alPHa
Association of Local PUBLIC HEALTH Agencies

alPHa's members are the public health units in Ontario.

alPHa Sections:

Boards of Health Section

Council of Ontario Medical Officers of Health (COMOH)

Affiliate Organizations:

Association of Ontario Public Health Business Administrators

Association of Public Health Epidemiologists in Ontario

Association of Supervisors of Public Health Inspectors of Ontario

Health Promotion Ontario

Ontario Association of Public Health Dentistry

Ontario Association of Public Health Nursing Leaders

Ontario Dietitians in Public Health

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March 8 2019

Hon. Vic Fedeli
Minister of Finance
Room 281, Main Legislative Building,
Queen's Park
Toronto, Ontario M7A 1A1

Dear Minister Fedeli,

Re: Alcohol Choice & Convenience Roundtable Discussions

On behalf of the Association of Local Public Health Agencies (alPHa) and its member Medical Officers of Health, Boards of Health, and Affiliate organizations, I am writing to thank you for inviting us to participate in the March 4th roundtable discussion on the proposed expansion of the sale of beverage alcohol in Ontario.

We found the discussions with representatives from the alcohol, retail and advocacy sectors to be informative and respectful, and we appreciated the receptiveness of MPP Doug Downey and the Ministry of Finance staff to stakeholders' ideas during the meeting.

We understand that this is a preliminary consultation that is meant to inform the development of future policy and we look forward to providing further input as your Ministry considers the various facets of changing the alcohol retail landscape in Ontario.

I am pleased to provide you with the notes and supplementary materials to which I referred and shared on paper with attendees and Ministry staff. From these, we wish to emphasize the following key messages, for which there was clear consensus at our table:

- Increasing access to alcohol may lead to increased alcohol consumption
- Excessive alcohol use is a key modifiable risk factor of chronic diseases and injuries and their associated health care costs
- The Ministry should expand the availability of only beer and wine with lower alcohol concentrations and the LCBO should continue be wholesaler to retail stores
- The Ministry should employ a comprehensive set of policy options to mitigate this risk including:
    - Retail siting and setbacks
    - Retail density and hours of operation
    - Public education, prevention strategies and treatment services
    - Pricing
    - Youth access deterrents
- The Ministry should ensure that the Alcohol and Gaming Commission of Ontario has sufficient capacity to effectively enforce the rules respecting additional retail stores

We would be pleased to meet with you to further discuss our views on the public health impacts of alcohol availability and to lend our expertise to the development of a made-in-Ontario alcohol strategy. To schedule a meeting, please have your staff contact Loretta Ryan, Executive Director, alPHa, at loretta@alphaweb.org or 647-325-9594.

Sincerely,

Dr. Robert Kyle,
alPHa President

COPY: Hon. Christine Elliott, Minister of Health and Long-Term Care
Dr. David Williams, Chief Medical Officer of Health
Doug Downey, MPP, Parliamentary Assistant to the Minister of Finance

Encl.

1. *Canadian Institute for Health Information. Alcohol Harm in Canada: Examining Hospitalizations Entirely Caused by Alcohol and Strategies to Reduce Alcohol Harm. Ottawa, ON: CIHI; 2017.*

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Retail Expansion Roundtable
Ontario Ministry of Finance

375 University Ave, 7th Floor, Toronto, ON M5G 2J5
Wednesday, March 6, 2019
Speaking Notes

Introduction

- alPHa represents all 35 boards of health and all associate/medical officers of health
- Thank you for inviting us to attend today's roundtable
- The focus of our remarks is on:
    - Rules for sale and consumption
    - Safe and healthy communities
- Alcohol is responsible for the second highest rate of preventable death and disease in Canada, following tobacco. Additionally, alcohol is responsible for the greatest proportion of costs attributed to substance use in Ontario;[i] it is well-established that increasing alcohol availability is directly related to increased consumption and alcohol-related harms. It is necessary to balance consumer demand for convenience with policy supports aimed at ensuring the health of Ontarians remains a priority.

