HASTINGS PRINCE EDWARD
Public Health

Hastings Prince Edward Public Health
Board of Health Meeting

Information Items

September 2, 2020

Listing of Information Items
Board of Health Meeting – September 2, 2020

1. County of Lambton – Letter to Minister Elliott re: Clarification on Ministry's Criteria to Move to Stage 3 in the – *Framework for Reopening Our Province* dated June 19, 2020
2. Haliburton, Kawartha, Pine Ridge District Health Unit – Letter to Minister Elliott re: Endorsement of the alPHa's response to the public health modernization discussion paper dated June 19, 2020
3. Haliburton, Kawartha, Pine Ridge District Health Unit – Letter to Justin Trudeau re: support for basic income for all Canadians during the COVID-19 pandemic and beyond dated June 19, 2020
4. Haliburton, Kawartha, Pine Ridge District Health Unit – Letter to Christine Elliott re: Endorsement of correspondence regarding the 2020 municipal cost share of public health funding from Eastern Ontario Health Unit and correspondence regarding COVID-19 and reconsiderations related to public health modernization from alPHa dated June 19, 2020
5. Timiskaming Health Unit – Letter to Justin Trudeau re: Basic income for income security during Covid-19 pandemic and beyond dated June 9, 2020
6. Grey Bruce Health Unit – Letter to Bruce Lauckner re: Ontario Health reporting inaccuracy Covid-19 enhanced surveillance of long-term care dated June 8, 2020
7. Simcoe Muskoka District Health Unit – Letter to Justin Trudeau re: Basic income for income security during Covid-19 pandemic and beyond dated May 20, 2020
8. Peterborough Public Health – Letter to Justin Trudeau re: Endorsement of the letter from Simcoe Muskoka District Health unit, basic income for income security during Covid-19 pandemic and beyond dated June 25, 2020
9. Porcupine Health Unit – Letter to Justin Trudeau re: Basic income for income security during Covid-19 pandemic and beyond dated June 29, 2020
10. Renfrew County and District Health Unit – Letter to Justin Trudeau re: Basic income for income security during Covid-19 pandemic and beyond dated July 16, 2020
11. Renfrew County and District Health Unit – Letter to Christine Elliott re: Endorsement of the alPHa's response to the public health modernization discussion paper dated July 16, 2020
12. Renfrew County and District Health Unit - Letter to Christine Elliott re: Endorsement of correspondence regarding the 2020 municipal cost share of public health funding from Eastern Ontario Health Unit and correspondence regarding COVID-19 and reconsiderations related to public health modernization from alPHa dated July 16, 2020
13. Chatham-Kent Public Health – Letter to Justin Trudeau re: Basic income for income security during Covid-19 pandemic and beyond dated July 27, 2020
14. Simcoe Muskoka District Health Unit – Letter to Christine Elliott re: Covid-19 funding dated August 19, 2020

The above information items can be found on the Hastings Prince Edward Public Health's website through the link in the Agenda Package or by going to our website at hpePublicHealth.ca.

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June 19, 2020 **BY EMAIL**

The Honourable Christine Elliott
Deputy Premier & Minister of Health
5th Floor, 777 Bay Street
Toronto, ON M7A 2J3

Attention: The Honourable Christine Elliott, Deputy Premier and Minister of Health

Re: Clarification on Ministry's Criteria to Move to Stage 3 in the - *Framework for Reopening Our Province*

On behalf of the Board of Health for Lambton County, I want to take this opportunity to thank you for your leadership during the COVID-19 pandemic. We also thank you for recognizing the hard work of our public health professionals and frontline heroes who have worked tirelessly on the ground to contain this deadly virus.

At its recent meeting on June 17, 2020, Lambton County Councillors (Board of Health) expressed concern about the lack of publicly available criteria that the province will use to advance public health unit jurisdictions from Stage 2 to Stage 3 of the Ministry's document ***A Framework for Reopening our Province***. In follow-up, we are requesting that you share the criteria that the Ministry of Health will rely upon to move into Stage 3 and ensure that this information is communicated early so that it is clearly defined and understood.

Knowing the province's criteria is important to all our community stakeholders who need to have advance notice to safely plan and prepare for reopening their businesses, agencies and organisations. The need to fully understand the province's criteria is an important next step for responsible reopening and this information needs to be publicly available.

Please know that the Board of Health for the County of Lambton is a committed local partner in working with the province to emerge from this crisis. Thank you for your attention to this important matter.

Sincerely,

Warden Bill Weber
County of Lambton

Dr. Sudit Ranade
Medical Officer of Health

cc: The Hon. Doug Ford, Premier of Ontario
The Hon. Monte McNaughton, Minister of Labour, M.P.P. Lambton-Kent-Middlesex
The Hon. Bob Bailey, M.P.P Sarnia-Lambton
Dr. David Williams, Chief Medical Officer of Health
The Hon. Lianne Rood, M.P. Lambton-Kent-Middlesex
The Hon. Marilyn Gladu, M.P. Sarnia-Lambton
Lambton County Councillors
Dr. Sudit Ranade, Lambton County Medical Officer of Health
Andrew Taylor, General Manager, Public Health Services, County of Lambton
All Ontario Boards of Health

HALIBURTON, KAWARTHA, PINE RIDGE DISTRICT HEALTH UNIT

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June 19, 2020

The Honourable Christine Elliott
Minister of Health
5th Floor, 777 Bay St.
Toronto, ON M7A 2J3
(Sent via email to: christine.elliottco@ola.org)

Dear Minister Elliott

RE: Endorsement of the Association of Local Public Health Agencies' Response to the Public Health Modernization Discussion Paper

At its meeting held on June 18, 2020, the Board of Health for the Haliburton, Kawartha, Pine Ridge District Health Unit passed the following motion:

"THAT the Association of Local Public Health Agencies' response to the Public Health Modernization Discussion Paper be endorsed and THAT a letter of support be sent to The Honourable Christine Elliott".

Sincerely

BOARD OF HEALTH FOR THE HALIBURTON,
KAWARTHA, PINE RIDGE DISTRICT HEALTH UNIT

Doug Elmslie
Chair, Board of Health

DE/aln/ed

Cc (via email): Alison Blair, Executive Lead for Public Health Modernization
Jim Pine, Special Advisor, Public Health Modernization
Ontario Boards of Health
Association of Local Public Health Agencies (alPHa)

Attachment

alPHa
Association of Local PUBLIC HEALTH Agencies

Public Health Modernization Discussion Paper Response Submitted to the Public Health Modernization Team

The Association of Local Public Health Agencies (alPHa) is pleased to present the following response to the Public Health Modernization Discussion Paper. We invited our members to provide answers to the questions that are posed in the paper to help us identify themes common to the local public health sector throughout the province. This feedback has been synthesized and presented within the framework of themes and questions laid out in the consultation survey.

alPHa's response is intended to be complementary to the individual responses of its members, not a summary or a substitute. alPHa urges the Public Health Modernization team to take the unique local circumstances and perspectives presented in its members' and partners' direct feedback to the survey and in-person consultations into careful consideration as it formulates its advice to the Minister.

PREAMBLE and PRINCIPLES

alPHa agrees with the Ministry's vision of a "coordinated public health sector that is nimble, resilient, efficient and responsive to the province's evolving health priorities". alPHa also agrees with improving consistency where it makes sense to do so and improving clarity and alignment of the related roles and responsibilities of the province, Public Health Ontario (PHO), and local public health. alPHa certainly agrees that enhanced investment in health promotion and prevention will be critical to the success of Ontario's plan to end hallway health care.

In November of 2019, alPHa transmitted its Statement of Principles for Public Health Modernization to the Minister and the Public Health Modernization Team and these remain the foundation of alPHa's present response. These principles are incorporated into the responses to the survey questions as appropriate and the full document is attached.

The foundational principle is that any and all changes must serve the goal of strengthening the Ontario public health system's capacity to improve population health in all of Ontario's communities through the effective and efficient local delivery of evidence-based public health programs and services. Public health unit (PHU) realignments, identification of efficiencies, clarification of roles and strengthening of institutional relationships must all have that central aim as their starting point.

It must be recognized that Ontario already has an enviable public health system, based on a network of 34 PHUs with expert staff, strong partnerships and a clear and authoritative mandate to protect and promote health within their local communities. These are supported by the central research and evidence functions of PHO and the oversight of the Chief Medical Officer of Health (CMOH) within the Ministry. Building on the Ontario system's existing strengths must be the strategic foundation for any proposed changes.

Theme: Insufficient Capacity

What is currently working well in the public health sector?

- Actions taken in response to the Walkerton and SARS crises in the early 2000s (e.g., increased provincial responsibility for funding, strengthened role of the Chief Medical Officer of Health (CMOH), creation of PHO) have led to measurable improvements to the Ontario public health sector's capacity to detect and respond to emerging threats. The swift collective and thorough response to the developing Novel Coronavirus (2019-nCoV) epidemic is a clear application by Ontario's public health sector of the lessons learned from the 2003 SARS outbreak.

- Ontario's public health sector is already an effective network of 34 local public health units (PHUs)with a strong and detailed mandate to identify and meet the health protection and promotion needs of their communities. That mandate is clearly spelled out in the Health Protection and Promotion Act (HPPA) and the Ontario Public Health Standards (OPHS), with explicit flexibility built in to ensure that programs and services can be adapted according to local circumstances.

- Within each of the existing PHUs' boundaries, strong partnerships have been forged with local municipalities, social services, school boards and health care providers among others to support this work.

- The sector benefits from the collaborative work of province-wide professional (e.g., alPHa, COMOH, ASPHIO, ODPH, OPHNL, APHEO) and topic-specific (e.g. TCAN, LDCP) groups. These groups provide ongoing opportunities for collaboration and information exchange across PHU boundaries throughout Ontario.

- There is clear public and political recognition of the critical importance of investments in health protection and promotion to improving population health and ensuring the sustainability of the health care system.

- There is an invaluable range of professional, political and technical expertise resident in the public health sector (public health physicians, elected officials, epidemiologists, nurses, public health inspectors, health promoters, policy analysts, dentists, dietitians, business administrators, lawyers and highly skilled support staff).

- Local representation on boards of health (in a variety of models that includes elected municipal officials in all cases, with provincial appointees and citizen representatives serving in many) reflects community characteristics and values within the PHU boundary and provides direct accountability.

- Collaboration among PHUs including the development of consistency of practice (e.g., HIV case management, immunization enforcement in schools and child care centres, infection prevention and control inspections in the health care sector, electronic medical record use, records retention policies), mutual aid agreements, cross-coverage, outbreak management, and voluntary mergers (Southwestern and Huron-Perth).

- PHO is a unique and invaluable resource within the sector that has strong roles in research, professional development, ethics review, knowledge translation and response to emerging threats.

- The cost-sharing model provides the framework to ensure a stable and predictable source of adequate funding for public health programs and services while ensuring accountability at both the provincial and municipal levels.

- PHUs with large populations have budgets that allow them to deliver services efficiently and cost-effectively while also ensuring surge capacity.

- PHUs that are integrated with Regions (e.g., Halton, Durham) and cities (e.g., Toronto, Ottawa) benefit from support services (e.g. administrative, IT) embedded within those structures. This integration also facilitates coordination among public health, social services, emergency health services and public works.

What are some changes that could be considered to address the variability in capacity in the current public health sector?

- Formal mechanisms and commitment at both the provincial and municipal levels to ensure that the total annual public health funding envelope is stable, predictable, protected and sufficient to cover all costs for the full delivery of all public health programs and services in all PHUs whether they are mandated by the province or developed to serve unique local needs as authorized by Section 9 of the HPPA.

- Provincial support for voluntary mergers of PHUs with complementary characteristics where it can be demonstrated that functional capacity will be improved. Any realignments of present PHU boundaries must be considered only to ensure critical mass to efficiently and equitably deliver public health programs and services. As a general rule, existing PHUs should be left intact, particularly with regard to municipal boundaries, and complementary geographic, demographic and organizational characteristics should be key factors in deciding which mergers should be considered. Evidence about the relationship between critical population mass and the effective allocation of public health resources should also be examined.

- Enhance centralized provincial supports, to increase efficiency and the capacity of all public PHUs to deliver the full scope of the OPHS. PHO already has important research and evidence roles but is also well-positioned to coordinate the strengths of different PHUs. Provincial-level strategic and topic-specific advisory tables that include PHO, the CMOH and local public health leadership have also proven very useful in the past.

- In partnership with local public health, educational institutions and other relevant organizations, develop a provincial public health human resources strategy to build on the successful recruitment and retention of a skilled and competent public health workforce. Maintaining the visibility of the public health sector, demonstrating its stability and importance, presenting the wide range of opportunities within it, providing incentives to work in remote areas and keeping salaries competitive will be vital components.

- Increase decision-making flexibility at the local level to develop their own models for the provision of mandated services according to local circumstances and resources, as well as to develop more formal arrangements to share resources if surge capacity is needed (e.g. epidemiology, analysis, evaluation).

What changes to the structure and organization of public health should be considered to address these challenges?

- alPHa does not believe that systemic structural and organizational changes are necessary to address capacity challenges. As we have demonstrated in our answers to the other discussion questions, any capacity issues can be appropriately addressed within the existing framework by building on its strengths.

- Capacity for most PHUs has been steadily eroding over the years largely due to the Ministry putting caps (often 0%) on annual budget increases that are necessary to cover the costs of delivery of new programs, annual Consumer Price Index (CPI) increases and honouring collective agreements. This erosion will be significantly magnified by the Province's decision to shift 5% of the cost-shared and 30% of previously 100% provincially funded public health programs to municipalities. More details on this were presented by alPHa to the Standing Committee on Finance and Economic Affairs on January 17, 2020 as part of its pre-budget consultation. Speaking notes and the transcript of this presentation are linked above and attached below.

- The autonomy of each local board of health (BOH) must be maintained and stronger mechanisms should be considered to reinforce their sole focus on and local decision-making authority over public health matters as well as to protect them from intrusive policies (e.g., municipal hiring freezes, vacancies on local boards and Associate Medical Officer of Health (AMOH) positions due to inappropriate delays in the provincial appointment and approval processes).

- Several organizational considerations are outlined in the attached alPHa Statement of Principles.

Theme: Misalignment of Health, Social, and Other Services

What has been successful in the current system to foster collaboration among public health, the health sector and social services?

- alPHa respectfully observes that the use of the term "misalignment" in the wording of this theme is misleading, as it creates the false impression that misalignments are a significant systemic problem. On the contrary, PHUs are very well aligned with municipalities, social services, school boards and other community-based services and partners. Previous proposals to align PHU boundaries with those of the health sector (i.e., LHINs) has threatened these existing local relationships without demonstrating the necessity for doing so. If misalignments in certain areas are identified, they must be measured against and prioritized in context of existing alignments in others.

- The reciprocal mandate between the local MOH and LHIN CEO became an important enabler for public health's relationship with the health care sector and this is being expanded upon with most PHUs having direct involvement in the new Ontario Health Teams (OHTs).

