ban on use in several public premises (post-secondary institutions included)
NL	Tobacco and Vaping Reduction Strategy[63] (2021) produced by the Newfoundland and Labrador Alliance for the Control of Tobacco, which is an alliance of government and non-government partners.	• No endorsement of endgame goal Action areas: • Community capacity building • Education and awareness • Healthy public policy • Cessation and treatment services • Research, monitoring and evaluation	• Vaping products: retail licensing/registration, tax, ban on sale in many public premises, ban on use in several public premises (post-secondary institutions included) • Highest level of overall taxation on cigarettes ($15.71 for a 20-pack)
YT	No strategic document identified. Public-facing information available on	• No endorsement of endgame goal	• Vaping products: ban on use in many public premises

F/P/T	Strategic Document	Alignment with Endgame Target[47] (less than 5% by 2035)	Recent Policy Implementation[4,32,44,46] (listed if not already implemented in Ontario)
	government webpage.		
NWT	No strategic document identified. Public-facing information available on Tobacco Control webpage.	• No endorsement of endgame goal	• Vaping products: ban on all flavours except tobacco, ban on possession below minimum legal age, ban on sale in some public premises, ban on use in many public premises
NU	Nunavut Tobacco Reduction Framework for Action[64] (2011-2016)	• No endorsement of endgame goal • Guiding principles draw from Inuit culture and practices. • Supports a coordinated communications plan using a range of media tools and using both universal and targeted approaches (including youth, pregnant women and their partners, and parents and Elders). • Younger age group is targeted through school and community youth programs because youth initiate tobacco use largely between 8 and 16 years of age.	• Vaping products (per Tobacco and Smoking Act[65], which received Assent on June 8, 2021, but is not anticipated to come into force until 2023): plan to consider vaping product price restrictions, plan to ban incentives to vaping product retailers, plan to ban sale and use in most public premises, plan to ban all flavours except tobacco and any product designed for use as flavouring for any smoking product, plan to make all publicly funding housing smoke-free, plan for biennial reporting requirements for vape retailers

Appendix B: Priorities for a Provincial Smoking and Nicotine Strategy — Key Informant Conversation Summary

To inform the call for a renewed and comprehensive provincial commercial tobacco and nicotine strategy, the Simcoe Muskoka District Health Unit (SMDHU) conducted a conversation on November 17, 2022, with a panel of key informants with extensive experience in commercial tobacco control in Ontario and Canada, in addition to following up individually upon request from some key informants for further discussion. The meeting was framed as an informal discussion around commercial tobacco and nicotine control, using past strategies and reports as a springboard to identify provincial priorities for a renewed commercial tobacco and nicotine strategy, as well as federal priorities to address relevant policy gaps.

Participants included:

- John Atkinson, Executive Director, Ontario Public Health Association
- Cindy Baker-Barill, Smoke-Free Program Manager, Smoke-Free Program and Central East Tobacco Control Area Network, Environmental Health Department, SMDHU
- Hillary Buchan-Terrell, Advocacy Manager (Ontario), Canadian Cancer Society
- Cynthia Callard, Executive Director, Physicians for a Smoke-Free Canada
- Vito Chiefari, Manager, Health Protection, Community & Health Services Dept, York Region
- Rob Cunningham, Senior Policy Analyst, Canadian Cancer Society
- Dr. Charles Gardner, Medical Officer of Health and Chief Executive Officer, SMDHU
- Dr. Lesley James, Director, Health Policy & Systems, Heart & Stroke Foundation
- David Neeson, Supervisor, Tobacco and Electronic Cigarette Control Team, Health Protection Division, Community and Health Services, York Region
- Michael Perley, former Director, Ontario Campaign for Action on Tobacco
- Dr. Emil Prikryl, Public Health and Preventive Medicine Resident, NOSM University
- Dr. Steven Rebellato, Vice President, Environmental Health Department, SMDHU
- Dr. Robert Schwartz, Executive Director, Ontario Tobacco Research Unit and Professor, Dalla Lana School of Public Health
- Linda Stobo, Program Manager, Substance Use Program, Healthy Living Division, Middlesex-London Health Unit
- Melissa van Zandvoort, Health Promotion Specialist, Smoke-Free Program and Central East Tobacco Control Area Network, Environmental Health Department, SMDHU

While it is our recommendation that the development of a renewed strategy be supported by a multidisciplinary panel of experts, Table B1 frames the priorities identified during the key informant conversation through the lens of an expanded version of the World Health Organization's MPOWER framework (i.e., MPOWER+):

Table B1: Priorities within the MPOWER+ Framework

MPOWER+ Measure	Priorities
Monitor tobacco and vaping use and prevention, cessation and protection/enforcement programs and policies.	• Re-invest in research/monitoring and evaluation to ensure practice and policy decisions are based on evidence. • Continue to explore age restrictions for smoking and vaping.
Protect people from tobacco smoke and e-cigarette aerosol.	• Further expand smoke- and vape-free public places. • Continue to increase access to smoke- and vape-free housing. • Direct focus towards consumer rights to be protected from marketing of nicotine products.
Offer help to quit smoking and vaping.	• Increase subsidization of smoking cessation pharmacotherapy for all residents.
Warn about the dangers of commercial tobacco and vaping products.	• Implement mass media and social marketing campaigns of greater intensity and duration targeted at youth and young adults addressing the real and potential harms of vaping such as its impacts on mental health, addiction, and environmental waste. • Implement mass media and social marketing campaigns of greater intensity and duration targeted at high-risk populations addressing the harms of smoking and the benefits of quitting.
Enforce bans on commercial tobacco and vaping product advertising, promotion and sponsorship.	• Return the focus of nicotine control efforts to the industry through activities such as leveraging litigation opportunities to further denormalize the industry and hold industry accountable for past and future harms to society. • Ban all flavours except tobacco flavour (if not achieved federally). • Restrict availability in brick-and-mortar settings and online access. • Strengthen retail registration and licensing requirements. • Further regulate vaping product design (e.g., plain and standardized packaging for vaping, health warnings). • Intensify tobacco and vaping product advertising promotion and sponsorship bans.

MPOWER+ Measure	Priorities
	• Ensure continued funding for enforcement through the *Smoke-Free Ontario Act, 2017*.
Raise taxes on commercial tobacco and vaping products.	• Implement a tax on vaping products, as well as regulatory fees as a means of cost recovery. • Further increase taxes on combustible tobacco products.
+ **Add** a strong health equity lens by linking commercial tobacco and nicotine control approaches to broader objectives addressing health inequities. **Add** bold interventions as indicated by evidence to further reduce the supply, demand, and access of all current and future industry nicotine delivery systems.	• Address the disproportionate use of commercial tobacco and nicotine use and associated health burdens among Indigenous populations, members of the LGBTQ2S+ community, youth, low-income populations, people with less formal education, people working in certain occupations (e.g., trades), individuals with mental health needs, individuals who use other substances, and incarcerated individuals. • Implement recommendations from the Council of Chief Medical Officers of Health to develop a "broad regulatory approach to all alternative methods of nicotine delivery (i.e. other than tobacco products) that offers strong youth protection while allowing appropriate access for adult smokers to products if they are proven effective in decreasing or stopping the use of all nicotine-containing products."[45]

RESOLUTION A23-03

TITLE: **Improving Indoor Air Quality to Prevent Infections and Promote Respiratory Health**

SPONSOR: **Niagara Region Public Health, Peterborough Public Health**

WHEREAS The Association of Local Public Health Agencies (alPHa) previously resolved on June 12, 2001 (Resolution A01-12) to petition the Province of Ontario to establish indoor air quality standards to protect the respiratory health of students.

WHEREAS The intense scientific inquiry conducted during the COVID-19 pandemic has discovered that COVID-19 can spread through the airborne route, and that new understanding around the role of aerosols in infection transmission has made it much more probable that other respiratory infections have a larger airborne transmission component than previously understood.

WHEREAS Canadians spend 90% of their time indoors, and indoor public settings such as food premises, meeting halls, athletics facilities, and congregate living settings have been some of the highest risk settings for COVID-19 transmission during the pandemic.

WHEREAS COVID-19 has emerged as the third leading cause of death in Canada, so measures that can reduce its transmission could have sizable impacts on health.

WHEREAS Improved indoor air quality would have additional positive benefits in terms of preventing lung disease, asthma attacks, and cancers.

WHEREAS Retrofitting indoor air handling equipment to improve air quality would also be an opportunity to move to more efficient air handling systems which would support environmental sustainability which would have its own health benefits.

WHEREAS The current Ontario Building Code includes only a requirement for minimum number of air exchanges, but not more detailed air quality standards, and no standards designed to protect individuals from infection risk.

WHEREAS Improved indoor air quality presents an opportunity for a universal, policy-driven, systems-level intervention to prevent respiratory infections, rather than reliance on individual behaviours within inequitable contexts.

WHEREAS Improved indoor air quality has been associated with improved academic performance in school, and improved productivity in workplaces.

WHEREAS Certain indoor air quality improvement strategies may require investments, however, others including natural ventilation strategies can be no or low cost.

WHEREAS Investments in indoor air quality are likely to achieve substantial economic savings through reducing infections, enhancing workplace/public safety, preventing absenteeism, and keeping the Ontario economy open for business.

NOW THEREFORE BE IT RESOLVED that the Association of Local Public Health Agencies (alPHa) calls on the Federal and Provincial governments to update building codes by incorporating higher standards of air quality such that respiratory diseases, especially COVID-19 and other emerging infections, can be sustainably mitigated in all new buildings, with regular updates to these building codes as best available evidence evolves;

AND FURTHER that alPHa encourages Municipal governments and First Nations governments to consider policy levers to improve indoor air quality in their regions, and particularly to assess and improve of indoor air quality in their own public facilities;

AND FURTHER that alPHa calls on the Federal and Provincial governments to create funds, incentives, and educational campaigns to support small businesses and other organizations in upgrading their HVAC systems, and/or otherwise improving their indoor air quality by using best practices and implementing technological advancements so that clean air becomes the norm in these spaces;

AND FURTHER that alPHa encourages members to liaise with other sectors (e.g. environmental engineers, municipal building departments, the business community, etc.) to fully understand how changes could be implemented in indoor public and residential settings and explore opportunities for improvement.