Background

- Alcohol availability in Ontario has increased 22 percent from 2007 to 2017 and will continue to increase under the government's proposed sale expansion plan.[ii]
- Ontario has committed to making wine, beer and cider available in up to 450 grocery stores.
- In August 2018, there was a reduction in the minimum retail price of beer (below 5.6% ABV) from 1.25 to $1.00; participating manufacturers were given enhanced promotion in LCBO retail stores.
- In December 2018, alcohol retail hours of sale were extended to 9 – 11 AM, seven days a week.

Current State

- Alcohol use is associated with addiction, chronic diseases, violence, injuries, suicides, fetal alcohol spectrum disorder, deaths from drunk driving, increased HIV infections, unplanned pregnancies, violence, assaults, homicides, child neglect and other social problems.
- Alcohol causes cancers of the mouth, esophagus, throat, colon and rectum, larynx, breast and liver.
- Even low to moderate alcohol consumption can cause cancer and damage to the brain.
- Alcohol outlet density has been shown to be related to heavy episodic drinking by youth and young adults.[iii] [iv]

- Privatized liquor sales, often associated with high density and increased sales to minors, can have troubling results for youth, including significantly more hospital visits, increased theft, increased acceptance of drinking among youth, and an increase in the number of "drinking days" among youth who were already drinking.[v]
- 1 in 3 Ontarians experience harms because of someone else's drinking.
- Evidence shows a consistent and positive association between alcohol outlet density and excessive alcohol consumption and related harms. The largest effect sizes were seen between outlet density and violent crime.[vi]
- Evidence shows that restricting the physical availability of alcohol by regulating the times when alcohol can be sold and limiting outlet density will decrease alcohol harm e.g., road traffic casualties, alcohol related disease, injury and violent crime.
- Increasing the hours of sale by greater than 2 hours has been shown to be related to increases in alcohol-related harms, such as an 11% relative increase in traffic injury crashes and a 20% relative increase in weekend emergency department admissions.[vii]
- A recent study by the Canadian Institute for Health Information estimated that there were over 25,000 hospitalizations in one year in Ontario that were entirely caused by alcohol; there were more hospital admissions in Canada in 2017 for alcohol-related conditions than heart attacks.[viii]
- Increasing access to alcohol works against the government's efforts to reduce health care costs and end "Hallway Medicine".
- Alcohol-related costs currently exceed alcohol-related net income within Ontario.
- Alcohol-related costs in Ontario amount to at least $5.3 billion annually:[ix]
    - $1.5billion in healthcare
    - $1.3 billion in criminal justice
    - $2.1 billion related to lost productivity
    - $500 million in other direct costs
- In the United States, growth in life expectancy has stagnated and even decreased slightly in recent years, owing mainly to deaths attributed to alcohol and drug use or to suicide in lower socioeconomic strata; in Canada, rates of "deaths of despair" have also increased, particularly for opioid overdoses and alcoholic liver cirrhosis; as such, it is important for Canada to avoid further inequalities in income, to reduce rates of opioid prescribing and to strengthen alcohol control policies.[x]

Recommended Risk Mitigation Actions/Options:

Retail Siting and Setbacks

- Consider implementing the following setbacks, density and sensitive land use measures related to alcohol retailers:
    - Child care centres
    - Post-secondary schools
    - Elementary and secondary schools
    - Gaming facilities/casinos
    - Health care facilities, such as hospitals

- Long-term care homes
- Recreation and sports facilities
- Arcades, amusement parks, and other places where children and youth congregate
- Separation distances between retailors
- High priority neighbourhoods where there is more crime or higher socioeconomic disparity. DRHD priority neighbourhood data can be found at the following link: https://www.durham.ca/health.asp?nr=/departments/health/health_statistics/health_neighbourhoods/index.htm

Retail Density and Hours of Operation

- Take an incremental approach to alcohol sales expansion, including retail density and hours of sale, which will allow the government to monitor and evaluate the impact of any changes or increase in harms gradually.[xi]

Public Education, Prevention Strategies and Treatment Services

- Provide financial assistance to public health agencies to implement comprehensive and sustained prevention and harm reduction approaches that promote awareness of alcohol related harms and delay age of initiation amongst youth and young adults.
- Allocate a portion of additional revenue generated by increased alcohol availability directly to mental health and addictions services, which would assist in meeting current gaps in funding for direct service provision.