- Our members provided us with many specific examples of successful local collaborations with the health care sector related to such topics as injury prevention, substance use, perinatal health, infectious disease prevention and health equity in program design. These will surely be presented in more detail in their individual submissions to the present survey.

- Our members provided us with many specific examples to demonstrate the strength of local collaboration with social services, boards of education and community agencies. The existing geographical alignments of these different groups was cited as critically important. Where public health is integrated within a municipal or regional government, links to their social services

departments are particularly strong. In other cases, formal service agreements and partnerships are highly dependent on shared community boundaries and characteristics.

- The OPHS are explicit in their requirement of all boards of health to carry out their mandated obligations in partnership with local stakeholders. Public health is in turn seen as a credible broker within the local community that can support multi-stakeholder engagement and community mobilization for healthy public policy.

How could a modernized public health system become more connected to the health care system or social services?

- Strengthen the health and social services sectors' focus on prevention and the social determinants of health. Explore the implementation of a "health in all policies" approach with parallel mandates, clear role expectations and accountability for protecting population health across related provincial government ministries and government-funded agencies.

- The Ministry of Health (Ministry) could provide a reciprocal and clearly defined mandate for PHUs and OHTs to utilize public health's surveillance and analysis expertise to conduct population-based needs assessments to inform the effective local allocation of primary health care resources and build capacity among health service providers to offer evidence-based health promotion and prevention interventions.

- Improvements to information technology to support interoperability and data standards to accelerate the appropriate inclusion of public health information into electronic health records and facilitate public health's receipt of vital information from primary care and the broader health care system. This collaboration would support disease prevention and health promotion at the individual to population-level to end hallway health care. More details on digital modernization will be provided in a separate submission by the COMOH Digital Health Committee.

What are some examples of effective collaborations among public health, health services and social services?

- Our members provided us with many specific examples of successful local collaborations among public health, health services and social services. These will surely be presented in more detail in their individual submissions to the present survey.

- The mandated reciprocal relationship between the local Medical Officer of Health (MOH) and Local Health Integration Network (LHIN) CEO was cited as instrumental in promoting a better understanding of public health's mandate, focus and functions to the health care conversation. Direct involvement of public health in local OHTs is expected to increase the momentum.

- The partnership between the Council of Ontario Directors of Education and COMOH (CODE-COMOH) is expected to contribute to the well-being of Ontario's children and students through enhancing PHU and school board partnerships in order to achieve optimal delivery of services and ongoing supports for children and students.

Theme: Duplication of Effort

As with the previous theme, alPHa would argue that the use of the term "Duplication of Effort" suggests that it is a systemic problem that underlies widespread inefficiencies. While we agree that

there are public health functions that could in fact be carried out jointly, regionally or centrally, the local nature of public health requires certain programs and services with similar aims to be developed and implemented in different ways to meet unique local needs.

Care must therefore be taken in defining the term and in identifying and eliminating duplication that is in fact redundant. Care must also be taken when examining alleged duplication of effort between sectors. Public health has a unique set of roles and responsibilities and it would be a mistake to assume that they are transferrable. For example, health promotion in public health differs fundamentally from health promotion in primary care. Only public health focuses on upstream population-level approaches to prevent injuries and illnesses before they occur, and success often depends on strong existing relationships with community partners.

What functions of public health units should be local and why?

- The health protection functions of public health are local by definition. Health hazard investigation and response, infection prevention and control, communicable disease outbreak management, water quality and food safety are examples of areas where local public health has clearly prescribed and detailed roles and responsibilities under the HPPA and OPHS. Carrying these out relies heavily on interaction with individuals, institutions, businesses and service providers throughout the local community. Timeliness and efficiency are supported by preexisting positive relationships.

- Health promotion work is also informed in large part by understanding the local population's characteristics, identifying local priorities and strategically developing approaches for policy development and program and service delivery that will be most responsive to local population health needs. Ongoing population health assessment and surveillance ensures that local data are at the root of program planning as well as healthy public policy development through public health's relationship with municipalities.

- Some public health services (e.g. harm reduction, screening programs, prenatal education, Healthy Babies Healthy Children, neighbourhood groups) focus on individuals and families with high needs. Public health's knowledge of the community and partnerships are a valuable resource for connecting clients with necessary services, which are also primarily local.

What population health assessments, data and analytics are helpful to drive local improvements?

- The epidemiological capacity to collect and access data to conduct detailed local population health assessments within local contexts must be enhanced. Public health programs and services benefit from solid data at the sub-health unit level (e.g., priority neighbourhoods, planning zones, ER admissions). Local epidemiologists have a keen understanding of the local context and are well positioned to collaborate with stakeholders to gather data, conduct analysis and inform recommendations for action and priority setting.

- The CMOH's 2017 Annual Report recommended a provincial population health survey to collect data at the local community and neighbourhood levels to contribute to a better understanding of community wellness. The survey would need to be flexible and nimble, with the ability to customize questions to local needs.

- The Rapid Risk Factor Surveillance System is an ongoing local health telephone survey conducted collaboratively since 2001 by numerous PHUs and the Institute for Social Research at York

University. Information is gathered using questionnaires on a wide variety of health topics to inform service planning for the broad range of public health programs that are required by the OPHS, to advocate for healthy public policy development and to improve community awareness of health risks.

- Strategies to identify and address gaps in data and information must be considered. The Children Count Locally Driven Collaborative Project is an important current example of a strategy to improve available data and interventions to improve child and youth health in Ontario.

What changes should the government consider to strengthen research capacity, knowledge exchange and shared priority setting for public health in the province?

- alPHa believes that the most important development in this regard was the establishment of the Ontario Agency for Health Protection and Promotion, a.k.a. PHO. PHO has been instrumental in supporting our health protection activities with excellent standards of practice developed in communicable disease control, vaccination, and infection prevention and control. We believe that there is an important opportunity to reinforce PHO's capacity to strengthen similar work in the areas of environmental health and non-communicable diseases (which account for over 70% of ill health in Ontario) by focusing on evidence, translating it into recommended practice, and setting common implementation standards. PHO is the key agency for scientific expertise, research and knowledge exchange and is one of the Ontario public health sector's strongest assets. This is one of the strengths that needs to be built upon as the Ministry seeks to achieve the outcomes outlined in this discussion paper.

What are public health functions, programs or services that could be strengthened if coordinated or provided at the provincial level? Or by Public Health Ontario?

- As noted above, the existing roles and responsibilities of PHO should be reinforced and expanded.

- Increased centralized supports, provided by PHO or the Ministry, have the potential to reduce duplication of effort, and contribute to increased consistency and improved delivery of public health programs and services. Examples include a provincial immunization registry, provincial electronic medical records, centralized digital supports including facilitation of data sharing, provincial health communication campaigns, continuing professional education opportunities, centralized reviews of evidence, bulk purchasing, access to data repositories, provincial advisory committees etc. Centralized supports must be designed to sustain the local capacity to develop and implement innovative and locally relevant campaigns.

- Developing provincial leadership on surveillance and population health assessment, technical direction (especially on emerging public health issues), emergency management, healthy policy development and chronic disease prevention coordination. Setting provincial population health goals with targets and cross-sectoral strategies would be a useful foundation upon which to carry out these functions.

- The Ministry, likely via the independent authority of the CMOH, needs to be more active in providing local public health with guidance and / or direction when asked to ensure consistent approaches where there is agreement that they are required. There have been instances (ISPA enforcement, IPAC investigations and HIV Case management for recent examples) where local public health asked for direction to address disparate and sometimes conflicting local practices. With none provided, local MOHs were compelled to work together to develop their

own recommendations for a collective approach.

Beyond what currently exists, are there other technology solutions that can help to improve public health programs and services and strengthen the public health system?

- The COMOH Digital Health Committee will be making a detailed submission to the Public Health Modernization consultation. It will call on the Province to develop a digital strategy for public health; provide sufficient resources to support aligned and necessary information systems and common applications; work with public health partners to facilitate the incorporation of public health information into a provincial electronic health record; centralized coordination and technical support for digital solution integration and Provincial leadership on data standards and interoperability.

- Other suggestions put forth by our members included bulk purchasing of information technology hardware and software, a centralized website with important public health information, a seamless provincial immunization registry, a centralized online inspection disclosure system, enhanced technology to reduce travel requirements (e.g., video calls for client interactions and videoconferencing for health unit staff in rural areas). Inequities in access to technology solutions and tech-mediated opportunities for collaboration were also raised. We expect that many other suggestions will be made in other submissions to the survey question.

Theme: Inconsistent Priority Setting

As with previous themes, alPHa would argue that the use of the term "Inconsistent Priority Setting" suggests a systemic problem that underlies widespread inefficiencies. The existence of different public health priorities in different parts of the province is a feature of the system, not a bug, and is one of its strengths. Local authority over priority setting must be preserved to ensure that the unique health needs of each community can be served. This should include the authority to adapt programs and services to address province-wide public health priorities according to the local context.

What processes and structures are currently in place that promote shared priority setting across public PHUs?

- PHUs are required, through the HPPA, to meet the requirements of the OPHS. These standards provide a framework to support consistent priority setting across Ontario and the related Accountability Agreements ensure provincial approval and awareness of each BOH's plan for the delivery of mandated programs and services each year.

- Ontario's 34 PHUs are connected to a wide range of networks that provide opportunities for sharing of information, priority setting and collective action. alPHa, including COMOH, BOHs and Affiliate Sections, is the most important of these at the systemic level as it brings the governance, medical and programmatic aspects of the entire system together at a single table, which in turn provides an ideal point of contact for government and other stakeholders.

- Profession-specific associations such as ASPHIO, OPHNL, APHEO, AOPHBA, OAPHD, ODPH and HPO provide similar opportunities for the collective identification of priorities within their purview. Each of these groups is represented at the alPHa table.

- Topic-specific collaboratives, spanning regions or the province, provide opportunities to share information and resources, and to collectively address common goals. For example, regional

TCANs allow for shared priority setting and planning related to reducing smoking behavior in regions spanning multiple PHUs. Similar collaborative groups have addressed cannabis, alcohol and opioids.

- Regional PHU groupings (South West, Central West, Central East, North East, North West, East) are networks that provide similar opportunities for neighbouring PHUs that share geographic and demographic characteristics.

- 100% provincially funded public health programs (e.g. Universal Influenza Immunization Program, Ontario Seniors Dental Care Program (OSDCP)) are a clear demonstration of priorities that are shared province wide.

What should the role of Public Health Ontario be in informing and coordinating provincial priorities?

- PHO's mandate is to provide a foundation of sound information, knowledge and evidence to support policy, action and decisions of government, public health practitioners, front-line health workers and researchers. Centralized and timely evidence reviews, provision of provincial and local data, guidance documents and best practices, research ethics, and coordination of tables to address significant province-wide needs (e.g., Healthy Human Development table, Provincial Infectious Disease Advisory Committee) are key functions that underlie evidence-based setting of priorities throughout the public health sector. Reinforcing PHO's capacity to perform these functions in the areas of health promotion and non-communicable disease prevention should be considered.

- PHO's "hub and spoke" model, which was the basis for the former Regional Infection Control Networks, could be used to establish collaborative regional tables in the various public health areas of focus to inform common priorities and joint projects. Such an approach would be valuable in setting province-wide priorities as common themes emerge.

- PHO would be instrumental in providing the evidentiary basis for the establishment of provincial population health goals as proposed above.

What models of leadership and governance can promote consistent priority setting?

- A model of leadership and governance to promote consistent priority setting is already in place. The HPPA provides a clear, detailed and specific framework for the organization and delivery of public health programs and services, including the composition, authority and duties of boards of health. The HPPA is in turn the enabling legislation for the OPHS, which set out clear, detailed and specific requirements for the delivery of public health programs and services in each of the province's 34 PHUs.

- The Office of the CMOH is responsible for ensuring that the OPHS continue to be relevant and based on evidence, and for supporting local public PHUs in meeting the requirements of the standards. Each BOH is required to submit annual business plans to the Ministry through this office as part of the budget and accountability processes.

- Leadership and governance principles are outlined in the attached alPHa Statement, including preserving the autonomy and authority of the local MOH and reinforcing local boards' autonomy, skill sets, effective governance and public health focus.

Theme: Indigenous and First Nation Communities

What has been successful in the current system to foster collaboration among public health and Indigenous communities and organizations?

- PHUs with significant indigenous populations long ago identified the importance of improving their access to public health programs and services, especially in First Nations communities. Many have independently entered into formal agreements with local bands under Section 50 of the HPPA for the provision of programs and services.

- The 2018 OPHS added a requirement for boards of health to engage with First Nations and Indigenous communities and organizations under the Health Equity Standard. The *Relationship with Indigenous Communities Guideline, 2018* was developed to support this work and a *Relationship with Indigenous Communities Toolkit* is said to be under development by the Ministry.

- The widespread acceptance of and commitment to the Truth and Reconciliation Calls to Action throughout the public health sector. Staff training in cultural awareness / competency /safety, the local involvement of Indigenous leaders in decision making, program planning and relationship development, and local partnerships and initiatives have sprung forth from that commitment in all of Ontario's PHUs.

Are there opportunities to strengthen Indigenous representation and decision- making within the public health sector?

- In its Statement of Principles, alPHa notes the necessity of special consideration being given to the effects of any proposed organizational change on Ontario's many Indigenous communities, especially those with a close relationship with the boards of health for the PHUs within which they are located. It is further notes that opportunities to formalize and improve these relationships must be explored as part of the modernization process. alPHa recommends that this exploration, including consideration of the above question, be conducted in full consultation with Indigenous communities and organizations as well as boards of health that have already demonstrated commitment to and experience with Indigenous engagement and service delivery to these populations.

- In its Statement of Principles, alPHa recommends that local BOHs be reflective of the communities that they serve. In areas with large indigenous populations and / or First Nations communities, consideration should be given to appointing one or more members of those communities to the BOH itself. This has already been done, for example, in Peterborough. This could be reinforced with the formation of local Indigenous health advisory committees with more widespread stakeholder involvement. These committees would be especially important for identifying and addressing the health needs of Indigenous people living off-reserve in a culturally sensitive way.

- Provincially, the Office of the CMOH should ensure that central resource and policy supports are in place to facilitate local engagement with Indigenous communities and reinforce pathways to increasing representation and decision-making. The Health Equity requirements of the OPHS that are specific to improving the health of First Nations, Métis, and Inuit people living in Ontario should be the foundation of these supports. The CMOH will also have an important role to play as a liaison with the Government of Canada (through the Public Health Agency of Canada) to ensure that it abides by its complementary obligation to contribute to the improvement of health care and health outcomes for these communities.

Theme: Francophone Communities

What has been successful in the current system in considering the needs of Francophone populations in planning, delivery and evaluation of public health programs and services?

- alPHa's members have extensive experience in providing programs and services aimed at different cultural and linguistic groups within their communities, including Ontario's significant Francophone population. PHUs with significant Francophone populations are best equipped to share what has been successful, identify the gaps and provide advice on how to address them. This is in fact a good example of the importance of ensuring that local boards of health retain decision-making authority over program planning and service delivery to best serve local needs.

