Disposition of Resolutions
2026

Resolutions Session
2026 Annual General Meeting
Tuesday, June 9, 2026

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alPHa RESOLUTION A26-01

TITLE: **Strengthening Hepatitis B Prevention in Ontario Through Vaccination in the First Year of Life**

SPONSORS: **The Board of Health for the District of Algoma Health Unit (Algoma Public Health); The Board of Health for the Simcoe Muskoka District Health Unit (Simcoe Muskoka District Health Unit)**

WHEREAS hepatitis B virus (HBV) infection causes a substantial burden of disease globally, with chronic infection leading to cirrhosis, liver failure, and liver cancer(1), noting that in 2021 alone, 3524 cases of HBV were reported in Canada(2); and

WHEREAS chronic HBV infection results in high lifetime healthcare utilization and substantial costs, with increased costs related to disease severity and for patients requiring liver transplantation(3); and

WHEREAS infants and young children who become infected with HBV are at the highest risk of developing chronic infection, with up to 90% of infected infants becoming chronic carriers compared with fewer than 5% of infected adults(4); and

WHEREAS Ontario currently administers HBV vaccine routinely in Grade 7, which leaves children susceptible to infection during their first 12 years of life when they are most vulnerable to developing chronic HBV infection(5); and

WHEREAS surveillance data from Public Health Ontario indicate that HBV infections continue to occur among children in Ontario prior to adolescence, including Canadian-born children (139 cases before age 12 between 2003 and 2013)(1), often due to missed prenatal screening for HBV, incomplete post-exposure prophylaxis, household exposure to undiagnosed carriers, travel, or immigration from regions of higher HBV prevalence(6); and

WHEREAS the National Advisory Committee on Immunization (NACI) has concluded that HBV vaccination in the first year of life provides long-lasting protection(4,6,7) and that acceptable schedule options in the first year of life include either vaccination at birth or later in infancy; and

WHEREAS birth dose HBV vaccination is safe and highly effective(3), and jurisdictions that implemented it decades ago now show lower adult HBV prevalence and reduced long-term disease burden, supporting the population-level benefits of early immunization(8); and

WHEREAS infant HBV vaccination at 2, 4, and 6 months of age is a well-studied safe and effective alternative to birth vaccination which has also been implemented in many jurisdictions in Canada and globally(9); and

WHEREAS a recent analysis modelling potential HBV immunization strategies for Ontario showed that providing 3 doses of the DTaP-HB-IPV-Hib vaccine (combination vaccine against 6 diseases) in infancy would lead to cost-savings compared to the current practice of administering the DTaP-IPV-Hib vaccines (combination vaccine against 5 diseases) in infancy plus the HBV vaccines in grade 7, due to reduced costs related to averted visits to healthcare providers, treatment costs, and complication costs, and noting this is also more favorable from a cost perspective than introducing birth dose HBV vaccination(10); and

WHEREAS several other Canadian jurisdictions already provide universal HBV vaccination in infancy, including British Columbia, Quebec, PEI, and Yukon; and

WHEREAS altogether, considering cost, safety, effectiveness, feasibility to integrate into the current vaccination schedule, and likelihood of acceptability to parents and health care providers, adopting HBV vaccination in infancy (at 2, 4 and 6 months of age) may be preferred for Ontario over birth vaccination, with the benefits of this immunization strategy over the Grade 7 program sufficiently justifying the required catch-up efforts.

NOW THEREFORE BE IT RESOLVED that the Association of Local Public Health Agencies (alPHa) writes to the Ontario Minister of Health recommending a review in consultation with the Ontario Immunization Advisory Committee and/or the National Advisory Committee on Immunization, as well as local public health agencies, regarding shifting universal HBV vaccination from Grade 7 to the first year of life, based on existing epidemiologic and economic evidence and programmatic considerations, in order to strengthen early protection against HBV, reduce preventable chronic infections, and advance health equity for children and families across Ontario;

AND FURTHER that alPHa recommends that the Minister of Health specifically considers the adoption of the combined DTaP-HB-IPV-Hib vaccine given at 2, 4, and 6 months of age as the preferred option for Ontario given its ability to seamlessly integrate into the existing vaccination schedule;

AND FURTHER that the Chief Medical Officer of Health be so advised.

Background

Hepatitis B is a liver disease that can lead to complications such as cirrhosis, liver failure, liver cancer, disability, and premature death, especially when acquired at an early age. Hepatitis B virus is very infectious; the virus can survive on surfaces for up to 7 days. Globally, the highest risk of transmission in childhood occurs in infants exposed during birth to their mothers who are carriers of Hepatitis B, many of them being immigrants from hepatitis B endemic areas such as Africa and Asia(4)(11); in such cases, 70% of infected pregnant women will transmit the virus to their baby.(12)

Transmission in childhood is also possible via close household contact with infected individuals (horizontal transmission), the risk being as high as 54%(13). Although rare, horizontal transmission in daycare settings is also possible (14). One of the challenges with childhood transmission is that Hepatitis B infection at an early age is mostly asymptomatic, therefore, not all cases are identified. Despite the absence of symptoms, 90% of infants infected will develop Chronic hepatitis B, and one out of four individuals with Chronic HB will die prematurely of cirrhosis or hepatocellular carcinoma.(12)

There are various Hepatitis B-containing vaccines available in Canada, alone or in combination with other vaccines that are already part of the current vaccination schedule[1].