Pricing

- Adopt alcohol pricing policies that more effectively target hazardous patterns of drinking. These policies include:[xii]
  - setting and enforcing a minimum price per standard drink and applying it to all products
  - altering markups to decrease the price of low alcohol content beverages and increase the price of high alcohol content beverages
  - indexing minimum prices and markups to inflation to ensure that alcohol does not become cheaper relative to other commodities over time.

Note: Saskatchewan has demonstrated an effective strategy to bring revenue to the province while reducing alcohol related harms:

- increasing alcohol pricing can achieve the financial goal of increased revenues while realizing the health benefits of reduced alcohol consumption; Saskatchewan increased minimum prices and saw a decline in alcohol consumption of 135,000 litres of absolute alcohol and a revenue increase of $9.4 million last year.[xiii]

Youth

- Maintain a government monopoly for off premise sales, including strong compliance checks.
- Limit retail density in areas frequented by youth.
- Ban the use of alcohol advertising, marketing and power walls in retailers that permit youth access.

Conclusion

- Notwithstanding competing pressures and priorities, government policies should strive to work in concert to support the health of all Ontarians.
- There are a number of options available to the government as in proceeds with alcohol retail expansion to mitigate the risks, especially to youth and vulnerable populations and to ensure safe and healthy communities.
- alPHa asks the government to fully consult with health experts, including the Association of Local Public Health Agencies, Centre for Addiction and Mental Health, and Ontario Public Health Association before making changes to the availability of alcohol.
- In addition, alPHa asks the government to develop, implement and evaluate a provincial alcohol strategy in consultation with the same experts cited above.

About alPHa: The Association of Local Public Health Agencies (alPHa) is a not-for-profit organization that provides leadership to the boards of health and public health units in Ontario. Membership in alPHa is open to all public health units in Ontario and we work closely with board of health members, medical and associate medical officers of health, and senior public health managers in each of the public health disciplines – nursing, inspections, nutrition, dentistry, health promotion, epidemiology and business administration. The Association works with governments, including local government, and other health organizations, advocating for a strong, effective and efficient public health system in the province. Through policy analysis, discussion, collaboration, and advocacy, alPHa's members and staff act to promote public health policies that form a strong foundation for the improvement of health promotion and protection, disease prevention, and surveillance services in all of Ontario's communities. Further information on alPHa can be found at: www.alphaweb.org

For further information contact:
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References

[i] The Canadian Centre for Substance Use and Addiction. (2018). Canadian Substance Use Costs and Harms in the Provinces and Territories. Retrieved from: http://www.ccdus.ca/Resource%20Library/CSUCH-Canadian-Substance-Use-Costs-Harms-Provincial-Territorial-Report-2018-en.pdf

[ii] Centre for Addiction and Mental Health (CAMH). (2017). Alcohol Availability in Ontario: The Changing Landscape. Retrieved from: http://eenet.ca/sites/default/files/2018/Alcohol%20Availability%20in%20Ontario%20Infographic.pdf

[iii] Babor, T., Caetano, R., Cassell, S., Edwards, G., Giesbrecht, N., Graham, K., Rossow, I. (2010). Alcohol: No Ordinary Commodity: Research and public policy (Second Ed.). New York, USA: Oxford University Press.

[iv] Bryden, A., Roberts, B., McKee, M., & Petticrew, M. A Systematic Review of the Influence on Alcohol use of Community Level Availability and Marketing of Alcohol. Health & Place: 2012, 18 (349-357). Retrieved from: https://www.ncbi.nlm.nih.gov/pubmed/22154843

[v] Becker, L., & Dilley, J. Studying the Impact of Washington State Initiatives: I-1183 (alcohol privatization) and I-502 (marijuana legalization)". Presentation to Joint House Committees on Early Learning and Public Safety, Washington State Legislature, February 19, 2014 Retrieved from: http://media.oregonlive.com/politics_impact/other/wash.priv.study.pdf

[vi] Campbell, C.A., et al., The Task Force on Community Preventative Services. (2009). The Effectiveness of Limiting Alcohol Outlet Density as a Means of Reducing Excessive Alcohol Consumption and Alcohol Related Harms. The American Journal of Preventative Medicine., 37 (6), 556.