What improvements could be made to public health service delivery in French to Francophone communities?

- The provision of a 100% provincially funded centralized translation service that is accessible to all boards of health was cited repeatedly in our members' feedback to this question, as was support for French-language training programs for health unit staff.

Theme: Learning from Past Reports

What improvements to the structure and organization of public health should be considered to address these challenges?

- Most past reports have recommended PHU mergers, and alPHa is not opposed to this in principle, as long as such mergers are of entities with complementary community characteristics and values, will lead to a demonstrable positive impact on capacity, are worth the extraordinary cost and disruption, and are favoured by all concerned parties. The Simcoe-Muskoka, North Bay-Parry Sound, Southwestern and Huron-Perth PHUs are the results of mergers that have taken place since 2005, and valuable insights on the process, including the identification of driving forces, key success factors and challenges, are readily available.

- As noted above, alPHa does not believe that structural and organizational changes are necessary to address capacity challenges. While we agree that health unit mergers as a means to finding efficiencies and reducing duplication of efforts are worth considering, we have not been presented with a clear and convincing argument that a wholesale restructuring of the Ontario's public health system – with its concomitant major costs and disruptions - is a prerequisite for making it nimble, resilient, efficient and responsive.

What about the current public health system should be retained as the sector is modernized?

From alPHa's Statement of Principles:

- Ontario's public health system must remain financially and administratively separate and distinct from the health care system.

- The strong, independent local authority for planning and delivery of public health programs and services must be preserved, including the authority to customize centralized public health programming or messaging according to local circumstances.

- Parts I-V and Parts VI.1 – IX of the HPPA should be retained as the statutory framework for the purpose of the Act, which 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".

- The OPHS should be retained as the foundational basis for local planning and budgeting for the delivery of public health programs and services.

- The leadership role of the local MOH as currently defined in the HPPA must be preserved with no degradation of independence, leadership or authority.

What else should be considered as the public health sector is modernized?

- Any and all changes must serve the goal of strengthening the Ontario public health system's capacity to improve population health in all of Ontario's communities through the effective and efficient local delivery of evidence-based public health programs and services.

- Achieving efficiencies must be defined in terms of improvements to service delivery and not cost savings. Each of the completed health unit mergers for example has had the former as their central aim but the merger process itself has always been costly.

- Provincial supports (financial, legal, administrative) must be provided to assist existing local PHUs in their transition to any new state without interruption to front-line services. Any costs associated with Public Health Modernization should be fully covered by the Ministry, including additional funding to address technology changes associated with any structure or governance changes.

- alPHa is very pleased with the format and process of the current consultation. That said, in the period between the initial 2019 budget announcement and the formal launch of this consultation (a period of over seven months), there was an unacceptable scarcity of information available to Ontario's considerable public health workforce. This has had a measurable and possibly irreversible negative impact on culture and morale within Ontario's public health workplaces. It has also put a considerable hindrance on the working relationship between local public health leadership and its partners within the Ministry. We hope that the transparency, comprehensiveness and reciprocity of this consultation will continue throughout the analysis and implementation phases to restore trust and demonstrate that the Government of Ontario values the public health professionals that are the foundational strength of the system.

ABBREVIATIONS

alPHa	Association of Local Public Health Agencies
AOPHBA	Association of Ontario Public Health Business Administrators
APHEO	Association of Public Health Epidemiologists in Ontario
ASPHIO	Association of Supervisors of Public Health Inspectors of Ontario
BOH	Board of Health
CMOH	Chief Medical Officer of Health
COMOH	Council of Ontario Medical Officers of Health
HPO	Health Promotion Ontario
HPPA	*Health Protection and Promotion Act*
HIV	Human Immunodeficiency Virus
IPAC	Infection Prevention and Control
ISPA	*Immunization of School Pupils Act*
LDCP	Locally Driven Collaborative Project
OAPHD	Ontario Association of Public Health Dentistry
OPHNL	Ontario Association of Public Health Nursing Leaders
ODPH	Ontario Dietitians in Public Health
OPHS	Ontario Public Health Standards
PHO	Public Health Ontario
PHU	Public Health Unit
TCAN	Tobacco Control Area Network

Enclosures:

alPHa Statement of Principles (November 2019), also attached.
alPHa Deputation, Standing Committee on Finance and Economic Affairs (January 17, 2020), also attached

BACKGROUND

On April 11, 2019 the Minister of Finance announced the 2019 Ontario Budget, which included a pledge to modernize "the way public health units are organized, allowing for a focus on Ontario's residents, broader municipal engagement, more efficient service delivery, better alignment with the health care system and more effective staff recruitment and retention to improve public health promotion and prevention".

Plans announced for this initiative included regionalization and governance changes to achieve economies of scale, streamlined back-office functions and better-coordinated action by public health units, adjustments to the provincial-municipal cost-sharing of public health funding and an emphasis on digitizing and streamlining processes.

On November 6, 2019, further details were presented as part of the government's Fall Economic Statement, which reiterates the Province's consideration of "how to best deliver public health in a way that is coordinated, resilient, efficient and nimble, and meets the evolving health needs and priorities of communities". To this end, the government is renewing consultations with municipal governments and the public health sector under the leadership of Special Advisor Jim Pine, who is also the Chief Administrative Officer of the County of Hastings. The aim of the consultation is to ensure:

- Better consistency and equity of service delivery across the province;
- Improved clarity and alignment of roles and responsibilities between the Province, Public Health Ontario and local public health;
- Better and deeper relationships with primary care and the broader health care system to support the goal of ending hallway health care through improved health promotion and prevention;
- Unlocking and promoting leading innovative practices and key strengths from across the province; and
- Improved public health delivery and the sustainability of the system.

In preparation for these consultations and with the intent of actively supporting positive systemic change, the alPHa Board of Directors has agreed on the following principles as a foundation for its separate and formal submissions to the consultation process.

PRINCIPLES

Foundational Principle

1) Any and all changes must serve the goal of strengthening the Ontario public health system's capacity to improve population health in all of Ontario's communities through the effective and efficient local delivery of evidence-based public health programs and services.

Organizational Principles

2) Ontario's public health system must remain financially and administratively separate and distinct from the health care system.

3) The strong, independent local authority for planning and delivery of public health programs and services must be preserved, including the authority to customize centralized public health programming or messaging according to local circumstances.

4) Parts I-V and Parts VI.1 – IX of the Health Protection and Promotion Act should be retained as the statutory framework for the purpose of the Act, which 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".

5) The *Ontario Public Health Standards: Requirements for Programs, Services, and Accountability* should be retained as the foundational basis for local planning and budgeting for the delivery of public health programs and services.

6) Special consideration will need to be given to the effects of any proposed organizational change on Ontario's many Indigenous communities, especially those with a close relationship with the boards of health for the health units within which they are located. Opportunities to formalize and improve these relationships must be explored as part of the modernization process.

Capacity Principles

7) Regardless of the sources of funding for public health in Ontario, mechanisms must be included to ensure that the total funding envelope is stable, predictable, protected and sufficient for the full delivery of all public health programs and services whether they are mandated by the province or developed to serve unique local needs as authorized by Section 9 of the Health Protection and Promotion Act.

8) Any amalgamation of existing public health units must be predicated on evidence-based conclusions that it will demonstrably improve the capacity to deliver public health programs and services to the residents of that area. Any changes to boundaries must respect and preserve existing municipal and community stakeholder relationships.

9) Provincial supports (financial, legal, administrative) must be provided to assist existing local public health agencies in their transition to any new state without interruption to front-line services.

Governance Principles

10) The local public health governance body must be autonomous, have a specialized and devoted focus on public health, with sole oversight of dedicated and non-transferable public health resources.

11) The local public health governance body must reflect the communities that it serves through local representation, including municipal, citizen and / or provincial appointments from within the area. Appointments should be made with full consideration of skill sets, reflection of the area's socio-demographic characteristics and understanding of the purpose of public health.

12) The leadership role of the local Medical Officer of Health as currently defined in the Health Protection and Promotion act must be preserved with no degradation of independence, leadership or authority.

DESIRED OUTCOMES

- Population health in Ontario will benefit from a highly skilled, trusted and properly resourced public health sector at both the provincial and local levels.
- Increased public and political recognition of the critical importance of investments in health protection and promotion and disease prevention to population health and the sustainability of the health care system.
- Local public health will have the capacity to efficiently and equitably deliver both universal public health programs and services and those targeted at at-risk / vulnerable / priority populations.
- The geographical and organizational characteristics of any new local public health agencies will ensure critical mass to efficiently and equitably deliver public health programs and services in all parts of the province.
- The geographical and organizational characteristics of any new local public health agencies will preserve and improve relationships with municipal governments, boards of education, social services organizations, First Nations communities, Ontario Health Teams and other local stakeholders.
- The geographical and organizational characteristics of any new local public health agencies will reflect the geographical, demographic and social makeup of the communities they serve in order to ensure that local public health needs are assessed and equitably and efficiently addressed.
- Local public health will benefit from strong provincial supports, including a robust Ontario Agency for Health Protection and Promotion (Public Health Ontario) and a robust and independent Office of the Chief Medical Officer of Health.
- The expertise and skills of Ontario's public health sector will be recognized and utilized by decision makers across sectors to ensure that health and health equity are assessed and addressed in all public policy.

Association of Local Public Health Agencies
Speaking Points
Standing Committee on Finance and Economic Affairs
Re: 2020 Ontario Budget
Friday, January 17, 2020

- Good afternoon, Chair and Members of the Standing Committee on Finance and Economic Affairs.

- I am Dr. Eileen de Villa, Vice-President of the Association of Local Public Health Agencies, better known as alPHa, and Toronto's Medical Officer of Health and with me is Loretta Ryan, alPHa's Executive Director.

- alPHa represents all of Ontario's 34 boards of health and medical officers of health (MOHs).

- As you may know, in essence, the work of public health is organized in the Ontario Public Health Standards as follows:

    - Chronic Disease Prevention and Well-Being
    - Emergency Management
    - Food Safety
    - Health Equity
    - Healthy Environments
    - Healthy Growth and Development
    - Immunization
    - Infectious and Communicable Diseases Prevention and Control
    - Population Health Assessment

- Safe Water
- School Health
- Substance Use and Injury Prevention

- Last January, in the alPHa Pre-Budget Submission, alPHa noted that:

  - Public Health is on the Front Line of Keeping People Well
  - Public Health Delivers an Excellent Return on Investment
  - Public Health is an Ounce of Prevention that is Worth a Pound of Cure
  - Public Health Contributes to Strong and Healthy Communities
  - Public Health is Money Well Spent

- Furthermore, alPHa recommended that:

  - The integrity of Ontario's public health system be maintained
  - The Province continue its funding commitment to cost-shared programs
  - The Province make other strategic investments, including in the public health system, that address the government's priorities of improving services and ending hallway medicine

- As regards to this last point, Public Health's contribution to ending hallway medicine is summarized in alPHa's Public Health Resource Paper .

- Despite this advice, the 2019 Ontario Budget announced that the Government would be changing the way the public health system was organized and funded.

- On October 10, 2019, Ontario named Jim Pine as its Advisor on Public Health (and Emergency Health Services) consultations.

- Subsequently, on November 18, the Ministry of Health launched renewed Public Health consultations and released a Discussion Paper.

- alPHa was pleased with these recent announcements and has been fully engaged with the consultation.

- For example, on November 15, alPHa released a Statement of Principles respecting Public Health Modernization.

- On a funding note, as was reported by alPHa on September 11, the Ministry of Health confirmed the cost-sharing formula for public health will change to 70% provincial/30% municipal to be applied to almost all mandatory public health programs and services.

- That said, as the Premier announced on August 19 at the AMO Conference, and which alPHa welcomed, municipalities would be receiving one-time transitional funding to limit the increase in costs borne by municipalities in 2020 to no more than 10%.

- Despite this, many boards of health have reported that they have had to draw on their reserves to ease the financial burden that this decision has placed on their obligated municipalities .

- A more positive announcement in the 2019 Ontario budget was the decision to proceed with a new 100% provincially funded, public health unit delivered Ontario Seniors Dental Care Program (OSDCP), which was officially launched on November 20.

- alPHa believes that a modernized, effective and efficient public health system that is adequately resourced is needed more than ever.

- alPHa agrees, for example, with the Standing Committee on Public Accounts Report about the importance of addressing key chronic disease risk factors such as physical inactivity, unhealthy eating, alcohol consumption and

tobacco use of which the attributable burden of illness places huge demands on the health care system.

- Moreover, in its presentation to the Standing Committee on Social Policy, alPHa warned about the unforeseen consequences of the legalization of cannabis and the promotion of vapour products, such as e-cigarettes and other similar products.

- Finally, as the Office of the Chief Medical Officer of Health has recently noted, the Public Health Agency of Canada is tracking a novel coronavirus outbreak in Wuhan, China; as our experience with SARS demonstrated, infectious diseases "know no borders".

- With all the foregoing in mind, alPHa respectfully recommends the following:

    - Led by Ontario's Advisor, the Ministry of Health continue to pursue meaningful consultations with key stakeholders, including alPHa, respecting Public Health Modernization
    - Any changes to the public health system be implemented in accordance with alPHa's Statement of Principles and pending response to the Public Health Modernization discussion paper
    - The public health system receives sufficient and sustainable funding to address population health needs
    - Ontario preferably restore the previous provincial-municipal cost-sharing (75/25) formula for Public Health and, at the very least, make no further changes to the current (70/30) formula
    - Ontario continue to invest in Public Health operations and capital, including 100% funding for priority programs, such as OSDCP

- Thank you for your attention. We would be pleased to answer any questions.

STANDING COMMITTEE ON FINANCE AND ECONOMIC AFFAIRS
FRIDAY 17 JANUARY 2020
PRE-BUDGET CONSULTATIONS

Full Transcript **(all presentations)**

Association of Local Public Health Agencies

The Chair (Mr. Amarjot Sandhu): Next, I would like to call upon the Association of Local Public Health Agencies. Please state your name for the record. You have seven minutes for your presentation.

Dr. Eileen de Villa: Thank you very much. Good afternoon, Chair and members of the Standing Committee on Finance and Economic Affairs. I'm Dr. Eileen de Villa, vice-president of the Association of Local Public Health Agencies, better known as ALPHA, and I'm also Toronto's medical officer of health. I'm joined today by my colleague Loretta Ryan, ALPHA's executive director.

ALPHA represents all of Ontario's 34 boards of health and medical officers of health. As you may know, in essence, the work of public health is organized in the Ontario Public Health Standards as follows: chronic disease prevention and well-being, emergency management, food safety, health equity, healthy environments, healthy growth and development, immunization, infectious and communicable diseases prevention and control, population health assessment, safe water, school health, substance use, and injury prevention.

Last January, in the ALPHA pre-budget submission, ALPHA noted that public health is on the front line of keeping people well. Public health delivers an excellent return on investment. Public health is an ounce of prevention that is worth a pound of cure. Public

health contributes to strong and healthy communities, and public health is money well spent.

