Legislative Assembly of Ontario

Assemblée législative de l'Ontario

Official Report of Debates (Hansard)

P-8

Standing Committee on Public Accounts

2017 Annual Report, Auditor General:

Ministry of Health and Long-Term Care

Public Health Ontario

1st Session
42nd Parliament

Wednesday 20 February 2019

Chair: Catherine Fife
Clerk: Christopher Tyrell

Journal des débats (Hansard)

P-8

Comité permanent des comptes publics

Rapport annuel 2017, vérificatrice générale :

Ministère de la Santé et des Soins de longue durée

Santé publique Ontario

1re session
42e législature

Mercredi 20 février 2019

Présidente : Catherine Fife
Greffier : Christopher Tyrell

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111 Wellesley Street West, Queen's Park
Toronto ON M7A 1A2
Telephone 416-325-7400; fax 416-325-7430
Published by the Legislative Assembly of Ontario

Service du Journal des débats et d'interprétation
Salle 500, aile ouest, Édifice du Parlement
111, rue Wellesley ouest, Queen's Park
Toronto ON M7A 1A2
Téléphone, 416-325-7400; télécopieur, 416-325-7430
Publié par l'Assemblée législative de l'Ontario

ISSN 1180-4327

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ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON PUBLIC ACCOUNTS

COMITÉ PERMANENT DES COMPTES PUBLICS

Wednesday 20 February 2019

Mercredi 20 février 2019

The committee met at 0900 in committee room 1.

2017 ANNUAL REPORT, AUDITOR GENERAL

MINISTRY OF HEALTH AND LONG-TERM CARE

PUBLIC HEALTH ONTARIO

Consideration of section 3.10, public health: chronic disease prevention.

The Chair (Ms. Catherine Fife): Good morning, everyone. Thank you for being here. I'd like to call this meeting to order. We are here today to resume consideration of section 3.10, public health: chronic disease prevention, from the 2017 Annual Report of the Office of the Auditor General of Ontario.

Following our first meeting on this topic back on October 24, 2018, the committee decided that it would like to hear from the heads of the four public health units who participated in the audit conducted by the Office of the Auditor General.

Thank you for all being here today to answer the committee's questions. I would like to invite you to introduce yourselves for Hansard before you begin speaking. You will have 20 minutes collectively for an opening presentation to the committee. We will then move into the question-and-answer portion of the meeting, where we will rotate back and forth between the government and the official opposition caucuses in 20-minute intervals.

You may now begin.

Dr. Robert Kyle: Good morning, Chair and members. I have some prepared remarks on behalf of the four of us. I believe they've been distributed. They begin on page 5 of the handout.

My name is Dr. Robert Kyle. I'm the commissioner and medical officer of health for the regional municipality of Durham. With me to my right are Dr. David Colby and Dr. Eileen De Villa, and to my left is Dr. Janet DeMille, who are the medical officers of health of Chatham-Kent, Toronto and Thunder Bay district respectively. Our bios are attached to the transmittal letter that's before you. Thank you for the invitation to appear before you today, and thanks to the audit team for working with us in researching and preparing its audit report.

Before proceeding, it should be noted that section 2.1.2 of the audit—and where you see page numbers, it's the page numbers of the audit report—refers to the previous Ontario Public Health Standards 2008, that were replaced by the new Ontario Public Health Standards: Requirements for Programs, Services, and Accountability, 2018, which are described in more detail below.

We acknowledge the public health significance of chronic diseases, in that most chronic diseases—diabetes and cancer, for example—are preventable, or their onset can be delayed by limiting four modifiable risk factors: physical inactivity, smoking, unhealthy eating and excessive alcohol consumption. Accordingly, the focus of our remarks is on the public health system and its role in chronic disease prevention. Questions about the Ministry of Health and Long-Term Care, the status of the audit's recommendations and Public Health Ontario are best directed to the ministry and public health officials respectively.

Public health focuses on the health and well-being of the whole population through the promotion and protection of health and prevention of illness. The Health Protection and Promotion Act is the primary legislation that governs the delivery of public health programs and services. Its purpose is to provide for the organization and delivery of public health programs and services, the prevention of the spread of disease, and the promotion and protection of the health of the people of Ontario. The public health system is an extensive network of government, non-government and community organizations operating at the local, provincial and federal levels.

The key provincial players are the ministry and Public Health Ontario. The ministry co-funds with obligated municipalities 35 public health units to directly provide public health programs and services.

The population and public health division is responsible for developing public health initiatives and strategies and for funding and monitoring public health programs and services delivered by public health units. The division is currently led by the Chief Medical Officer of Health, who reports directly to the deputy minister. His other duties include those listed on page 532. Public Health Ontario provides scientific and technical advice and support to the Chief Medical Officer of Health, the divisions and public health units, and it also operates Ontario's 11 public health laboratories.

Public health units deliver a variety of programs and services in their health units; examples are listed on page 533. Health unit populations range in size from 34,000 in

Timiskaming to three million in Toronto. Each public health unit is governed by a board of health, which is accountable for meeting provincial standards under the act. Each board of health appoints a medical officer of health whose powers and duties are specified in the act and include reporting directly to the board of health on public health and other matters.

Governance models vary considerably across all 35 public health units. All are municipally controlled to varying degrees. Each board of health has a Public Health Funding and Accountability Agreement with the ministry, which sets out the terms and conditions governing its funding. The ministry develops standards for delivering public health programs and services as required by the act. Each board of health is required to comply with these standards.

On January 1, 2018, each board of health began implementing the new Ontario Public Health Standards: Protocols and Guidelines. They set out the minimum requirements that public health units must adhere to in delivering programs and services. The standards consist of nine program standards, which include chronic disease prevention and well-being. The standards also consist of four foundational standards that underlie and support all programs and services. The other program standards and the foundational standards are listed in my notes.

Twenty-three protocols provide direction on how boards of health shall operationalize specific requirements identified within the standard. The aim is to have consistent implementation of specific requirements across all boards of health. In the past and now, boards of health must comply with these protocols.

Twenty guidelines provide direction on how boards of health shall approach specific requirements identified within the standards. The aim is to provide a consistent approach to, or application of, requirements across all boards of health while allowing for variability in programs and services across public health units based on local factors as defined in the guidelines. And now, boards of health must comply with these guidelines.

It should be noted that although there are fewer program standards, there are more foundational standards and, taken together with the protocols and guidelines, more requirements with which boards of health must comply.

Under the act, provincial funding of public health units is not mandatory, but rather is provided as per ministry policy. The act requires obligated—that is, upper-tier or single-tier—municipalities to pay the expenses incurred by or on behalf of public health units to deliver the programs and services set out in the act, the regulations and the standards.

Currently, the ministry funds up to 75% of mandatory programs and up to 100% of priority programs. The ministry updates the schedules of the Public Health Funding and Accountability Agreement annually, and the new standards take a coordinated approach to the standards listed above and a more robust accountability framework that covers several domains: delivery of programs and services; fiduciary requirements; good governance and management practices; public health practices; and some that are common to all domains.

Beginning in 2018, each board of health submits a prescribed annual service plan and budget submission to the division for approval. It should be noted that boards of health are now providing the division with far more information. Moreover, beginning in the fall of 2018, boards of health must report on their risk management activities. Finally, commencing with the current budget submission, boards of health must report on their 2018 program activities, as specified by the division.

With respect to chronic disease prevention, the standards require each board of health to develop and implement a program of public health interventions using a comprehensive health promotion approach that addresses chronic disease risk and protective factors. There are several topics that are considered based on an assessment of local needs—they're listed in my notes—and several guidelines also guide the work in this area.

For three of these programs, each board of health shall collect and analyze relevant data and report and disseminate the data and information in accordance with the Population Health Assessment and Surveillance Protocol.

Regarding program evaluation, each board of health is required to:

—routinely monitor program activities and outcomes to assess and improve the implementation of programs and standards;

—ensure a culture of ongoing program improvement and evaluation, and conduct formal program evaluations where required; and

—ensure all programs and services are informed by evidence.

Each board of health must comply with two research and knowledge exchange requirements that are listed in my notes.

In closing, Ontario has a mature, interconnected and well-regulated public health system. The system is capably led by the ministry and ably assisted by the Chief Medical Officer of Health and the division. Public Health Ontario provides the ministry and public health units with superb scientific, technical and laboratory support. Public health units are governed by boards of health, each of which appoints a medical officer of health who ensures the delivery of a wide array of public health programs and services, including chronic disease prevention, in accordance with the act, regulations, standards, protocols and guidelines.

As with all well-functioning health systems, there is always room for continuous quality improvement.

With the foregoing in mind, we would be happy to answer your questions.

The Chair (Ms. Catherine Fife): Thank you very much, Mr. Kyle. Would any of the other medical officers like to do opening comments? You still have nine minutes left. Or do you feel that, through question-and-answer, your testimony will be covered? Mr. Colby.

Dr. David Colby: If I may, Ms. Chair, we all collaborated on the address that Dr. Kyle read and agree with it wholeheartedly. I have nothing to add.

The Chair (Ms. Catherine Fife): Okay. Any others?

Dr. Eileen de Villa: Through the Chair, thank you very much. I think I will leave the summation that Dr. Kyle has provided. I'm happy to take any questions that the committee members may have.

The Chair (Ms. Catherine Fife): Very well. And you as well? Thank you.

This first line of questioning will go to the official opposition. MPP Gélinas.

M^me^ France Gélinas: Thank you so much for coming here today. It's much appreciated—and a very good summary as to how public health functions and all of the requirements that come with it.

0910

I'm sort of going to start at the 10,000-feet level when it comes to chronic disease. The first thing that sort of jumped out of the auditor's report is that, although you talk about alcohol consumption, unhealthy eating, inactivity and smoking, it seems like a lot of the resources that we saw through the auditor's report were targeting smoking cessation. Is this the reality in your respective health units—you can answer in whichever way you want—and if so, how come?

Dr. Robert Kyle: Thank you for the question. I'll start and then pass it on my colleagues.

What I would say is that tobacco control is probably more comprehensive. There are probably more developed resources to support tobacco control. There are several funding sources for tobacco control, and there was, at least at the time of the audit, a dedicated resource centre focused on tobacco control. That's not to say the other risk factors are not important. They are all addressed by all of us depending on local needs, depending on opportunities for collaboration and depending on the availability of local resources. So I wouldn't say, even though the audit demonstrated greater resources are directed toward tobacco control, that that necessarily means that is the most important risk factor. I think it's more a question of the development of tobacco control relative to the other risk factors and additional funding sources, which contribute at least in part to that audit finding.

I'll turn it over to my colleagues to add, if I may.

Dr. Eileen de Villa: If I can add further to the comments made by Dr. Kyle, I think, over and above that which is within the purview of public health, recognizing that those other risk factors are important, there are some areas in which levers are more readily accessible to public health practitioners.

I would certainly say that, as indicated through Dr. Kyle's comments, levers in respect of tobacco were far more available. I think the other important point to note is—Dr. Kyle mentioned in his remarks that tobacco may not be as important a risk factor now, but I would put to you that, in fact, the reason why it is less important a risk factor is because of the effort that has gone into place in tobacco.

I can assure you that we are concerned and we remain concerned about the other risk factors: alcohol consumption, healthy eating, optimizing physical activity. These are areas, risk factors in particular, that have far more complicated levers involved, some of which are at the behest of public health practitioners, others of which are much broader and involve other elements of society. We continue to be concerned about those risk factors and we are working on those, but I would suggest to you that tobacco is less important a risk factor now, and if so, it's because of the work that has been done to date.

Dr. Janet DeMille: I'm Janet DeMille. I'm the medical officer of health for the Thunder Bay District Health Unit. I'll echo the comments of my colleagues: We do address all of those four factors. I do find that the tobacco control programming that we do is better resourced because of the funding that we receive from the ministry and have received over a number of years, so we have been able to advance significant work around that.

As well, a comprehensive approach to tobacco control is not just about cessation; it's also about prevention and enforcement: prevention that targets youth and young adults, who are more likely to pick up the risk behaviour of smoking, and also enforcement, enforcing the Smoke-Free Ontario Act being one of those, but also looking at policies and policy development for multi-unit dwellings or city bylaws that support smoke-free spaces. It's a comprehensive approach.

I will note that in the north and in the Thunder Bay District Health Unit we have higher rates of smoking compared to the rest of the province, so I am very reluctant to feel like we've accomplished where we need to be with tobacco programming. It remains a very significant risk factor.

Looking at health disparities, there were certain populations that are more likely to smoke, and that includes Indigenous populations. That remains a significant issue in the north.

M^me^ France Gélinas: Can you give me an idea as to the smoking rates in the different parts of the Thunder Bay District Health Unit?

Dr. Janet DeMille: I think this is 2016 data. I can come back with more accurate data if you want, but I believe in 2016 the rate for smoking in the past year was 24% for Thunder Bay District and I believe in Ontario it was 17%. For First Nations populations or Indigenous populations it's very hard to get an accurate assessment of the percentage, but there are communities where it's up to 50%.

M^me^ France Gélinas: Thank you.

Dr. David Colby: Dr. Colby from Chatham-Kent. I will refrain from reiterating the points that I agree so much with, but I think it can't be overemphasized that so much progress has been made in smoking. The Auditor General's report noted that the lack of physical activity makes a greater contribution to chronic disease at this point in history than smoking does. But I'm in full agreement with my colleague from Toronto that this was not always the case and that great strides have been made.

Speaking specifically about the Chatham-Kent Public Health Unit, we devote more resources to physical activity

enhancement, physical literacy and the social determinants of health and poverty reduction than we do to smoking at this point in time. But it remains a very, very high priority for us. We, unfortunately, have a higher rate of smoking than the provincial average, but we do put emphasis on all of those things.

Mme France Gélinas: A few of you have mentioned that the success we've had—that you've had, for all of us—in reducing smoking rates seems to be directly linked to better resources and better funding from the government that enable you to put forward and be successful in smoking reduction and cessation.

We now have cannabis that is available. Most people smoke cannabis, and I was wondering if resources have come to support your health units due to the increase in smoking rates that are to be expected with cannabis becoming legal.

Dr. Robert Kyle: I can start there. I think we're all active with respect to raising awareness about the adverse effects of cannabis, and I would say that we share resources among ourselves. We work with community partners and so forth and so on. Have we received additional provincial funding to assist us in this work to date? The answer would be no.