[vii] Canadian Institute for Health Information. (2017). Alcohol Harm in Canada: Examining Hospitalizations Entirely Caused by Alcohol and Strategies to Reduce Alcohol Harm. Ottawa, ON: CIHI. Retrieved from: https://www.cihi.ca/sites/default/files/document/report-alcohol-hospitalizations-en-web.pdf

[viii] ibid

[ix] Thomas, G. (2012). Analysis of beverage alcohol sales in Canada. Alcohol Price Policy Series: Report 2. Retrieved from: http://www.ccsa.ca/Resource%20Library/CCSA-Analysis-Alcohol-Sales-Policies-Canada-2012-en.pdf

[x] Probst, Charotte and Rehm, Jürgen (2019) Alcohol Use, Opioid Overdose and Socioeconomic Status in Canada: A Threat to Life Expectance? Retrieved from: http://www.cmaj.ca/content/190/44/E1294

[xi] Canadian Mental Health Association Ontario (2019). Expansion of Alcohol Sales in Ontario. Perspectives from the Canadian Mental Health Association, Ontario. Retrieved from: https://ontario.cmha.ca/wp-content/uploads/2019/02/CMHA-Alcohol-submission.pdf

[xii] Thomas, G., Stockwell, T., & Reist, D. (2019). Alcohol Pricing, Public Health and the HST: Proposed Incentives for BC Drinkers to Make Healthy Choices. Retrieved from: https://www.researchgate.net/publication/242463777_Alcohol_Pricing_Public_Health_and_the_HST_Proposed_Incentives_for_BC_Drinkers_to_Make_Healthy_Choices

[xiii] Thomas, G. (2012). Analysis of beverage alcohol sales in Canada. Alcohol Price Policy Series: Report 2. Retrieved from: http://www.ccsa.ca/Resource%20Library/CCSA-Analysis-Alcohol-Sales-Policies-Canada-2012-en.pdf

Appendix

Summary of alPHa's Submissions Related to Alcohol

- Alcohol is an important public health issue.
- Alcohol is not an ordinary commodity and should not be treated as such.
- Decisions how it is regulated, promoted and sold must be made within the broader context of its known and measurable societal harms, negative economic impacts and most importantly, public health.
- Alcohol is the most commonly used drug among Ontarians and one of the leading causes of death, disease and disability in Ontario.
- Alcohol is responsible for the second highest rate of preventable death and disease in Canada, following tobacco.
- Ontario has a significant portion of the population drinking alcohol and exceeding the low risk drinking guidelines.
- Expenditures attributed to alcohol consumption cost Ontarians an estimated $1.7 billion in direct health care costs and $3.6 billion in indirect costs in 2011, for a total of $5.3 billion.
- Direct health problems include chronic diseases such as liver diseases, diabetes, cardiovascular disease, cancer and other chronic illness along with deaths from drunk driving, homicides, suicides, assaults, fires, drowning and falls. These are but some of the more obvious examples of the adverse impacts of alcohol use and abuse.
- Indirect costs are also substantial due to alcohol-related illness, disability and death along with lost productivity in the workplace and at home.
- There is a well-established association between easy access to alcohol and overall rates of consumption and damage from alcohol.
- Increasing access works against the government's efforts to reduce health care costs. A recent study by the Canadian Institute for Health Information estimated that there were over 25,000 hospitalizations in one year in Ontario that were entirely caused by alcohol. There were more hospital admissions in Canada in 2017 for alcohol-related conditions than heart attacks. Significant health care savings could be achieved through reduced health care burden from alcohol-related diseases and death.

- It is well-established that access increases consumption, which in turn increases the numerous alcohol-related harms as well as societal costs to the Province related to law enforcement. It is estimated that law enforcement related to alcohol costs Ontarians $3.18 yearly.

- We have expressed our opposition to expanding the nature and number of retailers permitted to sell alcohol in the past, based on clear evidence that increasing access is detrimental to public health, and this remains our position. Given that such expansion continues to proceed in Ontario however, we must reinforce the importance of developing a comprehensive, provincially led alcohol strategy that can help mitigate the otherwise entirely preventable negative impacts of increased alcohol availability, which include increasing hallway medicine and waste of taxpayers' money.