Furthermore, ALPHA recommended that the integrity of Ontario's public health system be maintained, that the province continue its funding commitment to cost-shared programs and that the province make other strategic investments, including in the public health system, that address the government's priorities of improving services and ending hallway health care. In regard to this last point, public health's contribution to ending hallway health care is summarized in ALPHA's public health resource paper.

Despite this advice, the 2019 Ontario budget announced that the government would be changing the way the public health system was organized and funded.

On October 10, 2019, Ontario named Jim Pine as its adviser on public health and on emergency health services for the consultations. Subsequently, on November 18, the Ministry of Health launched renewed public health consultations and released a discussion paper. ALPHA was pleased with these recent announcements and has been fully engaged with the consultation. For example, on November 15, ALPHA released a statement of principles respecting public health modernization.

On a funding note, on September 11, the Ministry of Health confirmed that the cost-sharing formula for public health will change to 70% provincial and 30% municipal, to be applied to almost all mandatory public health programs and services. This said, as the Premier announced on August 19 at the AMO conference—and which ALPHA welcomed—municipalities would be receiving one-time transitional funding to limit the increase in costs borne by municipalities in 2020 to no more than 10%. Despite this, many boards of health have reported that they have had to draw on their reserves to ease the financial burden that this decision has placed on their obligated municipalities.

A more positive announcement in the 2019 Ontario budget was the decision to proceed with a new, 100% provincially funded, public-health-unit-delivered Ontario Seniors Dental Care Program, or OSDCP, which was officially launched on November 20.

ALPHA believes that a modernized, effective and efficient public health system that is adequately resourced is needed more than ever. ALPHA agrees, for example, with the Standing Committee on Public Accounts report about the importance of addressing key chronic disease risk factors, such as physical inactivity, unhealthy eating, alcohol consumption and tobacco use, of which the attributable burden of illness places huge demands on the health care system. Moreover, in its presentation to the Standing Committee on Social Policy, ALPHA warned about the unforeseen consequences of the legalization of cannabis and the promotion of vapour products, such as e-cigarettes and other similar products.

Finally, as the Office of the Chief Medical Officer of Health has recently noted, the Public Health Agency of Canada is tracking a novel coronavirus outbreak in Wuhan, China. As our experience with SARS demonstrated, infectious diseases know no borders.

With all the foregoing in mind, ALPHA respectfully recommends the following:

—led by Ontario's adviser, the Ministry of Health continue to pursue meaningful consultations with key stakeholders, including ALPHA, respecting public health modernization;

—any changes to the public health system be implemented in accordance with ALPHA's statement of principles and pending response to the public health modernization discussion paper;

—that the public health system receive sufficient and sustainable funding to address population health needs—

The Chair (Mr. Amarjot Sandhu): One minute.

Dr. Eileen de Villa:—that Ontario preferably restore the previous provincial-municipal cost sharing 75-25 formula for public health and, at the very least, make no further changes to the current 70-30 formula; and

—that Ontario continue to invest in public health operations and capital, including 100% funding for priority programs such as the Ontario Seniors Dental Care Program.

I'll thank you for your attention, and we would be very pleased to address any questions you might have.

The Chair (Mr. Amarjot Sandhu): Thank you. We'll go to the opposition side this time. MPP Shaw.

Ms. Sandy Shaw: Thank you very much for your presentation. I commend you for your work. I would say that people didn't understand what public health did previous to these abrupt changes; we understand it now.

I would also like to say, we remember when SARS happened, and Dr. Sheela Basrur—the heroic efforts that we took to prevent that from being a full-blown crisis. It was 15 or 16 years ago; how quickly we forget, right? So I think we need to keep reminding ourselves that when we need public health to be able to mobilize, we really, really need it.

So I want to commend you. I understand the work that you do. I always did. I want to say that we're fully supportive of what you do. There's no misunderstanding on the part of the New Democrats of what you do.

My question is very specific because we've got a short time. About the changes to the public health unit, the geographic deployment—so 35 units that are going to now, perhaps, be shrunk down to 10. This is a question about my riding in Hamilton, where our medical officer of health, Dr. Richardson, has expressed some of her concerns, particularly now that we are an Ontario health team and we do not know how the Ontario health team is trying to get on with their work without any direction—really clear direction, I would say—from the government and without the understanding that this public health unit will now maybe be beyond the geographic area of the Ontario health team.

So there's a lot of confusion out there in terms of what's happening. I'm wondering if you have any understanding of that or any advice around what the impact will be when these health units shrink.

1620

Dr. Eileen de Villa: Thank you for the question. At this stage of the game and as alluded to in my remarks, there are ongoing consultations right now in respect of public health modernization as proposed by the current provincial government. My understanding at this stage is that there is still open discussion with respect to what will be the configuration of local public health units. You're right: Right now, there are currently 34. There were some original proposals made last year. We're understanding at this stage of the game that there is some revisiting, a "reset," I believe, is the word that has been used. So we don't know yet where the discussions will land.

However, I would say that there are some important questions to ask here and some important considerations for the committee. First public health as a system is separate from the health care system. There are important areas of interaction that we need to have between public health and health care, but they are in fact distinct and separate. The Ontario health teams fall more within the context of health care, and that's a very important role that needs to be played. I think there are certainly some questions as to how that will manifest itself in the future. However, it is in fact separate from public health.

The Chair (Mr. Amarjot Sandhu): One minute.

Dr. Eileen de Villa: That's not to take away from its importance.

Ms. Sandy Shaw: Thank you.

The Chair (Mr. Amarjot Sandhu): MPP Arthur.

Mr. Ian Arthur: Thank you so much for your presentation. I echo the sentiments of my colleague.

Just very quickly: The upstream causes of health care costs were talked about for a long time. It seems to have receded a bit in terms of the discussion. With skyrocketing health care costs, do you see any avenue other than dealing with those upstream causes for bringing those expenditures under control?

Dr. Eileen de Villa: Thank you for the question. As a public health practitioner, we are all about the upstream. That is our focus. That is where we live, and that's where we provide the most value to the system. There will always be some need for health care, which is downstream. However, we know that what constitutes and what maintains

health are the social determinants of health, the conditions within which people live and the environments within which they live—

The Chair (Mr. Amarjot Sandhu): Thank you. I apologize to cut you off. We'll have to move to the government side now. MPP Skelly.

Ms. Donna Skelly: Thank you for your presentation. This year our government committed over $700 million—close to $800 million—in funding for public health units right across Ontario. Yes, we believe that there is an opportunity and several challenges moving forward in the restructuring and modernization of delivery of those services, and we are consulting, I believe under the leadership and direction of Jim Pine. He is the emergency health services adviser. He is leading the dialogue, meeting with representatives from municipalities, meeting with health service sector representatives from right across the province, in order to understand what the challenges are, in order to identify perhaps some of the duplication of services. We have seen examples that have been brought forward to our government.

I'm just wondering if maybe you could, while we have this opportunity at this committee hearing, share with this committee some of the areas that you have identified as duplication in the delivery of health care services under these current boards.

Dr. Eileen de Villa: Thank you for the question. I'm going to talk about duplication in respect of public health as opposed to health care.

Ms. Donna Skelly: I should say "public health." Thank you.

Dr. Eileen de Villa: Yes, because they are quite distinct, as I indicated earlier. You're quite right around the consultations; I think that there is an opportunity to engage in conversation around what's best for public health. The public health system, however, does require the co-operation and collaboration of several partners. There's certainly a

role for provincial entities. There's a role for local entities, some of which are governmental and some of which are community-based.

Where are there areas that we could improve? There are always areas for improvement, whether we're talking about public health or health care. When it comes to public health, I think what we have seen through the various reports—some of which emanated from local public health; some of which have come through Auditor General-type reports—would include areas like research.

I think there is an opportunity, as well, to confer across the province around what are some of the directions and priorities that we should be seeking together, because we know that where we have had success in public health in the past, most of the successes have come through the collaborative efforts of a variety of local or regional public health entities, as well as the province.

I think those are just a few examples of some areas where we could collaborate better and perhaps reduce duplication.

Ms. Donna Skelly: One of the programs that you raised involves dental care for seniors, which is, of course, something I think most of us really believe is long overdue.

The Chair (Mr. Amarjot Sandhu): One minute.

Ms. Donna Skelly: Can you speak to some of the limitations, some of your observations, since we've started introducing that program?

Dr. Eileen de Villa: It's a relatively new program, launched in November and currently being delivered through public health units. I would say that for many of my colleagues around the province, one of the challenges is that they did not have pre-existing seniors'

dental care programs, or facilities through which to deliver such clinical services. Certainly, establishing those facilities is one of the challenges that exist right now.

But as mentioned in our remarks, we at ALPHA are extremely pleased. This was certainly one of the positives in respect of recent funding announcements when it came to public health and public health delivery programs.

Ms. Donna Skelly: Thank you.

The Chair (Mr. Amarjot Sandhu): Thank you so much for your presentation.

HALIBURTON, KAWARTHA, PINE RIDGE DISTRICT HEALTH UNIT

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June 19, 2020

The Right Honourable Justin Trudeau
Office of the Prime Minister
80 Wellington Street
Ottawa, ON K1A 0A2
Sent via email: justin.trudeau@parl.gc.ca

The Honourable Chrystia Freeland
Deputy Prime Minister
Privy Council Office, Room 1000
80 Sparks Street
Ottawa, ON K1A 0A3
Sent via email: chrystia.freeland@parl.gc.ca

The Honourable Bill Morneau
Minister of Finance
90 Elgin Street, 17th Floor
Ottawa, ON K1A 0G5
Sent via email: bill.morneau@parl.gc.ca

Dear Prime Minister Trudeau, Deputy Prime Minister Freeland and Minister Morneau

Re: Support for Basic income for all Canadians during the COVID-19 pandemic and beyond

At its meeting held on June 18, 2020, the Board of Health for the Haliburton, Kawartha, Pine Ridge District Health Unit discussed and endorsed correspondence from the Board of Health for the Simcoe Muskoka District Health Unit recommending the evolution of the Canada Emergency Response Benefit (CERB) into a basic income for all Canadians during the COVID-19 pandemic and beyond.

Inadequate income and household food insecurity results in poor health outcomes and higher health care costs. In the midst of the COVID-19 pandemic, that means increased susceptibility to severe complications of and death from COVID-19 and higher demands of an already strained health care system. A basic income guarantee is an essential component of a long-term solution to effectively eliminate poverty and household food insecurity and a short-term strategy to the economic consequences of the COVID-19 pandemic. The Haliburton, Kawartha, Pine Ridge District Health Unit's Board of Health supports the recommendations made by the Board of Health for the Simcoe Muskoka District Health Unit.

/…2

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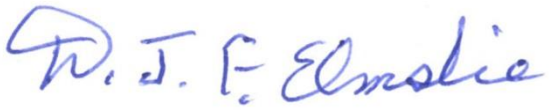
We appreciate your consideration of this important public health issue.

Sincerely

BOARD OF HEALTH FOR THE HALIBURTON, KAWARTHA,
PINE RIDGE DISTRICT HEALTH UNIT



Doug Elmslie, Chair, Board of Health, Haliburton, Kawartha, Pine Ridge District Health Unit

DE/st/ed

Attachments: The Board of Health for the Simcoe Muskoka District Health Unit's letter dated May 20, 2020
Haliburton, Kawartha, Pine Ridge District Health Unit's Basic Income Guarantee Position Statement (September 14, 2016)

cc: The Hon. Andrew Scheer
Mr. Jagmeet Singh
Ms. Jo-Ann Roberts
M. Yves-François Blanchet
The Hon. Premier Doug Ford
The Hon. Christine Elliott, Minister of Health
Dr. David Williams, Ontario Chief Medical Officer of Health
MP Philip Lawrence
MP Jamie Schmale
MPP Laurie Scott
MPP David Piccini
City of Kawartha Lakes
Haliburton County
Northumberland County
Association of Local Public Health Agencies
Ontario Public Health Association
Ontario Boards of Health

simcoe muskoka
DISTRICT HEALTH UNIT

May 20, 2020

The Right Honourable Justin Trudeau, P.C., MP
Prime Minister of Canada
Office of the Prime Minister
80 Wellington Street
Ottawa, ON K1A 0A2

The Honourable Chrystia Freeland, P.C., M.P.
Deputy Prime Minister
Privy Council Office
Room 1000
80 Sparks Street
Ottawa, ON K1A 0A3

The Honourable Bill Morneau, P.C., M.P.
Minister of Finance
90 Elgin Street, 17th Floor
Ottawa, ON K1A 0G5

Dear Prime Minister Trudeau, Deputy Prime Minister Freeland and Minister Morneau:

Re: Basic Income for Income Security during Covid-19 Pandemic and Beyond

On behalf of the Simcoe Muskoka District Health Unit (SMDHU) Board of Health, I am writing to convey our strong support for the evolution of the Canada Emergency Response Benefit (CERB) into a basic income for all Canadians, during the COVID-19 pandemic and beyond.

While we commend the federal government for the economic measures that have been put into place to support Canadians during this unprecedented time of the COVID-19 pandemic, we also know that many are falling through the cracks. Measures such as the CERB, the Canada Emergency Student Benefit (CESB) and the Canada Emergency Wage Subsidy (CEWS), though necessary and very important, have left many Canadians, who do not qualify for or not able to access these programs, vulnerable to household food insecurity and the negative consequences of income insecurity and poverty such as inadequate or unstable housing, and poorer mental and physical health, including chronic diseases. A basic income would address these gaps, offering support to the most vulnerable Canadians.

Before the COVID-19 pandemic, many Canadians were already experiencing household food insecurity. In 2017-18 approximately 4.4-million (1 in 8) Canadians reported being food insecure, including 1.2 million children under the age of 18.[I] As a result of COVID-19, this number is predicted to increase as many individuals are facing precarious employment, have had their hours reduced or have lost their jobs altogether. Many are relying on food banks and other charitable programs, however, this only meets the need on a temporary basis and is not a long term solution.

Examples of key Canadian initiatives that demonstrate the positive impact of basic income-like programs on health and well-being include the Old Age Security and Guaranteed Income Supplement through Canada's public pension system, the Canada Child Benefit, and the Newfoundland Poverty Reduction Strategy.

Basic income pilots for working-age adults in Canada have also led to promising findings, including the Mincome pilot in Manitoba and the recent Ontario Basic Income Pilot. The research study, *Southern Ontario's Basic Income Experience* released in March 2020, is based on Ontario's pilot. This pilot was implemented in three Ontario cities in 2018 by the provincial government, and the project was terminated in 2019 following a change in government. While the formal pilot evaluation was cancelled, this research study made use of surveys of individuals from Hamilton, Brantford and Brant County who had been enrolled in the pilot (217 individuals participated out of 1000 enrolled households), and interviews with 40 participants. Some of the key findings cited by participants in this report include improvements in physical and mental health; increased labour market participation; moving to higher paying and more secure jobs; reduced household food insecurity; housing stability; improved financial status and social relationships; less frequent visits to health practitioners and hospital emergency rooms; improved living standards; and an improved sense of self-worth and hope for a better future.