Canada's vaccination strategy varies by province, under the principle that circulation of hepatitis B in the country is low (less than 5% of Canadians have markers of past infection, and less than 0.5% are carriers).(4) However, between 2003 and 2013, there were six cases per every 1000 Canada-born children under age 12 (time at which they usually receive the vaccine in Ontario).(1) Infections in childhood may be more likely to be occur among racialized children.(15)

Currently, the National Advisory Committee on Immunizations (NACI) does not give a specific recommendation regarding the best age for Hepatitis B vaccination. Instead, they leave it up to the provinces to make updates based on local epidemiology and specific programmatic considerations.(7)

Currently in Ontario, the Hepatitis B vaccine is routinely offered in Grade 7 (12 years of age) through the school immunization program, and a high-risk program is offered for younger age of vaccination for those most at risk. Immunization nurses visit schools twice a year to administer two doses at least 6 months apart.(5) With the current approach, most children remain unprotected from hepatitis B for the first 12 years of life.

There are two other approaches to Hepatitis B vaccination in Canada: vaccination at birth and vaccination in infancy.(11) Research shows that vaccinating children early in life is effective and safe.(4,16)

Vaccination at birth[2] is done in New Brunswick, Northwestern Territories and Nunavut. WHO recommends universal vaccination at birth based on the evidence that mother to child transmission is the highest risk factor for Hepatitis B in childhood.(11) Vaccination in infancy[3] is routinely done in British Columbia, Yukon, PEI and Quebec. Countries in Europe and the Americas have too successfully included Hepatitis B vaccine into their immunization programs in infancy.(9)

Hepatitis B vaccine is safe. There is no information suggesting that administering the vaccine at an earlier age is associated with safety concerns, the only exception being an increased risk of side effects among premature babies under 1500 g birth weight.(4) Moreover, there is no evidence that hepatitis B interferes with the immune response to any other vaccine or vice versa.(11) Likewise, there are no clinically meaningful differences in the safety profile of combination vaccines with and without the hepatitis B component.(9)

Records from Public Health Ontario indicate that vaccination coverage achieved in infancy through the routine infant vaccination schedule is higher than what is achieved in adolescence through school-based programs. Immunization coverage in the first year is above 80%, higher than the 70% coverage of

[1] ENGERIX-B-Pediatric, INFARIX hexa (DTaP-HB-IPV-Hib), RECOMBIVAX HB-Pediatric and TWINRIX Junior.

[2] At birth, at 1 month of age and at 6 months.

[3] This can be achieved by giving a hepatitis B vaccine in addition to the current combination vaccine against five diseases (pentavalent vaccine + Hep B vaccine) or by giving one vaccine protecting against six diseases, including hepatitis B (hexavalent vaccine).

Hepatitis B vaccination offered in adolescence.(17) Shifting to vaccination in infancy would likely translate into a higher number of children protected from the infection.
An Irish study found universal vaccination in infancy using a combination vaccine cost effective when compared to selective vaccination to newborns at high risk.(18) In the Ontario case, switching from the current practice of vaccination in grade seven to vaccination at birth or in infancy would prevent 37-38% of acute hepatitis B cases and 30-31% of chronic hepatitis B cases. Furthermore, birth vaccination would be cost-effective and infant immunization -involving vaccinating with a combined vaccine at 2, 4 and 6 months of age- would be cost saving.(10) This study considered costs of each vaccination modality, healthcare costs of hepatitis B disease and complications, and costs of years lost due to premature death and due to disability resulting from complications of hepatitis B infection.
In conclusion, hepatitis B and its complications are preventable with vaccination. Giving the vaccine earlier in life is safe and effective. A shift to a schedule that includes starting hepatitis B vaccination in the first year of life in Ontario would protect our children earlier and provide long-term cost-savings.

A representative from both Algoma Public Health and Simcoe Muskoka District Health Unit will be present at the meeting to introduce, move, and answer questions about the resolution being presented and commits to undertaking actions as requested by alPHa for carrying out the strategy should the resolution pass.

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alPHa RESOLUTION A26-02

Title: **Strengthening Certified Public Health Inspector Capacity to Support Delivery of the Ontario Public Health Standards**

Sponsor: **Association of Supervisors of Public Health Inspectors of Ontario (ASPHIO (Affiliate Member Organization)**

WHEREAS Certified Public Health Inspectors (PHIs) are essential to the delivery of mandatory programs and services under the Ontario Public Health Standards (OPHS), including, but not limited to: Food Safety; Safe Water; Health Hazard Prevention and Management; Infection Prevention and Control; Rabies Prevention and Control; Recreational Water; and Emergency Preparedness and Response;

WHEREAS Certified PHIs have specialized training and regulatory authority under the Health Protection and Promotion Act (HPPA) and its regulations to conduct risk-based inspections, lead outbreak investigations, and make regulatory decisions that safeguard public health;

WHEREAS local public health agencies are required under the HPPA to ensure the provision of these programs and services in accordance with the OPHS;

WHEREAS PHI responsibilities have increased in scope and complexity in response to population growth, evolving regulatory requirements, emerging infectious diseases, climate-related health risks, and heightened expectations for infection prevention and control and timely response;