RESOLUTION A23-04

TITLE: **Ending Underhousing and Homelessness in Ontario**

SPONSOR: **alPHa Boards of Health Section**

WHEREAS housing is recognized as a human right in Canada under the International Covenant on Economic, Social and Cultural Rights [1]; and

WHEREAS the goal of Public Health is to reduce health inequities and improve the health of the whole population; and

WHEREAS housing is widely accepted as a key determinant of health, with the health of a population directly linked with the availability of adequate, affordable housing; and

WHEREAS the negative impacts of housing insecurity and homelessness include poor mental health, higher risk of infectious diseases, higher risk of chronic diseases, and higher risk of injuries among others [2]; and

WHEREAS ending underhousing and homelessness requires a range of housing, social service, and health solutions from a range of stakeholders; and

WHEREAS leadership and urgent action is needed from the provincial government on an emergency basis to develop, resource, and implement a comprehensive plan to prevent, reduce and ultimately end underhousing and homelessness in Ontario; and

WHEREAS The Association of Municipalities of Ontario, a strategic partner of alPHa has asked that their partners support their *Call to Action on Housing and Homelessness;*

THEREFORE BE IT RESOLVED THAT alPHa support AMO's *Call to Action on Housing and Homelessness*;

AND FURTHER THAT alPHa call on the Provincial Government to:

- acknowledge that housing is a social determinant of health and a human right.
- acknowledge that homelessness in Ontario is a social, economic, and health crisis.
- commit to the goal of ending underhousing and homelessness in Ontario.
- work with alPHa, AMO and a broad range of community, health, Indigenous and economic partners to develop, resource, and implement an action plan to achieve this goal.

AND FURTHER THAT the Association of Municipalities of Ontario and the Ministers of Health; Municipal Affairs and Housing; Ministry of Finance; the Premier's office; relevant ministries of the Federal Government; and Children, Community and Social Services be so advised.

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[1] Third report of Canada, International Covenant on Economic, Social and Cultural Rights : article 11 : housing : background report, https://publications.gc.ca/site/eng/9.847859/publication.html, retrieved April 20, 2023

[2] Public Health Ontario Evidence Brief: Homelessness and Health Outcomes: What are the associations? https://www.publichealthontario.ca/-/media/documents/E/2019/eb-homelessness-health.pdf

RESOLUTION A23-05

TITLE: **Monitoring Food Affordability in Ontario and Inadequacy of Social Assistance Rates**

SPONSOR: **Ontario Dietitians in Public Health**

WHEREAS the Population Health Assessment and Surveillance Protocol (2018) of the Ontario Public Health Standards require public health units (PHUs) to monitor food affordability, as well as assess and report on the health of local populations, describing the existence and impact of health inequities;

WHEREAS it is well documented that food insecurity has detrimental impacts on physical and mental health leading to increased healthcare utilization and greater healthcare costs;

WHEREAS adequate income is an important social determinant of health that greatly impacts household food security status;

WHEREAS results of monitoring food affordability in Ontario in 2022 highlight the inadequacy of both Ontario Works (OW) and the Ontario Disability Support Program (ODSP);

WHEREAS 67% of households in Ontario that rely on ODSP and OW as their main source of income experience food insecurity;

WHEREAS prices for food purchased from stores rose 10.6% from February 2022 to February 2023, the fastest pace since 1981;

WHEREAS ODSP rates were increased by 5% in 2022 and will be indexed to inflation going forward; however, current ODSP rates are not based on the costs of living. Further, OW has not been increased since 2018 and is not indexed to inflation; and

WHEREAS Previous alPHa resolutions A05-18 (Adequate Nutrition for Ontario Works and Ontario Disability Support Program Participants and Low Wage Earners), A15-04 (Basic Income Guarantee), and A18-02 (Minimum Wage that is a Living Wage) have underscored the need for income-based responses to poverty and food insecurity.

NOW THEREFORE BE IT RESOLVED that alPHa call on the Province of Ontario to utilize food affordability monitoring results from PHUs in determining the adequacy of social assistance rates to reflect the current costs of living and to index Ontario Works rates to inflation going forward;

AND FURTHER that alPHa call on the Province of Ontario to acknowledge the impact of rising food costs, particularly for individuals living on social assistance incomes, and legislate targets for reduction of food insecurity as part of Ontario's plan for poverty reduction.

BACKGROUNDER: Monitoring Food Affordability in Ontario and Inadequacy of Social Assistance Rates

SPONSOR: Ontario Dietitians in Public Health

Food insecurity, inadequate or insecure access to food due to household financial constraints, continues to be a serious and pervasive public health problem. Physical and mental health are tightly linked to individuals' household food security status.[1] The health consequences of food insecurity are a large burden on our healthcare system and are costly for public health care budgets.[1] The most current data indicate approximately one in six households in Ontario experience some level of food insecurity.[2]

Social assistance recipients, including those reliant on Ontario Works (OW) and the Ontario Disability Support Program (ODSP), are at extremely high risk of food insecurity. In 2021, approximately 67% of households in Ontario receiving social assistance experienced food insecurity.[2] The situation has undoubtedly worsened since then with extraordinary food inflation over the past year. The price of food purchased from stores from February 2022 to February 2023 increased by 10.6%, rising at a rate not seen since the early 1980s.[3]

Food affordability monitoring conducted by local Public Health Units (PHUs) in May/June 2022 substantiates that individuals receiving social assistance experience extremely dire financial situations, particularly single adults without children. Table 1 illustrates that for a sample of PHUs across all Ontario regions, monthly OW rates in addition to all potential tax credits (assuming individuals file income tax returns) fall short of covering only the cost of a bachelor apartment and food by a range of -$132 in Chatham-Kent to -$752 in Toronto. Other basic costs of living (e.g., clothing, personal care, transportation, phone, etc.) are not included. These data clearly indicate the extreme inadequacy of OW rates which have been frozen since 2018.[4]

Table 1: Single Adult receiving ONTARIO WORKS (OW)

Public Health Unit	Monthly income (OW[a] + tax credits[b])	Monthly cost of food[c]	Monthly cost of a bachelor apartment[d]	Remainder/ Shortfall
Chatham-Kent	$863	$381	$614	- $132
North Bay Parry Sound District	$876	$404	$650	-$178
Northwestern	$876	$466	$602	- $192
Ottawa	$863	$392	$1059	- $588
Peterborough	$863	$381	$805	- $323
Toronto	$865	$392	$1225	- $752
Wellington-Dufferin-Guelph	$863	$425	$936	-$498

[a] includes Basic Allowance ($343) + Maximum Shelter Allowance ($390)
[b] includes GST/HST tax credit, Ontario Trillium Benefit, and Climate Action Incentive Payment
[c] cost of the Ontario Nutritious Food Basket, collected by Public Health Unit in May/June 2022
[d] cost of market rental rates obtained from CMHC data tables (October 2021) or from municipal housing authorities; may or may not include utilities

Table 2 shows the monthly funds remaining or shortfall of ODSP and available tax credits after rent for a one-bedroom apartment and cost of food are deducted. Again, other basic costs of living are not included. The monthly funds remaining for ODSP recipients range from $121 in Chatham-Kent to a shortfall of -$525 in Toronto. Despite an increase of 5% to ODSP in September 2022, an increase from $200 per month to $1000 per month on employment earning cap, and an adjustment for inflation beginning in July 2023[4,5,6], ODSP falls well below the actual costs of living.

Table 2: Single Adult receiving ONTARIO DISABILITY SUPPORT PROGRAM (ODSP)

Public Health Unit	Monthly income (ODSP[a] + tax credits[b])	Monthly cost of food[c]	Monthly cost of a 1 bedroom apartment[d]	Remainder/ Shortfall
Chatham-Kent	$1309	$381	$807	$121
North Bay Parry Sound District	$1322	$404	$862	$56
Northwestern	$1322	$466	$814	$42
Ottawa	$1309	$392	$1280	- $363
Peterborough	$1309	$381	$1049	-$121
Toronto	$1313	$392	$1446	- $525
Wellington-Dufferin-Guelph	$1309	$425	$1277	-$393

[a] includes Basic Allowance ($343) + Maximum Shelter Allowance ($390)
[b] includes GST/HST tax credit, Ontario Trillium Benefit, and Climate Action Incentive Payment
[c] cost of the Ontario Nutritious Food Basket, collected by Public Health Unit in May/June 2022
[d] cost of market rental rates obtained from CMHC data tables (October 2021) or from municipal housing authorities; may or may not include utilities

Ontario's poverty reduction plan, Building a Strong Foundation for Success: Reducing Poverty in Ontario (2020-2025) includes various indicators (e.g., poverty rate, employment rate, graduation rate); however, it does not include an indicator or provincial targets for the reduction of household food insecurity (HFI). HFI is a highly sensitive measure of material deprivation that is strongly associated with health outcomes and health care utilization. Food insecurity data collected in the Canadian Community Health Survey and the Canadian Income Survey should be utilized to implement and evaluate effective policy interventions for alleviating food insecurity.[7]

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RESOLUTION A23-06

TITLE: **Advocating for a National School Food Program in Canada.**

SPONSOR: **Kingston, Frontenac and Lennox & Addington Board of Health**

WHEREAS children attending school hungry or undernourished have their energy levels, memory, problem-solving skills, creativity, concentration, and other cognitive functions negatively impacted[1,2]; and

WHEREAS over the past two years, rising costs of food and higher program uptake have significantly outpaced provincial school food programs (SFPs) funding[3]. In 2023, some programs have had to place limitations on the amount of food served or pause all operations for the school year due to insufficient financial support. Many SFPs are also projecting budget shortfalls for the 2023-24 school year and beyond which will have a significant negative impact on children who rely on these programs to meet their nutritional needs; and

WHEREAS providing children with adequate access to healthy food to grow, learn and thrive is important for achieving optimal child development outcomes and well-being[4]; and

WHEREAS children consume one third of their daily food at school[5], making it the ideal environment to support having nutritious food choices and improve food literacy; and

WHEREAS SFPs provide universally accessible school breakfast, lunch, and snack programs to students, and play a fundamental role in improving the diet of children and youth by providing access to nutritious food[6,7]; and

WHEREAS SFPs have been associated with reductions in behavioural and emotional problems, bullying, aggression, anxiety, and depression[8,9]; and

WHEREAS in Canada, only 35% of schools have some form of SFP that is funded, in part, by provincial and territorial governments[10,11,12]; and

WHEREAS this current patchwork of food programming varies greatly in scope, consistency, and quality, reaching a small percentage of the over 5 million students in Canada[10,11,12]; and

WHEREAS the lack of coordinated structure and adequate resources inhibits universal program access for all K-12 students, and results in an unsustainable delivery model that relies heavily on teacher and parent volunteers from the school community[7]; and

WHEREAS federal government action is required to establish an accessible, equitable, and sustainable nutritious SFP as a critical element of school food policy in Canada.

