MEDIA RELEASE: Friday, August 9, 2013, 4:30 p.m.

REGIONAL MUNICIPALITY OF WATERLOO
COMMUNITY SERVICES COMMITTEE
AGENDA

Tuesday, August 13, 2013
9:00 a.m.
Regional Council Chamber
150 Frederick Street, Kitchener

1. DECLARATIONS OF PECUNIARY INTEREST UNDER THE MUNICIPAL
   CONFLICT OF INTEREST ACT

2. DELEGATIONS
   a) Linda Terry and Kristine Allison, Social Planning Council of Cambridge and
      North Dumfries, re: Community Social Profile of Waterloo Region

   CONSENT AGENDA ITEMS
   Items on the Consent Agenda can be approved in one motion of Committee to
   save time. Prior to the motion being voted on, any member of Committee may
   request that one or more of the items be removed from the Consent Agenda
   and voted on separately.

3. REQUEST TO REMOVE ITEMS FROM CONSENT AGENDA

4. MOTION TO APPROVE ITEMS OR RECEIVE FOR INFORMATION
   a) SS-13-024, Social Assistance Changes And Implications For Ontario Works
      (Information)
   b) SS-13-025, Opportunities Waterloo Region Co-Location (Approval)
   c) CA-HR-13-006, Cardio-Pulmonary Resuscitation (CPR) and Automated
      External Defibrillator (AED) Training (Information)
   d) PH-13-029, Health Hazard Prevention and Management Program Report
      (Information)
   e) PH-13-030, Quarterly Charged/Closed Food Premises Report (Information)
   f) PH-13-031, Income Gap Report (Information)
   g) PH-13-032, Ontario’s Public Health Sector Strategic Plan (Approval)
   h) Memo: Update on Statistics Canada’s National Household Survey
i) **Memo: Update: Replacement of Technology for Delivery of Social Assistance** 31

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### REGULAR AGENDA RESUMES

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7. **NEXT MEETING – September 10, 2013**

8. **ADJOURN**
TO: Chair Sean Strickland and Members of the Community Services Committee  

DATE: August 13, 2013  

FILE CODE: A02-20  

SUBJECT: SOCIAL ASSISTANCE CHANGES AND IMPLICATIONS FOR ONTARIO WORKS  

RECOMMENDATION:  

For information only  

SUMMARY:  

The 2013 Provincial Budget outlined a general direction and introduced a number of changes that affect the Ontario Disability Support Program (ODSP) and the Ontario Works (OW) program. This report highlights some of the changes for the Ontario Works program and reviews potential implications for the Region, as the delivery agent for Ontario Works.  

REPORT:  

1.0 Background  

The 2013 Provincial Budget announced changes that affect both the ODSP and OW program. Recently, staff has received detail on a number of these changes and the direction of the Province in the delivery of social assistance. The changes are generally consistent with the recommendations of “Brighter Prospects”, the final report of the Commission for the Review of Social Assistance in Ontario. They are intended to make the two programs better for social assistance participants and improve income and employment outcomes. Below is a summary of the key changes.  

1.1 Income and Assets  

Ontario Works Rate Increase  

- The maximum basic needs portion of the monthly allowance for a single adult is increasing by $20 per month (from $230 to $250); the shelter portion is unchanged  
- The basic needs and shelter maximums for a family are increasing by 1%  
- These changes are effective October 1, 2013  

Asset Limits and Exemptions  

- An increase in asset limits to $2,500 for a single person and $5,000 for a couple applying for Ontario Works (and $500 for each additional dependent beyond a spouse)  
- Full exemption of a primary vehicle of any value as an asset (currently the exemption extends up to a value of $10,000 for the primary vehicle)  
- Exempt, as income, gifts or voluntary payments that are received for any purpose up to $6,000 in any 12-month period
• These changes are effective September 1, 2013.

**Earnings Exemption**

- Effective September 1, 2013 an adult may earn up to $200 per month without impacting their social assistance entitlement. Currently net earnings after mandatory payroll deductions and any child care costs are subject to a 50% exemption. This exemption will continue for earnings over $200.