WHEREAS The COVID-19 pandemic increased workload demands and exposed workforce vulnerabilities, contributing to recruitment and retention challenges and to service backlogs in routine OPHS programming;

WHEREAS Strengthening public health inspection capacity is a prevention-focused approach that can help avoid outbreaks and infrastructure failures, reduce emergency health-care utilization, and mitigate workplace disruptions and business closures, thereby supporting fiscal sustainability and economic productivity;

WHEREAS The Canadian Institute of Public Health Inspectors (CIPHI) Ontario Branch and the Association of Supervisors of Public Health Inspectors of Ontario (ASPHIO) are actively collaborating to enhance recruitment pathways, including outreach to CIPHI-accredited post-secondary academic institutions, internationally educated professionals, and newcomers;

WHEREAS The Ministry of Health has demonstrated leadership through the Ministry-led Public Health Inspector Workforce Capacity Working Group, established under the Office of the Chief Medical Officer of Health, to inform strategies that build PHI workforce capacity across recruitment, education pathways, practicums, mentorship, and retention;

THEREFORE BE IT RESOLVED THAT the Association of Local Public Health Agencies of Ontario(alPHa) respectfully request that the Province of Ontario, through the Ministry of Health:

1. Undertake a provincial PHI workforce assessment and forecasting approach, aligned with the Ministry-led PHI Workforce Capacity Working Group, to identify current and projected workforce needs and to inform evidence-informed and equitable distribution of PHI resources; and
2. Provide sustained, base funding to local public health agencies to support the hiring of additional certified Public Health Inspectors across Ontario, based on the workforce assessment and forecasting, which includes an assessment of training program capacity, to strengthen PHI staffing capacity and support consistent delivery of OPHS requirements.
3. Continue to advance education, recruitment, and practicum capacity initiatives—including mentorship supports and standardized practicum approaches—in partnership with accredited institutions, Boards of Health, ASPHIO, and the Canadian Institute of Public Health Inspectors (Ontario Branch); and
4. Support retention and professional sustainability strategies, including targeted approaches for northern and rural communities, and investments in professional development and mentorship to support early-career PHIs and succession planning; and
5. Recognize PHI capacity as essential health and economic system infrastructure requiring stable and predictable investment to support OPHS compliance, emergency readiness, and ongoing protection of Ontarians.

AND FURTHER that alPHa circulate this resolution to the Minister of Health, the Chief Medical Officer of Health, the Association of Municipalities of Ontario (AMO), Ontario Boards of Health, the Canadian Institute of Public Health Inspectors (CIPHI), Canadian Institute of Public Health Inspectors (Ontario Branch), and CIPHI-accredited post-secondary academic institutions.

Backgrounder: Strengthening Certified Public Health Inspector Capacity to Support Ontario's Public Health System

Prepared by: Association of Supervisors of Public Health Inspectors of Ontario (ASPHIO)
Dominique Bremner (ASPHIO Chair)
Heidi Pitfield (alPHa Affiliate Member Representative)
Peter Heywood (ASPHIO Member)

For: alPHa Annual General Meeting & Resolutions Session

Date: June 9, 2026

Purpose

This document provides background context to support an alPHa resolution requesting strengthened certified Public Health Inspector (PHI) staffing capacity in Ontario. It is intended to complement ongoing collaborative work led by the Ontario Ministry of Health to build capacity in the PHI workforce.

Background

1. Public Health Inspectors as essential public health system infrastructure

Certified Public Health Inspectors (PHIs) play a central role in delivering mandatory programs and services under the Ontario Public Health Standards (OPHS) and supporting Boards of Health in meeting requirements under the Health Protection and Promotion Act (HPPA). PHIs protect communities by preventing, identifying, and mitigating health hazards across multiple settings, including food premises, recreational water facilities, small drinking water systems, child care and congregate living settings, and other environments where preventable risks can have significant health and economic impacts.

Certified PHIs have specialized education, practicum training, and national certification, with competencies in risk assessment, infection prevention and control (IPAC), outbreak management, environmental health sciences, regulatory interpretation and enforcement, and effective public communication. This specialized training and regulatory authority supports consistent, high-quality inspection services and timely, evidence-informed decision-making.

2. Growing and evolving service demands

In recent years, PHI responsibilities have expanded in scope and complexity due to population growth, evolving regulatory requirements, emerging and novel infectious diseases, climate-related health risks,

heightened IPAC expectations, and increased public expectations for transparency and timely response. PHIs are also routinely called upon to respond to urgent and emergencies, consistent with OPHS requirements for 24/7 readiness.

3. Lessons from the COVID-19 response and the need to strengthen capacity

The ASPHIO White Paper (June 2023) documents the critical contributions of PHIs to Ontario's COVID-19 response, including outbreak management in long-term care and other congregate settings; IPAC assessments and guidance; support for enforcement and Section 22 orders; and surge support for evolving public health priorities. At the same time, routine OPHS programming experienced service disruption and backlogs as PHIs were redeployed to pandemic response activities.

The White Paper also highlights workforce impacts that challenge sustainability, including burnout and mental distress, increased resignations, leaves of absence, and retirements, and reported incidents of harassment directed at PHIs. These pressures have compounded long-standing recruitment and retention challenges, particularly in northern and rural communities, and have reduced the availability of experienced staff to mentor and train new PHIs.