NOW THEREFORE BE IT RESOLVED that the Association of Local Public Health Agencies (alPHa) call on the Federal Government to:

- Follow through on its commitment from 2021 and allocate $1 billion over five years in Budget 2024 to establish a National School Nutritious Meal Program as a key element of the evolving Food Policy for Canada, with $200 million per year to contribute to provinces, territories and First Nations, Métis, and Inuit partners to fund their school programs[10,13].
- Enter discissions with Indigenous leaders to negotiate agreements for the creation and/or enhancement of permanent independent distinctions based First Nation, Métis and Inuit school meal programs[10,13].
- Create a dedicated school food infrastructure to enhance food production and preparation equipment and facilities so they can reliably and efficiently serve healthy food in adequate volumes[10,13].

AND FURTHER that alPHa endorse the work of the Coalition for Healthy School Food; a non-partisan network of more than 260 non-profit organizations advocating for public investment in a universal cost shared nutritious SFP, with consistent national standards[13].

Backgrounder: A National School Food Program in Canada
Sponsor: Kingston, Frontenac and Lennox and Addington Board of Health

Background:

An important part of promoting health is ensuring equitable access to nutritious food. Internationally, School Food Programs (SFPs) are widely implemented, and are a successful driver of improved health and education[14]. Healthy students are better prepared to learn, yet in Canada one third of students in elementary schools and two thirds of students in secondary schools do not eat a nutritious breakfast before school[15]. When children attend school hungry or undernourished their energy levels, memory, problem-solving skills, creativity, concentration, and other cognitive functions are negatively impacted[1,2]. SFPs provide students with snacks or meals while at school and are common throughout the world. These programs can play a fundamental role in improving the diet of children and youth and addressing health disparities[7,16]. SFPs have been associated with reductions in behavioural and emotional problems, bullying, aggression, anxiety, and depression[8,9]. Increased student enrollment, retention and school performance have also been observed alongside SFPs[17]. Given that children consume 1/3 of their daily food at school[5], it is the ideal environment to support nutritious food choices and improve food literacy.

In Canada, only 35% of schools have some form of SFP that is funded, in part, by provincial and territorial governments[10,11,12]. In the 2018/2019 school year, provincial and territorial funding for these programs equated to $0.48 per participating student per day, with remaining funds provided by donors, private funders, and other sources depending on the region[11]. This current patchwork of food programming varies greatly in scope, consistency, and quality, reaching a small percentage of the over 5 million students in Canada[10,11,12]. The lack of coordinated structure and adequate resources inhibits universal program access for all K-12 students, and results in an unsustainable delivery model that relies heavily on teacher and parent volunteers from the school community[7]. Federal government action is required to establish an accessible, equitable, and sustainable nutritious SFP as a critical element of school food policy in Canada.

Current Status:

International Level

A national SFP is an opportunity for more than just food provision. Many programs in leading countries integrate other aspects of food literacy, food quality, sourcing, and policy into their program[10,17]. Ninety-one percent of schools surveyed in the Global Child Nutrition Foundation (GCNF) report incorporate nutrition education into their SFPs, and 78% paired their food programs with school gardens[17]. Food programs in Italy and Brazil include a strong focus on local food sourcing, with the latter stipulating that 30% of all school program foods be purchased from small family run farms[18,19]. In Japan and England, programs feature a strong emphasis on food systems, with funding allocated for sensory gardens and gardens designated for growing fruits and vegetables[20,21]. Food programs in the United States have focused on investment in school food preparation infrastructure and staffing[22].

Federal Level

In December 2021, mandate letters were released to cabinet and marked the first-ever commitment to a national SFP. These mandate letters, addressed to the Minister of Agriculture and Agri-Food (Marie-Claude Bibeau) and the Minister of Families, Children and Social Development (Karina Gould) included directives to work with provinces, territories, municipalities, Indigenous partners, and stakeholders to

develop a national program[23,24]. Accompanying these mandate letters was a commitment of $1 billion of funding over five years.

The Coalition for Healthy School Food (CHSF) is a Canada-wide, non-partisan network of more than 260 non-profit organizations advocating for public investment in a universal cost-shared nutritious SFP, with consistent standards[10]. The *#NourishKidsNow* campaign has encouraged member and endorsing organizations to engage with Ministers of Parliament to advance the government's commitment to a national, nutritious SFP. In fall 2022, the CHSF submitted two key documents to the federal government: (1) a set of proposals, strongly recommending that the federal government develop a National School Nutritious Meal Program as a key element of the evolving Food Policy for Canada, and (2) a written submission for the pre-budget consultations in advance of the 2023 budget.

Despite advocacy efforts, the federal government did not include funding for a National School Nutritious Meal Program in Budget 2023[25]. Over the next year, the CHSF will continue advocacy efforts; urging the Government of Canada to develop a National School Food Policy and an implementation plan to ensure successful rollout of a School Food Program for Canada as pledged in two federal election platforms in 2021 and as included in two Ministerial mandate letters.

Provincial & Local Level

In 2004, Ontario launched the Student Nutrition Ontario (SNO) program. SNO is made up of representatives from 14 Lead Agencies who distribute provincial funds from the Ministry of Children, Community and Social Services. These funds contribute up to 15% of program costs to help develop and implement healthy breakfasts, snacks, and lunch programs across the province. These 14 Lead Agencies work with over 39 community partnerships across the province. These community partnerships engage school boards, public health units, communities, and parents to support school programs at the local level[26].

Supporting Documents:

- The Coalition for Healthy School Food: Proposals for a National School Nutritious Meal Program
- The Coalition for Healthy School Food – Written Submission for the Pre-Budget Consultations in Advance of the 2023 Budget

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June 21, 2023

The Honourable Sylvia Jones
Deputy Premier and Minister of Health
Ministry of Health
777 Bay Street, Floor 5
Toronto, ON M7A 2J3

Email to: sylvia.jones@ontario.ca

Re: Simcoe Muskoka District Health Unit 2024 Budget

Dear Minister Jones,

On behalf of the Board of Health for the Simcoe Muskoka District Health Unit (SMDHU), I wish to express appreciation for the Ontario government's investment in public health during the COVID-19 pandemic, the most extraordinary emergency response of our lifetime. Public health remains a cornerstone of the health system during pandemics and at other times, providing cost-effective services that have reduced overall provincial health care costs and kept many people out of emergency departments and hospitals, while at the same time maintaining a healthy and productive population.

Sufficient, predictable, and timely provincial funding into the future is vital to maintaining these essential cost-saving services. The *Public Health Resilience in Ontario* report and the 2023 pre-budget submission of the Association of Local Public Health Agencies (alPHa), as well as the 2022 Annual Report from the Chief Medical Officer of Health (*Being Ready: Ensuring Public Health Preparedness for Infectious Outbreaks and Pandemics*) have spoken to the great value of the Province's ongoing investment in local public health.

The provincial Mitigation Funding of $2.2 million provides a very important contribution to the Province's overall grant to the budget for SMDHU, which is vitally important in maintaining the Board's full range of services to the communities it serves. In addition, ongoing dedicated funding for COVID-19 would allow SMDHU to continue to respond to COVID-19 as a disease of public health significance in accordance with the provincial guidelines.

Specifically the continuation of these funds would help to ensure that residents and visitors of Simcoe Muskoka receive a full range of essential public health programs and services that have kept Ontarians out of hospitals, such as food safety inspections to prevent foodborne illness, ensuring safe drinking water to prevent community-wide outbreaks, supporting parents and families for healthy growth and development, tobacco control to prevent lung cancer and chronic obstructive pulmonary disease, promoting healthy nutrition to prevent diabetes and cardiovascular disease, improving mental health in school children, immunization against vaccine-preventable diseases, and preparations for future public health emergencies, to name but a few. Funding would also support SMDHU's continued presence throughout our region such that public health services are accessible to all via various modalities, including in our local offices and by ready phone contact.

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❑ **Gravenhurst:**
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705-684-9090
FAX: 705-684-9887

❑ **Huntsville:**
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FAX: 705-789-7245

❑ **Midland:**
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705-526-9324
FAX: 705-526-1513

❑ **Orillia:**
120-169 Front St. S.
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FAX: 705-325-2091

Given the impacts identified above and the value achieved through ongoing funding from the Province for local public health services in our communities of Simcoe County, the District of Muskoka, and the Cities of Barrie and Orillia, the Board urges that the Province include its Mitigation Funding within its base funding grant commencing in 2024, and also continue funding for the COVID-19 response (vaccination and outbreak management). In this context, the Board notes and supports alPHa's position for a return to the provision of 75% of the funding by the Province for the base budgets of local public health units.

To maintain the public health services that are essential to the health of our communities, it is critical that local public health agencies be adequately resourced by the Province, now and into the future.