- It is well-established that increasing alcohol availability is directly related to increased consumption and alcohol-related harms. A comprehensive, evidence-based approach to alcohol policy is therefore critical to limiting these harms.

EXCERPTS FROM AGO REPORT, CHAPTER 3.10 PUBLIC HEALTH: CHRONIC DISEASE PREVENTION

1.0 Summary

OVERALL MINISTRY RESPONSE

The Ministry and public health units are actively involved in promoting the Low-Risk Alcohol Drinking Guidelines to support a culture of moderation and provide consistent messaging about informed alcohol choices and responsible use. Over 65 stakeholders have been consulted to inform the development of a provincial Alcohol Strategy (p. 531).

4.1.3 Comprehensive Policy Developed and Dedicated Funding Provided for Tobacco Control but Not Physical Activity, Healthy Eating and Alcohol Consumption

Alcohol Consumption

In the case of ensuring effective controls on alcohol availability, we found that while public health is tasked with promoting Canada's Low-Risk Alcohol Drinking Guidelines to reduce the burden of alcohol-related illness and disease, in 2015 the Province expanded alcohol sales in grocery stores, farmers' markets, and LCBO e-commerce sales channels. One public health unit released a public statement noting that this move undermines the objective of public health units' work to reduce the burden of alcohol-related illness and disease.

Similarly, in their report mentioned earlier, Cancer Care Ontario and Public Health Ontario noted that the evidence shows that increased availability of alcohol is associated with high-risk drinking and alcohol-related health problems (pp. 546-547).

RECOMMENDATION 3

To better address the risk factors that contribute to chronic diseases, we recommend that the Ministry of Health and Long-Term Care develop comprehensive policies to focus on the key risk factors of chronic diseases—physical inactivity, unhealthy eating and alcohol consumption—in addition to tobacco control (p. 547).

MINISTRY RESPONSE

The Ministry and public health units are actively involved in promoting the Low-Risk Alcohol Drinking Guidelines to support a culture of moderation and provide consistent messaging about informed alcohol choices and responsible use. Over 65 stakeholders have been consulted to inform the development of a provincial Alcohol Strategy.

Building on these achievements, the Ministry is currently developing an integrated provincial strategy to further increase adoption of healthy living behaviours across the lifespan to reduce risk factors for chronic diseases including unhealthy eating, physical inactivity, harmful use of alcohol, and tobacco use, while recognizing the impact of social determinants of health.

EXCERPTS FROM AGO NEWS RELEASE DECEMBER 6, 2017: *SUCCESS OF PUBLIC HEALTH PROGRAMS IN PREVENTING CHRONIC DISEASES UNKNOWN: AUDITOR GENERAL*

The audit found that although the Ministry of Health and Long-Term Care (Ministry) has made progress in reducing smoking, a chronic disease risk factor, more work is needed to address the other risk factors such as physical inactivity, unhealthy eating and heavy drinking (3rd ¶)

A 2016 research report from the Ontario-based Institute for Clinical Evaluative Sciences, says that four modifiable risk factors that contribute to chronic diseases—physical inactivity, smoking, unhealthy eating and excessive alcohol consumption—cost Ontario almost $90 billion in health-care costs between 2004 and 2013. One of public health's functions is to prevent chronic diseases, such as cardiovascular and respiratory diseases, cancer and diabetes. In Ontario, the number of people living with these diseases has been rising (4th ¶).

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February 20, 2019

Christopher Tyrell
Standing Committee on Public Accounts
Committee Clerk
Procedural Services Branch
Legislative Assembly of Ontario
1405-99 Wellesley Street West
Toronto, Ontario M7A 1A2

Dear Chair and Members:

Re: Public Health – Chronic Disease Prevention Audit

On behalf of my colleagues Drs. David Colby (Municipality of Chatham-Kent), Eileen de Villa (Toronto Public Health) and Janet DeMille (Thunder Bay District Health Unit), we are pleased to appear before you today to answer any questions you may have with respect to the Public Health – Chronic Disease Prevention audit of the 2017 Auditor General of Ontario's Annual Report.