4. Value of prevention and the case for sustained investment

Preventive inspection and hazard prevention programs reduce the likelihood and severity of foodborne illness outbreaks, water contamination events, and IPAC lapses, and support continuity of operations for businesses and institutions. Strengthening PHI capacity helps Boards of Health deliver OPHS requirements, clear backlogs, address emerging local priorities, and maintain readiness for future public health emergencies.

Local public health agencies are currently facing challenges in meeting the required inspection frequencies outlined in the Ontario Public Health Standards (OPHS). This is primarily due to constraints in the staffing capacity of Public Health Inspectors (PHIs), which increases organizational risk for the Boards of Health that are responsible for statutory oversight. This situation highlights the critical need to address PHI staffing levels to improve compliance and support the Boards of Health in fulfilling their essential oversight responsibilities.

Further, strengthening public health inspection capacity is a prevention-focused approach that can help avoid outbreaks and infrastructure failures, reduce emergency health-care utilization, and mitigate workplace disruptions and business closures, thereby supporting fiscal sustainability and economic productivity.

5. Building on Ministry of Health leadership and collaboration

ASPHIO recognizes and appreciates the Ontario Ministry of Health's leadership in convening the Ministry-led Public Health Inspector Workforce Capacity Working Group. The Working Group—established under the Office of the Chief Medical Officer of Health—provides a collaborative forum to identify, assess, and prioritize PHI workforce capacity issues and opportunities, and to make recommendations to the Public Health Leadership Team.

The Working Group's Terms of Reference identify practical, professional pipeline (education – practicum - workforce) focused objectives, including: increasing enrolment in Ontario's accredited environmental health programs; exploring fast-track pathways; strengthening practicum quality and mentorship supports; partnering to attract internationally educated public health professionals; and considering

targeted retention supports for northern and rural communities. This resolution is intended to complement this work by supporting timely, sustained staffing investments in PHI capacity.

6. Implementation considerations (for context)

As part of Ontario's 2026 budget consultation, the Canadian Institute of Public Health Inspectors (CIPHI), Ontario Branch, recommended a targeted provincial investment of $20 million to support the recruitment of 150 certified PHIs across Ontario, with a proposed cost-sharing approach in subsequent years (75% provincial / 25% municipal). This estimate reflects projected workforce gaps in the province identified through sector consultations, increasing inspection and compliance workloads, and forecasts of replacement rates due to attrition and anticipated retirements within the current PHI workforce.

The same submission recommended maintaining an annual investment of $435,000 to enhance the PHI practicum pipeline through local public health agencies and support future workforce development.

These figures are provided for background context only. The resolution below focuses on the core policy outcomes of sustained, base funding and coordinated workforce planning to support delivery of the OPHS province-wide. Any proposed increase in PHI capacity must adopt an evidence-informed and equitable distribution strategy. This strategy should take into account population growth trends, geographic size and remoteness, community risk profiles, and the practical challenges of serving diverse urban, suburban, rural, and northern populations.

Key message

A well-resourced certified public health inspector workforce is crucial for a strong public health system. Ongoing base funding to enhance PHI staffing capacity, combined with coordinated workforce assessments, education, and supply initiatives, will ensure equitable resource distribution. This approach will enable consistent delivery of Ontario's public health services and programs, improve emergency preparedness, and reduce organizational and compliance risks for Boards of Health tasked with fulfilling mandated public health responsibilities.

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alPHa RESOLUTION A26-03

TITLE	**Mandatory and Regulated Alcohol Labelling on Alcohol Manufactured or Sold in Canada**
SPONSORS	**Middlesex-London Health Unit (MLHU) and Toronto Public Health (TPH)**
WHEREAS	alcohol is a legal product with associated health harms and classified as a Group 1 carcinogen with a causal link to cancer (Babor, 2023; IARC, 1988; IARC, 2012; Paradis, 2023; Rumgay, 2021); and
WHEREAS	alcohol caused an estimated 4,330 deaths, 22,009 hospitalizations, and 194,693 emergency department visits each year in people aged 15 and older in Ontario (Ontario Health and Ontario Agency for Health Protection and Promotion, 2023); and
WHEREAS	77% of Ontarians self-report alcohol use in the past 12 months and 33% report drinking alcohol at more than a low-risk level as per the *Canadian Guidance on Alcohol and Health* in the past week (Ontario Health and Ontario Agency for Health Protection and Promotion, 2023); and
WHEREAS	the harms due to alcohol are disproportionally carried by individuals from lower socioeconomic groups, compared to those from higher socioeconomic groups, despite often drinking less alcohol; described as the alcohol harm paradox (Bloomfield, 2020; CIHI, 2017); and
WHEREAS	many Canadians are unaware of: • alcohol's relationship to cancer risk, especially at low levels of consumption, • what a standard drink of alcohol contains, and • guidance to reduce their alcohol risk (Government of Canada, 2024); and
WHEREAS	alcohol containers in Canada lack comprehensive health warning labels to inform consumers of the risks or ways to reduce risks; and
WHEREAS	labels are an effective tool to help consumers understand product risk (CCS, 2023; Hobin, 2022; Noar, 2016); and
WHEREAS	the membership previously carried alPHa RESOLUTION A24-03: A Proposal for a Comprehensive Provincial Alcohol Strategy: Enhancing Public Health through Prevention, Education, Regulation and Treatment.