**Income from Business**

- Effective September 1, 2013 OW participants with income from a business will be eligible for the $200 earnings exemption and a 50% partial earnings exemption (currently income from business is reduced by eligible business expenses and then deducted from assistance dollar-for-dollar).

**Earnings While Attending Secondary School**

- Effective September 1, 2013 the 100% exemption of earnings or training allowances will be extended to spouses under the age of 18, children receiving the Temporary Care Allowance and all members of a family over the age of 18 who are attending secondary school full-time.

### 1.2 Participation Requirements

The Province has indicated a commitment to remove barriers and increase employment opportunities for people receiving social assistance both Ontario Disability Support Program (ODSP) and Ontario Works (OW) participants. Participation in OW employment assistance activities is a requirement of eligibility for social assistance (unless deferred or waived as applicable) for the following groups: adults receiving Ontario Works including those who have applied to the ODSP and dependent adults and non-disabled spouses (i.e., non-disabled adults) in families receiving the ODSP allowance. The Province is taking steps to strengthen participation in Ontario Works employment assistance activities for these two groups. These include clarification to policy and initiatives within the ODSP to increase the referral and participation rate of dependent and non-disabled adults on ODSP in OW employment assistance activities. Consolidated Municipal Service Managers such as the Region are asked to work with local ODSP offices to review and confirm referral and transfer protocols during the Summer 2013.

### 2.0 Summary

The potential cost impacts of these changes are summarized below. In this regard the Province has provided estimates for planning purposes based upon the current caseload. While staff support the intent of the changes as consistent with the recommendations of the Social Assistance Review, staff would caution that the increase in asset levels to qualify for Ontario Works may lead incrementally to higher caseloads. Pressure on our caseloads may be further exacerbated if there is an increase in the number of ODSP non-disabled adults who are referred for employment assistance. As well, the ability to retain a greater level of earnings may lead to participants staying on the caseload longer. The level of funding to be approved by the Province for the administration of Ontario Works has been set for 2013 and 2014 based upon the caseload experience from October 2010 to September 2012.

**CORPORATE STRATEGIC PLAN:**
The delivery of Ontario Works supports the Region’s Corporate Strategic Plan, Focus Area 4: Healthy and Inclusive Communities; (to) Foster healthy, safe, inclusive and caring communities.

FINANCIAL IMPLICATIONS:

The social assistance rate changes will take effect October 1, 2013. The Province will fund the rate changes at 100% for 2013, and in 2014 the Region will be required to cost share this change. These costs are subject to upload and will be fully funded by the Province in 2018. The earnings, exemption and asset related changes will take effect on September 1, 2013.

The Province has provided an estimate of the financial impact of the changes for Waterloo Region based on the average 2012/13 caseload. This estimate does not factor in any change in the caseload, as discussed above. The Province estimates the Region’s share of the changes to be $48,000 in 2013, $333,000 in 2014 and $263,000 in 2015.

Since 2010, the Region has utilized the Tax Stabilization Reserve Fund (TSRF) to offset its share of higher costs associated with the Ontario Works caseload. The increased costs resulting from these changes will be funded by the TSRF until 2018, at which time all OW caseload costs will be funded by the Province of Ontario.

OTHER DEPARTMENT CONSULTATIONS/CONCURRENCE:

This report has been prepared by staff from Social Services and Finance.

ATTACHMENTS

N/A

PREPARED BY:  David Dirks, Director, Employment and Income Support

APPROVED BY:  Douglas Bartholomew-Saunders, Commissioner, Social Services
TO: Chair Sean Strickland and Members of the Community Services Committee

DATE: August 13, 2013

FILE CODE: A02-20

SUBJECT: OPPORTUNITIES WATERLOO REGION CO-LOCATION

RECOMMENDATION:

THAT the Regional Municipality of Waterloo approve an agreement to permit Opportunities Waterloo Region to continue to co-locate with Employment and Income Support, Social Services at 235 King Street East, Kitchener with no licence fee for the period September 1, 2013 to March 31, 2014, such an agreement to be satisfactory to the Regional Solicitor as outlined in Report SS-13-025, dated August 13, 2013.