Sincerely,

ORIGINAL Signed By:

Ann-Marie Kungl
Chair, Board of Health
Simcoe Muskoka District Health Unit

cc: Councils of the Simcoe Muskoka obligated municipalities
Association of Local Public Health Agencies
Ontario Boards of Health in Ontario
MPPs of Simcoe Muskoka

June 23, 2023

VIA EMAIL

The Honourable Sylvia Jones
Minister of Health
Ministry of Health
5th Floor, 777 Bay Street
Toronto, ON M7A 2J3
Sylvia.jones@ontario.ca

Dear Minister Jones:

Re: Public Health Funding

I am pleased to share with you Public Heath Sudbury & Districts Board of Health motion in support of the Board of Health for the City of Hamilton, which calls on the provincial government to improve funding to Public Health.

At is meeting on May 18, 2023, the Board of Health carried the following resolution #31-23:

> *THAT the Board of Health for Public Health Sudbury & Districts endorse the recommendations of the Board of Health for the City of Hamilton and urge the provincial government to:*
> - *Fully fund the provincial portion, at least 70%, of the total costs of the mandatory public health programs and services provided under the OPHS;*
> - *Continue the current mitigation funding until such time as the cost-shared arrangement is restored to the mixed 100% and 75%/25% model as it was the public health budget for 2018-2019; and,*
> - *Include expectations or on-going response in the OPHS and provide permanent funding to sustain these requirements.*

Boards of Health play a key role in improving the health of communities and Public Health Sudbury & Districts is committed to an effective and accountable public health system. With inflation costs, increasing costs in wages and benefits and operating expenses, there are growing concerns about our ability

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to meet the requirements of provincial legislation and related documents including the Ontario Public Health Standards (OPHS) and the increasing needs of our communities with the current provincial funding policy. It is critical that Public Health be adequately resourced. Without adequate funding, our ability to deliver on our requirements risk erosion over time impacting the health of our communities. We urge the government to support sufficient, stable, and sustained funding for local public health agencies.

We thank you for your attention to this important matter.

Sincerely,

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

cc: Jamie West, Member of Provincial Parliament, Sudbury
France Gélinas, Member of Provincial Parliament, Nickel Belt
Michael Mantha, Member of Provincial Parliament, Algoma-Manitoulin
Dr. Kieran Moore, Chief Medical Officer of Health
Council of Ontario Medical Officers of Health
All Ontario Boards of Health
Loretta Ryan, Executive Director, Association of Local Public Health Agencies

June 28, 2023

VIA ELECTRONIC MAIL

The Honourable Doug Ford
Premier of Ontario
Legislative Building
Queen's Park
Toronto ON M7A 1A1

Dear Premier Ford:

Re: Bill 103, Smoke-Free Ontario Amendment Act (Vaping is not for Kids), 2023

Teen vaping has increased steadily across the nation and within Sudbury and districts since 2017. There are significant health risks associated with vaping and nicotine use including lung damage, changes to the brain, dependence or addiction, difficulty learning, and increased anxiety and stress. Furthermore, there is an increased risk for future tobacco cigarette use among youth who vape (Ontario Agency for Health Protection and Promotion, 2018).

Bill 103 aims to prevent youth from starting to vape and seeks to decrease vaping rates through a number of important actions, including prohibiting the promotion of vapour products, and raising the minimum age for purchasing vapour products.

At its meeting on June 15, 2023, the Board of Health carried the following resolution #35-23:

> *WHEREAS vaping poses substantial health risks linked to the development of chronic illness, addiction, polysubstance use, as well as risks for injury and death; and*
>
> *WHEREAS vaping rates among youth have grown with 30.6% of Grade 7 to 12 students in Northern Ontario reporting having used electronic cigarettes(vaping) in 2019, compared with 22.7% for the province; and*
>
> *WHEREAS Board of Health motion 48-19 noted the Board's longstanding history of proactive and effective action to prevent tobacco and emerging product use and urged the adoption of a comprehensive tobacco and e-cigarette strategy; and*

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WHEREAS Bill 103 – Smoke-Free Ontario Amendment Act (Vaping is not for Kids), 2023 aims to prevent youth from initiating vaping and decrease the current usage of vaping products by targeting legislation changes, including banning the retail of flavoured vaping products, increasing minimum purchasing age to 21, and prohibiting the promotion of vapor products;

THEREFORE, BE IT RESOLVED THAT the Board of Health for Public Health Sudbury & Districts endorse Bill 103 - Smoke Free Ontario Amendment Act (Vaping is not for Kids), 2023; and

FURTHER THAT this endorsement be shared with relevant stakeholders.

Vaping among youth is a complex public health issue that requires immediate action. This suggests that a single intervention or approach will be insufficient to address the high rates of vaping among youth. At Public Health Sudbury & Districts, our efforts in addressing youth vaping involve a multi-faceted, comprehensive, upstream, and strengths-based approach that supports positive youth development. Strategies are community and school-driven and influence risk and protective factors associated with vaping. The strategies include education, policy development, prevention programs, research, collaboration, and enforcement activities, fostering the development of supportive social and physical environments in which youth can thrive and flourish. Yet, this is just one piece in a comprehensive approach addressing youth vaping.

The legislative solutions of Bill 103 are designed to make vaping less available and desirable for youth to address the increase in rates of vaping and to prevent the associated harms of vaping.

We thank you for your attention to this important health promotion initiative, and we continue to look forward to opportunities to work together to promote and protect the health for everyone.

Sincerely,

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

cc: France Gélinas, Member of Provincial Parliament, Nickel Belt
Dr. Kieran Moore, Chief Medical Officer of Health
Honourable Sylvia Jones, Deputy Premier and Minister of Health
Honourable Michael Parsa, Minister of Children, Community and Social Services
Honourable Steve Clark, Minister of Municipal Affairs and Housing
All Ontario boards of Health
Association of Local Public Health Agencies

Strategic Plan

2023-2024

Our Vision:

Healthy People. Healthy Places.

Our Values:

Respect

We believe that respect for all people is embedded within our relationships with each other and is reflected in our work.

Equity

We believe that all people are entitled to achieve their full health potential.

Collaboration

We believe that by working with others we can achieve the best health outcomes for all.

Excellence

We believe in providing the highest quality programs and services to achieve our vision.

Accountability

We believe in being transparent and responsible to the public and our stakeholders by using ethical and sustainable organizational practices.

Positive Workplace

We believe in a work environment where our employees are valued, communicate openly, and have work-life balance.

Our Mission:

With our communities, we prevent disease and injury, and promote and protect health for all in Simcoe Muskoka.

PRIORITY Programs and Services

Goal 1: Deliver efficient and effective programs and services.

Objective 1a) : Prioritize quality improvement and reporting processes to monitor organizational and program performance.

Objective 2b): Continue to respond to COVID-19 and other respiratory viruses and prepare for potential surges in activity where a coordinated agency response and allocation of resources is required.

Goal 2: Ensure programs and services are guided by principles of health equity.

Objective 2a): Continue the resumption and renewal of routine public health programs and services, guided by principles of health equity and recognizing the indirect impacts of the COVID-19 pandemic.

Goal 3: Enhance and solidify emergency preparedness mechanisms.

Objective 3a): Enhance emergency response plans based on recommendations from the COVID-19 evaluation and provincial reports.

PRIORITY People

Goal 1: Support employees as they participate in the delivery of our programs and services.

Objective 1a): Develop and refresh knowledge, skills, and competencies to achieve excellence in program and service delivery.

Objective 1b): Enhance organizational culture through employee engagement.

PRIORITY Partnerships

Goal 1: Foster and strengthen relationships with communities and partners.

Objective 1a): Continue to renew or enhance relationships with communities and partners, including Indigenous communities.

Objective 1b): Engage, collaborate, and coordinate with health system partners in relation to mutual priorities.

PRIORITY Future

Goal 1: Communicate for sufficient, predictable, and timely public health funding.

Objective 1a): Communicate to the Province for sufficient, predictable, and timely resources that allow for effective and efficient delivery of the Ontario Public Health Standards.

Goal 2: Plan for organizational change to optimize agency effectiveness.

Objective 2a): Develop a plan to optimize the organization of programs and services for agency effectiveness in consideration of available resources.

Correspondence O

www.hkpr.on.ca • info@hkpr.on.ca
1-866-888-4577

July 3, 2023

Honourable Sylvia Jones, Deputy Premier and Minister of Health
Province of Ontario
Hepburn Block 10th Floor 80 Grosvenor Street Toronto,
ON M7A 1E9
Sent via email: Sylvia.Jones@pc.ola.org

Dear Minister Jones,

I want to begin by thanking you and your government for your continued commitment to keeping the health and safety of Ontarians a top priority. Your steadfast financial support for public health units throughout the COVID-19 pandemic was critical to ensuring our ongoing ability to meet the needs of our communities.

On behalf of the Board of Health for Haliburton, Kawartha, Pine Ridge District Health Unit (HKPRDHU), I am writing to you to share our concerns about significant funding shortfalls anticipated for 2024.

The Province of Ontario invested significant funds across the health sector to support the response to the COVID-19 pandemic. The success of preventing the spread of COVID-19 through vaccination and other public health measures is something to celebrate. Given that COVID-19 is no longer a public health emergency of international concern, it is understandable that the scope and scale of interventions and financial support provided by the Province is pared back.

We are aware that several one-time buckets of funding are planned to end throughout 2023. This includes the School Focused Nurses Initiative, COVID-19 Extraordinary Funding, and Mitigation Funding. This leaves public health units to respond to increased community needs that arose during the pandemic (such as drug poisonings), address public health service back-logs (such as immunizations), and continue to manage COVID-19 as an endemic infectious disease using a base budget that is essentially the same as it was in 2018.

The end of the above-mentioned one-time funding, coupled with increased operational costs due to inflation, means that HKPRDHU will be challenged to meet the growing needs of our communities and the continued expanding requirements of the Ontario Public Health Standards (OPHS). Our anticipated financial shortfall to maintain our existing programs, assuming that Mitigation funding is continued, is estimated at $1.9 million. To illustrate the gap in funding solely related to inflationary pressures, had the consumer price index been applied annually since 2018 to the HKPRDHU base budget, the provincial portion of our base budget for mandatory programs would be $14,728.994 (an increase of $2.7 million dollars).