NOW THEREFORE BE IT RESOLVED that the Association of Local Public Health Agencies call on the Federal Government to amend the *Food and Drugs Act* to mandate alcohol labelling including:

- Health Warnings: prominent, rotating warnings on all alcohol containers.
- Canada's Guidance on Alcohol and Health: providing guidance for preventing or reducing consumption-related health risks.
- Standard Drink Size: static standard drink information per container and per serving.

AND FURTHER that the Association of Local Public Health Agencies endorse the Statement from Provincial/Territorial Chief Medical Officers of Health on Labelling of Alcohol Products.

AND FURTHER that the Association of Local Public Health Agencies recommend Health Canada update their website to reflect Canada's current Guidance on Alcohol and Health.

AND FURTHER that the Association of Local Public Health Agencies advise all Ontario Boards of Health to recommend their local Members of Parliament to advocate that all alcohol manufactured or sold in Canada have mandatory, regulated labels including health warnings, Canada's Guidance on Alcohol and Health, and standard drink size information.

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

Background

Alcohol – No Ordinary Commodity

In Ontario and across Canada, alcohol availability has increased significantly over the past decade, while health protective regulations have not kept pace. Alcohol is normalized in our society as an ordinary consumer good used to celebrate, commiserate, and has even been seen as a rite of passage; however, alcohol is anything but an ordinary commodity. It is a leading risk factor for disease and injury, responsible for over 17,000 deaths and nearly 120,000 hospitalizations every year in Canada (CISUR/CCSA, 2023). Alcohol contributes to over 200 health conditions, including cancers, liver disease, cardiovascular conditions, mental health concerns, and fetal alcohol spectrum disorder (Babor, 2023; Paradis, 2023). In addition to these significant health harms, the economic and social implications of alcohol are substantial, costing Canadians $19.7 billion/year (CISUR/CCSA, 2023) which is more than the societal costs of tobacco and opioids combined.

In Ontario, 77% of residents identify themselves as current drinkers and 33% report drinking above what is considered a low-risk level based on the Canadian Guidance on Alcohol and Health (Ontario Health and Ontario Agency for Health Protection and Promotion, 2023). Since it is well established that individuals chronically underreport the amount of alcohol consumed, these percentages are likely to be even higher (Stockwell, 2023; Stockwell 2018). Current consumption levels account for 4.3% of deaths, 2.1% of hospitalizations, and 3.7% of emergency department visits each year in Ontario (Ontario Health and Ontario Agency for Health Protection and Promotion, 2023). The population health burden from alcohol exceeds available capacity on already overstretched healthcare and policing systems. Furthermore, alcohol can have profound secondary harms to communities through impaired driving, intimate partner violence, and public disturbances.

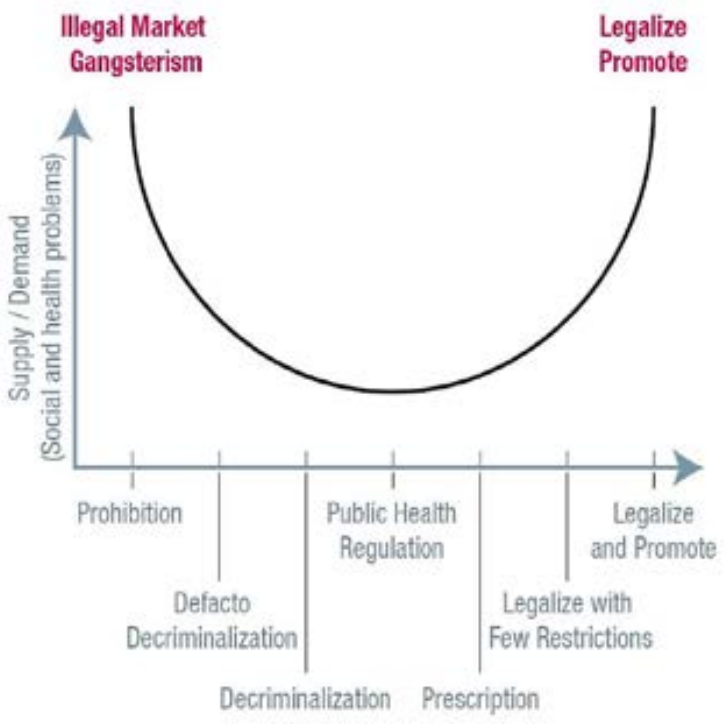
Public Health Approach to Preventing Harms from Alcohol

From a public health perspective, preventing harms from alcohol consumption requires a comprehensive, organized, and multi-sectoral approach that provides controlled access to a strictly regulated product, while removing the commercial and/or industry influence. A public health approach is anchored in social justice, human rights, equity, and the application of evidence-informed policy and practice (CPHA, 2017).

Since 2024, there have been significant changes to the alcohol retail market, expanding sales to many different retail settings in Ontario, including convenience stores and grocery stores. In a cross-sectional study from Ontario, alcohol outlet density was associated with higher alcohol-attributable emergency department visits; an association that had a larger impact in low compared to high socioeconomic status neighbourhoods (Forbes, 2024).