Our respective biographies are listed below, and our speaking points are attached to this letter. We respectively recommend that questions related to the Ministry of Health and Long-Term Care, including the status of the audit's recommendations, and Public Health Ontario (PHO) be directed to the appropriate officials within the Ministry or PHO. In addition, if we are unable to answer your questions, we are happy to take them back to our respective public health units and report back to the Committee.

Sincerely,

R.J. Kyle, BSc, MD, MHSc, CCFP, FRCPC, FACPM
Commissioner & Medical Officer of Health

If this information is required in an accessible format, please contact 1-800-372-1102 ext. 3324.

Dr. David Colby

Originally from Chatham, Dr Colby received his MD from the University of Toronto in 1984. Dr Colby was awarded Fellowship in the Royal College in 1990 (Medical Microbiology) and was appointed Chief of Microbiology at University Hospital, London in 1993. He was President of the Canadian Association of Medical Microbiologists from 1995 to 1997. Dr Colby is a Coroner for the province of Ontario and Professor of Microbiology/ Immunology and Physiology/ Pharmacology at Western. His research interests include antimicrobial resistance and wind turbine sounds. Dr Colby is the Medical Officer of Health in Chatham-Kent.

Dr. Eileen de Villa

Dr. Eileen de Villa is the Medical Officer of Health for the City of Toronto. Dr. de Villa leads Toronto Public Health, Canada's largest local public health agency, which provides public health programs and services to 2.9 million residents. Prior to joining Toronto Public Health, Dr. de Villa served as the Medical Officer of Health for the Region of Peel serving 1.4 million residents.

Dr. de Villa received her degrees as Doctor of Medicine and Master of Health Science from the University of Toronto and holds a Master of Business Administration from the Schulich School of Business. Dr. de Villa is also an Adjunct Professor at the Dalla Lana School of Public Health at the University of Toronto.

Dr. de Villa has authored, published and presented research on issues including public health considerations for city planning and emergency preparedness, communicable and infectious disease control, and public health policy development.

Dr. Janet DeMille

Dr. Janet DeMille is the Medical Officer of Health and CEO of the Thunder Bay District Health Unit (TBDHU), one of two provincial public health units covering all of Northwestern Ontario.

Dr. DeMille has lived and worked in Northwestern Ontario (NWO) for over 20 years, initially training and then practicing in Family Medicine in rural communities in NWO as well as in the City of Thunder Bay. In 2009, she entered the post-graduate medical training at the Northern Ontario School of Medicine and successfully completed her Master of Public Health degree and her Royal College certification in Public Health and Preventive Medicine in 2012. She started working at the TBDHU after this, first in the role of Associate MOH before officially taking on the role of MOH in early 2016.

Dr. Robert Kyle

Dr. Robert Kyle has been the Commissioner & Medical Officer of Health for the Regional Municipality of Durham since 1991. He obtained his Bachelor of Science degree in chemistry from Western University and medical degree and Master of Health Science degree from the University of Toronto. He is a certificant in the Specialty of Community Medicine from the Royal College of Physicians and Surgeons of Canada and holds a certificate in Family Medicine from the College of Family Physicians of Canada.

Dr. Kyle is a Fellow of the Royal College of Physicians and Surgeons of Canada and of the American College of Preventive Medicine and is a former Medical Officer of Health for the Peterborough County-City Health Unit. He is an Adjunct Professor, Dalla Lana School of Public Health, University of Toronto and a member of the medical staffs of Lakeridge Health Corporation and Markham-Stouffville Hospital.

Dr. Kyle is an active member of many provincial and regional health groups and organizations. For example, he is currently Chair of Public Health Ontario's Board of Directors, President of the Association of Local Public Health Agencies, and Chair of the Public Health and Preventive Medicine Exam Board for the Royal College of Physicians and Surgeons of Canada.