SUMMARY:

Nil

REPORT:

Opportunities Waterloo Region (OWR) is a registered charitable organization that facilitates and implements multi-sectoral collaborative solutions to reduce and prevent poverty in the Region of Waterloo. The Region has approved a one-time grant of $59,000 for the 2013 calendar year to pay for the costs of its core operating expenditures. OWR has developed a work plan in which it outlines five specific projects to achieve its mandate. One of these has included assisting Employment and Income Support with its very successful Canada Learning Bond initiative, which was reported to Council in the June 18, 2013 Information Memorandum, Canada Learning Bond Enrollment.

Opportunities has co-located with Employment and Income Support since September 2004. Given the budget limitations of the organization rent has not been charged. Other costs such as telephone, photocopier and parking are managed by the organization. OWR occupies up to 700 square feet and this space can be made available without detriment to Employment and Income Support. Additional space is made available from time to time (such as the use of a meeting room) to support the work of OWR.

CORPORATE STRATEGIC PLAN:

Co-location supports the Region’s 2011-2014 Corporate Strategic Plan, Focus Area 4: Healthy and Inclusive Communities; Strategic Objective 4.1 (to) work collaboratively to reduce poverty.

FINANCIAL IMPLICATIONS:

The Region has provided a one-time grant of $59,000 to pay for the costs of OWR’s core operating expenditures. Presently there is no rental cost to OWR to co-locate with Employment and Income Support. All other costs are assumed by the organization.
OTHER DEPARTMENT CONSULTATIONS/CONCURRENCE:

This report has been reviewed by Corporate Resources and Finance. Corporate Resources (Legal) will be involved in completing the agreement.

ATTACHMENTS

Nil

PREPARED BY: Graeme Fisken, Manager, Employment Services
               David Dirks, Director, Employment and Income Support

APPROVED BY: Douglas Bartholomew-Saunders, Commissioner, Social services
REGION OF WATERLOO
HUMAN RESOURCES DEPARTMENT
Employee Relations

TO: Chair Sean Strickland and Members of the Community Services Committee

DATE: August 13, 2013

FILE CODE: A26-50

SUBJECT: CARDIO-PULMONARY RESUSCITATION (CPR) AND AUTOMATED EXTERNAL DEFIBRILLATOR (AED) TRAINING

RECOMMENDATION:

For Information.

SUMMARY:

At the Regional Council meeting of November 27, 2012 it was suggested that all Regional employees should receive CPR and AED training. The following report provides information on our current programming and outlines the impact of having all employees trained in CPR.

REPORT:

Since the early ‘90’s First Aid and CPR (FA/CPR) training has been offered to Regional employees. Annually, the Region holds 15 – 20 Emergency (1-day) First Aid/CPR sessions and two Standard (2-day) First Aid/CPR sessions. Recognizing the importance of training new and young workers, two of these sessions are dedicated to summer students and one is dedicated to the new snow plow operators. Employee participation in the training is encouraged and classes are constantly full, often with waitlists. This FA/CPR training is valid for three (3) years.

The Region and its employees may benefit from a campaign to raise awareness in regard to responding to CPR events including such things as locating and using the building’s AED, knowing where the first aid resources are and asking the Joint Health and Safety Committees to add it to their agendas. Corporate Health and Safety could support Public Health with the development of a CPR/AED Awareness Program.

Our records show that of the approximately 3100 employees at the Region, we currently have just over 500, working in 45 different locations, with valid FA/CPR certificates. When someone new joins the Region who requires this training for their job they are automatically registered in the next available course. For existing employees FA/CPR courses are offered to those who require this training for:

- Their job or occupation;
- Those who will be volunteers for the first aid room/station;
- Those who operate regional vehicles (buses excluded) and equipment equipped with a first aid kit.

Integral to understanding how to do CPR is understanding how to use an automated external defibrillator (AED). Since 2003 the Region’s FA/CPR courses have included AED training with the facilitator/trainer using the same AED as found throughout Regional Buildings. We currently have
AED’s in 17 Regional buildings with 1 more building to receive an AED in 2013. When an AED is installed, our Emergency Medical Services will offer dedicated training on the use of the AED.

A recommendation has been made that all Regional employees receive CPR/AED training. There would be challenges associated with implementing a region-wide program.