Additional evidence supporting the potential of a basic income for reducing the prevalence and severity of household food insecurity is presented in: *Implications of a Basic Income Guarantee for Household Food Insecurity*, a research paper prepared for the Northern Policy Institute based on the Ontario Basic Income Pilot.

Moving forward during and following the COVID-19 pandemic is an opportune time for the federal government to take action to evolve the CERB into a basic income. This would provide income security to all Canadians during the economic challenges of the pandemic itself, the post-pandemic recovery, and into the future. This is particularly pertinent given the dramatic shifts in the labour market in recent decades, such that full-time permanent employment is no longer the norm. The current CERB has helped demonstrate the logistical feasibility of delivering a basic income, and it could be readily evolved into an ongoing basic income for anyone who falls below a certain income floor. There is evidence of growing support for this concept, as outlined in Appendix A. The Basic Income Canada Network has outlined key features of basic income design for Canada, which we support.

The SMDHU has been a strong proponent of basic income repeatedly since 2015. This includes having sponsored a resolution at the Association of Local Public Health Agencies (alPHa) general meeting endorsing the concept of basic income and requesting the federal and provincial governments jointly consider and investigate a basic income policy option for reducing poverty and income insecurity (2015), and expressing support and input into the Ontario Basic Income Pilot (2017). SMDHU has also been encouraging advocacy for income solutions to household food insecurity through our No Money for Food is Cent$less initiative since 2017.

In keeping with this, we strongly recommend your government take swift and immediate action on the evolution of the CERB Benefit into legislation for a basic income as an effective long-term

response to the problems of income insecurity, persistent poverty and household food insecurity, as well as a response to the economic impact of the COVID-19 pandemic.

Sincerely,

ORIGINAL Signed By:

Anita Dubeau
Chair, Board of Health

AD:CS:cm

Encl. (1)

cc. Hon. Doug Ford, Premier of Ontario
Simcoe and Muskoka MPs and MPPs
Simcoe Muskoka Municipal Councils
Association of Local Public Health Agencies
Ontario Public Health Association
Ontario Boards of Health

Appendix A: Examples of Support for Basic Income in Response to COVID-19 and Beyond

On April 21, 2020, 50 members of Canada's Senate wrote a letter to the federal government calling for a restructuring of the CERB into a minimum basic income to "ensure greater social and economic equity", especially for those who are most vulnerable. In support of this letter, Senator McPhedran's Youth Advisory Council, the Canadian Council of Young Feminists, in collaboration with the Basic Income Canada Youth Network, sent their own letter to the federal government.

In our region, Simcoe North MP Bruce Stanton has expressed agreement that it's time to consider basic income. He is quoted as saying "Based on my reading of this, like Senator Boniface, I am persuaded that it could be very good public policy" (News Story).

The Ontario Dietitians' of Public Health (ODPH) have also written a letter to the federal government stating "We ask that you take immediate action to enact legislation for a basic income guarantee as an effective long-term response to the problem of persistent poverty and household food insecurity as well as shorter-term consequences of the economic fallout of the COVID-19 pandemic".

The Board of Health of the Kingston, Frontenac, Lennox and Addington Health Unit in Ontario also passed a motion requesting the federal government to provide a basic income support to all Canadians (News Story).

HALIBURTON KAWARTHA PINE RIDGE DISTRICT HEALTH UNIT
BASIC INCOME GUARANTEE

Position Statement

It is the position of the Haliburton Kawartha Pine Ridge District Health Unit that eliminating poverty is an urgent health, human rights and social justice issue that requires action on the part of the municipal, provincial and federal governments. Basic income guarantee, which is an unconditional cash transfer from the government to citizens to provide a minimum annual income and is not tied to labour market participation, is an essential component of a strategy to effectively eliminate poverty, ensure all Canadians have a sufficient income to meet their basic needs, and live with dignity and to eliminate health inequities.

Backgrounder

Income has been identified as the most important determinant of health as it influences living conditions, physical and mental health and health-related behaviours including the quality of one's diet, extent of physical activity and tobacco use[1]. People living in poverty are more likely to experience poorer health, have two or more chronic conditions, have more injuries, be more likely to have a disability, use health care services more frequently and live shorter lives.

Based on the Low-Income After Tax (LIM-AT), the incidence of low-income in 2013 was 13.5% for the Canadian population.[2] More specifically, 16.5% of children aged 17 and under lived in low-income families and for children living in lone-parent families headed by a woman, the incidence rose to 42.6%.

Locally in the Haliburton Kawartha Pine Ridge District Health Unit, in 2010, 12.7% of the population lived in low-income situations based on LIM-AT.[3] In terms of children under the age of 6 years, 21.8 % lived in low-income families. [4]

Currently, households that rely on Ontario Works or Ontario Disability Support Programs as their primary source of income have income levels that are inadequate to meet core basic needs such as housing and food. According to a report on household food insecurity in Canada

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[1] In Focus The Social Determinants of Health, Epidemiology and Evaluation Services, Fall 2014 available from http://www.hkpr.on.ca/Portals/0/PDF%20Files/PDF%20-%20Epi/InFocus14-Web.pdf

[2] Statistics Canada Canadian Income Survey 2013 available from http://www.statcan.gc.ca/daily-quotidien/150708/dq150708b-eng.htm

[3] 2011 National Household Survey, Statistics Canada available from https://www12.statcan.gc.ca/nhs-enm/2011/dp-pd/prof/details/page.cfm?Lang=E&Geo1=HR&Code1=3535&Data=Count&SearchText=Haliburton,%20Kawartha,%20Pine%20Ridge%20District%20Health%20Unit&SearchType=Begins&SearchPR=01&A1=All&B1=All&GeoLevel=PR&GeoCode=3535&TABID=1

[4] Ibid

in 2012, 70% of households whose primary source of income was social assistance were food insecure.[5]

Over the past 20 years there have been tremendous changes in technology and globalization, which impacts job stability and security. Almost half of working adults are employed in precarious employment, which is part-time, seasonal or contract work that has little or no benefits and often pays low wages. Research shows that 70% of Canadians living in poverty are considered to be the working poor, which means they are employed but do not earn enough to make ends meet. [6]

Basic Income Guarantee

The causes of poverty are complex, and a multipronged approach is required to eliminate poverty and to improve health and social equity for all. One component of a poverty reduction strategy is to provide a basic income guarantee (BIG). It is an unconditional income transfer from the government to individuals and families that is not tied to labour market participation. [7] The objective of a basic income guarantee is to provide a minimum annual income at a level that is sufficient to meet basic needs and allows individuals and families to live with dignity, regardless of work status.[8] Since research shows that basic income guarantee could have health promoting effects and reduce health and social inequities, it is considered to have merits as an effective policy option.

A basic income guarantee was piloted in Dauphin Manitoba from 1974-1979 to study the impact of a guaranteed income supplement. Research showed a number of substantial benefits including a decrease in hospitalization rates, which were 8.5% less when compared to the control group. There were fewer incidents of work-related injuries, fewer visits to the emergency department from motor vehicle accidents and domestic violence and there was a reduction in the rates of psychiatric hospitalizations and the number of mental illness consultations with health care professionals. The research also showed that teenagers and new mothers were the only populations to significantly work less. The study showed that more teenagers completed high school and new mothers extended their maternity leaves. Once the

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[5] Tarasuk, V., Mitchell, A., Dachner, N.,(2014) Household food insecurity in Canada, 2012 available from http://nutritionalsciences.lamp.utoronto.ca/wp-content/uploads/2014/05/Household_Food_Insecurity_in_Canada-2012_ENG.pdf

[6] Lewchuk, W. et al. It's More than Poverty: Employment Precarity and Household Well-being United Way Toronto-McMaster University Social Sciences, 2013. www.pepso.ca

[7] Pasma, C., and Mulvale, J. Income Security for all Canadians Understanding Guaranteed Income. Ottawa: Basic Income Earth Network Canada; 2009. Available from http://www.cpj.ca/files/docs/Income_Security_for_All_Canadians.pdf

[8] Ibid

pilot finished and the cash transfers stopped, the number of teens not graduating from high school rose, returning to the previous rate that existed before the pilot.[9]

Currently in Canada, Old Age Security (OAS) and Guaranteed Income Supplements (GIS) are forms of guaranteed income supplement programs, which are income tested cash transfers for seniors at age 65 and older. Since their implementation, the incidence of poverty in seniors dropped substantially from 21.4% in 1980 to 5.2% in 2011. As a result, Canada has one of the lowest rates of seniors living in poverty in the world and the incidence of food insecurity is 50% less for those age 65 to 69 than for those age 60-64.[10]Similarly, other programs such as the Canadian Child Tax Benefit and National Child Benefit Supplement (which are tax free monthly payments for eligible families with children) have shown benefits in terms of improved math and reading skills and improved mental and physical health measures.[11]

Cost Considerations for a Basic Income Guarantee Program

It is widely agreed upon that the costs of poverty are very high. The total cost of poverty in Ontario is approximately $32.2-$38.3 billion dollars.[12] It is estimated that between $10.1 billion and $13.1 billion is spent on the social costs of poverty related to social assistance, housing and justice programs and health care costs associated with the effects of poverty. Lost opportunities for income tax revenue are estimated to be $4- $6.1 billion dollars and an additional $21.8-25.2 billion is attributed to lost productivity and revenue and intergenerational poverty low-income cycles.

Given the magnitude of the social and economic costs of poverty and the resources being spent on countering the negative effects of poverty, it is more prudent to spend those resources on prevention.

The costs of a basic income guarantee program in contrast to the costs of social and private costs of poverty have yet to be extensively researched. Estimates from Queen's University and the University of Manitoba identify that the amount for a basic income guarantee program for

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[9] Forget, E. **The Town with No Poverty: Using Health Administration Data to Revisit Outcomes of a Canadian Guaranteed Annual Income Field Experiment 2011** available from http://nccdh.ca/images/uploads/comments/forget-cea_(2).pdf

[10] Hyndman, B., and Simon, I., Basic Income Guarantee Backgrounder October 2015 alPHA and OPHA available from ww.opha.on.ca/getmedia/bf22640d-120c-46db-ac69-315fb9aa3c7c/alPHa-OPHA-HEWG-Basic-Income-Backgrounder-Final-Oct-2015.pdf.aspx?ext=.pdf

[11] Ibid

[12] Laurie, N. **The cost of poverty: an analysis of the economic cost of poverty in Ontario.** Toronto Ontario Association of Food Banks, 2008. http://www.oafb.ca/assets/pdfs/CostofPoverty.pdf

all of Canada would cost between $40 and $58 billion. Considering the total costs of poverty for just Ontario, a basic income guarantee would be very achievable.[13]

Provincial and National Support for a Basic Income Guarantee Program

Support for the basic income guarantee program exists across the political spectrum including politicians from several provinces and municipalities, economists and the health and social service sectors. Many large associations have given formal expressions of support such as The Canadian Medical Association, the Association of Local Public Health Agencies and the Ontario Public Health Association, the Ontario Society of Nutrition Professionals in Public Health, the Canadian Association of Mental Health, the Canadian Association of Social Workers and many health units in Ontario. Citizen groups in communities across Canada have also been forming to express their support for this initiative.

This past winter the Ontario provincial government embraced the opportunity to engage in the needed research to provide a clearer understanding of the implications and outcomes of the basic income guarantee program. By conducting a pilot study of the program, evidence will be gathered to determine if this is a more efficient manner of delivering income support, if it strengthens engagement in the labour force and if savings are achieved in areas such as the health care and justice systems. In 2016, the Ontario provincial government will work with researchers, communities and stakeholders to develop and implement a basic income guarantee pilot study.

HALIBURTON KAWARTHA PINE RIDGE DISTRICT HEALTH UNIT RESOLUTION ON BASIC INCOME GUARANTEE

WHEREAS addressing the social determinants of health and reducing health inequities are fundamental to the work of public health in Ontario; and

WHEREAS the Haliburton Kawartha Pine Ridge District Health Unit's strategic direction is to address the social determinants of health and health equity; and

WHEREAS income is recognized as the most important determinant of health and health inequities; and

WHEREAS 12.7% of the population in the Haliburton Kawartha Pine Ridge District live-in low-income circumstances based on the Low-Income After-Tax (2011 National Household Survey, Statistics Canada); and

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[13] Roos, N., and Forget, E. **"The time for a guaranteed annual income might finally have come."** The Globe and Mail, August 4, 2015. Available at http://www.theglobeandmail.com/report-on-business/rob-commentary/the-time-for-a-guaranteed-annual-income-might-finally-have-come/article25819266/

WHEREAS low income and income inequality have well-established, strong relationships with a wide range of adverse health and social outcomes as well as lower life expectancy; and

WHEREAS income insecurity continues to rise in Ontario and Canada as a result of an increase in precarious employment and an increasing number of working-age adults who rely on employment that pays low wages; and

WHEREAS existing federal and provincial income security programs are insufficient to ensure that all Canadians have adequate and equitable access to the social determinants of health (e.g., food, shelter, education); and

WHEREAS a basic income guarantee, which is an unconditional cash transfer from the government to citizens to provide a minimum annual income and is not tied to labour market participation, has the potential to ensure all Canadians have a sufficient income to meet basic needs and to live with dignity; and

WHEREAS a basic income guarantee resembles existing income security supplements currently in place for Canadian seniors and children, which have contributed to improved health status and quality of life in these age groups; and

WHEREAS a pilot project of basic income for working age adults conducted in Dauphin Manitoba in the 1970s, indicates that the provision of a basic income guarantee can reduce poverty and income insecurity, improve physical and mental health and educational outcomes, and enable people to pursue educational and occupational opportunities relevant to them and their families; and

WHEREAS the concept of a basic income guarantee has received support from the health and social sectors including the Canadian Public Health Association (CPHA), the Canadian Medical Association (CMA), the Canadian Association of Social Workers, the Association of Local Public Health Agencies (alPHa) and the Ontario Association of Public Health Agencies (OPHA), the Ontario Society of Nutritional Professionals in Public Health and the Ontario Mental Health and Addictions Alliance as a means to alleviate poverty and improve health outcomes of low income Canadians; and

WHEREAS there is growing support from economists, political affiliations and other sectors across Canada for a basic income guarantee;

NOW THEREFORE BE IT RESOLVED THAT the Haliburton Kawartha Pine Ridge District Health Unit Board of Health endorse a position statement of a basic income guarantee;

AND FURTHER that the Haliburton Kawartha Pine Ridge District Health Unit Board of Health join alPHa and OPHA in requesting that the federal Ministers of Employment, Workforce Development and Labour, Families, Children and Social Development, Finance and Health, as well as the Ontario Ministers Responsible for the Poverty Reduction Strategy, Community and

Social Services, Children and Youth Services, Finance and Health and Long-Term Care, prioritize joint federal-provincial consideration and investigation into a basic income guarantee as a policy option for reducing poverty and income insecurity;

AND FURTHER that the Prime Minister, the Premier of Ontario, the Chief Public Health Officer, the Chief Medical Officer of Health for Ontario, the Canadian Public Health Association, the Association of Local Public Health Agencies, the Ontario Boards of Health, the Federation of Canadian Municipalities, the Association of Municipalities of Ontario, MP Kim Rudd, MP Jamie Schmale, MPP Lou Rinaldi and MPP Laurie Scott as well as the City of Kawartha Lakes, the County of Haliburton and Northumberland County be so advised.