Standing Committee on Public Accounts
Room 151, Main Legislative Building

February 20, 2019

Speaking Points

- Good morning; I am Dr. Robert Kyle, Commissioner & Medical Officer of Health, Regional Municipality of Durham
- With me are Drs. David Colby, Eileen de Villa and Janet DeMille, Medical Officers of Health for Chatham-Kent, Toronto, and Thunder Bay District, respectively
- Our bios are attached to our transmittal letter, together with these speaking points, which we would be happy to leave with the Committee Clerk
- Thank you for the invitation to appear before you today
- Thanks to the Audit Team for working with us in researching and preparing its audit report
- Before proceeding, it should be noted that section 2.1.2 of the audit (p 533) refers to the previous Ontario Public Health Standards, 2008 (revised March 2017) that were replaced by the new Ontario Public Health Standards: Requirements for Programs, Services, and Accountability, 2018 (OPHS), which are described in more detail below
- We acknowledge the public health significance of chronic diseases, in that:
    - Most chronic diseases (e.g., diabetes, cancer, etc.) are preventable, or their onset can be delayed by limiting four modifiable risk factors:
        - Physical inactivity
        - Smoking
        - Unhealthy eating
        - Excessive alcohol consumption (p 527)

    - The MOHLTC estimated that major chronic diseases and injuries accounted for 31% of direct, attributable health care costs in Ontario (p 534)
    - Preventing chronic diseases helps reduce the burden on the health-care system and promotes a better quality of life (p 534)

- Accordingly, the focus of our remarks is on the public health system and its role in chronic disease prevention

- Questions about the Ministry of Health and Long-Term Care (Ministry), the status of the Audit's recommendations, and Public Health Ontario (PHO) are best directed to Ministry and PHO officials, respectively

- Public health focuses on the health and well-being of the whole population through the promotion and protection of health and prevention of illness (p 531)

- The *Health Protection and Promotion Act* (Act) is the primary legislation that governs the delivery of public health programs and services; its purpose is to provide for the organization and delivery of public health programs and services, the prevention of the spread of disease, and the promotion and protection of the health of the people of Ontario (p 532)

- The public health system is an extensive network of government, non-government and community organizations operating at the local, provincial and federal levels (p 532)

- The key provincial players are the Ministry and PHO (p 532)

- The Ministry co-funds with obligated municipalities 35 public health units (PHUs) to directly provide public health programs and services (p 532)

- The Population and Public Health Division (Division) is responsible for developing public health initiatives and strategies, and funding and monitoring public health programs and services delivered by PHUs (P 532)

- The Division is currently led by the Chief Medical Officer of Health (CMOH) who reports directly to the Deputy Minister; his other duties include those listed on p 532
- PHO provides scientific and technical advice and support to the CMOH, Division and PHUs; it also operates Ontario's 11 public health laboratories (p 532)
- PHUs deliver a variety of program and services in their health units; examples are listed on p 533
- Health unit populations range in size from 34,000 (Timiskaming) to 3 million (Toronto) (p 533)
- Each PHU is governed by a board of health (BOH), which is accountable for meeting provincial standards under the Act (p 533)
- Each BOH appoints a medical officer of health (MOH) whose powers and duties are specified in the Act and include reporting directly to the BOH on public health and other matters (P 533)
- Governance models vary considerably across the 35 PHUs; all are municipally controlled to varying degrees (p 533)
- Each BOH has a Public Health Funding and Accountability Agreement with the Ministry, which sets out the terms and conditions governing its funding (p 533)
- The Ministry develops standards for delivering public health programs and services as required by the Act; each BOH is required to comply with these standards (p 533)
- On January 1, 2018, each BOH began implementing the new OPHS, Protocols and Guidelines
- The OPHS set out the minimum requirements that PHUs must adhere to in delivering programs and services

- The OPHS consist of the following nine Program Standards:
    - Chronic Disease Prevention and Well-being
    - Food Safety
    - Healthy Environments
    - Healthy Growth and Development
    - Immunization
    - Infectious and Communicable Diseases Prevention and Control
    - Safe Water
    - School Health
    - Substance Use and Injury Prevention

- The OPHS also consist of the following four Foundational Standards that underlie and support all Program Standards:
    - Population Health Assessment
    - Health Equity
    - Effective Public Health Practice, which is divided into 3 sections:
        - Program Planning, Evaluation, and Evidence-Informed Decision-Making
        - Research, Knowledge Exchange, and Communication
        - Quality and Transparency
    - Emergency Management