However, we are in the process of preparing our budget submissions. They're due April 1 and we'll find out some time thereafter whether our budget submissions will be funded, and I'm sure we all will make provision in our budgets for work in this area.

I'll turn it over to my colleagues to see if they have anything else to say.

Dr. David Colby: Thank you. In our health unit I've taken the position that smoke is smoke and have used the tobacco reduction strategy to apply the same way toward the smoking of tobacco in public places. In Chatham-Kent we also have stronger municipal bylaws that control where anything can be smoked in public places and so forth than the provincial regulations allow for.

0920

Mme France Gélinas: Can you give me an example of those differences?

Dr. David Colby: The number of metres from public places—as you're well aware, there are different levels of legislation in this province: federal, provincial—I don't have to say that. But our municipal ones—I can't give you specific examples. It's mainly numbers. For example, parks are public places where smoking is not prohibited by provincial legislation but it is prohibited in Chatham-Kent by municipal bylaw. That's the best example I can give you.

Mme France Gélinas: Okay.

Dr. Eileen de Villa: I think the only other further comment I would add to that which my colleagues have raised is that within the area of local public health practice, I think we're quite used to having new and emerging issues come out that we have to address. Society is constantly changing and I think public health practice has to change along with it.

As cannabis becomes something more prominent in our area of practice, I agree with the notion of smoke is smoke and we will have to think about it within the context of our existing budget resources; make determinations, as we do each and every year, around those issues that impact on the health status of our populations; and then address them in accordance with what's available in the scientific literature and what the experiences of other jurisdictions tells us makes good sense to address those issues.

Dr. Janet DeMille: I do see some challenges with the legalization of cannabis currently, and even with the rising rates of vaping that are quite concerning. As Dr. Colby mentioned, smoke is smoke. We often deal with them in the same way with the same kind of approach. It does appear, though, that things are changing and it's quite concerning, certainly in our area, about how that will go.

When you talked about funding, I think that it has been helpful having Smoke-Free Ontario funding. But not only that; it has been a commitment of the government to very clearly deal with the tobacco issue and the harmful effects of tobacco over a number of years and even beyond that. It's not only the funding of public health but it is funding of other initiatives, even at hospitals or with other partners, to be able to address the issue. That just reflects a comprehensive approach to a complex public health issue. Certainly, looking at vaping and cannabis the same way would be helpful.

Mme France Gélinas: Because right now in Ontario, we have different sets of rules for vaping than we do for smoking.

You've all spoken about making investments in smoking cessation, making investments into your different communities to help people quit smoking and not pick it up in the first place if at all possible. How much of a risk do you see the legalization of cannabis in taking us in the wrong direction? Rather than going into 17% to 18% of Ontarians being smokers—rather than continuing to go down, this percentage is starting to go up. How much of a risk are we looking at, between vaping and cannabis smoking?

Dr. Robert Kyle: I guess I'll start. If your question is, "Is cannabis a gateway towards increased smoking use, generally?" I'm not sure what the research has to say. Quite frankly, my greater concern is over vaping products, because a vaping product, a cigarette—they're all nicotine delivery devices. I think the big concern is, having been successful in terms of driving down through comprehensive programming rates of cigarette use, to the extent that vaping products are attractive to youth, we're looking at an impending new generation, if you will, of nicotine addicts. That's why it's so important to not only prohibit display of vaping devices, but to crack down, in my judgment, with respect to the advertising of such products.

I'm a bit off your question in terms of cannabis. I think time will tell as to whether or not there are unforeseen health consequences as a result of the legalization of cannabis. I think it's early days, and I'm sure it will be an active area of research for the years ahead. I think there is the possibility that we're creating not only a new market and a younger market for cannabis, but, as I said, a new generation of nicotine addicts.

I'll turn it over to my colleagues to see if they have anything—

M^me^ France Gélinas: I'm quite willing to go to vaping. It was going to be my next question, but if you want to address it now I'm quite willing.

How much of a threat do you see this to the good work that had been happening in decreasing the amount of people who smoke or vape but are nicotine addicted?

Dr. Robert Kyle: I'll start and then—I've had too much air time. I deputed before the Standing Committee on Social Policy to talk about what I thought were the unforeseen consequences of vaping products. I think it's a very serious concern, for the reasons I've already outlined. Nicotine is addictive and, by making its use the norm, the risk is that you're creating a new generation of nicotine addicts.

I'll turn it over to my colleagues to get more air time than I've had. Thanks.

Dr. David Colby: I would like to add that there are direct and indirect hazards associated with vaping. That being said, smoking is by far the most hazardous way to enjoy cannabis, vaping is much less hazardous than smoking, and ingestion is probably a lot less hazardous than vaping. It's very unfortunate, in my opinion, that the federal legislation provided for legalization of cannabis before edible products were available for people to enjoy, which is the safest way to enjoy that. Society has decided that cannabis is going to be okay; we have to deal with that as public health.

The lack of control of the components of vaping solutions is a regulatory law issue that needs addressing very, very much. My remarks that vaping is inherently less hazardous than smoking is based on levels of toxic compounds, both in what is inhaled and what is in the room—orders of magnitude less than smoking. That doesn't mean it's completely innocuous, and it hasn't been well studied. To say something is not as hazardous as something else doesn't say that it's safe. "Safe" is a relative term. Many of the things that we do every day are not particularly safe, like driving in cars, but we accept those risks—

The Chair (Ms. Catherine Fife): I just want to let you know there's one minute left in this question set.

Dr. David Colby: Thank you. I'll be very, very brief.

The indirect risk of vaping, which I think my colleague alluded to, is the renormalization of smoking behaviours, which we're very concerned about in public health. We don't want a return to where that's okay.

M^me^ France Gélinas: And there were no resources given to the health units to deal with the impact of vaping?

Dr. David Colby: That is correct.

The Chair (Ms. Catherine Fife): Okay. Thank you very much. We'll move to the government side. MPP Miller.

Mr. Norman Miller: Thank you for coming in today. You certainly represent different areas of the province—Chatham-Kent, Durham, Thunder Bay and Toronto—so my question is related to the fact that you are responsible for different areas.

How do you tailor your approach to meet the specific chronic disease prevention needs of the populations in your specific regions? If you could pease respond to that.

0930

Dr. Robert Kyle: Very briefly, because I'm taking up too much air time: In Durham region, we have about 670,000 people. Most population is in south Durham. We have a rural north Durham. We have enough of a population that we've mapped various health indicators by neighbourhood, and through that resource and that process we have identified seven priority neighbourhoods where they have the lowest income, but if you look at certain health indicators, including chronic diseases, they have a disproportionate burden of illness.

One of the ways that we would tailor chronic disease prevention programming would be to tailor programs and services and deliver them in concert with the priority neighbourhoods themselves, so that we're trying to tackle the disproportionate burden of illness. That's just one example.

We all have various players/partners in our areas that bring various talents, skills, resources to the table. We leverage our talents, skills and resources and work together to try and comprehensively deal with chronic disease preventions in a variety of settings: schools, workplaces and so forth.

That's just sort of a general kind of answer, and I'll turn it to my colleagues now for more specific examples.

Dr. Eileen de Villa: I may start at the general level first as well to talk about what Dr. Kyle described, which is the use of surveillance and epidemiology resources within the context of local public health practice as akin to the diagnosis that a physician does for an individual patient. Right?

Our respective jurisdictions are our patients, and as Dr. Kyle mentioned in his opening remarks, some of us have jurisdictions of 34,000 patients, some of us have jurisdictions of almost three million. It's our responsibility, along with our respective staffs, to actually understand the needs of our population so that we can address public health programming, services and policies to meet those needs. Fundamentally, we have to do surveillance and epidemiology work. It's what physicians within the context of a hospital or clinic rely on: lab tests, a history of physical exams, X-rays and all those things. Those are their diagnostic methods.

We have surveillance and epidemiology methods to use, so that we can understand the needs of our populations, determine subpopulations and their unique needs and then program appropriately to meet those needs.

I think the only other point I would mention is that it's important as well that we're actually situated within our communities and are fully invested in our communities because so much of that which we do is done in concert with community partners.

So, over and above the very technical skills of surveillance and epidemiology, we also rely quite heavily on our relationships with community partners, which include health care partners but go beyond that, to fully understand

the needs of our communities so that we can appropriately provide local public health service.

Dr. David Colby: I fully agree with my colleague from Toronto, but I would like to add to that that all health units are required to implement the Ontario Public Health Standards. This applies across the board; it's not optional. Tailoring these programs to our own population needs and variances is not that easy to do because, first of all, you have to satisfy the standards to which we are all judged. There is some discretion in that way, but I personally think we could have more resources allocated to exactly the kind of local tailoring that the structure of the public health systems in Ontario, among all provinces, is optimized to deliver as long as we have the freedom to be able to do that.

An example I can give you from Chatham-Kent is—and it has been alluded to already in what has been said this morning—that there are many community resources that are available for smoking cessation. We believe, at the Chatham-Kent health unit, that preventing young people from starting to smoke is far more important. Once people are nicotine-addicted, it's very difficult to get them to stop. They often don't want to, and how do you create the desire to quit in somebody who isn't interested in quitting? It's a real challenge for us. But we can get to young people and get them to realize that one of the poorest health choices that they can make is to start smoking. We choose to emphasize that whenever we have discretion.

The Chair (Ms. Catherine Fife): Okay. One last one: Thunder Bay.

Dr. Janet DeMille: It's a lot of what my colleagues have already said, in terms of using data and evidence to look at where we should be putting our focus and understanding the needs in the priority populations. That could be a bit challenging for a health unit like Thunder Bay district, where there's a smaller number of people—160,000—but very geographically spread out. We look at the evidence and what we could apply in our area.

I would also note, though, that because of significant health disparities that we're aware of, we do always look at how we might specifically address the needs and the issues for First Nations populations.

Mr. Norman Miller: When you were responding to an earlier question from the NDP, you talked about the fact that, in the tobacco part of it, there was a huge disparity in the First Nations community. I believe you said that up to 50% were smoking. Maybe you could expand a bit on how you deal with, or whether you're able to deal with, that situation.

In addition to that, on the tobacco questioning line, I'm just wondering how, with all of the programs, the contraband tobacco issue is dealt with—whether you have any role in trying to address that.

The Chair (Ms. Catherine Fife): Just for clarification, are you just asking Ms. DeMille, based on Thunder Bay?

Mr. Norman Miller: At this point, yes.

The Chair (Ms. Catherine Fife): Okay. Thank you.

Dr. Janet DeMille: With respect to the health disparities, it is hard to get very good quality data for First Nations populations. I'll refer specifically to First Nations because that's a very significant group in northwestern Ontario. For further context, there are 25 First Nations communities that fall within the geographical area of TBDHU and about 60 to 70 across the two health units in northwestern Ontario. The data is lacking, really, for many issues related to First Nations.

What we do, though, specifically with those groups: We do have very strong partnerships and relationships across the north. I'll use the ministry language of "engaging First Nations in a way that's meaningful to them," because I believe that's where we could be most successful as a population. We often do different things depending on what community or what group we might be dealing with. Sometimes we might be providing direct services or we might be partnering with them on other initiatives or they might be doing their own work, and we're aware of it. We work together. We might learn a lot from them as well—so, different ways of doing this.

The issue of contraband tobacco I'm less familiar with. I know we do have issues. We do discuss this with the province and working groups provincially to try to address some of these issues.

Mr. Norman Miller: I guess my point with contraband is that there's so much control of legally sold tobacco, and the many programs directed to trying to get people not to use tobacco, that if contraband is totally outside of your control and that's the way it's a gateway for people to start smoking, it makes your programs less effective.

You all mentioned partnerships, and that was my second question: What is your approach to collaborating with key partners in your region to support chronic disease prevention for everyone?

Then I'll pass it on to whoever of my colleagues would like to ask a question.

0940

The Chair (Ms. Catherine Fife): MPP Skelly is next. She has already been identified as next.

Dr. Robert Kyle: Again, I'll start and just say, generally, there are a multitude of partners out there that come to mind: CAMH, hospitals, community health centres, other players within the health system, school boards, workplaces—setting-specific partners.

There are partners that have organized around specific risk factors: Cancer Care Ontario, the Canadian Cancer Society, the Ontario Physical and Health Education Association, and the list goes on and on.

There are multiple partners. We all can bring to the table various talents, skills and resources, and we do. I'd be remiss if I didn't say that we all work together.

There are work-specific networks that exist across the province at the public health unit level. There are pan-province associations—the chronic disease prevention alliance comes to mind—where provincial players not only work with local public health, but they work with one another.

So the lists are endless. We have a rich tradition in public health of working with community partners. In some ways, you can't deliver programs and services effectively without them.

That just scratches the surface. I'll turn it over to my colleagues to flesh out—

Mr. Norman Miller: Sorry. To follow up on that, if the lists are endless, how do you prioritize to get the best results with the limited resources that you have?

Dr. Robert Kyle: Well, I think it's part of professional judgment. It goes back to planning principles: What is your target audience? What is the message? What are the best interventions? What are the resources that you have to mobilize? I think we all develop—I think I used the term "a plan of public health intervention." It's really an implementation plan that fleshes out your goals, objectives, timelines, resources and so forth. That's the approach we take with all of our programs. As I said in my remarks, we use that information to populate our budget submissions that go to our respective boards of health—as well, to the population and public health division.

Dr. Eileen de Villa: I think that Dr. Kyle is quite right: Trying to delineate every partnership we have would pretty much eat up the entire day before you. But if I can add a few more to the already lengthy list that was provided by Dr. Kyle, we do partner with local public health across the country, as well, because we can learn from other jurisdictions; they're facing similar issues to what we face. I would suggest to you that the partnerships are as broad as are the determinants of health, because we're active—and each of these health issues arises within that societal context. So we have to partner across the board.

However, I think what Dr. Kyle was trying to speak to was that our interventions and the partnerships that we then have to engage in are fundamentally part of good public health planning. We have to understand:

—what are the health issues that impact the health status of our population and drive disparities within health status in our populations;

—what are the existing effective interventions—what do we know from the scientific literature, what do we know from the experiences of other jurisdictions' work—in terms of addressing those health issues; and

—of those effective interventions that are out there, which ones are within the public health mandate and/or within our sphere of influence.

If we can find the sweet spot between those three things, we then start to figure out which partners we need to engage with, on what issue, at what time.

The Chair (Ms. Catherine Fife): Have we got all the partnerships down? We're still going. Okay, please go ahead.