A CPR/AED course is 4 hours long, can accommodate 24 participants/session and would cost about $65.00 per participant. The training costs to train the remaining 2600 employees would be about $190,000.00 and would require over 110 training sessions be arranged. Based on the time spent arranging existing Regional training a dedicated resource would be required to manage and arrange this amount of training at an estimated cost of $78,000. This training is only valid for 3 years therefore a constant renewal cycle would need to be managed and funded.

As well, approximately 1/3 of our employees work in 24/7 operations where removing an employee from their regular job to attend training would require a replacement employee to cover their shift. This would at a minimum double the wage costs to attend this training for about 900 positions.

Emergency response and emergency awareness is very important to the Region, as demonstrated by the training programs that are available. As well, Emergency Awareness was a dedicated topic during North American Occupational Health and Safety Week (NAOSH) in May 2013, with messages about dialing 9-9-1-1, and information on the locations of the AEDs and First Aid rooms.

CORPORATE STRATEGIC PLAN:

Focusing on emergency awareness supports the Region’s strategic objective to deliver excellent and responsive services that inspire public trust which is identified in the Region’s Strategic Plan under Focus Area 5, Service Excellence.

FINANCIAL IMPLICATIONS:

Implementing CPR/AED training for all staff would cost approximately $268,000.00 on an annual basis, excluding staff replacement costs.

OTHER DEPARTMENT CONSULTATIONS/CONCURRENCE:

Public Health was consulted in the development of this report.

PREPARED BY: Cindy Blair, Manager, Corporate Health and Safety

APPROVED BY: Penny Smiley, Commissioner, Human Resources
TO: Chair Sean Strickland and Members of the Community Services Committee  
DATE: August 13, 2013  
FILE CODE: P07-80

SUBJECT: HEALTH HAZARD PREVENTION AND MANAGEMENT PROGRAM REPORT

RECOMMENDATION:

For information

SUMMARY:

This initial program report highlights the activities that fall under the Health Hazard Prevention and Management Program at Region of Waterloo Public Health, a new program mandated by the Ontario Public Health Standards (2008). This report and future periodic updates are designed to keep the Board of Health (i.e. Regional Council) informed on how the Health Unit is meeting the requirements of the Ontario Public Health Standards.

The goal of the Health Hazard Program is to prevent or reduce the burden of illness from health hazards in the physical environment. This goal is achieved by fulfilling the requirements described in the Ontario Public Health Standards, taking into account priority health hazards in the community.

The Health Hazard Program is divided into response-based activities and proactive activities. Response-based activities include responding to and investigating complaints, questions or other requests related to health hazards. Effective programming also requires proactive activities to identify priority health hazards and address the prevention of these priority hazards or mitigate their effects. Both types of activities often involve working in partnership with other municipal or provincial government agencies.

Due to the broad definition for a health hazard, the issues that potentially fall under this Program range widely. For a number of health hazards, other municipal or provincial government agencies have primary responsibility or overlapping mandates. In instances where another agency is the lead, Public Health provides support such as providing health-related information and advice to the public.

In 2012, Public Health responded to 325 community health hazard requests for service. Priority health hazard issues in Waterloo Region were also identified. In addition, Public Health worked on strengthening relationships with key partner agencies to enhance its ability to effectively respond to, mitigate or prevent health hazards in Waterloo Region in partnership with these agencies.

REPORT:

Health Protection and Promotion Act

Under the Health Protection and Promotion Act, Boards of Health are required to respond to health hazard complaints related to environmental or occupational health (Section 11 of the
Health Protection and Promotion Act). When a complaint is received, the Health Unit must “notify the ministry of the Government of Ontario that has primary responsibility”, such as the Ministry of the Environment for environmental issues and the Ministry of Labour for occupational ones. The Health Unit must work in consultation with the lead agency to conduct an investigation of the complaint in order to determine if a health hazard exists.

**Ontario Public Health Standards**

In the Ontario Public Health Standards, the Health Hazards Prevention and Management Program Standard is one of three standards that fall under the Environmental Health Standards, along with Food Safety and Safe Water. Although Public Health Units have been responding to health hazards in the past, the formalization of its activities under the Health Hazard Program of the Ontario Public Health Standards better recognizes all the activities that are performed by Health Units with regards to environmental health hazards.