HALIBURTON, KAWARTHA, PINE RIDGE DISTRICT HEALTH UNIT

www.hkpr.on.ca • info@hkpr.on.ca
1-866-888-4577

June 19, 2020

The Honourable Christine Elliott
Minister of Health
5th Floor, 777 Bay St.
Toronto, ON M7A 2J3
(Sent via email to: christine.elliottco@ola.org)

Dear Minister Elliott

RE: Endorsement of correspondence regarding the 2020 Municipal Cost Share of Public Health Funding from Eastern Ontario Health Unit and correspondence regarding COVID-19 and Reconsiderations Related to Public Health Modernization from the Association of Local Public Health Agencies

At its meeting held on June 18, 2020, the Board of Health for the Haliburton, Kawartha, Pine Ridge District Health Unit (HKPR District Health Unit) passed the following motion:

"THAT the correspondence sent by the Eastern Ontario Health Unit to the Minister of Health regarding the 2020 Municipal Cost Share of Public Health Funding (attached), and the correspondence sent by the Association of Local Public Health Agencies to the Minister of Health requesting consideration of a pause on the Public Health Modernization initiative (attached) be endorsed; and THAT the provincial share of public health funding be reinstated to its previous level; and THAT a letter of support be sent to The Honourable Christine Elliott".

The Board Health agrees with the Eastern Ontario Health Unit and the Association of Local Public Health Agencies that the Public Health Modernization process should be deferred until after the COVID-19 response is examined and that public health funding should be restored to its previous level for 2020.

Sincerely

BOARD OF HEALTH FOR THE HALIBURTON,
KAWARTHA, PINE RIDGE DISTRICT HEALTH UNIT

D. J. F. Elmslie

Doug Elmslie
Chair, Board of Health
DE/aln/ed

Cc (via email): Dr. David Williams, Ontario Chief Medical Officer of Health
Alison Blair, Executive Lead for Public Health Modernization
Jim Pine, Special Advisor, Public Health Modernization
Association of Municipalities of Ontario (AMO)
Jennifer Moore, CAO, Northumberland County
Mike Rutter, Chief Administrative Officer, County of Haliburton
Ron Taylor, Chief Administrative Officer, City of Kawartha Lakes
Ontario Boards of Health
Association of Local Public Health Agencies (alPHa)

Attachments: 2

EOHU Eastern Ontario Health Unit | BSEO Bureau de santé de l'est de l'Ontario

Cornwall, February 12, 2020

The Honorable Christine Elliott
Minister of Health and Deputy Premier
Hepburn Block, 10th Floor, 80 Grosvenor Street
Toronto ON M7A 1E9

Dear Minister Elliott:

RE: 2020 Municipal Cost Share of Public Health Funding

At its meeting on January 30, 2020, the Eastern Ontario Health Unit (EOHU) Board of Health unanimously passed the following motion number 2020-1393:

> ***WHEREAS*** *the Ontario Government's Public Health Modernization Consultation process is still ongoing and in fact delayed;*
>
> ***WHEREAS*** *the Public Health Modernization Consultation process does not address public health funding models including municipal cost-share;*
>
> ***WHEREAS*** *without prior consultation nor discussion with health units or municipalities and before a new public health structure model has been devised and implemented, the municipal public health funding share for 2020 has been increased to 30% and now extends to include programs not previously cost-shared with municipalities;*
>
> ***WHEREAS*** *the 30% share across all programs, including those previously not cost-shared will result in significant and likely unsustainable increase of close to 50% to the EOHU's 3 obligated, mostly rural municipalities which have a limited tax base;*
>
> ***WHEREAS*** *the EOHU's obligated municipalities have planned for a 2020 modest overall contribution increase of up to 2% which is less than their new 30% cost-share formula 2020 contribution, even offset by verbally confirmed one-time transitional funding by the Ministry of Health;*
>
> ***THEREFORE, BE IT RESOLVED THAT*** *for the calendar year of 2020 the provincial Ministry of Health reverse the 30% cost-share formula and return to previous years' municipal share of 25% applicable only to previously shared mandatory programs;*
>
> and
>
> ***FURTHERMORE THAT*** *copies of this motion be forwarded to local municipalities, the Wardens Caucus of Eastern Ontario, the Association of Municipalities of Ontario (AMO), ROMA, local MPPs, MPP Steven Clark, all Ontario Boards of Health, the Association of Public Health Agencies (alPHa) in request for their support to urge the provincial Ministry of Health not to change the 2019 cost-share formula.*

…/2

Thank you for your attention to this important public health issue.

Sincerely,

Dr. Paul Roumeliotis, MD, CM, MPH, FRCP(C)
Medical Officer of Health/CEO
Secretary, Board of Health

Copy: Municipalities of Stormont, Dundas, Glengarry, Prescott & Russell
Warden's Caucus of Eastern Ontario
Association of Municipalities of Ontario (AMO)
ROMA
City of Cornwall
Ontario Boards of Health
Association of Public Health Agencies (alPHa)
Office of the Chief Medical Officer of Health
Jim McDonell, MPP, Stormont - Dundas - South Glengarry
Amanda Simard, MPP, Glengarry - Prescott-Russell
Steven Clark, Minister of Municipal Affairs

alPHa
Association of Local PUBLIC HEALTH Agencies

480 University Ave., Suite 300
Toronto, Ontario M5G 1V2
Tel: (416) 595-0006
E-mail: info@alphaweb.org

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

March 6, 2020

Hon. Christine Elliott
Minister of Health
5th Floor
777 Bay St.
Toronto, ON M7A 2J3

Dear Minister Elliott,

Re: COVID-19 and Reconsiderations Related to Public Health Modernization

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 today to urge you to consider pausing the Public Health Modernization initiative until the COVID-19 emergency is declared over in order to ensure that the response can be analysed, evaluated and incorporated into the consultations.

After a long period of uncertainty within the public health sector, we were indeed very grateful for your January 31 news release that included your praise of public health's "remarkable responsiveness" to the 2019 novel coronavirus and your expression of confidence that dedicated public health professionals are keeping Ontarians safe.

As we noted in our submission to the Public Health Modernization consultation paper, commitments to strengthening Ontario's public health system in response to the Walkerton, SARS and H1N1 health emergencies (including increased provincial responsibility for funding, strengthened role of the Chief Medical Officer of Health and creation of The Ontario Agency for Health Protection and Promotion) have led to measurable improvements to the Ontario public health sector's capacity to detect and respond to emerging threats. The swift collective and thorough response to the COVID-19 epidemic is a clear application by Ontario's public health sector of the lessons learned from the 2003 SARS outbreak.

This is not to say that activating our emergency response mechanisms has become a simple matter. Emergency response is by its very nature incredibly resource intensive and requires a high degree of ingenuity and nimbleness to adapt the response to a constantly evolving situation. Unfortunately, this can have a measurable impact on the equally important health protection and promotion activities that Ontario's dedicated public health professionals carry out every day to keep Ontarians well.

As we also noted in our submission to the Public Health Modernization team, the capacity for most public health units has been steadily eroding over the years largely due to the Ministry putting caps (often 0%) on annual budget increases that are necessary to cover the costs of delivery of new programs, annual CPI increases and honouring collective agreements. This erosion will be significantly and immediately compounded by the Province's abrupt and unjustified decision to immediately shift 5% of the cost-shared and 30% of previously 100% provincially funded public health programs to municipalities.

It is often said that public health is at its best when it's invisible to the public. In other words, its most important and effective contributions to population health are in fact those day-to-day health promotion, disease prevention and surveillance activities that we know will protect people from ever-present threats to their health and well being. In the Ontario Public Health Standards, this province has one of the world's strongest foundations for these contributions. The chronic inadequacy of resources to meet our daily obligations is regrettably brought into stark relief when they need to be diverted to emergency response duties.

As the response to COVID-19 has progressed, the PH-EMS Modernization team has recognized the need for local public health to focus on its work without distraction and postponed further face to face consultations with local public health in addition to extending the deadline for written submissions. We are respectfully asking that you reinforce this by providing official direction to pause the modernization process at least until the COVID-19 emergency is declared over, a full analysis of the response has been conducted and the lessons learned have been applied.

In addition, we are asking you to immediately reverse the download of the provincial portion of the public health funding envelope to restore the degree of financial certainly required to ensure that the both the extraordinary response and routine public health activities remain robust.

We see this test of public health as an important opportunity to take a collective step back and reconsider the approach that is being taken towards Ontario's public health sector, as a keener understanding of its purpose is re-entering the public and political discourse. We are eager to assist you in achieving your vision of a "coordinated public health sector that is nimble, resilient, efficient and responsive to the province's evolving health priorities" and we look forward to continuing the vital Public Health Modernization discussions that have already begun.

In the meantime, we are once again asking that the public health aspect of the PH-EMS Modernization endeavour be deferred until such a time as the COVID-19 response can be examined in retrospect and inform those discussions, and that the provincial share of public health funding be restored to its previous level at least until the discussions have concluded.

We would be pleased to discuss this with you further. To schedule a meeting, please have your staff contact Loretta Ryan, Executive Director, alPHa, at loretta@alphaweb.org or 416-595-0006 x 222.

Yours sincerely,

Carmen McGregor,
alPHa President

COPY: Dr. David Williams, Chief Medical Officer of Health
Alison Blair, Executive Lead for Public Health Modernization
Jim Pine, Special Adviser, Public Health Modernization

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www.timiskaminghu.com

June 9, 2020

The Right Honourable Justin Trudeau, P.C., MP
Prime Minister of Canada
Office of the Prime Minister
80 Wellington Street
Ottawa, ON K1A 0A2

The Honourable Chrystia Freeland, P.C., M.P.
Deputy Prime Minister
Privy Council Office
Room 1000
80 Sparks Street
Ottawa, ON K1A 0A3

The Honourable Bill Morneau, P.C., M.P.
Minister of Finance
90 Elgin Street, 17th Floor
Ottawa, ON K1A 0G5

Dear Prime Minister Trudeau, Deputy Prime Minister Freeland and Minister Morneau:

Re: Basic Income for Income Security during Covid-19 Pandemic and Beyond

On June 3, 2020, at a regular meeting of the Board for the Timiskaming Health Unit, the Board supported the enclosed correspondence of Simcoe Muskoka District Health Unit, dated May 20, 2020 and passed the following motion:

MOTION #26R-2020
Moved by: Kim Gauthier
Seconded by: Patrick Kiely

BE IT RESOLVED that the Board of Health endorses the Simcoe Muskoka District Health Unit (SMDHU) call for the federal government to 'take swift and immediate action on the evolution of the CERB Benefit into legislation for a basic income as an effective long-term response to the problems of income insecurity, persistent poverty and household food insecurity, as well as a response to the economic impact of the COVID-19 pandemic'; AND
FURTHER THAT Prime Minister Trudeau, Deputy Prime Minister Freeland and Minister Morneau, Timiskaming's MPs, MPPs and Chief Medical Officer of Health, and all Ontario boards of health are so advised.

CARRIED

Sincerely,

Carman Kidd, Board of Health Chair

Enclosure

cc Mr. John Vanthof, MPP - Timiskaming-Cochrane
Mr. Anthony Rota, MP – Timiskaming-Nipissing
Dr. David Williams, Chief Medical Officer of Health
Mrs. Loretta Ryan, Association of Local Public Health Agencies
Ontario Boards of Health
Ms. Pegeen Walsh, Executive Director, Ontario Public Health Association
Mr. Doug Jelly, Chairman of District of Timiskaming Social Services Administration Board

simcoe muskoka
DISTRICT HEALTH UNIT

May 20, 2020

The Right Honourable Justin Trudeau, P.C., MP
Prime Minister of Canada
Office of the Prime Minister
80 Wellington Street
Ottawa, ON K1A 0A2

The Honourable Chrystia Freeland, P.C., M.P.
Deputy Prime Minister
Privy Council Office
Room 1000
80 Sparks Street
Ottawa, ON K1A 0A3

The Honourable Bill Morneau, P.C., M.P.
Minister of Finance
90 Elgin Street, 17th Floor
Ottawa, ON K1A 0G5

Dear Prime Minister Trudeau, Deputy Prime Minister Freeland and Minister Morneau:

Re: Basic Income for Income Security during Covid-19 Pandemic and Beyond

On behalf of the Simcoe Muskoka District Health Unit (SMDHU) Board of Health, I am writing to convey our strong support for the evolution of the Canada Emergency Response Benefit (CERB) into a basic income for all Canadians, during the COVID-19 pandemic and beyond.

While we commend the federal government for the economic measures that have been put into place to support Canadians during this unprecedented time of the COVID-19 pandemic, we also know that many are falling through the cracks. Measures such as the CERB, the Canada Emergency Student Benefit (CESB) and the Canada Emergency Wage Subsidy (CEWS), though necessary and very important, have left many Canadians, who do not qualify for or not able to access these programs, vulnerable to household food insecurity and the negative consequences of income insecurity and poverty such as inadequate or unstable housing, and poorer mental and physical health, including chronic diseases. A basic income would address these gaps, offering support to the most vulnerable Canadians.

Before the COVID-19 pandemic, many Canadians were already experiencing household food insecurity. In 2017-18 approximately 4.4-million (1 in 8) Canadians reported being food insecure, including 1.2 million children under the age of 18.[i] As a result of COVID-19, this number is predicted to increase as many individuals are facing precarious employment, have had their hours reduced or have lost their jobs altogether. Many are relying on food banks and other charitable programs, however, this only meets the need on a temporary basis and is not a long term solution.

Examples of key Canadian initiatives that demonstrate the positive impact of basic income-like programs on health and well-being include the Old Age Security and Guaranteed Income Supplement through Canada's public pension system, the Canada Child Benefit, and the Newfoundland Poverty Reduction Strategy.

Basic income pilots for working-age adults in Canada have also led to promising findings, including the Mincome pilot in Manitoba and the recent Ontario Basic Income Pilot. The research study, *Southern Ontario's Basic Income Experience* released in March 2020, is based on Ontario's pilot. This pilot was implemented in three Ontario cities in 2018 by the provincial government, and the project was terminated in 2019 following a change in government. While the formal pilot evaluation was cancelled, this research study made use of surveys of individuals from Hamilton, Brantford and Brant County who had been enrolled in the pilot (217 individuals participated out of 1000 enrolled households), and interviews with 40 participants. Some of the key findings cited by participants in this report include improvements in physical and mental health; increased labour market participation; moving to higher paying and more secure jobs; reduced household food insecurity; housing stability; improved financial status and social relationships; less frequent visits to health practitioners and hospital emergency rooms; improved living standards; and an improved sense of self-worth and hope for a better future.

Additional evidence supporting the potential of a basic income for reducing the prevalence and severity of household food insecurity is presented in: *Implications of a Basic Income Guarantee for Household Food Insecurity*, a research paper prepared for the Northern Policy Institute based on the Ontario Basic Income Pilot.