Dr. David Colby: I think the more community resources you can mobilize, the more bang for buck you get. So it's not actually costing money, usually, to partner with community organizations. It ultimately saves you money.

The Chair (Ms. Catherine Fife): Okay, thank you. MPP Skelly?

Mr. Norman Miller: Sorry, I'm interested in the north.

The Chair (Ms. Catherine Fife): Oh, I thought you said—please go ahead.

Can you turn their mike on, please?

Dr. Janet DeMille: I think that public health is done by everyone. At least that's what I try to convince people of. It's a principle of the Ontario Public Health Standards. So I have staff and managers that are very good at negotiating partnerships. We often work in coalitions and other networks on particular public health issues. Yet we have gotten out of partnerships or coalitions if, when we evaluate them, they are not necessarily in line with maybe the direction that we want to go in, or that they're not really moving us forward, so we've gotten out. We have ways of looking at our partnerships to see if they're advancing the work that we want to achieve and whether they are working well. When they're not in line with our priorities, we've gotten out of them.

Mr. Norman Miller: And do you have partnerships with all those various First Nations that you were describing?

Dr. Janet DeMille: We have relationships, connectivity with a variety of First Nations communities, populations and people, whether it's urban organizations or related to First Nations communities. There are not only the communities; there are also tribal councils and political territorial organizations that we do various different work with or different connectivity.

The Chair (Ms. Catherine Fife): Okay, thank you. MPP Skelly, you have four minutes left.

Ms. Donna Skelly: Thank you. I'll get right to my point. In the Auditor General's report, page 530, it speaks to a lot of the information that you raised today. It's very high-level. But I'm more concerned about measuring outcomes. In this report, the Auditor General says, "the public health units need a methodology to evaluate, measure and report on whether their chronic disease prevention and health promotion programs have been effective in reducing the cost burden on the health care system and improving population health outcomes."

Reducing the cost burden on the health care system: Have you ever tracked the success or not of the programs that you're offering? And if you do—or maybe I could just get you to even speak to this finding.

Dr. Eileen de Villa: So if I can, I think that there are challenges, certainly, with respect to understanding the benefits of public health intervention, for a variety of reasons, the first of which is that the investments in public health tend to be towards prevention. They're what is characterized as "upstream" and, therefore, their effects are often not felt for 10, 20, 30 and maybe even 40 years. So that's one of the challenges.

I think the other elements that are relevant to this audience would be the fact that the issues that we're characterizing—and I've tried to mention that in some of my remarks—involve the actions and the involvement of several different players, of which public health is only one. Something like healthy eating, something like physical activity is not in the exclusive purview of public health to effect change in terms of outcomes.

The Chair (Ms. Catherine Fife): One minute left, so keep going.

Ms. Donna Skelly: If I could just—because we are running out of time. Why then, and how, can you justify

moving forward with a program if you have no means of evaluating its success?

Dr. Eileen de Villa: Because, in fact, where we can evaluate success, we're able to demonstrate that, for example, for each $1 invested in mental health and addictions, you save $30 in lost productivity and social costs. For each $1 invested in immunizing children, you save $16 in health costs.

Ms. Donna Skelly: Are you tracking that? Then are you suggesting that this particular conclusion is not accurate?

Dr. Eileen de Villa: No, I would suggest that there is always room for improvement in respect of understanding our impact on outcomes. We're eager to partner with our provincial counterparts and with counterparts across the country to make sure that we're consistently improving our ability to demonstrate our value.

The Chair (Ms. Catherine Fife): Okay, so there's going to be a 10-minute cycle with the official opposition, and then we'll come right back to you as well. So please continue, MPP Morrison.

Ms. Suze Morrison: Thank you so much. My question is with respect to, from an equity lens, the work being done in partnership with schools. So the audit report indicates that public health units are currently only providing one service to 18% of schools and not at all engaged with 28% of schools.

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Given the strong link between health outcomes and low socioeconomic status—the social determinants of health is really what I'm getting at here—how are your respective public health units ensuring that the schools you are engaged with are the ones that are the highest need with respect to being in the lowest-income communities, and how are you tracking the health outcome improvement in those children in relation to the social determinants of health?

Dr. Eileen de Villa: I have the microphone on, so I may as well start. I would suggest to you that in Toronto specifically we actually do identify priority schools precisely on those dimensions that you described, whether they're low-income neighbourhoods, areas where parental levels of education tend to be on the lower side, newcomers to the country, for example. Those are just a few dimensions by which we determine and order priority schools, and we are actively working with the vast majority of them. Almost 85% of schools we are able to interact with in Toronto and actually provide programming for priority schools.

Ms. Suze Morrison: Toronto would probably be an exception or on the higher end of the data set of what's in the report. If you're in 85% of schools, then perhaps I'd like to hear from some of the other public health units where they're not in as many schools and how you're prioritizing them.

The Chair (Ms. Catherine Fife): Mr. Colby?

M^me^ France Gélinas: It'll come on by itself.

Dr. David Colby: Okay. I didn't realize that. I thought I was supposed to press a button.

We have a small health unit. We only have 100,000 or so people in my health unit. We get all the schools. We don't miss any.

The Chair (Ms. Catherine Fife): Mr. Kyle?

Dr. Robert Kyle: In Durham, we have staff assigned to all of our schools. The school boards themselves have identified priority schools. They expanded their list to include all of the schools in our priority neighbourhoods. We work with them to develop strategies dealing with a variety of health issues, including chronic diseases and mental health, and we have been publishing an annual performance report that tries to tell that story for years, and it's posted on our website.

The Chair (Ms. Catherine Fife): Ms. DeMille.

Dr. Janet DeMille: We have connectivity with all of the schools in the area. There are actually seven school boards. Two larger ones are within the city of Thunder Bay. We've worked with one of those school boards to identify the priority schools. That's working out really well in terms of delivering comprehensive school health programming there.

We continue to have ongoing discussions with school boards and with schools to identify what the priorities are. There are also surveys that are done within schools that help us identify what the needs are, along with the school board or the schools, and target our interventions to them.

Ms. Suze Morrison: Just following up on the evaluation piece and specifically on one of the comments made earlier around the challenges with evaluating public health initiatives in relation to the duration of the time it takes to see those health outcomes and particularly tying that back into the schools piece: What sort of evaluations are you undertaking in terms of tracking the health outcome of the youth you are engaging with in these programs specifically in the schools? Are you engaging in any sort of longitudinal studies or any other practices to identify any evaluation?

Dr. David Colby: My microphone is on. We constantly do as you're suggesting, and I think I can clarify this a bit for you. It takes sometimes decades to measure the long-term impact of chronic health measures, but we know what the risk factors are and it's easy to measure how much risk-factor reduction you're able to do: whether your health promotion programs are able to get people to stop smoking, to get more exercise and so forth. There is a variety of sources for that kind of data, and we track that very, very carefully. So it is not a direct measure of health outcomes, but all the evidence would indicate that these are the major predicators of those health outcomes. We can measure those, and we do.

The Chair (Ms. Catherine Fife): Do you have a question for somebody else?

Ms. Suze Morrison: No.

The Chair (Ms. Catherine Fife): MPP Gélinas?

M^me^ France Gélinas: Right in line with this discussion, in my first line of questioning we talked about changes in legislation that made cannabis legal, changes in legislation that made vaping products—now you can advertise them. Believe me, in northern Ontario they are everywhere. I see

Juul everywhere I go. It's the same thing with the increased access to alcohol. So the health unit will work really hard at decreasing smoking, but then the provincial government allows Juul to advertise everywhere, and lots of kids pick up vaping and then make the transition to smoking. You work really hard at educating people about alcohol consumption, but then the provincial government makes alcohol more accessible in your community, and it goes up rather than down.

When it comes to program evaluation, how do you put this all in? You could be working really hard locally, but the rate of smoking is still going to go up, and it has nothing to do with you; it has to do with us. We're all in this together, so good luck, and tell me how you do your program evaluations.

Dr. Robert Kyle: In terms of how we go about planning, I'll go back to the standards. We all have to implement them. With respect to chronic disease prevention, we tailor them according to local population health and surveillance status—

M^me^ France Gélinas: I'm interested in the evaluation. How can you set a goal, how can you set an objective, how can you set a time frame and evaluate yourself against those?

Dr. Robert Kyle: We focus on trying to measure the impact of a particular intervention, and the design depends on what the intervention is. If you're trying to provide an education intervention, you may do a pre-test survey of participants, do the intervention, and then do a post-survey and see if there's a difference. If you're trying to assess whether you should do programming in this area, you may do a survey. There are a variety of different data sources that you can turn to.

Are there factors outside of your intervention that may have an impact on the outcome of your evaluation? Yes, and to the extent possible you mention that in the limitations of the data when you're reporting out.

We all do this for a variety of different programs, and it depends on the intervention, the data sources and the best design as to what path you take in terms of evaluation.

M^me^ France Gélinas: When the auditor says that three of you had no measurable outcome target for their objectives in chronic disease management—instead, the health unit established general goals. How do you reconcile this in the auditor's report with what you've just told me?

Dr. Robert Kyle: We were the one who did have goals, so I'll let the others respond.

Dr. Eileen de Villa: You're quite right. This is that point that we've mentioned a few times now: that there are the impacts—

The Chair (Ms. Catherine Fife): You have one minute left in this.

Dr. Eileen de Villa: —of public health actions and impacts of other changes within the environment.

I would suggest to you that one of the most important things we do in public health is exactly this health status assessment, that monitoring, that surveillance in epidemiology that I spoke of.

One of the things that we can do is to measure the impact of policy changes similar to that which you've just described, and what that has meant on health behaviours and how that may either help or hinder the specific activities that we've undertaken ourselves.

The Chair (Ms. Catherine Fife): Mr. Colby.

Dr. David Colby: With all respect to the Auditor General's office, I think that having a specific goal and a specific target is a distinction without a difference.

The Chair (Ms. Catherine Fife): With that cryptic comment, we will move on to the government side. MPP Parsa.

Mr. Michael Parsa: Thank you all for being here. I know some of you have come a long way.

From your experience in your respective regions, what are some of the most important chronic disease factors to address going forward in specific regions?

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Dr. Robert Kyle: I think I can reiterate what is in the auditor's report, which is that tobacco use, excessive alcohol use, physical inactivity and related factors are the key ones. Are there other things that contribute? You've heard that they are the social determinants of health. They're not only important factors for good health in general, but also, the social determinants of health may lead to those unhealthy behaviours that are listed in the auditor's report.

Other chronic diseases, apart from those listed in the auditor's report—you've heard that mental health and addiction is a huge issue, particularly in school populations.

I would reiterate that I agree with what's in the audit report. I would say that in addition to those unhealthy behaviours, they are influenced to a very great degree by the social determinants of health. You can't deal with those risk factors in isolation; you do have to deal with the broader social determinants of health.

I'll turn it over to my colleagues to flesh out.

Dr. Eileen de Villa: Within the context of Toronto's urban environment, it's exactly as Dr. Kyle said: The risk factors, as identified in the report, are clearly important, but they are either helped or hindered by factors within our environment: the determinants of health, the built environment, our housing environment, our economic environment, income levels and that kind of thing. Mental health and addictions figure prominently, as we know, in this city.

These are just a few of the elements that have significant influence on these risk factors and our ability to actually support people and allow people to enjoy the best health, and to start off life healthy and stay healthy for as long as possible.

These are significant challenges. I think they are all relevant within all of our environments. The specific manifestations are slightly different, depending on our context, but the determinants of health are the determinants of health.

Dr. David Colby: It also needs to be said that everything is skewed towards what public health can directly

intervene towards. For example, air pollution is a very important factor in chronic respiratory disease and cardiovascular disease, but there's not much a single health unit can do to deal with air pollution other than advocating for lowered pollution levels everywhere, and we do that.

Dr. Janet DeMille: I agree with what my colleagues have said. I think all of those four factors are important in the Thunder Bay District Health Unit area, and understanding the health disparities that exist around those four factors is important.

I think the upstream approach of public health, whether it's dealing with determinants of health—even supporting early childhood development as a foundation for somebody's life going forward, and some of our programming that helps deal with chronic disease prevention.

We certainly try to focus on the interventions that have the biggest impact at the policy level, because that can impact a broader population, as well as creating supportive environments where the healthy choice is the easiest choice.

Mr. Michael Parsa: May I?

The Chair (Ms. Catherine Fife): Please.

Mr. Michael Parsa: Earlier, Doctor, twice you referred to obtaining data, and the challenges of getting correct data when it comes to the First Nations. Can you elaborate on that and why that is the case, please?

Dr. Janet DeMille: That's a really complicated question, actually. We're a small population—160,000—but very geographically dispersed. Some of the sources of epidemiological data capture, perhaps, the broader city of Thunder Bay as the most populous area in the health unit and don't necessarily reflect what's happening in other areas.

Some of the data is not collected in First Nations communities. We have a national survey called the Canadian Community Health Survey that does not survey First Nations communities, as well as, for example, BORN, Better Outcomes Registry and Network, which collects information related to prenatal and postnatal for infants, young children and families. We don't have access to First Nations' data within that database. As well, sometimes the data is just not collected. For example, when somebody attends to hospital, there are no indicators of whether somebody is First Nations or not, for example, in terms of their OHIP number or others. Those are some of the challenges we face. It's hard to get accurate data. It's hard to get accurate data on smoking rates, which is a really common risk factor, for example.

The ways of addressing that are actually fairly complex. I have been involved in a project, actually, called Mamow Ahyamowen, which is led by the Sioux Lookout First Nations Health Authority and the Weeneebayko Area Health Authority on the James Bay coast, working with the province and federal organizations to try to get and collect meaningful information around First Nations in First Nations communities. I think that they started coming up by combining, for example, the Indian registry health admin data from the province and coroner data, for example, for deaths and chronic disease present at death and that kind of information. I think some meaningful work has been done, and it has been brought to First Nations communities that were involved in the project. So there's a very innovative kind of project where I think First-Nations-led initiatives supported by the province and the feds have really provided a bit of a breakthrough, I would say, in the collection of data.

As well, with the Sioux Lookout First Nations Health Authority, which the province and the feds again have supported some of the work of, they recently produced a health status report, which is an attempt to look at some of the data for 33 remote First Nations in northwestern Ontario. There are still data gaps, but it's really impressive that they were able to come up with that.