Although one-time funding enabled health units to address urgent needs arising in a timely fashion, the lack of sufficient, predictable funding is a barrier to establishing a permanent strong and resilient public health system. Strong infrastructure for local public health is paramount to ensuring that Ontario is ready for the next surge in COVID-19, the next pandemic, the next extreme weather event, or the next emerging health hazard.

PROTECTION · PROMOTION · PREVENTION

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LINDSAY OFFICE
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Fax · 705-324-0455

Now, more than ever, our communities need a robust public health system. While the threat of COVID-19 has dimmed, the need for an agile public health response to infectious disease threats was clearly articulated in the Chief Medical Officer of Health report for 2022 (insert link to Being Ready).

Public health units are a fundamental part of the solution to address the current challenges faced in primary and acute care. By preventing the spread of infectious diseases, preventing illnesses associated with environmental exposures, and preventing chronic diseases through policy development and health promotion, public health units keep people out of emergency departments and out of hospitals. Investing in public health is a long-term, sustainable approach to building a strong health care system.

For the above reasons, the Board of Health for HKPRDHU urges the provincial government to demonstrate their ongoing support for public health by increasing the provincial contribution to mandatory programs and continuing Mitigation funding. Should Mitigation funding end, we urge the provincial government to reverse the 70/30 policy decision made in 2019.

As we look to a future that holds a strong, resilient health system for all Ontarians, we urge the Province to provide the necessary supports for the recovery and strengthening of public health in a comprehensive and sustainable way.

Respectfully,

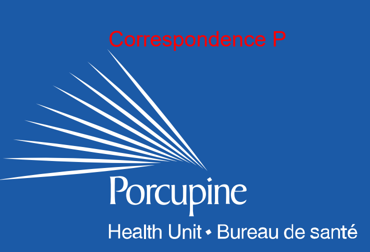
BOARD OF HEALTH FOR THE HALIBURTON, KAWARTHA,
PINE RIDGE DISTRICT HEALTH UNIT

David Marshall, Chair, Board of Health

DE/nb

Cc (via email): The Hon. Doug Ford, Premier
Laurie Scott, MPP Haliburton-Kawartha Lakes-Brock
David Piccini, MPP Northumberland-Peterborough South
Dr. Kieran Moore, Ontario Chief Medical Officer of Health
Loretta Ryan, Association of Local Public Health Agencies

Correspondence P



July 5, 2023

Honourable Minister David Piccini
Minister of Environment, Conservation and Parks
5th Floor, 777 Bay Street
Ministry of Environment, Conservation and Parks
Toronto, Ontario M7A 2J3
Sent Via E-mail

Subject: Request for Air Quality Monitoring Stations in the Porcupine Health Unit region

Dear Minister Piccini,

We are writing to request the installation of air quality monitoring stations in the Porcupine Health Unit (PHU) region. On June 8, 2023, the Board of Health for the Porcupine Health Unit carried the following resolution #BOH-2023-06-66:

***Be It Resolved,** that the Board of Health for the Porcupine Health Unit direct the Medical Officer of Health/Chief Executive Officer and Board of Health Chair to write a letter requesting the installation of air quality monitoring stations in the Porcupine Health Unit Region.*

The implementation of these monitoring stations is crucial to ensure the health and well-being of the residents in this region. As per the Ontario Public Health Standards (OPHS), boards of health are required to prepare for emergencies, and protect public health and reduce the risk of adverse health outcomes resulting from poor air quality.[1] Unfortunately, the Porcupine Health Unit (PHU) region currently lacks the necessary infrastructure for comprehensive air quality monitoring. This deficiency prevents accurate assessment of poor air quality exposure and potential health risks faced by PHU communities, thus limiting data-informed and community specific recommendations for community members, especially those at higher risk of negative health impacts.

The need for this capacity has become more urgent with the ongoing forest fire season and significant air quality alerts due to wildfire smoke. As the largest geographic health unit in the province, covering over 274,000 square kilometers, sharing lands with 11 distinct First Nation communities, poor air quality due to forest fire smoke is not new however is an increasing concern and we need access to the appropriate information to respond to these emergencies.

Air pollution is a significant public health concern, as it has detrimental effects on human health. Exposure to poor air quality is associated with increased rates of respiratory diseases, cardiovascular conditions, and even premature death.[2] The PHU population experiences poorer health status compared to Ontario, with a higher percentage of the population reporting chronic diseases such as asthma, diabetes, high blood pressure,[3] and thus many community members are at greater risk from the ill effects of poor air quality due to pollution as well as wildfire smoke.

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Email info4you@porcupinehu.on.ca
Website porcupinehu.on.ca

Branch Offices Cochrane, Hearst, Hornepayne, Iroquois Falls Kapuskasing, Matheson, Moosonee, Smooth Rock Falls

Correspondence P

Climate change has exacerbated air pollution issues, leading to increased health risks and environmental challenges. Rising temperatures, increased frequency of wildfires, and changing weather patterns contribute to the release of pollutants into the air, posing significant health risks to our communities.[4] Monitoring air quality will enable a better understanding of the complex interactions between climate change and air pollution across the vast region, allowing us to assess exposure levels to air pollution and develop targeted strategies to address these interconnected issues.

These targeted strategies for air pollution would also benefit environmental justice. Environmental justice is of the utmost importance in the Porcupine region, which is home to many equity-deserving and marginalized communities. These communities are often disproportionately affected by poor air quality and environmental hazards, resulting in disproportionate health disparities.[5,6] By installing air quality monitoring stations, we can better protect the health of all residents, regardless of their socio-economic status or geographical location. This initiative aligns with our commitment to promote environmental justice and reduce health inequities in the Porcupine region. Installing air quality monitoring stations in strategic locations of the Porcupine region would also be an investment in the health and well-being of our communities. By proactively monitoring air quality, we can detect pollutant trends, identify potential sources of pollution, and implement targeted interventions. This approach has been proven to reduce the burden of disease, improve overall health outcomes, and ultimately lead to cost savings for the healthcare system.[2, 7,8]

Furthermore, the implementation of air quality monitoring stations would provide several immediate benefits to the communities in the Porcupine region. Firstly, it would increase public awareness and knowledge regarding air quality and its impact on health. With access to real-time air quality data, residents can make informed decisions about outdoor activities, particularly for higher risk groups such as children, the elderly, and individuals with pre-existing cardiac and respiratory conditions. It is also critical to inform local collaborative emergency response plans to ensure risk reduction measures and indoor spaces with clean air are available to all, including the increasing population facing under housing and homelessness. Secondly, these monitoring stations would enable us to assess the effectiveness of pollution control measures and policies. By analyzing the data collected, we can evaluate the impact of various interventions, advocate for evidence-based policies, and ensure that air quality standards are being met.

We urge you to consider this request for the timely installation of air quality monitoring stations in the Porcupine Health Unit region. By doing so, we will fulfill our obligations under the OPHS, protect the health of our residents, and promote sustainable development. The availability of accurate air quality data will empower communities to make informed decisions, reduce exposure to pollutants, and improve overall health outcomes.

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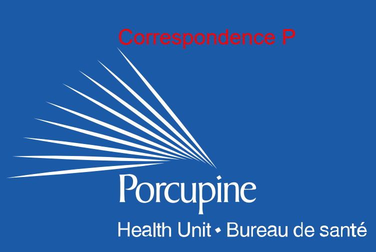

Thank you for your attention to this matter. We look forward to your positive response and discussing the next steps in implementing air quality monitoring stations in the Porcupine Health Unit region.

Yours sincerely,

Michelle Boileau
Board of Health Chair

Dr. Lianne Catton
Medical Officer of Health/Chief Executive Officer
Porcupine Health Unit

Copy: Honourable Doug Ford, Premier of Ontario
Honourable Sylvia Jones, Deputy Premier of Ontario, Minister of Health
Honourable Steven Guibeault, Minister of Environment and Climate Change
Bernard Derible, Parliamentary Deputy Minister, Emergency Management, Treasury Board Secretariat
Commissioner of Emergency Management
Honourable George Pirie, Member of Provincial Parliament Timmins
Honourable John Vanthof, Member of Provincial Parliament Timiskaming - Cochrane
Honourable Guy Bourgouin, Member of Provincial Parliament Mushkegowuk-James Bay
Honourable Charlie Angus, Member of Parliament Timmins
Honourable Jean-Yves Duclos, Member of Parliament, Minister of Health
Dr. Kieran Moore, Chief Medical Officer of Health
Council of Ontario Medical Officers of Health
Loretta Ryan, Executive Director, Association of Local Health Agencies (alPHa)
All Ontario Boards of Health
All Member Municipalities of the Porcupine Health Unit

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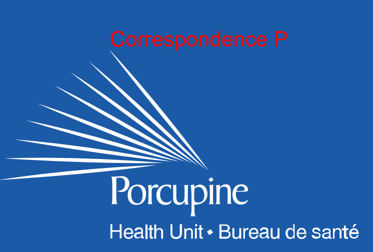

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AOPHBA
ASSOCIATION OF ONTARIO PUBLIC HEALTH BUSINESS ADMINISTRATORS

July 7, 2023

The Honourable Sylvia Jones
Deputy Premier and Minister of Health
Ministry of Health

Delivered via email: Sylvia.Jones@ontario.ca

Dr. Kieran Moore
Chief Medical Officer of Health
Ministry of Health

Delivered via email: Kieran.Moore1@ontario.ca

Dear Minister Jones and Dr. Moore,

On behalf of the Association of Ontario Public Health Business Administrators (AOPHBA), I write to you to express our interest in sharing our collective wisdom and experience to strengthen our public health system, enabling it to be responsive to growing demand and complexity, and accountable to Ontarians for the public dollars it spends. Our Association membership is comprised of business leaders in the 34 public health units across Ontario.