Figure 1, pictured below, shows the population health benefit to reducing health and social harms when there is a balance between alcohol availability and the enactment of measures to protect public health and safety**.** Through the implementation of strict public health regulations, including simple, evidence-based health warning labels on alcohol containers sold in Canada, the consumer would be informed about the health risks associated with alcohol, as well as better understand how much alcohol they are consuming, allowing for a more informed decision.

Figure 1. The Paradox of Prohibition – Adapted from Marks U-Shaped Curve (Health Officers Council of British Columbia, 2005)



Rationale

Alcohol Labelling Supports Informed Choice by Consumers

In Canada, other legalized substances like commercial tobacco products and non-medical cannabis are required to display standardized labels that include health warnings and product information to inform consumers about associated health risks and have standardized packaging designed to reduce product promotion and appeal (Government of Canada, 2023; Government of Canada, 2025). While tobacco's labelling evolution took significant public health efforts to move from small text warnings in the 1970s to graphic health warnings and the plain packaging requirements that we see in Canada today, evidence confirms that these warning labels have increased awareness of health risks, reduced product appeal, and contributed to declines in smoking rates (Noar, 2016; CCS, 2023). The benefits of these tobacco warning labels were significant enough to influence Canada's approach to packaging and labelling legalized, non-medical cannabis products in 2018, pictured below in Figure 2. Alcohol remains the outlier, as the only legalized substance that currently does not have a warning label.

Figure 2. Examples of tobacco and cannabis warning labels mandated by the government of Canada (CCS, 2023; Israel, 2019)

Evidence indicates that alcohol warning labels impact individuals' knowledge, awareness, behavioural intentions, and perceptual judgements (Babor, 2023; CAPE, 2022; Correia, 2024; Hobin, 2020; WHO, 2022). Labels can reach all consumers regardless of education, income, or whether living in large urban centres or remote rural communities (Hammond, 2011), and exposure to labels is highest among those consuming the highest volume of alcohol as messaging is at point of pour.

Canadians have the right to informed decision making, including the risks associated with alcohol consumption, accurate standard drink sizing descriptions, and up-to-date guidance to help reduce their risk. The "duty to warn" obligation under product liability law could reasonably be applied to the alcohol industry since "the basic underlying rationale for the duty to warn is that consumers rely on manufacturers to provide accurate information about the risks inherent in the use of their products" (Shelly, 2021, p.268). Drawing upon lessons learned from the regulation of commercial tobacco products, warning labels are an evidence-informed policy tool that have been proven to help educate the public about the health risks associated with smoking, and instrumental in building public support for strengthening tobacco control policies, including bans on marketing and tobacco tax increases (Hammond, 2011; Noar, 2016; PHO, 2017)

Canadians Are Unaware of Health Harms from Alcohol

Alcohol is a known carcinogen and has been classified by the International Agency for Research on Cancer (IARC, 1988; IARC, 2012) as a Group 1 carcinogen for over 35 years causing at least 7 kinds of cancers and was linked to nearly 7,000 new cancer cases in Canada in 2020 (Rumgay et al., 2021). Unfortunately, most Canadians are unaware of alcohol's relationship to cancer, especially at low levels of consumption. The Government of Canada's 2023 Public Awareness of Alcohol-related Harms Survey confirmed that less than one-third of Canadians believe that alcohol increases the risk for breast, throat, or mouth cancers. Additionally, only one-third of Canadians were familiar with the concept of a "standard drink" and just

over half of respondents were aware of Canada's Guidance on Alcohol and Health, despite widespread promotion (Government of Canada, 2024).

The majority of Canadians agree that alcohol products should display or provide:

- the number of standard drinks;
- guidance to reduce health risks; and,
- health warnings.

Furthermore, most believe that health labelling of alcohol products would help them

- track their alcohol consumption;
- think more readily about alcohol-related harms; and,
- think about cutting back on drinking or talking to others about cutting back (Government of Canada, 2024).

Alcohol Labelling and Youth Prevention

Between 2015 and 2020, expansion of alcohol sales to approximately 450 grocery stores licensed to sell beer, wine, and cider led to increased alcohol product promotion and exposure to children and youth (Friesen, 2022). Drawing upon the lessons learned from comprehensive tobacco control, tobacco warning labels are especially effective in preventing youth initiation (Hammond, 2011; Francis, 2019). With the increased visibility of alcohol products in stores accessible to children and youth, alcohol labelling has the potential to reach them with messages that will counter industry-based advertising. The health warnings are visible to all consumers, including children and youth, on store shelves in their local convenience or grocery store. The labels also provide an opportunity for meaningful conversations between parents and their children regarding the health harms associated with alcohol.

Summary

To address complex societal problems with significant public health burden, cooperation and collaboration between local, municipal, provincial, and federal partners are required. Impacts of alcohol consumption remain a substantial population health burden, and one that exceeds social and health care system capacity. The Middlesex-London Health Unit and Toronto Public Health support mandatory and regulated alcohol labelling including health warnings, Canada's Guidance on Alcohol and Health, and standard drink size on all containers of alcohol manufactured and sold in Canada. It is a modest and evidence-informed policy that ensures that consumers are aware of the health harms associated with alcohol and is in alignment with Canada's approach to commercial tobacco products and the legalization of non-medical cannabis.