I will also note that they are implementing, essentially, an electronic medical record. It's actually a community health record that they're looking at implementing in those First Nations communities that will allow them to better use the data that they may actually have at the community level. That really falls under First Nations and Inuit health, in many cases, because of their role in delivering health services. But having a better community health record and EMR might actually allow them to get better data at the community level for their communities.

Mr. Michael Parsa: Okay. Chair?

The Chair (Ms. Catherine Fife): There's about a minute and a half left.

Mr. Michael Parsa: Earlier on, I think it was Dr. de Villa who referenced newcomers. I know that there was a lot of work that was done to—you talked about the smoking rates going down. I'm sure that was a mainstream campaign. Are any efforts or initiatives being taken to address newcomers? I know that language barriers still exist with a lot of newcomers. Are there any new initiatives to address newcomers?

Dr. Eileen de Villa: There are several initiatives to address newcomers. When I was speaking of newcomers, I was thinking about priority schools and priority school areas. That was the context within which I mentioned newcomers. But certainly, in a city like Toronto, with all aspects of our programming, we have to actively consider who the audience is and what proportion of that target audience might be comprised of newcomers. So whether it's about smoking cessation or whether it has to do with increasing the likelihood of active transportation to and from school, we have a newcomer element that has to be part of the consideration and the planning of those programs.

Mr. Michael Parsa: Is that just in urban areas, Doctor, or is that an initiative? I know newcomer settlements are typically in urban areas, but is that initiative something that you would undertake in rural areas, for example, as well—maybe Thunder Bay?

The Chair (Ms. Catherine Fife): I'll have to hold the testimony there because we're out of time. Thank you very much for the work the committee has done, but also for the testimony.

We will reconvene this afternoon at 12:30, same room, and we'll see you then. Thank you.

The committee recessed from 1012 to 1231.

The Chair (Ms. Catherine Fife): Good afternoon. I'd like to call this meeting back to order. We are resuming consideration of section 3.10, public health chronic disease prevention: from the 2017 Annual Report of the Office of the Auditor General of Ontario.

When we left off, the government side had completed their 10-minute cycle, so we will return to 20-minute cycles but now beginning with the official opposition. MPP Gélinas.

M^me^ France Gélinas: Welcome back, and thank you for being here again.

I've been on public accounts for a long time, and the reason we have public accounts is to be able to show value for money, to be able to show that the government investments do what they're supposed to do and they do this in a way that is respectful of the taxpayers' money. A lot has to do with how we can evaluate you or any other programs that the provincial government funds.

I'm going to start again, because we have a little bit of time—remember, this morning, I started at the 30,000-feet level; I'm back at 30,000 feet and then I'll go back on the ground floor.

There is a lot of pressure on health care dollars because we have hospital overcrowding, because we have people waiting a long time for mental health services, because of everything else—the home care system, the long-term care wait-list and all of this. If I was to ask, can you show me that an investment in public health is a good use of taxpayer money—I'm putting it to you—what would you answer?

Dr. Robert Kyle: I'll take a stab at that. If you're asking, will investments in chronic disease prevention lead to, say, downstream cost savings with respect to the health care system as a whole, the short answer is, I don't think we in public health can demonstrate that. I think what we can demonstrate, given the resources we get from the province, is that we can have a robust plan, we can implement that plan, we can evaluate that plan and we can report out. But in terms of measuring impacts on other aspects of the health care system from interventions in public health, it really requires other actors, other players and other data sources and that sort of thing.

I think you've heard previous to this, however, that, more generally, are there returns on investments in public health? There are, and they have been monetized in terms of immunization, in terms of mental health and addictions, community water fluoridation. I think tobacco control comes to mind. And all of those examples are included in our pre-budget submission to the Standing Committee on Finance and Economic Affairs.

I'm going to stop there and turn it over to my colleagues.

Dr. Eileen de Villa: If I can get more specific—I talked already about the kinds of value propositions that are afforded through investing in such things as public health. We said for each dollar that's invested in mental health and addictions, you save $30 in lost productivity and social costs; $1 in immunizing children saves $16 in health care costs; each dollar invested in tobacco prevention saves $20 in future health care. That's just the health care side alone. That doesn't actually speak of time lost from work and the other social costs.

A dollar invested in fluoridated drinking water saves $38 in dental care. Each dollar invested in early childhood development saves about $9 in future spending on health, social and justice services. These are the kinds of things that we can speak to in respect of public health.

But Dr. Kyle is quite right: Many of our actions actually involve a multitude of other players. There was a report a few years ago from medical officers of health from around the greater Toronto and Hamilton area talking about the savings that could be provided and the benefits that would be provided to society if we actually increased active transportation, in terms of savings in diabetes care costs and those kinds of things.

I think when we look at public health writ large and our unique role in the system, both at the municipal level—what we provide to our municipal partners as they seek to work on things like housing and transportation and mobility—and the work that we do in partnership with our provincial colleagues and our federal colleagues, and the work that we do within the health care system, our unique role in prevention and health promotion, I think we're a major value add.

It's not always easy to characterize. I think we could better coordinate data, but we need that coordination to occur, not only amongst ourselves at the local level and with our local partners, but with our provincial partners and our federal partners as well.

M^me^ France Gélinas: In the auditor's report, she makes reference to work that British Columbia has done. They've released a guiding framework for public health with long-term goals and targets to drive system-wide action and improve health outcomes. She compared this and said that in Ontario we have a hard time measuring the overall population health status and certainly do not have these long-term goals as to, "Here's the health status now and here's where we want to be in 2023," or whatever. Is this something feasible?

Dr. David Colby: I can take a crack at that one, if you'd like.

It's feasible, but it operates at a level higher than the four of us operate at. Those types of strategic decisions and overarching strategies are really in the bailiwick of the ministry. They're not at the local implementation level. There is broad consultation across all levels. It's not that we don't talk to the ministry and vice versa; we don't operate in a vacuum from each other. But that's really a ministry decision.

With regard to what you had asked, there's an old saying that you attack the rate-limiting step when you're trying to deal with a problem. Acute care is far, far more expensive than public health intervention measures no matter how you look at it. Anything that prevents chronic disease, which either delays the onset of chronic diseases or, better yet, even prevents them so that people die of old age healthy, has the potential, at least, to save huge amounts of money in the health care system. But these are

long-term goals, not short-term goals, and the short-term ones are the ones you can measure easily.

M^me^ France Gélinas: I see. Back to measuring: You've talked about healthy eating, exercise, smoking and alcohol consumption. If we were to tackle those four, we would have a healthier population, but would we be able to measure how much healthier we would be?

Dr. David Colby: My microphone is still on. I'll take a crack at this.

The answer is, it depends on every scenario. The quicker you see benefit, the easier it is to measure. That's obvious, really, when you think about it. It's almost a dependency. For example, when trans fats are banned in foods, you can see very quickly a decrease in cardiovascular mortality and morbidity at a population level; you can. But other things effect changes over long periods of time, particularly when our role in health promotion is persuasive. We can tell people to stop smoking, to get more exercise and to eat healthy, but that doesn't mean they're going to do it. But over long periods of time, we are seeing some positive changes in that regard, both from a legislative point of view and just from people listening to our messages. Again, that lengthens the amount of time that it will take to measure these kinds of changes.

M^me^ France Gélinas: Talking about measurement and data, is it that those measurements are doable and we are not collecting this data, or is it that the data exists, but we are not analyzing the data to see if we've achieved our outcome?

Do you follow where I'm going?

Dr. David Colby: Yes. I want to be brief to allow my colleagues an opportunity to speak.

A lot of data is collected, and most of what is collected is analyzed, but you never have a complete picture. You have a series of snapshots that require some interpretation in terms of how we're doing in the long term. So a more overarching and comprehensive look would be helpful. We can always do better in that regard.

Dr. Eileen de Villa: If I could add to that, I think in one of your earlier questions, you alluded to the success that we had seen in respect of tobacco. I think that's a perfect example that shows that there is an opportunity to demonstrate the value. But when we look at what the factors were, what went into that success with respect to reducing the prevalence of tobacco use and therefore the health impacts associated with tobacco use, in fact, what you had was a concerted effort by all levels of government—municipal, provincial, federal—all with a clear goal and objective in mind, working in concert with each other. Coordinated data systems, coordinated use of evidence: I think these are the kinds of things that you saw through the report and, in fact, are borne out in that particular example.

M^me^ France Gélinas: Did that effort that led us to success—is it because you guys pushed for governments to do those things, or is it the government that decided and laid that to you to carry out?

Dr. Robert Kyle: I think it's a bit of both. I would agree that the data is there. I would agree that it is analyzed. I think our main role is as implementers. We implement government policy.

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But take, say, tobacco control. Many of us have been ongoing advocates with respect to continually improving policy, continually improving legislation, continually improving resources and tools that we can use to implement. The target of our advocacy has been local, it has been provincial and it has been federal. You look at all the players. You continue to implement. Healthy public policy is one of your many, if you will, deliverables, and depending on the chronic disease or the risk factor, you may advocate locally and/or provincially and/or federally. I think tobacco control is a very good example.

Dr. Janet DeMille: If I may go back to some comments that you made just recently, with the investment in public health and the return on that investment: I think the challenge that we have in public health is that it's very difficult to measure what we prevent. If we do work or assist a municipality in adopting a policy that maybe increases multi-use trails, as happened in Thunder Bay, and people are exercising more, it's hard to measure what didn't happen, because there are multi-use trails, because people got more active.

There is a tool that we've used recently at the Thunder Bay District Health Unit called DPoRT, which is the Diabetes Population Risk Tool, if I got it correctly. I'm being a bit simplistic with this: I believe it is some sort of modelling program done by epidemiologists that can look at the factors in a community like Thunder Bay, look at the data for Thunder Bay. Then you take an active transportation policy that may have been applied in another jurisdiction, and if there's evidence around that policy, you could then say, "Okay, given the Thunder Bay context in this modelling, what would happen if we applied this policy and it had a similar effect to what it did somewhere else?"

Because it's diabetes, we had some estimates from this tool about how many diabetes cases would be expected over the next 10 years. If we applied this policy, if this policy were to be implemented by the municipality, it would change the factors in that community and reduce the number of diabetes cases by, let's say, 10%, and there's a monetary amount that could be applied to that. We actually used that tool. I must admit, the technical aspects of it are a little bit more complicated than I understand, but we used that as a way of helping the municipality make that decision.

I'm understanding that there is a chronic disease prevention risk tool that is in progress. I think tools like that would be very helpful to demonstrate the kind of impact that we have in preventing things, or looking at different policies—like around the built environment, for example—and how we can show value in implementing a policy, but also demonstrating better that return on investment.

M^me^ France Gélinas: And have we ever done this? Have you ever gone back to some policies, to some risk factors that you've influenced, to look at them—"We thought there would be 10% less diabetes," for the

example you've given us—and go back and say, "Oh, actually, it was 15%"?

Dr. Janet DeMille: I think, from my perspective at the Thunder Bay District Health Unit, we don't necessarily have the capacity to be able to do that, or to measure the effect of our particular policy. These are more modelling tools. I'm wondering if this one was done by ICES, the Institute for Clinical Evaluative Sciences. It would be hard, I think, for us to be able to do that. However, these tools are validated, as I understand, and if they could be broadened out or we could have assistance in being able to use those, I think we would support that case for a return on investment.

M^me^ France Gélinas: If you don't have the capacity in-house to do this analysis, does the Ministry of Health have the capacity to do that?

Dr. David Colby: That would mainly fall under Public Health Ontario.

M^me^ France Gélinas: Do you know enough of the system to know if Public Health Ontario has the means, the know-how, the skills? Can they?

Dr. David Colby: They most definitely do. That's where that kind of expertise and consultative assistance is centralized. They are a resource for all of us. They not only take their own initiatives to produce reports, but they will help if there are any specific questions from the field. They will assign people who are very knowledgeable and skilled to be able to do that for us.

M^me^ France Gélinas: On a scale of importance, how much importance do we put on evaluating the effectiveness of the programs that you've carried out versus convincing people to carry out programs in chronic disease management and health promotion and disease prevention etc.?

Dr. Robert Kyle: I can start. I think, first and foremost, it's important to measure impact locally. Going back to some of Janet's comments, one of the tools that we use—and it's referenced in the audit report—is the rapid risk factor surveillance system. This is a system that we've had in place. We piloted it in Durham in 1999. We survey our community monthly and we've been doing so since that time.

We have been able to look at the downward trend in terms of smoking behaviour in Durham region over a 10-year period and there's been a significant decline. That decline can be partly attributable to actions by public health.

The Chair (Ms. Catherine Fife): There's one minute left in this question set.

Dr. Robert Kyle: There are other actions as well.

I do think that you can use local data to try and influence local decision-makers just as you could use provincial data to influence provincial policy-makers as well. I don't think it's either-or. I think it's both.

M^me^ France Gélinas: Okay.

The Chair (Ms. Catherine Fife): Okay, thank you. Seeing that there are only 20 seconds left in this set, we'll transfer it back over to the government. MPP Parsa was going to finish his question set, or—okay, we'll defer to MPP Miller. Now you have 20 minutes.

Mr. Norman Miller: Thank you, and I'll do a question, then I think either Mr. Parsa or Ms. Surma will have a question.

It all seems so simple: To have a benefit, you know, don't smoke, get more exercise, eat properly and don't drink too much. If we all did those things, I think we'd save the whole system billions of dollars. I guess that's really what your job is about, is trying to get more people to do those simple things. As I say, on the surface it seems simple, but then it's much more complicated when it comes to actually trying to make it happen, particularly in areas like the north, in Indigenous communities etc.

I want to follow up on Ms. Gélinas's line of questioning because it is all about getting value for money. Going back to the auditor's report, one of the recommendations is specifically to do with health units, number 8: "To effectively measure the impact of chronic disease prevention programs and services, we recommend that the Ministry of Health and Long-Term Care require public health units to develop measurable program objectives and establish time frames for achieving these objectives."

Could you tell me what you're doing to fulfill that recommendation of developing measurable program objectives and establishing time frames for achieving those objectives at the health unit level, please?

1250

Dr. Robert Kyle: Okay, so a couple of things: In terms of the provincial budget submission that I mentioned, we are required—and it's in my notes—to submit what's known as a plan of public health intervention. It gets to what you're just asking: What is the activity, who are the community partners, what is the budget, and, where appropriate, what are the targets? Depending on government policy, they may ask for input with respect to a specific set of indicators, say, related to chronic diseases. That's the provincial budget submission.