- 23 Protocols provide direction on how BOHs shall operationalize specific requirement(s) identified within the OPHS; the aim is to have consistent implementation of specific requirements across all 35 BOHs; in the past and now, BOHs must comply with these Protocols

- 20 Guidelines provide direction on how BOHs shall approach specific requirement(s) identified within the OPHS; the aim is to provide a consistent approach to/application of requirements across all BOHs while also allowing for variability in programs and services across PHUs based on

local contextual factors as defined in the guidelines; now, BOHs must comply with these Guidelines

- It should be noted that although there are fewer Program Standards, there are more Foundation Standards and taken together with the Protocols and Guidelines, more requirements with which BOHs must comply
- Under the Act, provincial funding of PHUs is not mandatory but rather is provided as per Ministry policy; the Act requires obligated (upper-tier or single-tier) municipalities to pay the expenses incurred by or on behalf of the PHUs to deliver the programs and services set out in the Act, the regulations and the OPHS (p 534)
- Currently, the Ministry funds up to 75% of mandatory programs and up to 100% of priority programs (p 534)
- The Ministry updates the schedules in the Public Health Funding and Accountability Agreement annually (p 534)
- The new OPHS takes a coordinated approach to the Standards listed above and a more robust Accountability Framework that covers the following domains:
    - Delivering of Programs and Services
    - Fiduciary Requirements
    - Good Governance and Management Practices
    - Public Health Practice
    - Common to All Domains
- Accordingly, beginning in 2018, each BOH submits a prescribed Annual Service Plan and Budget Submission to the Division for approval
- It should be noted that BOHs are now providing the PPHD with far more information; moreover, beginning in the fall of 2018, BOHs must report on their risk management activities; finally, commencing with the 2019 ASPBS,

BOHs must report on their 2018 program activities, as specified by the PPHD

- With respect to chronic disease prevention, the OPHS require each BOH to develop and implement a program of public health interventions using a comprehensive health promotion approach that addresses chronic disease risk and protective factors

- The following topics (by program) are considered based on an assessment of local needs:

    - Built environment (Chronic Disease Prevention and Well-being {CDP})
    - Comprehensive tobacco control (Substance Use and Injury Prevention {SUIP})
    - Healthy eating behaviours (CDP, School Health {SH})
    - Mental health promotion (CDP, SH, SUIP)
    - Oral health (CDP, SH, SUIP)
    - Physical activity and sedentary behaviour (CDP, SH)
    - Substance use (SH, SUIP) and harm reduction (SH)
    - UV exposure (CDP, SH)

- Several Guidelines (i.e., *Chronic Disease Prevention*, *Health Equity*, *Mental Health Promotion*, and *Substance Use Prevention and Harm Reduction*) and one Protocol (*Tobacco, Vapour and Smoke)* guide the work in this area

- For these three (CDP, SH, SUIP) programs, each BOH shall collect and analyze relevant data and report and disseminate the data and information in accordance with the *Population Health Assessment and Surveillance Protocol, 2018*

- As regards program evaluation, each BOH is required to:

    - Routinely monitor program activities and outcomes to assess and improve the implementation of programs and services

- Ensure a culture of on-going program improvement and evaluation, and conduct formal program evaluations where required
- Ensure all programs and services are informed by evidence

- Each BOH must comply with 2 research and knowledge exchange (KE) requirements:

  - Engage in KE activities with public health practitioners, etc. regarding factors that determine populations health
  - Foster relationships with researchers, academic partners and others to support research and KE activities

- In closing, Ontario has a mature, inter-connected, and well-regulated public health system
- The system is capably led by the Ministry and ably assisted by the CMOH and the Division
- PHO provides the Ministry and PHUs with superb scientific, technical and laboratory support
- PHUs are governed by BOHs each of which appoints a MOH who ensures the delivery of a wide array of public health programs and services, including chronic disease prevention, in accordance with the Act, regulations, OPHS, Protocols and Guidelines
- As with all well-functioning health systems, there is always room for continuous quality improvement
- With the foregoing in mind, we would be happy to answer your questions