The AOPHBA wishes to acknowledge the Province of Ontario's support both past and on-going, in relation to the COVID-19 Pandemic. Whether through one-time funding for COVID-19 activities including case and contact management, enforcement, vaccination, the school-focused nurses initiative or through guidance documents, messaging, provision of cold storage units, information technology applications such as CCM and COVAX, your support allowed public health to increase capacity and our ability to respond to the ever-changing pressures of the COVID-19 pandemic. We also wish to acknowledge the exhaustive efforts of our public health units' public health professionals that went above and beyond to care for their communities. But our collective work is far from over. We now need to regroup and reflect upon the learnings of the COVID-19 Pandemic. Dr. Moore's 2022 Annual Report, *Being Ready: Ensuring Public Health Preparedness for Infectious Outbreaks and Pandemics*, rightly points to a call for action to be prepared to protect ourselves from future health threats, but also to invest in building a strong and resilient system and communities that create the best possible health for all. Preparedness is an on-going process, not an end state.

Above all, to be effective in reducing the demand on the health care system while simultaneously building an adaptive and resilient public health system that is responsive to threats to population health, sustainable and stable funding is required. Sustainable and stable funding will not only allow public health units to meet the requirements of the Ontario Public Health Standards (OPHS), but also the increased demand caused by the COVID-19 pandemic as well as build on current capacity to respond to emergent public health issues. The 2024 budget year presents a substantial risk to the capacity of public health units with the discontinuance of mitigation funding, rising operating costs, and increased and on-going work involving COVID-19. Head count reductions of highly valued health professionals will be required to address these pressures, negatively impacting our ability to meet the requirements of the OPHS.

We know that a balanced approach is necessary, managing the health care needs of today and preparing for the disease threats of tomorrow. Recognizing that there are always fiscal limitations, AOPHBA appreciates the need to ensure the system is designed to optimize the use of every dollar invested in public health. Our members have a keen interest and unique knowledge-base to contribute to system-wide or regional planning for an improved public health system, in particular with respect to administrative effectiveness and efficiency.

Dr. Moore's 2022 Annual Report states "To be ready for the next outbreak, Ontario's public health sector must take a collective, forward-thinking approach to pandemic planning. It must make sustained investments in strengthening sector and system, community, and societal readiness." We encourage you to create sustained public health funding levels that are supportive of public health's response to the requirements of the Ontario Public Health Standards, including sector and system readiness to emerging public health issues. We are eager for the opportunity to collaborate on the strengthening of public health and offer our collective wisdom and experience to create a strong, effective, and efficient public health system for the future.

Our Association Executive would be pleased to meet with you, in person, to discuss this matter of mutual importance and we are available at your convenience.

Sincerely,

Cynthia St. John
President
Association of Ontario Public Health Business Administrators (AOPHBA)

C: The Hon. Doug Ford, Premier
AOPHBA Membership
Association of Local Public Health Agencies (alPHa) Board of Directors
Ontario Boards of Health
Association of Municipalities of Ontario (AMO)
Dr. Catherine Zahn, Deputy Minister of Health

May 18, 2023

ATTN: John Clare
Director General
Strategic Policy, Cannabis
Controlled Substances and Cannabis Branch
Email: cannabis.consultation@canada.ca

RE: Notice of Intent - Consultation on Potential Amendments to the Cannabis Regulations

INTRODUCTION:

The Middlesex-London Health Unit (MLHU) appreciates the opportunity to participate in Health Canada's consultation on *Potential Amendments to the Cannabis Regulations.*

We would like to commend Health Canada for recognizing the importance of setting out clear regulations and developing a legislative framework that aims to protect the health and safety of Canadians. The maintenance of strict regulations and controls governing the production and sale of cannabis is vital to mitigating the potential health and safety harms from these products.

A public health approach to cannabis regulation aims to find the balance between making regulated legal cannabis accessible while removing commercial influence and promotion of the product. There are health harms associated with cannabis consumption, but harms can be minimized with a thoughtful and intentional public health regulatory approach.

The recommendations that follow correspond to three of the five priority areas for which Health Canada has requested feedback, specifically:

- Priority Area 3: Production requirements for cannabis products;
- Priority Area 4: Packaging and labelling requirements for cannabis products; and,
- Priority Area 5: Record keeping and reporting for cannabis license holders.

The recommendations contained within this submission support Health Canada's goals to:

1. Reduce the risks of accidental consumption and overconsumption;
2. Reduce the appeal of cannabis products to young people; and,
3. Provide consumers with the information they need to make informed decisions before using cannabis products.

Priority Area 3: Production requirements for cannabis products

4. Should the limits on the maximum quantity of delta-9-THC that can be contained in a cannabis product (by container and ingestible unit) apply to the sum total of all intoxicating cannabinoids found in the product? Why or why not? How could such a requirement be established in an efficient manner that is simple to comply with?

RECOMMENDATION

Yes. The maximum quantity of delta-9-tetrahydrocannabinol (THC) that can be contained in a cannabis product (by container and ingestible unit) should apply to the sum total of all intoxicating cannabinoids found in the product. Until more research is completed, product manufacturers should be required to account for and communicate any potentially intoxicating substances to consumers. Moreover, maintaining current limits of intoxicating cannabinoids within the standards set by the *Cannabis Act*, will continue to protect public safety.

RATIONALE

Consumers have the right to be informed of the presence and quantity of intoxicating cannabinoids in the product they are consuming as this can affect their level of impairment which can increase the potential for health harms. As more research becomes available on the effects of other intoxicating cannabinoids, Health Canada is encouraged to ensure the maximum amount of such cannabinoids equates to the current limits for delta-9-THC. This will help continue to minimize the potential impact on public health and safety.

It is recommended Health Canada continue to restrict the quantity of delta-9-THC or equivalent intoxicating cannabinoid effect to:

- Edibles - 10 mg per package
- Ingesting - Cannabis Extract 10 mg of THC per unit (such as a capsule) or dispensed amount 1000 mg of THC per package
- Inhaling - Cannabis Extract: 1000 mg of THC per package
- Topical Cannabis - 1000 mg of THC per package (Government of Canada, 2018)

Priority Area 4: Packaging and labeling requirements for cannabis products

1. Should Health Canada consider amending packaging requirements for dried and fresh cannabis?

RECOMMENDATION

MLHU recommends that existing *Regulations* for cannabis product packaging remain in effect, including:

- Plain, opaque/translucent packaging in accordance with colour/font restrictions;
- Child-resistant packaging with tamper-evident controls in place;
- A prohibition on coatings, cut-outs, or peel-away labels;
- A prohibition on hidden features, including heat-activated ink or scent-features;
- A prohibition on the use of images or brand information on the wrapper; and,
- No more than 30g of dried cannabis in one immediate container.

In addition, MLHU recommends Health Canada considers restricting all packaging to a plain and standardized colour (e.g., brown or grey).

MLHU recommends that alternative packaging materials are investigated and mandated by way of regulation to address the issues of waste from cannabis product packaging. Current packaging requirements should be maintained to the fullest extent while also considering alternative, environmentally conscious materials in accordance with the Government of Canada's ambitious plan to reduce plastic pollution.

RATIONALE

The current *Cannabis Regulations* require plain packaging and labelling for all cannabis products. The aim of this approach is to reduce the risks of accidental consumption and overconsumption as well as reducing the appeal of cannabis products to young persons. Additionally, consumers are provided with the information they need to make informed decisions before using cannabis. As such, these requirements should be maintained.

The current *Regulations* restrict colours to a single uniform colour, prohibiting the use of fluorescent colours on containers or wrappers or metallic colours on containers. We recommend that packaging (including wrappers and internal and external packaging) be restricted to one standardized colour, ensuring there is a contrast with the yellow colour of the health warning message and the red colour of the standardized cannabis symbol. This eliminates the ability for the industry to select background colours for branding and would align with the more stringent requirements for tobacco packaging. Tobacco research indicates that dark brown product packaging is dissuasive in the United States (Hammond et al., 2011; Al Hamdani et al., 2020). Continued research specific to cannabis packaging is important to further understand the impact of packaging elements on cannabis use behaviours.

Health Canada should maintain current packaging requirements for public health and safety. However, in accordance with the Government of Canada's commitment to bring forward measures to prevent plastic pollution and to reduce the amount of waste that ends up in landfill sites, alternative recyclable packaging options should be considered to minimize any potential environmental impact of cannabis product waste.

2. Are there labelling requirements that could be changed without public health or public safety impacts? What required information should remain, and what information could be removed? Why or why not?

RECOMMENDATION

MLHU recommends Health Canada maintain all existing labeling requirements, and not remove any information.

RATIONALE

Current labelling requirements include the standardized cannabis symbol, mandatory health warning message, and specific product information (e.g., brand name of the cannabis product, class of cannabis, THC and CBD information, license holder information, ingredients, etc.). These requirements should remain in place as they contribute to reducing the risks of accidental consumption, overconsumption, and reduce the appeal of cannabis products to young persons. Cannabis labelling provides consumers with the information they need to make informed decisions before using cannabis. Mandated health warnings on tobacco products are proven to be an effective

strategy to increase awareness of the health harms associated with tobacco and to reduce tobacco product use (Cunningham, 2022). Similarly, cannabis research has found that brand imagery on packaging can increase the appeal of cannabis products whereas plain/standardized packaging with health warnings decreases appeal, especially to youth and young adults (Leos-Toro et al., 2021). It is recommended that Health Canada continues to apply this body of evidence to cannabis product regulation.

3. Do you have any suggestions to simplify the requirements to include delta-9-THC and CBD content information on product labels?

RECOMMENDATION

MLHU recommends continued regulation of cannabis labelling that provides consumers with the information they need to make informed decisions before using cannabis, including labelling of cannabinoids within products.

MLHU does not have any specific suggestions of how to simplify the requirements to include delta-9-THC and CBD content information on product labels but recognizes the importance of consumer product comprehension to assist in protecting public health and safety.

MLHU recommends further consumer education about the potential effects of THC/CBD, including Canada's Lower-Risk Cannabis Use Guidelines, to help individuals understand how to reduce risks to their health when consuming cannabis products. This could be achieved via a website link on the label in addition to more comprehensive federal public health education initiatives.

RATIONALE

From a public health perspective, the labelling requirements for cannabis (THC/CBD content) are meant to provide consumers with clear, easy to read, and understandable information when it comes to the contents of the product (Government of Canada, 2016). Cannabis product labels are only effective if their meaning is clear to the consumer. While consumers need to know how much THC and CBD a product contains, they also need to understand how the products and the amounts of cannabinoids found within products can affect their health and well-being.