In our health unit—and I'll turn it over to my other colleagues—we do an annual program support survey which is then fed into the development of a work plan for our health analytics and research team. It helps the programs evaluate their programs. It may also assist them with population health assessment and surveillance data. It may involve them conducting research. We've embedded that into our planning cycle, so regardless of what the ministry is requesting of us in our budget submission, we, on an annual basis, develop a work program around population health assessment and surveillance, about program evaluation, research and knowledge exchange, and so forth. All of these activities are required by the current standards, and I've spoken to most of those in my speaking notes.

I'll turn it over to my colleagues for more specifics.

Mr. Norman Miller: And has anything changed since the auditor's report? Have you brought in new objectives and time frames since the auditor's report?

Dr. Robert Kyle: In a word, yes. It's all covered in my speaking notes. We have new standards and we have new

requirements. With respect to chronic disease prevention, new is what is known as guidelines, which are binding on boards of health. We have a new accountability framework. We have a new annual service plan and budget submission. The ground has shifted considerably since the Auditor General reported out in 2017.

Dr. Eileen de Villa: If I can add further to that, over and above these new requirements that are part of the new Ontario public health standards—the updated standards since the auditor's report was done—I think I tried to mention in earlier remarks that we have a very significant role in public health in terms of identifying the major issues that are impeding optimal health status in our population and are creating disparities, looking for effective interventions and making sure that we're implementing those that are within the public health mandate. That's over and above the standards and the requirements as articulated by the ministry. We have professional obligations and responsibilities as professional public health practitioners, along with our teams.

When I look specifically at Toronto within the realm of chronic disease prevention in particular, I know that our team has done a great deal of work to ensure that we have what are characterized in public health terms as logic models, which basically outline: What are the objectives that we are seeking to achieve, through what actions, and what are the short-term outcomes and what are the longer-term outcomes?

Mr. Norman Miller: Can you give some practical example to help me understand better?

Dr. Eileen de Villa: For example, let's talk about trying to increase physical activity amongst school-age students. There can be a series of activities, some of which will be specifically around that which happens in the school, and that comes through the provincial policy on daily physical activity. But we may also engage very specifically with the school community on increasing the likelihood that people will engage in active transportation to school, which by definition increases physical activity in the day. We can talk about educational steps that can be taken in respect of families to tell them—if people are not letting their children walk to school out of safety concerns, we make sure that we delineate: What are the safety issues? Sometimes it's a bit of a knowledge-raising or awareness-raising. Sometimes it's a question of then addressing some of the safety concerns through, for example, making walking school buses, organizing groups of people to walk together, that kind of thing.

We can delineate what sorts of activities do we need to engage in in order to increase physical activity through those routes, amongst many others, and propose, "Over the course of X period of time, we expect to have this much more participation. We're at this level now; we're aiming for this level. How are we going to get there? This series of activities." That's a very quick example, so as not to take away from others.

Mr. Norman Miller: Anyone else want to add anything?

Dr. Janet DeMille: I could add another example, if you're interested. This was from a couple of years ago and it relates to smoking. We have a lot of blue-collar work sites: mines and mills. That's a priority population, because there are higher rates of smoking. We had some evidence about what are effective policies and factors in that workplace that can support smoking cessation in employers.

We did set goals in the plans of reaching out to different workplaces and working with them to implement those. We did have the measurables, which are the shorter-term measurables, that within a year, we would have worked with five workplaces in a comprehensive way and that they would have the policies in place. Overall, that would support cessation in the employees, more quit attempts and, hopefully, more people quitting smoking, which then reduces the burden of tobacco-related disease.

Mr. Norman Miller: Thank you. I'll pass it on to one of my colleagues.

The Acting Chair (Ms. Suze Morrison): MPP Surma.

Miss Kinga Surma: What are some of the priority focus areas in your respective regions in terms of chronic disease? Anyone can start.

Dr. Robert Kyle: I've tried to cover off some of the topics that are required under the standards. Again, you develop your plan of public health intervention based on local factors and so forth. They could include the built environment. It could include chronic disease prevention. It could include oral health. It could include mental health promotion. It could include substance use and harm reduction. It could include UV radiation, for example. In our health unit, we have programming in all of those areas.

As you heard previously, you have a given set of resources, a given set of staff, so you set priorities. Most of us probably have an annual planning process. We probably all follow a program logic model—this is the long-term objective; this is the short; this is what we're going to do this year. You look at what are possible interventions. You look at target populations and so forth. You develop an annual plan.

I think all of those areas are important. You can't do everything, so you try to target your resources appropriately. As you heard from me previously, with some of those interventions, we focus on our priority populations who have a disproportionate burden of illness and have a low income.

That's kind of a general comment. I'll turn it over to my colleagues for other specifics.

Dr. Eileen de Villa: Yes, just to be very brief: When I think about the city of Toronto and our unique challenges and priorities, they may not appear to be entirely related to chronic disease prevention, but I would put to you that I think they're very germane to chronic disease prevention.

Housing is a major challenge within the context of this city. Affordable housing and the negative impact that it has in respect of health status, including chronic disease status, I think is a major challenge for us here in this city.

Mobility and transportation is another major priority for us here in this city. You're all here. I'm sure each of you got here and had your own unique challenges. I know my colleague had some challenges getting here this morning.

It is a difficult area and environment to navigate. I think it's an opportunity not only to reduce stress in each of our respective lives, but frankly also to engage in more physical activity within our day, if we can increase the proportion of our population that actually engages in active transportation to and from work or school.

1300

Certainly, we have challenges here in this city, as do many other jurisdictions. We are not by any stretch of the imagination the worst in the province, but substance use issues and mental health challenges are something that we're seeking to address here at the city of Toronto.

I think that at a high level, what might also be interesting for this committee to hear about is that while public health talks a lot about prevention and upstream interventions and interactions, traditionally that has focused on getting people to start life healthy and stay that way for as long as possible, so our focus has largely been on children and youth. However, with life expectancy having increased significantly over the last 100 years, there are prevention opportunities that my public health colleagues and I are increasingly engaged in when we're talking about prevention opportunities into adulthood and even into the senior years.

It wasn't that long ago that I seem to recall—and forgive me, Grandmother—thinking that my grandmother was old at 65. But I would not deign to call anybody at the age of 65 old anymore.

Dr. David Colby: Thank you.

Laughter.

Dr. Eileen de Villa: Not even Dr. Colby.

I think there are prevention opportunities later in life as well.

Dr. David Colby: To answer your question, which I thank you for: In Chatham-Kent, we favour a Health in All Policies approach. This gives us an opportunity to influence all municipal policies, including long-range plans, which are critical to built environment. The healthy way has to be the easy way. Ideal communities should be built around—if they're too large to have one city centre, they should have multiple centres around so that everyone is within easy walking distance of schools, shopping—especially quality food stores; we don't like food deserts. The only way that one can really influence that in a significant way is through the zoning and the official plan of the community.

With the Health in All Policies approach, we have input on that. They do listen; they don't always implement what we suggest, of course. There are realities of tax bases and everything else and competing priorities of municipalities, but we think that this is a valuable way to look at things.

Dr. Janet DeMille: I could take any one of those four factors that are linked to chronic disease and tell you what we do. I've picked one to share with you. It's around healthy eating and a variety of the work that we do around that. This is not comprehensive, but just to give you an example: We've been working a lot with the city of Thunder Bay around foods that they serve at the local recreation facilities and in their after-school programs that they deliver in the recreation facilities and arenas. We did a pilot project with them in one of the arenas around serving healthy foods, as opposed to the usual unhealthy foods. That evaluated well, and city council actually committed to a longer-term strategy to increase the availability of healthy foods in the facilities they serve.

We also sit on the Thunder Bay and Area Food Strategy, which has a very broad mandate. However, some of it relates to easy access to healthy, inexpensive and culturally appropriate foods. We do work around that. It's more of a food system issue.

Recently, we actually hosted a group of the 14 road-accessible First Nations in the Thunder Bay District Health Unit area. It was an Indigenous consultant that we engaged to be able to talk about food system and food access in First Nations communities—a huge problem where there's no simple solution. But in bringing them together, a lot of ideas came forward, and each community will be developing a community food assessment, I believe. That will open up opportunities about working together to be able to support healthier foods in First Nations communities.

The final thing I will mention is the Northern Fruit and Vegetable Program, which we just officially launched in the last couple of weeks. That provides fruit and vegetables to schoolchildren in all schools in the Thunder Bay District Health Unit, including in First Nations communities, every week from January to June. It is supported by supports we might be providing to the schools, the teachers and even our healthy schools staff, to be able to prepare fun and engaging activities to bring the kids to use those fruits and vegetables.

That is an evidence-based program. Exposing kids to a variety of fruits and vegetables, prepared in maybe more fun and exciting ways, helps to increase the consumption of fruits and vegetables. Not only does it impact the students in schools, but they also go home to their parents and instead of asking for more unhealthy foods, they might say, "Oh, I'd like to try those cherry tomatoes," for example.

Those are some of the things that we do—

The Acting Chair (Ms. Suze Morrison): There's two minutes remaining in this block of questions.

Dr. Janet DeMille: Okay.

The Acting Chair (Ms. Suze Morrison): Do you want to go ahead? Go ahead.

Miss Kinga Surma: Okay. In terms of the work you do, do you evaluate trends that are arising today, based on the data you collect? Then what do you do when that information appears? Go ahead.

Dr. Robert Kyle: Sure. The answer is yes, we all assess our population health using available data, which could be survey data, hospitalization data, ER visits, morbidity, mortality, that sort of thing.

We live in a digital age, so the challenge is translating that into knowledge products that are readily understandable. We're all moving towards getting this information out, say, in attractive ways—infographics and so forth—and also by resorting to a variety of different social media

platforms. That's the external audience. Of course, there are internal audiences as well, and we try and get the information out to our staff.

I'll stop there.

Dr. Eileen de Villa: As I had mentioned earlier, in the sense that health status data are our diagnostic tools, it's no different than when, say, your physician in a clinical setting notices that the blood pressure is going up despite the treatment, and then the treatment plan changes. The same can be said for us, right? When we notice trends, changes in particular behaviours, we can then adjust in accordance with that.

We talked in one of our earlier comments about logic models and what we expect the outcomes to be. If we're seeing that the short-term outcomes are not right—

The Chair (Ms. Catherine Fife): Thank you, Dr. de Villa. That concludes this 20-minute cycle for the government side.

We'll move now to the official opposition. MPP Gélinas.

M^me^ France Gélinas: Continuing on my train of thought as to how you measure, we're here at public accounts looking at value-for-money audits. Is an investment in public health an investment that the government should do? And how would we know if a health unit is a super-performer that really improves the health—they've got it together; they do the right program in the right way for the right population, and they really shine?

The follow-up question to this will be, how will we know when a health unit really misses the mark?

You've talked about the nine program standards. You've talked about the four foundational standards in all of this. Are we measuring the right thing? Have we got the right tools for measurement? Take it the way you want.

Dr. Robert Kyle: Well, I'll start. We all want to provide benefit to our publics, and there are a variety of ways of ensuring that.

At the program level, we probably all have quality assurance programs in place which ensure that staff in similar programs are doing it the right way and perhaps, depending on the indicator, doing it either efficiently or more efficiently. But in Durham, we, for example, get accredited by Accreditation Canada. A peer review team comes in every three years, kicks the tires, assesses us according to our last accreditation—over 600 requirements. We did very well.

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M^me^ France Gélinas: Is this accreditation process mandatory by the Ministry of Health or something that you chose to do?

Dr. Robert Kyle: It's something we chose to do. It's part of our brand. If you see my business card, it's an accredited public health agency. I think other health units—I would say most are not accredited or most have not gotten certification from Excellence Canada, which is the other body.

We, of course, report to our boards of health. They provide general oversight, particularly at year-end, when we're reporting on our performance. We all have an opportunity to submit abstracts, papers and posters to the Ontario Public Health Conference, which is really the leading conference in Ontario, where we share best practices, we share stories and we strut our stuff.

In Durham region, we hold a spring and fall research and knowledge exchange symposium. It's an opportunity for us to have staff present their findings with respect to program evaluations, research and that sort of thing.

M^me^ France Gélinas: How come everything you've told me so far shows a very strong and committed health unit but none of this comes from the ministry, which means that other health units may very well choose to do none of what you're doing right now?

Dr. Robert Kyle: I'm just trying to demonstrate the mechanisms that I'm aware of that are out there to demonstrate you're doing a good job, and not only do you think by self-assessment that you're doing a good job, but others pass eyes on you and also confirm that.

In terms of ministry policy in this area, you would need to speak to ministry officials. I can't speak for them. But we think there's value added in not only doing self-assessment, not only participating in the Ontario Public Health Conference and other public gatherings like that, but also to have a peer team come in and assess us every three years.

M^me^ France Gélinas: I fully agree. Everything you've said shows your commitment to, I would say, value for money, to making sure you do the right thing and you do it the right way for the right reason with the right population. You have me convinced. But I'm here as a legislator from the Ontario Parliament, looking at how—all of this you've done is very good. But you choose to do that. You could have chosen to do none of that, and the government would still be supporting you in the same way. Do you see what I'm getting at?

Dr. Robert Kyle: Yes.

M^me^ France Gélinas: So if you were to help us with your wisdom as to how we make sure that—the auditor had talked about—there were 10 health promotion performance indicators that you used to report back to the government of fairly limited value in the reporting that you were doing, because some of the indicators were not that useful and other parts of chronic disease were not looked at at all.

Dr. Robert Kyle: Just briefly, and then I'll turn it over: I think the ministry—I'm not speaking for them, but my observation is they've tried to get at this in part by the new standards, particularly with respect to guidelines that are now binding on boards of health with respect to, for example, chronic disease prevention and, two, by a renewed accountability framework. It has only been one year and a bit out, so there's probably more to come. For example, the new standards speak to a central repository where it can be the place where best practices and so forth can be submitted and exchanged and used. Well, I think that's still a work in progress. Again, you'd need to speak to the ministry. But I think that's a demonstration of where the ministry has responded in part to the Auditor General's report.

Mme France Gélinas: Do you think that with those new standards, we would know if a health unit was not doing the right thing with the right instrument to the right people? Do you think that this is robust enough to be able to tell us, of the 35 of you, which ones shine and which ones need help?