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alPHa RESOLUTION A26-04

TITLE	**Enhancing the Ontario Works Benefit**
SPONSORS	**Middlesex-London Health Unit (MLHU), Huron Perth Public Health Unit (HPPH), Windsor-Essex County Health Unit (WECHU) and Oxford-Elgin-St. Thomas Public Health Unit (also known as Southwestern Public Health Unit, SWPH)**

WHEREAS household food insecurity (HFI), the inadequate or insecure access to food due to financial constraints, is a critical indicator of a household's financial situation, their ability to afford basic needs, and a highly sensitive measure of material deprivation;

WHEREAS HFI is an important social determinant of health, a strong predictor of poor health, and is associated with an increased risk of a wide range of physical and mental health challenges, including chronic conditions, non-communicable diseases, infections, depression, anxiety, and stress;

WHEREAS poor diet quality costs Ontario an estimated $5.6 billion annually in direct healthcare costs and indirect costs (e.g., lost productively due to disability and premature mortality), with higher costs associated with more severe food insecurity;

WHEREAS from 2020 to 2024, Ontario's food insecurity rates have significantly increased from 1 in 6 households (17.1%) to 1 in 4 households (25.3%);

WHEREAS Ontario Works (OW) rates are inadequate for households to afford basic needs;

WHEREAS 67.2% of Ontario households reliant on OW or Ontario Disability Support Program (ODSP) were food insecure in 2021;

WHEREAS OW income plus all eligible family and tax benefit entitlements is $11,500-$23,500 below Canada's Official Poverty Line and $4,000-$11,500 below the Deep Income Poverty threshold for various household scenarios (e.g., single person household, single parent with one child, and couple with two children);

WHEREAS based on average provincial rent and food costs, Ontario households (e.g., single person, family of 4) receiving OW and all eligible family and tax benefit entitlements need an additional $333-$817 per month to afford rent and food, plus funds for all additional expenses, and a single parent with 2 children has only $447 remaining to pay for all additional expenses;

WHEREAS the OW earned income exemption of $200 per month after a 3-month waiting period, with benefits reduced by 50 cents for every additional dollar earned, was established to encourage workforce participation;

WHEREAS the OW earned income exemption has not increased since 2013 while minimum wage and the cost of living have greatly increased;

WHEREAS greater than 11.5 hours of minimum wage work per month results in a reduction in OW benefits, impacting the ability to afford the cost of living and creating a deterrent to workforce participation;

WHEREAS an increased OW earned income exemption would help households afford the cost of living and help support people working toward leaving the OW program;

WHEREAS the ODSP earned income exemption increased from $200 to $1,000 per month in 2023, with benefits reduced by 75 cents for every additional dollar earned and no waiting period;

WHEREAS ODSP rates are increased annually based on inflation, with the first inflation-based increase in 2025;

WHEREAS OW rate increases indexed to inflation are needed as part of OW enhancements and were previously supported by alPHa (A23-05);

NOW THEREFORE BE IT RESOLVED that the Association of Local Public Health Agencies call on the Government of Ontario to increase the OW earned income exemption to align with ODSP exemption increases, and adjust the OW benefit reduction rate to align with ODSP reduction rates;

AND FURTHER that the Government of Ontario eliminate the three-month waiting period for the OW earned income exemption to ensure that exemptions apply immediately upon entry to assistance;

AND FURTHER that the Association of Local Public Health Agencies reaffirm and advance its previously adopted position in Resolution A23-05, *Monitoring Food Affordability in Ontario and Inadequacy of Social Assistance Rates,* calling for increases to Ontario Works base benefit rates and the indexation of those rates to inflation, and urge the Government of Ontario to implement these measures as foundational components of a sustained approach to income adequacy;

AND FURTHER that the Government of Ontario conduct periodic reviews of the OW earned income exemption to maintain alignment with labor market conditions and cost-of-living trends;

AND FURTHER that a copy of this resolution be sent to the Premier of Ontario, the Minister of Children, Community and Social Services, and local Members of Provincial Parliament.

Statement of Sponsor Commitment
Drs. Alexander Summers, Miriam Klassen, Mehdi Aloosh and Ninh Tran, Medical Officers of Health for the endorsing health units, will be present at the 2026 Annual General Meeting to introduce, move, and answer questions about the resolution being presented and commit to undertaking actions as requested by the Association of Local Public Health Agencies should the resolution pass.

Background

aIPHa previously endorsed various resolutions in support of social assistance reform and income-based solutions to household food insecurity including:

- A24-05: Early Childhood Food Insecurity: An Emerging Public Health Problem Requiring Urgent Action
- A23-05: Monitoring Food Affordability in Ontario and Inadequacy of Social Assistance Rates
- A18-02: Public Health Support for a Minimum Wage that is a Living Wage
- A18-04: Extending the Ontario Pregnancy and Breastfeeding Nutritional Allowance to 24 Months
- A15-04: Public Health Support for a Basic Income Guarantee
- A05-18: Adequate Nutrition for Ontario Works and Ontario Disability Support Program Participants and Low Wage Earners

Food Insecurity in Ontario

Household food insecurity (HFI) is the inadequate or insecure access to food due to financial constraints[1]. HFI is a critical indicator of a household's financial situation and their ability to afford basic needs, and a highly sensitive measure of material deprivation[1].

HFI is an important social determinant of health, a strong predictor of poor health, and is associated with an increased risk of a wide range of physical and mental health challenges, including chronic conditions, non-communicable diseases, infections, depression, anxiety, and stress[1,2,3].