Investigation into consumer product comprehension has shown that the current manner in which information is provided on cannabis products can be difficult for individuals to interpret and put into context (Health Canada, 2020). Therefore, comprehensive consumer education about the potential effects of THC/CBD may aid in product label understanding by consumers. Canada's Lower-Risk Cannabis Use Guidelines provide recommendations for individuals to reduce their health risks from cannabis use (Fischer et al, 2017), and increase consumer understanding of ways to reduce their risk when consuming cannabis products. The development of a comprehensive public health education strategy to inform youth and young adults about the potential health harms from cannabis use and strategies to reduce those risks is warranted.

4. Should the requirement to include delta-9-THC content information on product labels apply to the total of all intoxicating cannabinoids, such as delta-8-THC? Why or why not? How could such a requirement be established in an efficient manner that is simple to comply with?

RECOMMENDATION

For public safety and consumer knowledge, MLHU recommends that cannabis product labels include the amounts of any intoxicating cannabinoids in a product, and that labelling continues to be based on regulated laboratory testing. Efforts should be taken to increase consumer understanding of lower risk and higher risk use, including quantities or concentration of cannabinoids, and potential physiological effects of both intoxicating and non-intoxicating cannabinoids.

We recommend that any new cannabis product (including semi-synthetic cannabinoids) continue to be assessed for safety under the *Cannabis Act* and that any potential effects are communicated effectively to consumers.

RATIONALE

Labelling all intoxicating cannabinoids found within cannabis products allows consumers to make informed choices about their cannabis consumption. It is important to note that cannabis labels are only effective if their meaning is clear to the consumer. While consumers need to know how much THC and CBD a product contains, they also need to understand how those amounts can affect their health and wellbeing.

The continuous monitoring of identified cannabinoids and their impacts on consumers was recommended by the Canadian Task Force on Cannabis Legalization and Regulation. The Task Force highlighted the need for "a flexible legislative framework that [can] adapt to new evidence to set rules for limits on THC or other components" (Government of Canada, 2016).

5. Are there other packaging and labeling requirements that Health Canada should consider for a regulatory amendment? Why and what is the current impact of these requirements on licence holders and consumers?

RECOMMENDATION

Continue to strictly regulate packaging and labeling and implement further restrictions to reduce appeal to young persons. In addition to the current requirements outlined in the *Regulations*, MLHU recommends implementing the following:

- Ban the words "candy" or "candies" on packages;
- Include "not for kids" text on the package label;
- Require safer storage messaging on all packages to address ways to reduce risk of unintentional exposure of this product to children (e.g., "This product can cause harm if consumed by children. Keep out of reach of children in a locked area, and store in original packaging.");
- Restrict packaging colour to a standardized, single, uniform colour (e.g., brown or grey);
- Consider methods to educate and promote additional health messaging contained within Canada's Lower-Risk Cannabis Use Guidelines. For example, this might be achieved by including a website link on the cannabis product label, the inclusion of a statement on the package itself, or the roll-out of a comprehensive federal public health education strategy; and,

- Require labels for all cannabis-infused products intended for ingestion to include a health statement about the delayed onset of impairing effects and information on accidental ingestion or overconsumption.

RATIONALE

Maintaining and strengthening measures to reduce risks of accidental consumption, overconsumption, and appeal of products to infants, children, and young people are critical. If the current *Regulations* are relaxed or omitted on cannabis products, it may provide ambiguity of rules and lead to packaging and labelling practices which are harmful to consumers and may increase appeal to vulnerable individuals such as youth and children.

Despite efforts to regulate cannabis packaging and public health measures to remind adults to lock cannabis products up and out of reach of children and youth, the incidence of cannabis overdose in children continues to rise. A recent study published in 2022 found that the proportion of cannabis-related emergency department visits for children aged 0-9 in Ontario increased significantly after the legalization of cannabis edibles (Myran et al., 2022).

The Poison Control Centre in Ontario states the following on their website: "The Poison Centre is seeing an increase in cases of children unintentionally eating edible cannabis products and requiring hospital admission. In many cases these products were unregulated, looked almost identical to popular brands of candy, and contained many more milligrams of THC than approved by Health Canada. While cannabis use is legal in Canada, there are many products available on the market that are unregulated, meaning that they do not come from an authorized provincial or territorial retailer." This demonstrates what can happen when regulations around packaging become more lenient: increased harms to children by unintentional consumption. These statistics also demonstrate the need for further action to prevent unintentional consumption by children.

Prohibiting the use of the words "candy" or "candies" would further enhance the existing plain packaging requirements. "Candy" is an easily recognizable and enticing word to children and youth. Following legalization, Colorado saw an increase of edible-related cannabis overdoses, increased calls to poison control centres, and increased ER visits for accidental ingestion by children (Wang et al., 2016). To combat accidental consumption by children and youth, Colorado has banned the word "candy" or "candies" on packaging (State of Colorado, n.d.). Similarly, Washington State has mandated "not for kids" warning labels on cannabis products (Washington State, 2019).

Plain packaging and the inclusion of health warnings on labels reduces appeal, brand influence, and enticements to purchase and use products. They also increase awareness of harms associated with use. This approach has been shown to be effective through tobacco product research (Dronvandi et al., 2019; Gravely et al., 2021), as well as cannabis product research (Goodman et al., 2019; LeosToro et al., 2021). The current *Regulations* restrict colours to a single uniform colour, prohibiting the use of fluorescent colours on containers or wrappers or metallic colours on containers. MLHU recommends that packaging (including wrappers and internal and external packaging) be restricted to one standardized colour, ensuring there is a contrast with the yellow colour of the health warning message and the red colour of the standardized cannabis symbol. This approach would limit the industry's ability to select background colours for branding purposes and would align with the more stringent requirements for tobacco product packaging. Tobacco research has shown that dark brown packaging is more dissuasive in the United States (Hammond et al., 2011; Al Hamdani et al., 2020).

Continued research specific to cannabis packaging is important to further understand the impact of background colours on cannabis use behaviours.

Labeling is an important resource for consumers in making informed decisions about using cannabis. We recommend including information on Canada's Lower-Risk Cannabis Use Guidelines, which could be accomplished through a website link on the product label or the inclusion of a statement from the Guidelines on the package. Lower-risk and safer-use messaging is important for everyone who uses cannabis, especially people who are first trying a product. It is important for warning messages to be clear and to use language that does not leave room for doubt by the consumer (Al Hamdani et al., 2020).

Priority Area 5: Record keeping and reporting for cannabis licence holders

6. Should Health Canada remove the requirement to provide a promotion expenditure report to Health Canada? Why or why not?

RECOMMENDATION

It is recommended that Health Canada continue to require cannabis license holders to provide a report of any promotional expenses and activities related to cannabis. This includes any money spent on the promotion of cannabis accessories or services related to cannabis. Health Canada should also monitor industry practices with marketing and advertising to reduce normalization of cannabis use and incentives or cues to use cannabis products. In addition, it is recommended that Health Canada mandates the cannabis industry to publicly disclose costs and activities associated with influencing government policy reform.

RATIONALE

The *Cannabis Act* generally prohibits the public promotion of cannabis. This is to support the Government's objective to protect public health and safety, and to protect vulnerable populations such as youth from exposure to cannabis and enticements to use cannabis. By requiring license holders to report on promotion expenditures, Health Canada can monitor industry practices to ensure they are staying compliant with prohibited practices and ensure the types of promotions are not directly or indirectly enticing individuals to use cannabis. In addition, by continuing to monitor promotion expenditures, Health Canada can ensure that the industry is not spending an excessive amount of funding on promotions, given evidence that marketing practices can influence substance use behaviour and potential harms (Leos-Toro et al., 2021).

The extent to which cannabis is promoted to individuals may influence their decisions to purchase and use cannabis. Health Canada can incorporate the substantial evidence of the impact of alcohol marketing on drinking behaviour and translate that to cannabis regulations. It has been shown that exposure to alcohol advertising can act as environmental cues to drink, influence social norms, and influence lifestyles such as an individual's motives to drink and drinking patterns (Giesbrecht & Wettlaufer, 2013). In addition, restricting promotions will remove incentives to drink and cues to drink (PHAC, 2018; Giesbrecht & Wettlaufer, 2013; Liem, 2018; WHO, 2018). The application of the evidence from alcohol consumption combined with lessons learned from tobacco control literature is recommended to inform requirements pertaining to mandatory industry reporting.

OTHER CONSIDERATIONS FOR THE PRODUCTION OF CANNABIS

In addition to the labelling and packaging requirements, we recommend the following production restrictions be implemented to further reduce appeal to young people, minimize undue inducements to purchase or use cannabis products, and to enhance the safety of products for consumers:

- Restrict the shape of cannabis products and accessories further, by banning the use of shapes, sprinkles, or bright colours that may appeal to children (e.g., bright colours, recognizable shapes like real or fictional animals or humans or fruit shapes.)
- Prohibit the use of flavouring agents in cannabis extracts.
- Prohibit any product that resembles or mimics familiar food items, or is associated with a well-known brand of food or candy and could be appealing to children, such as gummy bears, lollipops, well-known chocolate bars or cookie brands, etc.
- Require that edible products be stamped, marked or imprinted with the standardized THC symbol on at least one side of the edible product itself. An exception for products that are impracticable to stamp, mark or imprint, such as liquids, would be required.

RATIONALE

Products that resemble familiar food items or are associated with well-known brands of food or candy could be appealing to children, such as gummy bears, lollipops, well-known chocolate bars or cookie brands (Government of Canada, 2016; University of Washington School of Law, 2016; General Assembly of the State of Colorado, 2016).

COMMERCIAL DETERMINANTS OF HEALTH

The request for consultation states, “Health Canada recognizes there may be regulatory measures that could be made more efficient and streamlined without compromising the public health and public safety objectives in the *Act*”, and we appreciate that Health Canada has emphasized that efficiencies will not compromise public health and safety objectives.