Dr. Eileen de Villa: I'm going to step in and help out my colleague here a little bit to say that I don't know that there is any one, singular tool that will answer all of these questions. I think it's a multitude of things. Certainly I would concur with Dr. Kyle's observation that there are these new standards in place, still relatively new. I would like to think that they would augment what I hope you see as our commitment, both as medical professionals—we take our profession very seriously—but there are also all these other elements in place that help to show the public that we are working as best we can, along with our respective teams, to provide the best service possible.

You use Accreditation Canada; my health unit is more on the Excellence Canada stream—again, a similar sort of process by which to ensure quality service is being provided to the public that we serve. We have public reporting mechanisms. Our board of health meetings are all public. Our budgets are public. We're constantly reporting to our public about what it is that we're doing for them and how we're allocating resources in that regard.

The other piece that I wanted to add, over and above the quality assurance work that each of us undertakes within our respective organizations, is that we all participate—we're all professionals here—in our own professional standards processes as well, which are part and parcel of our job. Many of our staff belong to regulated colleges as well and have obligations to maintain their professional standing.

I think it's this combination of things, and I don't know that it exclusively rests on any one level of government, just as success in any public health endeavour actually requires concerted effort across all three levels.

Mme France Gélinas: Could you give me an example of a program or an initiative that you used to do that you don't do anymore because the body of evidence, because the accreditation, because whatever quality improvements showed you that there's a better way to do this, or it was not achieving its desired outcomes?

Dr. Robert Kyle: Sure. There are many. Off the top of my head, first of all, when I got in the business, in the 1980s, they allowed smoking in the health unit. Those days are long gone.

We used to provide labour and delivery coaching for pregnant women and their partners. We got out of that business primarily because we weren't really reaching the right audiences who were at greatest risk for reproductive health challenges.

A few years ago, we would host prenatal health fairs—again, to try to marshal resources by ourselves with our partners in the community. Not only were the wrong audiences attending these—these were usually well-to-do mothers who had great concern and so forth—but the attendance dropped off considerably. I could go on.

If you're going to evaluate a program to see whether or not it still hits the mark, whether it's relevant or not, and you don't act on your findings, then why do it in the first place? There are probably numerous examples where either trends in attendance or a better understanding of our communities based on population health assessment and/or findings from our program evaluations have led to us either changing practice or, in some cases, stopping practice altogether.

Dr. Eileen de Villa: I think there have been improvements to practice, for example, that are made. As new technologies come into play—and we recognize that there are potentials for those new technologies. I can think of very specific programs where we used to do home visits involving travel time, and now we can manage those through video-conferencing instead with clients directly—again, having to balance out the many concerns, including privacy concerns as well.

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Dr. David Colby: At Chatham-Kent, we looked very carefully at external accreditation agencies and we found—I hesitate very much to disagree with my esteemed colleagues here, but we did not find those to be an appropriate use of our funds. They were not value for money. They were largely a paper-chasing exercise with very few palpable increases in quality. I cannot speak for the ministry, but I certainly would not endorse an approach where these were mandated by the ministry for health units to do, because we looked at it and did not find that this would be useful for us at all.

We're not afraid to undertake the process, but for what benefit? And they do have a cost. It is not cut and dried that these are always a good thing. I think, largely, it depends on how your health unit is structured, how much one might benefit from some of the things they show.

Mme France Gélinas: Okay. You did say, though, that in your municipality you have Health in All Policies. I have hoped for the government of Ontario to do the same for a long time. I'm a very optimistic person and I'm really patient, but it has been a long time and it has not happened. What leads you to success in having your municipality agree to Health in All Policies?

Dr. David Colby: If my words would be read back to me, I believe I said that we favoured a Health in All Policies approach. I don't believe we've been successful at implementing a binding Health in All Policies approach, but for the big things like the long-term plans and everything like that, we have a very prominent seat at the table. Hopefully, in that long-term plan that we have input in, that will require the Health in All Policies approach by the whole municipality. We're almost there, but I would not be telling you accurate information if I said we were completely there. But I fully endorse this.

Mme France Gélinas: Is this something, as a health unit, that you've ever talked about, that the government should take a Health in All Policies approach?

Dr. David Colby: We have a lot of opinions on what the government should do, but we recognize there are limited financial resources available.

Dr. Robert Kyle: What I would say is, like David, I am part of a regional municipality so I have a seat at the table beyond just the health department. We provide advice to our planning division with respect to official plan amendments and the like, so we've been able to influence, if you will, the built environment. We have a seat at the table with respect to source water protection, with respect to solid waste management and so forth.

Is there a formal policy within the region of Durham such that the health department has to be consulted before a policy initiative goes forward? No. But I like to think that we all, at this table, look for opportunities and we all try to bring solutions with us to those opportunities. Because I am embedded in a regional municipality, it's somewhat easier for me to do because I'm co-housed, co-located; there are fewer barriers than there would be if you were a stand-alone, say, board of health. But have we advocated for Health in All Policies at the provincial level? I don't recall doing that.

M^me^ France Gélinas: That's okay. Coming back to chronic disease prevention, what would keep the government from saying, "Well, chronic disease prevention has to be done across a lot of sectors. A lot of players have to come together to be successful, whether you look at alcohol or activities or obesity or healthy eating. Why don't we give this mandate to X, Y, Z"—fill in the blank—"rather than the health unit?" Why does that program have to reside with you?

Dr. Janet DeMille: I think because we're already doing it at the local level, influencing our partners. We work with schools. We work with municipalities. We work with social service agencies. We work with health care, whether it's with the hospital or primary care. We already have those connections to all the things that influence health. I think we have a lot of strength by doing it at the local level and with those partnerships.

A lot of the stuff that we deal with on alcohol is at the local level. The Thunder Bay Drug Strategy has an alcohol working group that advances stuff where all the different partners and all the different—the health care and the social services are all there, each doing their own thing to advance it in that community.

I think the government can play a role to assist in the policies that they're choosing or the legislation that they're enacting, but really, we're already doing that. We're already working with all those other people who influence health.

Dr. Eileen de Villa: Dr. DeMille is quite right; we are the experts when it comes to disease prevention and health promotion. This is our unique role within the health system writ large. But I think we're also uniquely situated. You've heard my colleagues speak about how we work in partnership—

The Chair (Ms. Catherine Fife): I just want to let you know there are two minutes left in this cycle.

Dr. Eileen de Villa: —with other players within the context of municipal government and with provincial government and federal government, as well, and with community partners outside of government. So we have this unique place within the system and a unique skill set and knowledge base and evidence base from which to work, as well, in support of disease prevention and health promotion—unique skills I think that we bring to the table.

Dr. David Colby: Great Britain has a health system which is the envy of the entire world, and it's public health that implements the entire health system in Britain, the acute care, prevention, chronic care, everything. Be careful what you wish for; you might get it. But it's true what I told you.

M^me^ France Gélinas: What I get out of what you said is that because of the expertise, because of the knowledge, because of the skills, this is how we ensure that taxpayers get value for their money when it comes to health promotion, disease prevention and, more specifically, chronic disease management.

Dr. Eileen de Villa: I think it's more than that. I think those are some of the value-add that we bring to the table, but in fact the value proposition is ascertained through the many mechanisms we spoke about, whereby the public actually understands and knows what it is they're getting in return for the investment that they've placed through the public reporting mechanisms, through the budget processes, through improved standards, that kind of thing. It's the combination, I think, of mechanisms by which to assure the public that we're providing value, that you actually get that value.

The Chair (Ms. Catherine Fife): We're going to leave it there, and we will move over to the government side. MPP Parsa.

Mr. Michael Parsa: We've all heard the term "early prevention," especially in the medical field. That's very, very important. We hear that all the time. Going back to the legalization of cannabis, it's a factor we're dealing with now. You've said that data is very important to you. I think it was Dr. Kyle who mentioned that we don't have enough data yet to be able to address this. It's a reality. How is data being collected on cannabis, in particular? We know the impacts of it—we might not know exactly. How is data being gathered at this early stage, right now?

Dr. Robert Kyle: There is the Ontario student drug and health survey that is conducted by the Centre for Addiction and Mental Health every two years. Some of us participate by purchasing an over-sample so that we can see and get data at the local level. There is hospitalization data. There is ER visit data. There are a variety of sources of data that we can collect.

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I would have to say that, from probably day one of legalization, we've been involved in collecting such data and developing knowledge products. We know, for example, that there are concerns in the school population in Durham region with respect to the harmful effects of cannabis use, as well as what the use is, overall. So we've prepared information ourselves, based on the data that we've collected. We've also collected resources from other reputable sources—Health Canada; CAMH, I mentioned, and so forth—and made that available to students and to the school population.

Finally, to clarify my point: I think my point was not that data was not being collected, but I think my point was that it's early days and we would need to look at the research over many years to try to ascertain the full human health consequences of cannabis use.

Mr. Michael Parsa: Before you go any further, Dr. Kyle, maybe I could just, if you don't mind—

The Chair (Ms. Catherine Fife): Yes, please.

Mr. Michael Parsa: Doctor, are you saying that we're going to continue looking at data and research and numbers before anything is done proactively? Is that what you're saying?

Dr. Robert Kyle: No, I was trying to say that since legalization has happened, various audiences have turned to public health for information on health consequences, as we know it today, in terms of data on usage and so forth. We've used available data sources to try and pull packages of resources, infographics and so forth available and turned them around to the audiences who have requested this information from us, as well as posting it on our website. I think we've been fairly active in this area, and we'll keep a close eye on research resources from other reputable sources, our colleagues and so forth. We'll continue to provide information to our audiences, as I said previously, in the digital world, which is becoming increasingly sophisticated but also challenging.

I'll turn it over to my colleagues; they maybe have some things to add.

Dr. Eileen de Villa: Yes. I think that we are actively, through the various sources that Dr. Kyle referred to, collecting data now on usage and emergency room visits and that kind of thing. What remains outstanding is: What are the longer-term consequences? Because cannabis has been illegal for so long, it hasn't been studied to the same extent as, say, for example, tobacco or alcohol. Its status as an illicit drug has hindered research on the long-term consequences of cannabis use. That, I think, still remains. There are still some questions that we have in respect of longer-term impacts and health impacts related to cannabis use.

Mr. Michael Parsa: What are we looking at, Doctor? What's the time frame—five years; 10 years? I don't want to put you on the spot, even though you probably are on the spot. What are we looking at? Is it five years, 10 years? How long would you have to wait before you got some substantive data to say, "Okay, now we can start with this"? Because we're looking at $90 billion in nine years on four areas—22% of our health care budget. For me, I'm looking at it and saying: Proactively, what can we do to be able to offset that and to be able to at least reduce the cost of it on the taxpayers and the burden that we're going to be carrying? I'll leave that up to you.

Dr. Eileen de Villa: I think there are a couple of things here. I think what you're talking about is ensuring—and I just don't want to conflate two things. We need to make sure that we're monitoring the use and the impacts on the health care system in a very acute way, on an acute basis: How many emergency room visits, at what cost, and what then can we do specifically in the short term to address those unique challenges?

On a longer-term basis, some of the outcomes that we're talking about have yet to be actually fully understood. Those kinds of things, I think, will take several years in the making. We're talking about research agendas to say that if a young person begins using cannabis at a relatively young age and uses frequently, we have some knowledge that suggests that they will have more health challenges because they're initiating use at a point in their life and with high frequency when their brain is still developing. What exactly those manifestations are, and how much it costs to take care of those health outcomes, I think is still very much a question.

I don't know that we can answer the long-term question right away. On a shorter-term basis, I think actually following carefully with respect to the various data sources that we have available to us now that are more immediate will help us with more immediate actions.

Dr. David Colby: I think it needs to be added that much of what we need to learn are the consequences of this watershed legal change, but it would not be correct to leave you with the impression that this was done with a paucity of data. There have been at least five very large and broad-reaching commissions that have looked at this, starting with the Indian hemp commission in 1894, Mayor LaGuardia's special task force in 1944, the Wootton Report from England, the large report—I forget the name of it—of the United States, very comprehensive, and the Le Dain commission right here in Canada. They all recommended that this is mainly a nuisance and that it should be decriminalized.

But people have taken this line of thought beyond that now, that even drugs that are clearly more harmful than cannabis—keeping them in the shadows by making them criminal rather than medical issues is not the best way to prevent and deal with abuse situations that we have. My own health unit in Chatham-Kent has endorsed the decriminalization of all drugs for personal use. That is in no way, shape or form to be construed as endorsing the use of these kinds of drugs. It's to bring it out of the shadows to be able to deal with it with the medical model, rather than the unsuccessful criminal model that we are currently using for most of these things.

Mr. Michael Parsa: Is there anything else that anyone would like to add? Because I want to follow up on the—sorry, Doctor. Go ahead.

Dr. Robert Kyle: The only other thing I was going to say is: In terms of how long, it depends on what the end point is. Going back to tobacco, it takes decades in order for cancer to develop. For unforeseen health consequences that are cancer-like, for example, it may not come to light for decades. So it depends on the outcome of interest as to how long it will take for research to get caught up with the actual human health impacts.

Mr. Michael Parsa: In the report, it was noted that each public health unit does their research independently and it results in significant duplication of effort. Why is that?

Dr. Robert Kyle: I'll start.

Mr. Michael Parsa: Sorry, Doctor, before you go ahead—I apologize—I just want to add that I do understand the factor that there may be certain areas that might have certain issues that may not cater to other—not a cookie-cutter approach. But when you're looking at a province-wide solution, perhaps, or study or research, I'm sure there's some sort of collaboration that could go into it.

Dr. Robert Kyle: Research depends on the question that you ask. In my health unit, we would consider program evaluation to the extent it's asking, is this intervention research effective or not? Because interventions differ from health unit to health unit, what works in one health unit with respect to the study design, the intervention itself, the participants and so forth may change from health unit to health unit. At the end of the day, regardless of there being central supports, there may be differences among us.

But the report also mentioned, for example, that Public Health Ontario supported what's known as Locally Driven Collaborative Projects. That is a process whereby PHO, up until recently, would have interested health units flesh out a research question. There would be a vetting process and the top candidates would then be invited to submit a proposal. If successful, then the collaborating public health units would carry out that research.

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I would say, as a former non-teaching health unit, that this was a much more effective model than the previous teaching health unit model, where there was a limited audience and less public health unit involvement. I think that's a success story, and that is noted in the audit report.

Lastly, in terms of building capacity at the central level, which is another finding in the audit report, it lists a number of resource centres that were funded up until the end of 2017. They've been defunded. So with respect to, for example, program evaluation capacity-building, that was done by Public Health Ontario, and it was very successful in terms of levelling up, if you will, the level of program evaluation expertise.