Poor diet quality costs Ontario an estimated $5.6 billion annually in direct healthcare and indirect costs (e.g., lost productively due to disability and premature mortality)[4], with higher costs associated with more severe food insecurity[5].

Current Situation

- From 2020 to 2024, Ontario's food insecurity rates significantly increased from 17.1% (1 in 6 households) to 25.3% (1 in 4 households)[6].
- In 2024, 4,055,000 people lived in a food insecure household in Ontario, including 33.3% of children under 18[7].
- From 2022 to 2024, Middlesex-London's food insecurity rates significantly increased from 17.5% (1 in 6 households) to 31.3% (1 in 3 households)[6].

Inadequacy of Ontario Works

Ontario Works (OW) rates are inadequate for households to afford basic needs and haven't increased since 2018.

- In 2021, 67.2% of Ontario households reliant on social assistance were food insecure[1].
- In 2024, Ontario Works income plus all eligible family and tax benefit entitlements was $11,504-$23,498 below Canada's Official Poverty Line (i.e., Market Basket Measure) and $4,171-$11,452 below the Deep Income Poverty threshold (i.e., Market Basket Measure – Deep Income Poverty) for various household scenarios (e.g., single person household, single parent with one child, and couple with two children)[8].
- Based on average provincial rent and food costs, Ontario households (e.g., single person, family of 4) receiving Ontario Works and all eligible family and tax benefit entitlements (e.g., Ontario Trillium Benefit, Canada Child Benefit) need an additional $333-$817 per month to afford rent and food, plus funds for all additional expenses, and a single parent with 2 children has only $447 remaining to pay for all additional expenses[2].
- Middlesex-London households receiving Ontario Works (e.g., single person, single parent with 2 children, family of 4) and all eligible family and tax benefit entitlements (e.g., Ontario Trillium Benefit, Canada Child Benefit) need an additional $7-$558 per month to afford rent and food, plus funds for all additional expenses[9].

Ontario Works Earned Income Exemption

Under current OW rules, the first $200 per month of (net) earned income is exempt from OW clawbacks, with benefits reduced by 50 cents for every additional dollar earned. The earned income exemption amount starts after a 3-month waiting period, meaning all earned income reduces benefits by 50 cents for every dollar earned in the first 3 months receiving assistance.

The earned income exemption was established in 2013 to encourage workforce participation[10]. However, the exemption has not increased since it started[11], while minimum wage in Ontario has increased from $10.25 to $17.60 per hour and cost of living, as measured by the Consumer Price Index in Ontario, has increased by 36.9% (121.3 to 166.1)[12].

In 2013, greater than 19.5 hours of minimum wage work per month resulted in a reduction in OW benefits ($10.25 x 19.5 = $199.88). In 2026, greater than 11.5 hours of minimum wage work per month results in a reduction in OW benefits ($17.60 x 11.5 = $202.40). Benefit reductions at the current level impact the ability to afford the cost of living and create a deterrent to workforce participation[13]. An increased earned income exemption would help households afford the cost of living and help support people working toward leaving the OW program.

The 3-month waiting period for the earned income exemption limits income at entry to assistance, where financial need is often greatest, and reduces the effectiveness of earned income exemptions as a work incentive. Removing the three-month waiting period would allow exemptions to apply immediately, improving income stability during the point of greatest vulnerability.

Comparison to Ontario Disability Support Program (ODSP)

Aligning select OW rules with ODSP rules would provide short-term and long-term improvements to the adequacy of OW rates.

- ODSP rates are increased annually based on inflation, with the first inflation-based increase in 2025[14].

- ODSP earned income exemption increased from $200 to $1,000 per month in 2023, with benefits reduced by 75 cents for every additional dollar earned[15]. There is no waiting period for the ODSP earned income exemption.
- Aligning OW earned income rules with those of ODSP would improve income adequacy and reduce inequities between social assistance programs.
- While the OW benefit reduction rate (50%) appears lower than ODSP's reduction rate (75%), the much lower OW earned income exemption ($200 vs. $1,000) means that OW recipients begin to lose benefits at far lower levels of earned income.
- As shown in Table 1, an individual receiving OW would need to earn approximately $2,600 per month before experiencing the same $1,200 reduction in benefits as an individual receiving ODSP. This level of earned income is unrealistic for most OW recipients, given that individuals typically qualify for OW due to significant barriers to employment, including unstable work, caregiving responsibilities, health challenges, or recent job loss.
- In practice, the current OW structure results in earlier and steeper benefit reductions, discouraging workforce participation and undermining income stability. Aligning OW earned income exemptions and reduction rates with ODSP would allow individuals to increase earnings without immediate loss of essential income supports.

Table 1. Ontario Works and ODSP Earned Income Exemption Comparison

Earned Income (Monthly, Net)	Ontario Works $200 Exemption 50% Clawback		ODSP $1,000 Exemption 75% Clawback	
	$ Above Exemption	Reduction	$ Above Exemption	Reduction
$200	$0	$0	$0	$0
$500	$300	$150	$0	$0
$1,000	$800	$400	$0	$0
$1,500	$1,300	$650	$500	$375
$2,000	$1,800	$900	$1,000	$750
$2,600	$2,400	$1,200	$1,600	$1,200
$3,000	$2,800	$1,400	$2,000	$1,500

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