Moving forward during and following the COVID-19 pandemic is an opportune time for the federal government to take action to evolve the CERB into a basic income. This would provide income security to all Canadians during the economic challenges of the pandemic itself, the post-pandemic recovery, and into the future. This is particularly pertinent given the dramatic shifts in the labour market in recent decades, such that full-time permanent employment is no longer the norm. The current CERB has helped demonstrate the logistical feasibility of delivering a basic income, and it could be readily evolved into an ongoing basic income for anyone who falls below a certain income floor. There is evidence of growing support for this concept, as outlined in Appendix A. The Basic Income Canada Network has outlined key features of basic income design for Canada, which we support.

The SMDHU has been a strong proponent of basic income repeatedly since 2015. This includes having sponsored a resolution at the Association of Local Public Health Agencies (alPHa) general meeting endorsing the concept of basic income and requesting the federal and provincial governments jointly consider and investigate a basic income policy option for reducing poverty and income insecurity (2015), and expressing support and input into the Ontario Basic Income Pilot (2017). SMDHU has also been encouraging advocacy for income solutions to household food insecurity through our No Money for Food is Cent$less initiative since 2017.

In keeping with this, we strongly recommend your government take swift and immediate action on the evolution of the CERB Benefit into legislation for a basic income as an effective long-term

response to the problems of income insecurity, persistent poverty and household food insecurity, as well as a response to the economic impact of the COVID-19 pandemic.

Sincerely,

ORIGINAL Signed By:

Anita Dubeau
Chair, Board of Health

AD:CS:cm

Encl. (1)

cc. Hon. Doug Ford, Premier of Ontario
Simcoe and Muskoka MPs and MPPs
Simcoe Muskoka Municipal Councils
Association of Local Public Health Agencies
Ontario Public Health Association
Ontario Boards of Health

Appendix A: Examples of Support for Basic Income in Response to COVID-19 and Beyond

On April 21, 2020, 50 members of Canada's Senate wrote a letter to the federal government calling for a restructuring of the CERB into a minimum basic income to "ensure greater social and economic equity", especially for those who are most vulnerable. In support of this letter, Senator McPhedran's Youth Advisory Council, the Canadian Council of Young Feminists, in collaboration with the Basic Income Canada Youth Network, sent their own letter to the federal government.

In our region, Simcoe North MP Bruce Stanton has expressed agreement that it's time to consider basic income. He is quoted as saying "Based on my reading of this, like Senator Boniface, I am persuaded that it could be very good public policy" (News Story).

The Ontario Dietitians' of Public Health (ODPH) have also written a letter to the federal government stating "We ask that you take immediate action to enact legislation for a basic income guarantee as an effective long-term response to the problem of persistent poverty and household food insecurity as well as shorter-term consequences of the economic fallout of the COVID-19 pandemic".

The Board of Health of the Kingston, Frontenac, Lennox and Addington Health Unit in Ontario also passed a motion requesting the federal government to provide a basic income support to all Canadians (News Story).

June 8, 2020

Bruce Lauckner
Transitional Regional Lead West, Ontario Health
CEO for Erie St. Clair, Hamilton Niagara Haldimand Brant, South West and Waterloo Wellington LHINs

Dear Mr. Lauckner,

Re: Ontario Health reporting inaccuracy COVID-19 Enhanced Surveillance of Long-Term Care

On the May 7, 2020, Bruce-Grey COVID-19 Update Call you debriefed myself as the Board of Health Chair and Warden of Bruce County, and Paul McQueen, Warden of Grey County among others on the status of the Grey Bruce Health Unit (GBHU) with regards to the Enhanced Surveillance of COVID-19 testing in Long-Term Care, as directed by the Ministry of Health, and the data reporting inaccuracy that took place.

In your debrief, you spoke very highly of Dr. Ian Arra as the Medical Officer of Health (MOH) for the Grey and Bruce Counties, and of the GBHU performance. You attested that the GBHU has met and exceeded the Ministry of Health's expectation by reaching testing targets before the required deadlines.

You also explained what led to presenting inaccurate testing data to the Premier erroneously reflecting suboptimal performance of a number of the health unit in the South West Ontario Health Region. The reported number of swabs completed was substantially lower than actual number by a wide margin. For the GBHU, the inaccuracy showed 5% completion rate instead of the actual 45% at the time.

You explained that data from the Ontario Laboratory Information System (about 2 week old data) was possibility used instead of the diligently reported data by these health units on a daily basis.

The inaccurate data resulted in the Premier's statement in the media on May 5, 2020 describing the less than optimal performance of these health units and their MOHs. The Premier's statement was appropriately proportionate to the data that was presented.

You indicated in the meeting, what you had confirmed with the MOH on May 6, 2020, that the data inaccuracy was immediately communicated to the Premier's Office and that correction of the data was to follow.

No further communication has been forth coming from yourself as the CEO or your office representatives regarding this data inaccuracy, nor if the issue has been reported to the Premier's Office for knowledge and correction.

We respectfully request a written response confirming and outlining the following points. First, that the data inaccuracy was appropriately reported to the Premier's Office and the correction was completed. Second, and equally important, that mitigation measures have been implemented to prevent such inaccuracy from occurring in the future.

Yours truly,

Mitch Towlan

Chair of the Board of Health
Grey Bruce Health Unit
101 17th Street East
Owen Sound ON N4K 0A5
Phone: (519)376-9420, Ext. 1241

CC

Office of the Premier
Minister of Health
Minster of Long-Term Care
MPP Lisa Thompson
MPP Bill Walker
Chief Medical Officer of Health, Dr. David Williams
Boards of Health – Ontario

simcoe muskoka
DISTRICT HEALTH UNIT

May 20, 2020

The Right Honourable Justin Trudeau, P.C., MP
Prime Minister of Canada
Office of the Prime Minister
80 Wellington Street
Ottawa, ON K1A 0A2

The Honourable Chrystia Freeland, P.C., M.P.
Deputy Prime Minister
Privy Council Office
Room 1000
80 Sparks Street
Ottawa, ON K1A 0A3

The Honourable Bill Morneau, P.C., M.P.
Minister of Finance
90 Elgin Street, 17th Floor
Ottawa, ON K1A 0G5

Dear Prime Minister Trudeau, Deputy Prime Minister Freeland and Minister Morneau:

Re: Basic Income for Income Security during Covid-19 Pandemic and Beyond

On behalf of the Simcoe Muskoka District Health Unit (SMDHU) Board of Health, I am writing to convey our strong support for the evolution of the Canada Emergency Response Benefit (CERB) into a basic income for all Canadians, during the COVID-19 pandemic and beyond.

While we commend the federal government for the economic measures that have been put into place to support Canadians during this unprecedented time of the COVID-19 pandemic, we also know that many are falling through the cracks. Measures such as the CERB, the Canada Emergency Student Benefit (CESB) and the Canada Emergency Wage Subsidy (CEWS), though necessary and very important, have left many Canadians, who do not qualify for or not able to access these programs, vulnerable to household food insecurity and the negative consequences of income insecurity and poverty such as inadequate or unstable housing, and poorer mental and physical health, including chronic diseases. A basic income would address these gaps, offering support to the most vulnerable Canadians.

Before the COVID-19 pandemic, many Canadians were already experiencing household food insecurity. In 2017-18 approximately 4.4-million (1 in 8) Canadians reported being food insecure, including 1.2 million children under the age of 18.[i] As a result of COVID-19, this number is predicted to increase as many individuals are facing precarious employment, have had their hours reduced or have lost their jobs altogether. Many are relying on food banks and other charitable programs, however, this only meets the need on a temporary basis and is not a long term solution.

Examples of key Canadian initiatives that demonstrate the positive impact of basic income-like programs on health and well-being include the Old Age Security and Guaranteed Income Supplement through Canada's public pension system, the Canada Child Benefit, and the Newfoundland Poverty Reduction Strategy.

Basic income pilots for working-age adults in Canada have also led to promising findings, including the Mincome pilot in Manitoba and the recent Ontario Basic Income Pilot. The research study, *Southern Ontario's Basic Income Experience* released in March 2020, is based on Ontario's pilot. This pilot was implemented in three Ontario cities in 2018 by the provincial government, and the project was terminated in 2019 following a change in government. While the formal pilot evaluation was cancelled, this research study made use of surveys of individuals from Hamilton, Brantford and Brant County who had been enrolled in the pilot (217 individuals participated out of 1000 enrolled households), and interviews with 40 participants. Some of the key findings cited by participants in this report include improvements in physical and mental health; increased labour market participation; moving to higher paying and more secure jobs; reduced household food insecurity; housing stability; improved financial status and social relationships; less frequent visits to health practitioners and hospital emergency rooms; improved living standards; and an improved sense of self-worth and hope for a better future.

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Moving forward during and following the COVID-19 pandemic is an opportune time for the federal government to take action to evolve the CERB into a basic income. This would provide income security to all Canadians during the economic challenges of the pandemic itself, the post-pandemic recovery, and into the future. This is particularly pertinent given the dramatic shifts in the labour market in recent decades, such that full-time permanent employment is no longer the norm. The current CERB has helped demonstrate the logistical feasibility of delivering a basic income, and it could be readily evolved into an ongoing basic income for anyone who falls below a certain income floor. There is evidence of growing support for this concept, as outlined in Appendix A. The Basic Income Canada Network has outlined key features of basic income design for Canada, which we support.

The SMDHU has been a strong proponent of basic income repeatedly since 2015. This includes having sponsored a resolution at the Association of Local Public Health Agencies (alPHa) general meeting endorsing the concept of basic income and requesting the federal and provincial governments jointly consider and investigate a basic income policy option for reducing poverty and income insecurity (2015), and expressing support and input into the Ontario Basic Income Pilot (2017). SMDHU has also been encouraging advocacy for income solutions to household food insecurity through our No Money for Food is Cent$less initiative since 2017.

In keeping with this, we strongly recommend your government take swift and immediate action on the evolution of the CERB Benefit into legislation for a basic income as an effective long-term

response to the problems of income insecurity, persistent poverty and household food insecurity, as well as a response to the economic impact of the COVID-19 pandemic.

Sincerely,

ORIGINAL Signed By:

Anita Dubeau
Chair, Board of Health

AD:CS:cm

Encl. (1)

cc. Hon. Doug Ford, Premier of Ontario
Simcoe and Muskoka MPs and MPPs
Simcoe Muskoka Municipal Councils
Association of Local Public Health Agencies
Ontario Public Health Association
Ontario Boards of Health

Appendix A: Examples of Support for Basic Income in Response to COVID-19 and Beyond

On April 21, 2020, 50 members of Canada's Senate wrote a letter to the federal government calling for a restructuring of the CERB into a minimum basic income to "ensure greater social and economic equity", especially for those who are most vulnerable. In support of this letter, Senator McPhedran's Youth Advisory Council, the Canadian Council of Young Feminists, in collaboration with the Basic Income Canada Youth Network, sent their own letter to the federal government.

In our region, Simcoe North MP Bruce Stanton has expressed agreement that it's time to consider basic income. He is quoted as saying "Based on my reading of this, like Senator Boniface, I am persuaded that it could be very good public policy" (News Story).

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The Board of Health of the Kingston, Frontenac, Lennox and Addington Health Unit in Ontario also passed a motion requesting the federal government to provide a basic income support to all Canadians (News Story).

Peterborough Public Health

Jackson Square, **185 King Street**, Peterborough, ON K9J 2R8
P: **705-743-1000** or 1-877-743-0101
F: 705-743-2897
peterboroughpublichealth.ca

June 25, 2020

The Right Honourable Justin Trudeau, P.C., MP
Prime Minister of Canada
Office of the Prime Minister
80 Wellington Street
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justin.trudeau@parl.gc.ca

The Honourable Chrystia Freeland, P.C., M.P.
Deputy Prime Minister
Privy Council Office
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80 Sparks Street
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The Honourable Bill Morneau, P.C., M.P.
Minister of Finance
90 Elgin Street, 17th Floor
Ottawa, ON K1A 0G5
bill.morneau@parl.gc.ca

Dear Prime Minister, Deputy Prime Minister and Minister Morneau:

Subject: Endorsement of the letter from Simcoe Muskoka District Health Unit, *Basic Income for Income Security during COVID-19 Pandemic and Beyond*

I am writing on behalf of the Board of Health for Peterborough Public Health to express support for recommendations from the Simcoe Muskoka District Health Unit (SMDHU) Board of Health, for the "evolution of the Canada Emergency Response Benefit (CERB) into a basic income for all Canadians, during the COVID-19 pandemic and beyond."

As mentioned in the letter endorsed by SMDHU, from the Ontario Dietitians in Public Health, there is a lack of evidence that charitable food distribution systems can lower household food insecurity rates. Basic income is an evidence-based strategy to address poverty and household food insecurity in Canada.

Poverty and household food insecurity are severe problems in Peterborough. For example, half of single mothers in Peterborough are food insecure, worrying about running out of money for food.[1] Also, many residents have little income left over after paying rent: Peterborough has the highest percentage of renting households with unaffordable shelter costs in Canada, and over half of local renters are housing insecure.[2] There are also significant income challenges faced by rural communities, including those in the Peterborough County. Of note, net farm incomes in Ontario were almost 50% lower in 2019 when compared to 2017, highlighting risk of poverty for farmers.[3]

During the COVID-19 pandemic and beyond, local residents and all Canadians require adequate incomes to meet basic needs and live with dignity. Basic income is a strategy that has been shown to facilitate critical outcomes including housing stability, household food security, and improved physical and mental health. Basic income would also allow for flexibility of Canadians to meet needs in ways that are reflective of their cultures and traditions. A basic income is what our country needs to address impacts of COVID-19 and other adversity we will face, to allow for an equitable, healthy, and resilient future.

Sincerely,

Original signed by

Mayor Andy Mitchell
Chair, Board of Health

/ag
Encl.

cc: Local MPs
Opposition Critics
The Association of Local Public Health Agencies
The Ontario Public Health Association
Ontario Boards of Health

---

[1] Peterborough Public Health. (2019). Limited Incomes Report: No Money for Food is Cent$less. Retrieved from: https://www.peterboroughpublichealth.ca/reports-and-data/

[2] United Way Peterborough and District. (2019). Housing is Fundamental. Retrieved from https://www.uwpeterborough.ca/housing-is-fundamental/

[3] Statistics Canada. (2020). Net Farm Income (x1000). Retrieved from https://www150.statcan.gc.ca/t1/tbl1/en/tv.action?pid=3210005201

Porcupine
Health Unit • Bureau de santé

June 29, 2020

Head Office:
169 Pine Street South
Postal Bag 2012
Timmins, ON P4N 8B7

Phone: 705 267 1181
Fax: 705 264 3980
Toll Free: 800 461 1818

The Right Honourable Justin Trudeau, P.C., M.P.
Prime Minister of Canada
Office of the Prime Minister
80 Wellington Street
Ottawa, ON K1A 0A2

The Honourable Chrystia Freeland, P.C., M.P.
Deputy Prime Minister
Privy Council Office
Room 1000
80 Sparks Street
Ottawa, ON K1A 0A3

The Honourable Bill Morneau, P.C., M.P.
Minister of Finance
90 Elgin Street, 17th Floor
Ottawa, ON K1A 0G5

Dear Prime Minister Trudeau, Deputy Prime Minister Freeland and Minister Morneau:

Subject: Basic Income for Income Security during COVID-19 Pandemic and Beyond

The Board of Health for the Porcupine Health Unit strongly supports a basic income for all Canadians to ensure everyone has a sufficient income to meet their basic needs. As such, the Board of Health endorses the enclosed correspondence to the federal government from Simcoe Muskoka District Health Unit, dated May 20, 2020, Timiskaming Health Unit, dated June 9, 2020, the Ontario Dietitians in Public Health, dated May 9, 2020 and Canada's Senate, dated April 21, 2020. These letters request that the federal government change the Canada Emergency Response Benefit (CERB) into a basic income for all Canadians, during the COVID-19 pandemic and beyond.