I would say that research was done which was public health unit-specific, and it has continued to do so. I would say that there were consortia of public health units working on a question of general interest to the field, and I think that was a very successful model.

I think that capacity-building, to the extent it was funded, until it was defunded, was very successful in terms of levelling up our capacity in this area.

Excuse me. I'm losing my voice. But I'm done.

Dr. Janet DeMille: Thunder Bay District Health Unit is one of the smaller health units in the province—not geographically, but certainly in terms of the number of staff and our budget—and we don't necessarily have the resources to be able to do a lot of our own research, the full scope of it, so we've actually benefited from a lot of the work that Public Health Ontario has done. They have snapshots—they've provided work on data around opioids, for example—which look at health behaviours, chronic disease and infectious diseases.

As well, when looking at effective practices, Public Health Ontario has produced everything from smaller evidence briefs on a particular topic to a more comprehensive overview of the evidence. I think of our conversation earlier around tobacco programming—Public Health Ontario led a review of the evidence on all the pillars of tobacco control a number of years ago—or work that they did around the Healthy Kids Strategy and the evidence around that. For our health unit, that kind of thing is very helpful.

Then there are things that we need to do because it's local or it's contextual to our area. We have partnerships there that help us with that; for example, with Lakehead University or St. Joe's health care. Some of the research partners that exist can work with us. We do have capacity and have increased our own internal capacity to be able to search for evidence, or do evaluation or epidemiological support.

Dr. David Colby: We share information, official reports and best practices extensively with each other all through Ontario. We may do some research in isolation when things come up, but that information is not kept; it's shared, and everyone benefits from it, ultimately.

The Chair (Ms. Catherine Fife): Okay, thank you. We're going to move on to Mr. Barrett. He's been waiting.

Mr. Toby Barrett: Thank you. You're done, are you?

Mr. Michael Parsa: If there's time, I want to ask one question.

Mr. Toby Barrett: How much time do we have, Chair?

The Chair (Ms. Catherine Fife): There is less than five minutes left in this cycle, and then there will be another 20-minute cycle, so I'll come back. Go ahead, Mr. Barrett.

Mr. Toby Barrett: Do you want to finish up, then?

Mr. Michael Parsa: How much of it is duplicated, in your estimate; for example, some of the research that you are doing? I understand that afterwards, you're sharing information. But if you were to put a number to it, an estimate, how much of this is duplication?

Dr. David Colby: This would be the broadest, loosest estimate you've probably ever heard—

Mr. Michael Parsa: I've heard a lot of estimates.

Dr. David Colby: I bet you've heard a lot of them. I'd say 20%.

Mr. Michael Parsa: Okay. Thank you.

The Chair (Ms. Catherine Fife): Mr. Barrett, please go ahead.

Mr. Toby Barrett: Okay. I may need more than three minutes.

The Chair (Ms. Catherine Fife): We'll come back to you after that.

Mr. Toby Barrett: I do want to kick off with, obviously, the concern with chronic diseases. Many of us here are with you. We feel the answer does lie in disease prevention and health promotion. You talk about the success of the tobacco program—other than illegal tobacco, which is a failure, and there is a blind eye turned toward that.

With respect to alcohol and other drugs: I was in that business for 20 years. I worked for the Ontario Addiction Research Foundation, now the centre. You mentioned the two-year surveys. There may have been one-year surveys before. We were under the gun every year when I first started over at 33 Russell Street. We knew that the consumption of alcohol and other drugs—most of the surveys were young person surveys—was increasing every year. We were under the gun. It was embarrassing. Finally it turned, but that was over our head, and that was a real incentive to try to do something about it.

With respect to chronic disease: I weigh 200 pounds. I know there's a stigma around weight for some people—not with me, necessarily. I don't get the exercise I should, sitting on committee; although, I own a farm and I get some exercise there. But I have no reading of where we are with respect to obesity year by year or lack of physical activity. From perception, I think 30 years ago I took the kids to Disneyland and I was shocked at how overweight young people were in the United States. To this day, I still see that. I see that in much of Ontario.

I represent a riding based on labour-intensive agriculture. In another month or two, we have to put 9,000 people out into the fields. Ginseng, fruit and vegetable, tobacco—we're tobacco country. We cannot find young people who are physically able to work anymore, to do the kind of work that I always did. So I can measure it just by observation.

Do you have an annual perception on people's weight or an annual reading or a monitoring—you mentioned surveillance—of people's physical activity status?

The Chair (Ms. Catherine Fife): You have one minute left in this.

Mr. Toby Barrett: I'll have to probably pick up on the next round.

The Chair (Ms. Catherine Fife): Yes, you will.

Dr. Robert Kyle: What I would say is I'm not aware that obesity has turned the corner. I don't have a grasp of the immediate numbers, but we would get that information from the Canadian Community Health Survey, perhaps from the Rapid Risk Factor Surveillance System. I'm not aware that it's not on the rise. I'm aware that obesity continues to be a wicked problem. The audit report makes reference to the Healthy Kids Panel report, for example, that specifically looked at this issue. It may be worthwhile for the committee to get information about how effective that intervention was. I think it's still a work in progress. I think PHO is evaluating in particular the Healthy Kids Community Challenge. But yes, it's still a problem.

The Chair (Ms. Catherine Fife): Thank you very much. We'll reconvene with you after the last 20-minute cycle for the official opposition.

MPP Gélinas.

M^me^ France Gélinas: I was going to go into the same train of thought as MPP Barrett. You've talked quite a bit—you've enlightened us, anyway—about tobacco control. I would like to focus on physical activities and healthy eating. Yes, the kids report showed us that one in four children is overweight or obese, and one in three adults. In some areas of my riding, it's one in two.

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Can you explain to us how the health unit is working through their chronic disease prevention approach on physical activities and healthy eating? Is this connected to the overweight and obesity crisis that we're looking at and that was explained in the report you were just referencing?

Dr. Robert Kyle: Well, I can take a stab. I would say that obesity is certainly related to unhealthy eating and poor physical activity. I would say that in general—I keep coming back to tobacco, but we've learned so much. I think, because it is such a multi-pronged challenge, you do need to take a comprehensive approach, and I'm sure we all take a comprehensive approach. You look for opportunities for prevention. You look for opportunities to replace unhealthy food with healthy food. You heard from Janet with respect to the Northern Fruit and Vegetable Program.

We have shied away in Ontario with respect to the use of legislation and policy, but some jurisdictions have implemented a soda tax. In Ontario we've implemented the Healthy Menu Choices Act. It's early days; it's only been enforced in the past couple of years, so we have to see what impact it has, but there is policy and legislation and, of course, there is enforcement.

I think you take a comprehensive approach writ large and then, in particular settings, you also take a comprehensive approach. The report makes mention of the Comprehensive School Health model. You look at opportunities for policy: What is the menu selection with respect to cafeteria meals? What is the messaging in the classroom with respect to not only physical activity and the importance of that in healthy eating, but as well you look at, for example, daily active physical activity.

I think you use a comprehensive approach both within settings and more writ large. It's a wicked problem. If people could do something about their weight, if people could do something about increasing their physical activity, if people could do something about healthy eating without all of these external factors that promote making bad choices the easy choices—low-cost food etc. etc.

We have to be mindful that the external environment has an impact on a person's choices with respect to healthy eating and physical activity. There's only so much we can do in public health and we do need to advocate for changes within the environment around us and use a comprehensive approach to tackle this issue.

Dr. Eileen de Villa: If I can just speak further to that, there are specific activities, say, for example, through the school programs and through our interactions with schools, that actually seek to improve physical activity and healthy eating.

In Toronto we have a program called Into Kids' Health. It is specifically directed toward a combination of things. There's a healthy eating component to it. There is an increased physical activity component. There is a component to it that is premised on the model that you should not be consuming sugar-sweetened beverages at all and that

you should reduce your screen time so that there is more time spent on physical activity.

I think what's interesting is that beyond that which we can do in these programmatic areas, as Dr. Kyle was alluding to, it's the environment that actually creates the ability or facilitates the ability for people to engage in appropriate and healthy behaviours. While we may not think of transportation policy as having something to do with physical activity, there are actual decisions that we make in respect of transportation that make it easier for people—or more difficult, conversely, for people—to engage in daily physical activity. Whether we support more active transportation, whether it's walking, cycling or using public transit, and what decisions we make in respect of transportation and mobility within our cities and throughout our province actually facilitates or hinders the capacity for people to engage in the appropriate level of physical activity.

When it comes to something like healthy eating, unaffordable housing means that there is less money available for healthy food. Fruits and vegetables tend to be rather on the expensive side.

Again, housing policy and how we plan our municipalities and jurisdictions and how that, in turn, has an impact on housing cost—it doesn't have a direct link, per se, to healthy eating, but I think it has an important impact that we cannot ignore.

M^me^ France Gélinas: I fully agree with everything you said. This is how health promotion is done. This is how disease prevention, including chronic disease prevention, is done. It's always the link to you guys, as in, let's say people didn't like you and said, "We could do without health units." What would we be missing? The municipal government would still run this bus service that we want. They would still decide whether we have affordable housing or we don't. The grocery store will still say a pound of potatoes costs whatever.

It's to make the link back to the knowledge and the skills that you bring, to bring all of that together, and to show value for money in doing this that is the tough part. Are you able to make the link back?

Dr. Eileen de Villa: I think we can in many instances and examples. There have been policy decisions taken outside of the realm of health and the health system that demonstrate that we are having that impact. For example, in the city of Toronto, actually making public transit more accessible—the transit fare equity program is one such example. Facilitating the ability for those who are on the lower end of the income scale to actually get access to public transit is one such example. Facilitating access to active transportation through bicycle lanes, as an example, would be another. I think there are many others like this. There are programs.

In respect of planning, I know that we have been active participants. I would hazard that my colleagues across the table here have also actively participated within the planning contexts of their jurisdictions so that health is more actively considered as part of the discussion and in some cases even required before the decision can be taken in respect of, say, a new development or a redevelopment. So we do have that impact.

M^me^ France Gélinas: Can you give me some success stories that you've had, that because you were there—the built environment, the availability of food and the level of exercise—because of your expertise and knowledge, things turned out better? Can you give me examples?

Dr. Eileen de Villa: I gave you a few there. A specific bicycle lane example, specific developments—

M^me^ France Gélinas: So those were real—

Dr. Eileen de Villa: Those are real. Those are not theoretical.

I think Dr. DeMille spoke about different food policies within the context of their recreational environments—we have that same impact as well—or food policies within the context of children's services environments. I know we work actively with our children's services partners at the city of Toronto to ensure that their nutritional offering is as optimal as it can be. These are just a few examples. I could eat up most of your time telling you many more.

M^me^ France Gélinas: Oh, good. I didn't realize there were live examples. I thought they were just—

Dr. Eileen de Villa: No, no. Those are not theoretical; those are real.

M^me^ France Gélinas: Did you want to add?

Dr. David Colby: Yes. Chatham-Kent's health unit pushed the municipality to adopt the very strict anti-smoking law that I alluded to earlier. That was basically a public health initiative. It was before my time; I can't take personal credit for it.

There are difficulties in trying to conceptualize obesity as being a direct result of caloric intake and energy expenditure. It has become more and more apparent through research that all of our body weights are highly regulated, whether you're very thin or whether you're overweight. There's a lot of physiology that is unknown at this point: the role of brown fat and metabolic regulation and energy expenditure that occurs by any number of subtle mechanisms of adjusting the basal metabolic rate, and so forth.

I'm not trying to buffalo you, but it's not simple, that it's, "Oh, yes, you're eating too much or not getting enough exercise or both." Those are both approaches to help with this problem. But it's a lot more complicated than that, and that complicates outcome measurements with regard to what public health does. Again, it's not a simple method of just measuring how many people are obese in your society, because there are differences between individuals, between racial groups. There are cultural differences that predicate certain behaviours. It's really complicated.

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Dr. Eileen de Villa: But I think that's why many of us have moved away from the discussion on weights exclusively per se and talked more about optimizing physical activity as part of health, rather than focusing on weight—over and above the fact that focusing on weight tends to stigmatize people and then moves it more into the shadows, rather than bringing it out and saying, "Well, what can we do?"

M^me^ France Gélinas: The auditor talks about how very few health units identified physical activity as a number one priority in your priority setting; although ICES talks about optimizing physical activity as having the greatest impact on chronic disease prevention. Can you talk to the difference between the two?

Dr. Robert Kyle: I'll take a stab. I guess I'm getting the hard questions.

I think that's a function of other actors that are currently active in promoting physical activity. If you look over the history of public health, we're kind of latecomers to the game.

If you want a specific example, in Durham region, we work with our local municipalities with what's known as the Grade 5 Action Pass. Basically, we promote attendance at rec centres, and the municipalities fund the access to the rec centres, given that there is a dearth of rec centres near schools and, in fact, both paying and transportation are barriers. That's just one example.

But I think that finding in the audit is more of a reflection of how we're latecomers. There are many other actors involved in promotion of physical activity. I think the audit report points, as well, to perhaps a lack of specific staffing in this area—say, kinesiologists—when maybe those specialists would be more likely to be found in other partners' organizations.

I think that would—in part, at least—explain the difference. It's just where we are in our trajectory—skill set, other actors involved in this and making choices with respect to where do you allocate your resources versus healthy eating. I'll stop there and turn it over to my colleagues.

Dr. Eileen de Villa: I think that's the same in the Toronto context. In fact, our partners have asked us specifically for support on healthy eating and nutritional support in particular because they have got, in their minds, the requisite skill set on physical activity. It's just not an area that they have solicited our assistance on.

M^me^ France Gélinas: All right. If you thought the previous question was tough, wait for this one: If the health unit was not there, what difference would it make to chronic disease prevention?

Dr. Robert Kyle: I used one example. I think a concept like a Grade 5 Action Pass could be taken on by the municipality in and of itself, but there is a history of public health getting things up and started and letting others run with a good idea.

What may be missed, I think, are the skills and expertise that we can bring to the table with respect to—maybe not this example; I'm thinking about trying to influence health systems planning at the LHINs. We can provide and bring to the table our knowledge of population health assessment and surveillance—where do you focus your resources? We can be an active player in terms of not only the suite of health professionals that we can bring to the table, but also the expertise we have in-house. In Durham, we have an excellent community and resource development team: graphic technicians, social media and so forth.