We ask that Health Canada takes into account the Commercial Determinants of Health when considering any recommendations that are submitted, and that any amendments proposed put public health and safety before benefits that would be afforded to the industry. The Commercial Determinants of Health “are a key social determinant, and refer to the conditions, actions and omissions by commercial actors that affect health” (WHO, 2021). Industry actions, such as production and targeted marketing of products, can impact and shape the physical and social environments that people live in, and ultimately impact their health. The potential impacts on health from cannabis include child poisonings, overdose, and/or effects on parenting through use of their products. Early age of onset of use and the continued use of cannabis increases the risk of dependency and mental health problems, and can impact memory, concentration, academic success and decision-making. When smoked, cannabis use impacts lung health, increasing risk of bronchitis, lung infections, chronic cough, and mucus (Health Canada, 2022). Cannabis products are not a benign substance, and as such, it is recommended they be regulated to control commercial influence.

Product packaging, labeling, product manufacturing, and advertising are particular areas of focus where industry may not, and historically have not, put public health and safety above industry profits and benefits.

It has been documented that corporations actively mislead and confuse the public when it comes to the harm their products cause (Mailon, 2022; Ulucanlar et al., 2016; Humphreys et al., 2022). The study of internal documents across tobacco, alcohol, chemical, soft drink, sugar, and pharmaceutical industries has formed a body of evidence describing the ways that corporations seek to produce and distribute research findings that are favourable to their interests, to suppress findings that are not, and to create doubt around the scientific agreement (Mailon, 2022; Humphreys et al., 2022). Another way corporations influence mainstream thinking is by capturing civil society through corporate front groups, philanthropic efforts, consumer groups and think tanks, allowing them to create doubt and promote their framing of the products they produce and their messages (Mailon, 2022; WHO, 2021).

Thank you for the opportunity to provide input on the potential amendments to the *Cannabis Regulations*. We would be happy to discuss any of our recommendations or comments upon your request and look forward to the summary from Health Canada following this consultation.

Sincerely,

Dr. Alexander Summers, MD, MPH, CCFP, FRCPC
Medical Officer of Health
Middlesex-London Health Unit

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June 9, 2023

Bureau of Policy, Intergovernmental and International Affairs, Food Directorate
Health Products and Food Branch, Health Canada
251 Sir Frederick Banting
Postal Locator 2204C
Ottawa, ON K1A 0K9

Re: Consultation on Restricting Food Advertising Primarily Directed at Children

At the May 18, 2023 meeting, the Middlesex-London Board of Health carried the following motion regarding Bill C-252, *An Act to amend the Food and Drugs Act (prohibition of food and beverage marketing directed at children*:

It was moved by **A. DeViet, seconded by M. Smibert,** *that the Board of Health:*

1) *Receive Report No. 35-23 re: "Support for Health Canada's policy update on restricting advertising of food and beverages to children"; and*
2) *Submit a letter on behalf of the MLHU Board of Health in support of Health Canada's recent policy update on restricting the commercial advertising of food and beverages to children along with these additional measures:*
    - *Increasing the age to under 18 for restricting commercial advertising*
    - *Expanding restrictions to all advertising types such as celebrity and character endorsements as indicated in Bill C-252.*

Youth are vulnerable to the advertising of the food and beverage industry. This exposure influences children and youths' food preferences, purchase requests, and consumption patterns which negatively impacts their health and wellbeing. Advertising of food and beverages influences choices in food and is considered an environmental determinant of health.

Current proposed amendments to Bill C-252, *An Act to amend the Food and Drugs Act (prohibition of food and beverage marketing directed at children* include focuses on television and digital media and limits restrictions to children under 13. This leaves various advertising techniques unrestricted and youth aged 13-17 vulnerable to harmful advertising.

The Middlesex-London Board of Health would like to propose the following additional measures (amendments) be considered for the policy update:

- Increasing the age to under 18 for restricting commercial advertising; and
- Expanding restrictions to all advertising types such as celebrity and character endorsements as indicated in Bill C-252.

Attached to this letter is Report 35-23 re: Support for Health Canada's Policy Update on Restricting Advertising of Food and Beverages to Children for further reference.

Sincerely,

Matthew Newton-Reid
Board Chair
Middlesex-London Health Unit

CC: Honourable Jean-Yves Duclos, Minister of Health of Canada
Honourable Patricia Lattanzio, Member of Parliament, Saint-Léonard—Saint-Michel
Dr. Theresa Tam, Chief Public Health Officer of Canada
Dr. Alexander Summers, Medical Officer of Health
Julie Goverde, Acting Manager, Community Health Promotion
All Ontario Boards of Health

MIDDLESEX-LONDON HEALTH UNIT

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 35-23

TO: Chair and Members of the Board of Health

FROM: Dr. Alexander Summers, Medical Officer of Health
Emily Williams, Chief Executive Officer

DATE: 2023 May 18

SUPPORT FOR HEALTH CANADA'S POLICY UPDATE ON RESTRICTING ADVERTISING OF FOOD AND BEVERAGES TO CHILDREN

Recommendation

It is recommended that the Board of Health:

1) ***Receive Report No. 35-23 re: "Support for Health Canada's policy update on restricting advertising of food and beverages to children";***
2) ***Submit a letter on behalf of the MLHU Board of Health in support of Health Canada's recent policy update on restricting the commercial advertising of food and beverages to children along with these additional measures:***
   - ***Increasing the age to under 18 for restricting commercial advertising***
   - ***Expanding restrictions to all advertising types such as celebrity and character endorsements as indicated in Bill C-252.***

Key Points

- Children and youth are vulnerable to the advertising of the food and beverage industry. Constant exposure influences children and youths' food preferences, purchase requests, and consumption patterns which negatively impacts their health and wellbeing.
- Health Canada released a policy update in April 2023 to protect children by restricting food and beverage advertising. However, the policy update solely focuses on television and digital media and limits restrictions to children under 13. This leaves various advertising techniques unrestricted and youth vulnerable to harmful advertising.

Background

Food and Beverage Advertising

Food and beverage advertising substantially influences food and beverage choices and preferences, and has been identified as an environmental determinant of health (Potvin Kent et al., 2022). Children and youth are exposed to food and beverage advertising on a constant basis. In 2019, approximately $628,600,000 was spent on food advertising, with more than 90% of the advertising being for foods that do not meet Canada's Food Guide (Potvin Kent et al., 2022). Over 50 million food and beverage advertisements were found on popular children's websites in 2015-2016, and over 90% of those ads were for foods high in sodium, sugar, and/or saturated fat (Heart & Stroke, 2021). Digital advertising via social media, the internet, and mobile devices is less costly, and has been shown to be more effective and persuasive compared to traditional media (Potvin Kent et al., 2022). Social media advertising provides companies with the ability to directly interact with consumers, which provides valuable information to companies (Potvin Kent et al., 2022). In addition, the use of digital media by children and youth has been increasing, resulting in increased exposure to digital marketing (Potvin Kent et al., 2022).

Negative Health Impacts of Food and Beverage Marketing to Children and Youth
The food industry appeals to children and youth using cartoons, celebrities, popular music, slang, and sports to market their products (Heart & Stroke, 2021, Truman & Elliott, 2019; Harris et al., 2020). Children are targeted because they are unable to critically assess advertisement messages, can influence family spending, and provide an opportunity to establish brand loyalty at a young age (Ontario Dietitians in Public Health [ODPH], 2019). Youth are also vulnerable to marketing due to their cognitive and emotional development, peer pressure, high levels of exposure to advertising, and increased independent purchasing power (Harris et al. 2020; Truman & Elliot, 2019). These factors can influence children and youths' food preferences, purchase requests, and consumption patterns, which negatively impacts their health and wellbeing (Hastings et al., 2006; & Cairns, Angus, & Hastings, 2009; Wilcox et. Al., 2004; Carter et al., 2011; Dietitians of Canada 2010).

History of Legislation
The Canadian Children's Food and Beverage Advertising Initiative set voluntary standards for the food industry to follow. However, this voluntary approach has not been effective at reducing food and beverage advertising to children (ODPH, 2019). Policies to protect this vulnerable population from food and beverage advertising have been established in many countries including Mexico, Spain, Sweden, Norway, Brazil, and the province of Quebec in 1980 (ODPH, 2019). Legislation in Quebec has resulted in children seeing fewer food and beverage ads, and fewer characters being used for food and beverage marketing in comparison to other Canadian provinces (Potvin Kent et al., 2011).

In September 2015, *Bill S-228, An Act to amend the Food and Drugs Act (prohibiting food and beverage marketing directed at children)*, was introduced, and passed by the Senate and the House of Commons, however, was not called to final vote in 2019. In 2016, Health Canada committed to protecting vulnerable populations as part of the Healthy Eating Strategy through restricting commercial advertising of food and beverages that do not support the health of children and youth. *Bill C-252, An Act to amend the Food and Drugs Act (prohibition of food and beverage marketing directed at children)* was introduced in November 2021, and has been adopted by the Standing Committee on Health on April 18th, 2023, and presented to the House of Commons on April 26, 2023.

Current Legislative Action
Health Canada has committed to implementing restrictions on food and beverage advertising to children by the fall of 2023 in their *Forward Regulatory Plan* for 2022-2024. Health Canada recently released a policy update in April 2023, indicating intention to amend the *Food and Drug Regulations* to "*restrict advertising to children under the age of 13 of foods that contribute to excess intakes of sodium, sugars and saturated fat… focusing on television and digital media first"* and is accepting comments until June 12, 2023.

Conclusion
Legislation that regulates food and beverage advertising to children and youth helps to protect this population from negative health impacts. The current policy proposal from Health Canada limits restrictions to children under 13, leaving some youth vulnerable. It also limits legislation to television and digital media, allowing other persuasive advertising methods such as celebrity endorsements to continue. References for sources within this report are noted in Appendix A.

This report was prepared by the Community Health Promotion Team, Healthy Living Division.

Alexander T. Summers

Dr. Alexander Summers, MD, MPH, CCFP, FRCPC
Medical Officer of Health

EWilliams

Emily Williams, BScN, RN, MBA, CHE
Chief Executive Officer

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