The measures taken during COVID-19 to support Canadians are an important opportunity to address the economic disparities that impact health. Income insecurity impacts the health of the population. This includes housing instability, food security, poorer physical and mental health outcomes as well as chronic health conditions. Food insecurity is an important public health issue in the Porcupine Health Unit (PHU) area. The PHU is located in Northeastern Ontario and serves communities in the Cochrane District as well as Hornepayne, in Algoma District. Geographically, the PHU is the largest of the 34 health units in Ontario. As the most sparsely populated of all the health units, about one-third of the PHU area is rural. There are many demographic and socioeconomic factors that make the PHU district unique in the province, including a higher Francophone and Indigenous population in addition to a higher unemployment rate, a higher percentage of those not completing high school and lower life expectancy.(1)

. . 2

E-mail:
info4you@porcupinehu.on.ca
Web site: www.porcupinehu.on.ca

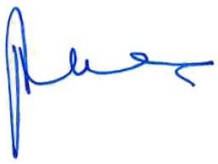
Branch Offices: Cochrane, Hearst, Hornepayne, Iroquois Falls, Kapuskasing, Matheson, Moosonee, Smooth Rock Falls

Furthermore, access to affordable, nutritious foods is a challenge, especially in the smaller communities in the region. Many of the communities only have one grocery store and some do not have a grocery store and must travel to other communities to purchase food. The PHU has experienced a 10% increase in the cost of healthy food since 2015. In 2019, the cost of the Nutritious Food Basket was approximately $25 higher per week than the Ontario provincial average. When the cost of healthy eating is added to local rent rates and various income scenarios are compared, year after year this survey demonstrates that many residents in the PHU area living on a low income are unlikely to have sufficient income to purchase a basic healthy diet for themselves and their families.

Food-insecure Canadians are much more likely than others to have serious physical and mental health problems[4], and they are less able to manage these conditions. Research shows that severe food insecurity can reduce a person's life expectancy by 9 years, as well as pose a significant cost to our health care system.

We strongly recommend your government take immediate action on developing the Canada Emergency Response Benefit into legislation for a basic income as an effective long-term response to the problems of income insecurity, poverty and household food insecurity, as well as a response to the economic impact of the COVID-19 pandemic.

Sincerely,



Sue Perras
Board Chair, Porcupine Health Unit

cc: *Hon., Doug Ford, The Premier of Ontario*
Mr. Charlie Angus, MP – Timmins – James Bay
Ms. Carol Hughes, MP – Algoma – Manitoulin – Kapuskasing
Mr. Gilles Bisson, MPP – Timmins – James Bay
Mr. Guy Bourgouin, MPP – Mushkegowuk - James Bay
Municipal Councils
Association of Local Public Health Agencies (alPHa)
Ontario Boards of Health
Ontario Public Health Association

1. Porcupine Health Unit. Health Status Report 2020 (Draft); 2020 [cited 2020 May 29].

2. Tarasuk V, Mitchell A. (2020). Household food insecurity in Canada, 2017-18. Toronto: Research to identify policy options to reduce food insecurity (PROOF). Retrieved from https://proof.utoronto.ca/.

3. Mohammad Ferdosi, Tom McDowell, Wayne Lewchuk, Stephanie Ross. Southern Ontario's Basic Income Experience [Internet]. 2020 [cited 2020 May 25]. Available from: https://labourstudies.mcmaster.ca/documents/southern-ontarios-basic-income-experience.pdf

4. Nutritious Food Basket [Internet]. [cited 2019 Mar 1]. Available from: http://www.porcupinehu.on.ca/en/your-family/nutrition-food-basket/

July 16, 2020

The Right Honourable Justin Trudeau, P.C., M.P.
Prime Minister of Canada
Office of the Prime Minister
80 Wellington Street
Ottawa, ON K1A 0A2
justin.trudeau@parl.gc.ca

The Honourable Chrystia Freeland, P.C., M.P.
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chrystia.freeland@parl.gc.ca

The Honourable Bill Morneau, P.C., M.P.
Minister of Finance
90 Elgin Street, 17th Floor
Ottawa, ON K1A 0G5
bill.morneau@parl.gc.ca

Dear Prime Minister Trudeau, Deputy Prime Minister Freeland and Minister Morneau:

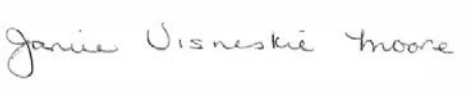
Re: Basic Income for Income Security during Covid-19 Pandemic and Beyond

On June 30, 2020, at the Regular Board meeting for the Renfrew County and District Health Unit, the Board of Health approved a motion to endorse Timiskaming Health Unit's letter of support for the attached correspondence of Simcoe Muskoka District Health Unit, dated May 20, 2020.

Simcoe Muskoka District Health Unit (SMDHU) called for the federal government to *take*

swift and immediate action on the evolution of the CERB Benefit into legislation for a basic income as an effective long-term response to the problems of income insecurity, persistent poverty and household food insecurity, as well as a response to the economic impact of the COVID-19 pandemic.

Sincerely,



Janice Visneskie Moore
Chair, Board of Health

Attachments

c. Honourable Doug Ford, Premier of Ontario
Dr. David Williams, Chief Medical Officer of Health
Pegeen Walsh, Executive Director, Ontario Public Health Association
Association of Local Public Health Agencies—Loretta Ryan
Ontario Boards of Health
Honourable John Yakabuski, M.P.P.—Renfrew-Nipissing-Pembroke
Honourable Chery Gallant, M.P.—Renfrew-Nipissing-Pembroke
Local Municipalities
AMO/ROMA

Services de santé du TIMISKAMING Health Unit
Enhancing your health in so many ways.

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Branch Offices:
Englehart Tel.: 705-544-2221 Fax: 705-544-8698
Kirkland Lake Tel.: 705-567-9355 Fax: 705-567-5476

www.timiskaminghu.com

June 9, 2020

The Right Honourable Justin Trudeau, P.C., MP
Prime Minister of Canada
Office of the Prime Minister
80 Wellington Street
Ottawa, ON K1A 0A2

The Honourable Chrystia Freeland, P.C., M.P.
Deputy Prime Minister
Privy Council Office
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80 Sparks Street
Ottawa, ON K1A 0A3

The Honourable Bill Morneau, P.C., M.P.
Minister of Finance
90 Elgin Street, 17th Floor
Ottawa, ON K1A 0G5

Dear Prime Minister Trudeau, Deputy Prime Minister Freeland and Minister Morneau:

Re: Basic Income for Income Security during Covid-19 Pandemic and Beyond

On June 3, 2020, at a regular meeting of the Board for the Timiskaming Health Unit, the Board supported the enclosed correspondence of Simcoe Muskoka District Health Unit, dated May 20, 2020 and passed the following motion:

MOTION #26R-2020
Moved by: Kim Gauthier
Seconded by: Patrick Kiely

BE IT RESOLVED that the Board of Health endorses the Simcoe Muskoka District Health Unit (SMDHU) call for the federal government to 'take swift and immediate action on the evolution of the CERB Benefit into legislation for a basic income as an effective long-term response to the problems of income insecurity, persistent poverty and household food insecurity, as well as a response to the economic impact of the COVID-19 pandemic'; AND
FURTHER THAT Prime Minister Trudeau, Deputy Prime Minister Freeland and Minister Morneau, Timiskaming's MPs, MPPs and Chief Medical Officer of Health, and all Ontario boards of health are so advised.

CARRIED

Sincerely,

Carman Kidd, Board of Health Chair

Enclosure

cc Mr. John Vanthof, MPP - Timiskaming-Cochrane
Mr. Anthony Rota, MP – Timiskaming-Nipissing
Dr. David Williams, Chief Medical Officer of Health
Mrs. Loretta Ryan, Association of Local Public Health Agencies
Ontario Boards of Health
Ms. Pegeen Walsh, Executive Director, Ontario Public Health Association
Mr. Doug Jelly, Chairman of District of Timiskaming Social Services Administration Board

simcoe muskoka
DISTRICT HEALTH UNIT

May 20, 2020

The Right Honourable Justin Trudeau, P.C., MP
Prime Minister of Canada
Office of the Prime Minister
80 Wellington Street
Ottawa, ON K1A 0A2

The Honourable Chrystia Freeland, P.C., M.P.
Deputy Prime Minister
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Ottawa, ON K1A 0A3

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Minister of Finance
90 Elgin Street, 17th Floor
Ottawa, ON K1A 0G5

Dear Prime Minister Trudeau, Deputy Prime Minister Freeland and Minister Morneau:

Re: Basic Income for Income Security during Covid-19 Pandemic and Beyond

On behalf of the Simcoe Muskoka District Health Unit (SMDHU) Board of Health, I am writing to convey our strong support for the evolution of the Canada Emergency Response Benefit (CERB) into a basic income for all Canadians, during the COVID-19 pandemic and beyond.

While we commend the federal government for the economic measures that have been put into place to support Canadians during this unprecedented time of the COVID-19 pandemic, we also know that many are falling through the cracks. Measures such as the CERB, the Canada Emergency Student Benefit (CESB) and the Canada Emergency Wage Subsidy (CEWS), though necessary and very important, have left many Canadians, who do not qualify for or not able to access these programs, vulnerable to household food insecurity and the negative consequences of income insecurity and poverty such as inadequate or unstable housing, and poorer mental and physical health, including chronic diseases. A basic income would address these gaps, offering support to the most vulnerable Canadians.

Before the COVID-19 pandemic, many Canadians were already experiencing household food insecurity. In 2017-18 approximately 4.4-million (1 in 8) Canadians reported being food insecure, including 1.2 million children under the age of 18.[i] As a result of COVID-19, this number is predicted to increase as many individuals are facing precarious employment, have had their hours reduced or have lost their jobs altogether. Many are relying on food banks and other charitable programs, however, this only meets the need on a temporary basis and is not a long term solution.

Examples of key Canadian initiatives that demonstrate the positive impact of basic income-like programs on health and well-being include the Old Age Security and Guaranteed Income Supplement through Canada's public pension system, the Canada Child Benefit, and the Newfoundland Poverty Reduction Strategy.

Basic income pilots for working-age adults in Canada have also led to promising findings, including the Mincome pilot in Manitoba and the recent Ontario Basic Income Pilot. The research study, *Southern Ontario's Basic Income Experience* released in March 2020, is based on Ontario's pilot. This pilot was implemented in three Ontario cities in 2018 by the provincial government, and the project was terminated in 2019 following a change in government. While the formal pilot evaluation was cancelled, this research study made use of surveys of individuals from Hamilton, Brantford and Brant County who had been enrolled in the pilot (217 individuals participated out of 1000 enrolled households), and interviews with 40 participants. Some of the key findings cited by participants in this report include improvements in physical and mental health; increased labour market participation; moving to higher paying and more secure jobs; reduced household food insecurity; housing stability; improved financial status and social relationships; less frequent visits to health practitioners and hospital emergency rooms; improved living standards; and an improved sense of self-worth and hope for a better future.

Additional evidence supporting the potential of a basic income for reducing the prevalence and severity of household food insecurity is presented in: *Implications of a Basic Income Guarantee for Household Food Insecurity*, a research paper prepared for the Northern Policy Institute based on the Ontario Basic Income Pilot.

Moving forward during and following the COVID-19 pandemic is an opportune time for the federal government to take action to evolve the CERB into a basic income. This would provide income security to all Canadians during the economic challenges of the pandemic itself, the post-pandemic recovery, and into the future. This is particularly pertinent given the dramatic shifts in the labour market in recent decades, such that full-time permanent employment is no longer the norm. The current CERB has helped demonstrate the logistical feasibility of delivering a basic income, and it could be readily evolved into an ongoing basic income for anyone who falls below a certain income floor. There is evidence of growing support for this concept, as outlined in Appendix A. The Basic Income Canada Network has outlined key features of basic income design for Canada, which we support.

The SMDHU has been a strong proponent of basic income repeatedly since 2015. This includes having sponsored a resolution at the Association of Local Public Health Agencies (alPHa) general meeting endorsing the concept of basic income and requesting the federal and provincial governments jointly consider and investigate a basic income policy option for reducing poverty and income insecurity (2015), and expressing support and input into the Ontario Basic Income Pilot (2017). SMDHU has also been encouraging advocacy for income solutions to household food insecurity through our No Money for Food is Cent$less initiative since 2017.

In keeping with this, we strongly recommend your government take swift and immediate action on the evolution of the CERB Benefit into legislation for a basic income as an effective long-term

response to the problems of income insecurity, persistent poverty and household food insecurity, as well as a response to the economic impact of the COVID-19 pandemic.

Sincerely,

ORIGINAL Signed By:

Anita Dubeau
Chair, Board of Health

AD:CS:cm

Encl. (1)

cc. Hon. Doug Ford, Premier of Ontario
Simcoe and Muskoka MPs and MPPs
Simcoe Muskoka Municipal Councils
Association of Local Public Health Agencies
Ontario Public Health Association
Ontario Boards of Health

Appendix A: Examples of Support for Basic Income in Response to COVID-19 and Beyond

On April 21, 2020, 50 members of Canada's Senate wrote a letter to the federal government calling for a restructuring of the CERB into a minimum basic income to "ensure greater social and economic equity", especially for those who are most vulnerable. In support of this letter, Senator McPhedran's Youth Advisory Council, the Canadian Council of Young Feminists, in collaboration with the Basic Income Canada Youth Network, sent their own letter to the federal government.

In our region, Simcoe North MP Bruce Stanton has expressed agreement that it's time to consider basic income. He is quoted as saying "Based on my reading of this, like Senator Boniface, I am persuaded that it could be very good public policy" (News Story).

The Ontario Dietitians' of Public Health (ODPH) have also written a letter to the federal government stating "We ask that you take immediate action to enact legislation for a basic income guarantee as an effective long-term response to the problem of persistent poverty and household food insecurity as well as shorter-term consequences of the economic fallout of the COVID-19 pandemic".

The Board of Health of the Kingston, Frontenac, Lennox and Addington Health Unit in Ontario also passed a motion requesting the federal government to provide a basic income support to all Canadians (News Story).