I think public health has a history of bringing those talents, skills and resources to the table, being an active player and maybe pulling back if, in fact, an intervention is a success and others can take it on. If it is not successful—I gave a couple of examples where we were reaching the wrong audiences after our intervention, or attendance was declining and so forth—then we would pull out. That may be good, because just because you've done things over and over and over again doesn't mean that you should continue to do that.

I think we have a tremendous set of talents, skills and resources we can bring to the table. As I listed on page 7 of the speaking notes, we have a very, very good, solid, interconnected, well-regulated system. I think it does work well as a solid foundation for physical activity promotion, healthy eating and so forth.

Yes, you reset your priorities on a regular basis using a variety of lenses, including program evaluation—are you making a difference; can others step up and take over, and that sort of thing.

I'll stop there and turn it over to my colleagues.

The Chair (Ms. Catherine Fife): There are two minutes left in this question cycle.

Dr. Eileen de Villa: I also wonder how much of it is the issue that we don't necessarily characterize or describe our work in; for example, an area like transportation policy as chronic disease prevention. It's not to say that we don't recognize that; it's just that we may not conceptualize it or describe it that way.

As I said, I think all four of us have staff that actually advocate for and/or work directly with transportation partners so as to create environments that allow our respective populations to engage in more daily physical activity. Do we necessarily conceptualize that as part of our chronic disease prevention portfolio? Maybe not in the first instance, but that doesn't make it any less relevant.

Dr. David Colby: Having a group of medical experts able to advise our municipalities—without us, they would be at the mercy of ideologically driven activist groups that have strong opinions but not evidence to support their assertions, often.

M^me^ France Gélinas: The body of evidence resides with you and there is no other part in the health care system that has access to this body of evidence that can drive prevention forward?

Dr. David Colby: They may have access, but it's not their business to do it; it's ours.

M^me^ France Gélinas: Okay. Thank you.

The Chair (Ms. Catherine Fife): Okay. Thank you very much. That concludes the question sets from the official opposition.

We'll move into the final 20 minutes for the government side. We will return to MPP Barrett.

Mr. Toby Barrett: Thank you, Chair. Continuing the discussion, in a sense, with respect to the prevention of chronic disease: Beyond tobacco or beyond alcohol or drug use—although there is certainly a failure with respect to narcotic analgesics; that's apparent in certainly just about every small town in Ontario.

Again, with respect to the lack of physical activity and to inappropriate eating, it seems like maybe the health

units aren't the answer. There doesn't seem to necessarily be the surveillance or the measurement on a regular basis, and I'm not sure if there is direction, whether it's from the Ministry of Health or from the Ontario government, to set this as a priority. Maybe it is not a priority. Is there a strategy? Is there a framework?

While we don't necessarily talk about weight as far as a stigma, having 20 years working with alcohol and other drugs—you talk about the stigma with respect to alcoholism, but we didn't shy away from it until lately. We didn't change the name of our organization. It was always "addiction." That was the reality. One of the answers—and I'm not saying it's simple; after 20 years in the field, I felt I knew less about alcohol than when I started, but much of it related to consumption. It's like tobacco. It's a problem. Don't consume it. With certain kinds of food it's a problem. Don't consume it. I know that's simplifying it.

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I guess my question is: Is there any direction from society to perhaps focus more on this, or perhaps should other groups be targeting this in developing a framework or a strategy? Even with those other ailments, it wasn't the health units alone that dealt with it. There were activist groups. In the early 1980s, there was a tremendous movement against drinking and driving, and that was a game-changer. It didn't take long. You could safely go out on Saturday night and drive around without being smashed into by somebody. Can we just continue that discussion along those lines?

Dr. Robert Kyle: I can start. A former Chief Medical Officer of Health, Dr. Sheela Basrur, focused on obesity in her annual report—I can't remember the year, but quite a long time ago. I think in time that gave rise to the Healthy Kids Panel. Since then, of course, we've had several iterations of the standards that we have to adhere to, which I'm most familiar with, and which certainly require us to address the risk factors for obesity and the diseases related to obesity.

If your question is if we need somebody at that level to shine the light on obesity and reinvigorate, if you will, our action in this area, I would say that any such leadership at that level, at all levels, would be welcome, because it is a wicked problem. When I was growing up—I'm 61—my focus was on outdoor activities. Nowadays, I look at my kids, I look at my kids' friends, and they're all involved in a lot of screen time. They're all involved in digital technology, and it's competing with either active living or recreational or other opportunities.

It's a very, very steep challenge, but I think any major player, actor, whoever that would be who would shine a light on this problem and reinvigorate it would be welcome. We can only do what we can at the local level. We're involved in this on a regular basis and we try to shine the light on it locally as best we can.

That's my view. I'll turn it over to my colleagues.

Dr. Eileen de Villa: I would agree. I think when you're talking about the areas where we've had some success, and we've talked quite a bit about tobacco, it's because there was a coordinated strategy, coordinated use of data, coordinated use of evidence with a very clear application of a health lens on policies that were both directly relevant and those that were a little bit more perhaps indirectly connected. We also saw concerted efforts at all levels of government—not just the local public health units or the local level of government, but at the provincial level and at the federal level.

If we are to have success on a very complicated issue, chronic disease prevention—you talked specifically around obesity and suboptimal physical activity and suboptimal nutritional status. I think we need that level of a coordinated approach, with a very clear view to the fact that there are policies in arenas outside of the strict health realm that are relevant, and it has to occur at all levels of government.

Dr. David Colby: Specifically with regard to your question about what's being done, our health unit advocates physical literacy. It lobbies the municipality to create active transportation, to turn our place into a walking environment that's very supportive, to have trails that connect our smaller municipalities, away from our main urban centres—and there are few in my health unit—as well as working with the new Canada food guide.

Not only is that associated with an appropriate nutrient intake to prevent obesity, but also to prevent heart disease, stroke and diabetes, the other big chronic diseases that we're talking about today. So it all is interconnected, and we like to think that all of our programs are trying to improve the odds for Canadians in our municipalities at these levels.

Mr. Toby Barrett: And you may not be getting the ask from society. Going back to tobacco, I think of the US Surgeon General's report. That was the 1960s, and it took a few decades. I mentioned drinking and driving. I don't know whether it was Time magazine—they had a front page and all of sudden it dawned on people, "This isn't appropriate." It was something that was accepted in so much of North America.

You mentioned the Le Dain commission. When I was first hired, there was just one document on my desk, several volumes of the Le Dain commission. I'm one of the few people that's read it. But that was a game-changer in Ontario. Alcohol—the impetus came from this place. Heavy drinking after the Second World War, young people in Toronto—I think most of the Ontario cabinet in the late 1940s were alcoholics, including the Premier. We did research on this. I have it documented. In 1949—

The Chair (Ms. Catherine Fife): Well, we really shouldn't be speculating on other people's addictions, Mr. Barrett—

Mr. Toby Barrett: Well, again, it's the stigma—

The Chair (Ms. Catherine Fife): Please keep your comments factual.

Mr. Toby Barrett: I'll send the documentation to the committee.

Again, people get touchy about the stigma. The wives of the cabinet ministers asked the Premier to do something about it, and in 1949, they created legislation, the Ontario Addiction Research Foundation—at that time, the alcoholism act—in 1949, when it came from cabinet. So it

takes a game-changer to change attitudes. Even today, some of these attitudes against people drinking remain. The stigma is something we don't talk about. You talk about the stigma around rape.

But maybe there has not been that big report from somewhere with respect to eating habits, and there are a lot of vested interests. I mean, we saw pushback to the food guide that just came out. There are vested interests. Public health units, as I understand it, inspect restaurants. You probably inspect maybe the vats that fry the grease for the french fries and all that kind of stuff. I don't know whether you inspect their menu to see whether it's heart-healthy or not. Maybe government doesn't have that kind of power.

Dr. Robert Kyle: Yes, so we inspect for food safety purposes, and if they're captured under the Healthy Menu Choices Act, we make sure that they have appropriate caloric information. But we don't, if you will, sanitize their menus.

Mr. Toby Barrett: No, there are limits, and people probably don't want government sticking their nose into that kind of stuff.

Dr. Robert Kyle: No, but there have been programs to promote healthy eating choices with appropriate, kind of, logos, which are purely voluntary. Sometimes it's through partnerships with public health.

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The other thing I would say is going back to the message. I think, and I can't attribute this observation to any one person, but I think we're looking at a generation of kids whose longevity may be shorter than their parents' because of the obesity crisis. That's what gave rise, as I understand it, to the Healthy Kids Panel, and that's why the ongoing implementation of its recommendations is so important if we're going to turn the tide in terms of the health consequences of childhood obesity.

Mr. Toby Barrett: It's a tough sell. Disease prevention, health promotion: It's tough to justify. Research is tough to justify because you don't see the results for decades down the road.

With prevention, how can you explain that that person does not have a broken arm because of a prevention program? Our hospitals aren't oriented this way. Our physicians aren't oriented this way; they're not necessarily paid to do this.

I assume there's a very small percentage of the Ontario government budget alone that goes to health promotion—I'm not sure; 1%. It's probably the same level as what goes to the Ministry of Agriculture. It's very small, in the big picture.

Our health system—we talk about the Ministry of Health; it's the ministry of disease, as we know. It's not the ministry of—

Dr. Robert Kyle: What I would say is, you're talking to some true believers. I've been in the business for 30 years. I had my training in family practice. What I saw coming through the door were a lot of preventable types of diseases and injuries.

I devoted my career to public health. I have no regrets. I'm a true believer. I think that we just bash on and do what we can to improve the health of our communities. I wouldn't have stayed in the business for 30 years if I didn't believe that.

Dr. Eileen de Villa: Unfortunately, there have been some circumstances from other jurisdictions where we've seen what has happened, where the value of prevention does manifest itself. You have other jurisdictions that may not have invested in prevention.

But I think that is the classic conundrum within the realm of public health. It's hard to talk about the value of what didn't happen.

Mr. Toby Barrett: Yes. It's hard to measure through our other, more practical things that could be measured. I think the Auditor General has indicated that more work could be done there, to set targets. But if there's no framework or overall strategy or direction, then you maybe spend your time on tobacco or some of the other issues, rather than these issues.

The Chair (Ms. Catherine Fife): I'm cognizant that we have six minutes left in this question set, so I think we're going to move to MPP Miller. Thank you.

Mr. Norman Miller: I wanted to go back to the Auditor General's recommendations, specifically recommendation number 6, which is, "To support public health units to more efficiently and cost-effectively obtain and analyze epidemiological data for program planning and evaluation, we recommend"—and I wanted to go to the part to do with Indigenous communities. Perhaps, Dr. DeMille, it might be appropriate for you.

The recommendation is, "approach and work with Indigenous community leadership to obtain epidemiology data that would serve to inform program development to benefit the Indigenous communities in Ontario." That was the recommendation of the Auditor General. I'm just wondering what specifically—your area would obviously be one that that would apply to.

Dr. Janet DeMille: I've been involved in the last three years, since I became medical officer of health, in a number of different initiatives, with a couple of more significance related to Indigenous populations. This is more directly First Nations populations and, in particular, First Nations in communities, because there's a real lack of data there.

I mentioned some of them. These are Indigenous-led initiatives that are generally done with the support of the province as well as with First Nations and Inuit Health, for example, and with the leadership and with the individuals in the communities.

For example, Mamow Ahyamowen—which is an Ojibway or a Cree term meaning "everybody counts" or "voices matter"— started several years ago. It was assessing the lack of data that's available for Indigenous populations. It moved forward with a joint project involving ICES. It was Laurentian University as well, which I think has ICESs there.

SLFNHA, Sioux Lookout First Nations Health Authority, and the Weeneebayko Area Health Authority,

or WAHA, on the James Bay coast have recently produced some data reports. I think there are actually about 59 First Nation communities that have signed on, a lot of them in northern Ontario. Each community can receive a report, or a tribal council could receive a report for their communities, or SLFNHA or WAHA could receive reports that looked at mortality. It compared the mortality of that population versus the Ontario mortality. It analyzed the chronic disease present at death and the cause of death. It was linked to the Indian registry, the Ontario health admin databases and coroner data to be able to do that. That was a very concrete example. Right now, these are draft—

Mr. Norman Miller: And that's work that has happened post the auditor's report then?

Dr. Janet DeMille: Actually, it was happening around the same time as that, so I'm not sure how much the auditor's report influenced that. I think that the ministry was also involved in some of this prior to that. Some of the work—I can't remember the exact—was initiated by the feds as well.

We're doing work—the Thunder Bay District Health Unit—with the Sioux Lookout First Nations Health Authority on a public health system for those 33 communities. The chiefs endorsed that. The chiefs of the Sioux Lookout First Nations endorsed that in February 2015, so four years ago. That has resulted in some work to seek epidemiological data for their community.

I'm not sure, though, how much of it stems from the Auditor General's report versus some of it just happening at the same time, but certainly the Ministry of Health was supporting that work.

Mr. Norman Miller: Okay, thank you. There has been a lot of talk about the success of the tobacco programs. I'm just wondering, do we measure how—we've had a change in Ontario—we compare to other jurisdictions?

The Chair (Ms. Catherine Fife): Last minute.

Mr. Norman Miller: There's, obviously, societal change around the world, in most places anyway. How do we compare to other provinces, to the United States—so we can know whether the health programs are actually making the difference versus just general societal change.

Dr. Eileen de Villa: I can't speak to the specific numbers from elsewhere. There's variation, but there has been a decline, for sure, I think in most of the Ontario public health units. I can speak best to the Toronto context. We're below the provincial average in respect of smoking rates, with adult smoking rates just a little over 14% in the city of Toronto. The provincial average is higher.

It's my understanding that in British Columbia, their numbers are generally a little bit better when it comes to something like smoking. But I think that in comparison to jurisdictions around the United States and throughout the world, we do quite well on this front. I think that's attributable to a comprehensive, well-resourced strategy with involvement at all levels of government.

The Chair (Ms. Catherine Fife): Thank you very much. That concludes our question sets for this afternoon.

I would like to thank Dr. Colby, Dr. Kyle, Dr. DeMille and Dr. de Villa for your participation today. It has been very valuable, I think, for our committee members. Of course, it's also part of Hansard now, so we share this information with our fellow colleagues as health care policy is developed on a go-forward basis. Your testimony will also inform our report-writing, which we are going to move into right now.

I will ask all members of the public, please, to leave the room so that we can commence writing.

Once again, thank you very much for your testimony and for your service to your communities.

The committee continued in closed session at 1432.

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