**Health Hazard Prevention and Management Program**

The goal of the Health Hazard Prevention and Management Program is to prevent or reduce the burden of illness from health hazards in the physical environment by identifying, investigating and managing reported health hazards. A health hazard is defined by the Health Protection and Promotion Act as: “(a) a condition of a premise, (b) a substance, thing, plant or animal other than man, or (c) a solid, liquid, gas or combination of any of them, that has or that is likely to have an adverse effect on the health of any person.” A ‘health hazard in the environment’ is defined by the Ontario Public Health Standards as “health hazards in the physical environment that are not addressed in other programs under the Ontario Public Health Standards.”

Due to the broad definition for a health hazard, the issues that potentially fall under the jurisdiction of the Health Hazard Program range widely. This includes issues that are deemed not to be a health hazard after an initial assessment or investigation. Examples of health hazard issues that Public Health has reported on to the Board of Health (i.e. Regional Council) in recent years can be viewed in Table 1.

<table>
<thead>
<tr>
<th>Health Hazard Topic</th>
<th>Community Services Committee Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indoor Air Quality - Radon</td>
<td>PH-13-004 Radon Health Promotion Initiative</td>
</tr>
<tr>
<td>Pests - Bedbugs</td>
<td>PH-12-014 Bedbug Initiative</td>
</tr>
<tr>
<td>Extreme Weather - Heat</td>
<td>PH-12-024 Humidex Advisory Response</td>
</tr>
<tr>
<td>Outdoor Air Quality - Smog</td>
<td>PH-12-024 Smog Advisory Response</td>
</tr>
<tr>
<td>Contaminated Sites – Northstar Aerospace and General Electric Canada</td>
<td>PH-11-036 TCE Remediation</td>
</tr>
<tr>
<td>Extreme Weather – Cold</td>
<td>PH-10-016 Extreme Cold Weather Protocol</td>
</tr>
</tbody>
</table>

The Health Hazard Program is divided into response-based activities and proactive activities. Response-based activities include responding to and investigating complaints, questions or other requests related to health hazards. Proactive activities are planned activities aimed at ensuring priority hazard areas are identified, and addressing the prevention or mitigation of priority hazards where possible. Both types of activities often involve working in partnership with other municipal or provincial government agencies that have respective mandates related to health hazards.

**Response-based Activities**

*Health Hazard Follow-Up and Investigations*
A key component of the Health Hazard Program is the 24 hours per day / 7 days per week Public Health Inspector Intake System for receiving and responding to reports of potential health hazards in Waterloo Region. Upon receipt of a complaint, question or other service request related to health hazards, a Public Health Inspector will provide an initial response within 24 hours. In 2012, Public Health Inspectors responded to 325 community health hazard requests for service. Figure 1 highlights the types of health hazard requests Public Health received and responded to in 2012. Of the 325 health hazard requests, the top two were related to indoor air quality (38 per cent – of which mould represented 66 per cent) and pests (32 per cent – of which bed bugs represented 72 per cent).

Figure 1: 2012 health hazard complaints, questions and requests received through Public Health Inspector Intake System

![Image of bar chart showing types of health hazard requests in 2012]

Source: ROWPH Hedgehog Database  
Date extracted: July 8 2013

After the initial assessment, Public Health may take the lead in the follow-up response or may refer the request to other, more appropriate government agencies and provide support where needed. A number of requests are referred to City/Township By-law Departments due to the high volume of issues related to individual properties. Public Health has begun to work more closely with City/Township By-Law Departments in order to improve and enhance our response to commonly reported health hazards or complaints.

Public Health also receives health hazard related requests for information or service via methods other than the Intake System (e.g. requests from other Regional departments or municipal partners, Committee Service Committee, the media, etc.) Responses to these requests can take the form of briefing notes, position statements, position papers, responses to media requests and enhancement of our public and website resources.

Skills Maintenance and Expertise Consultation

To ensure skills remain current in a broad and evolving field, Public Health Inspectors and Public Health Planners supporting the Health Hazard Program participate in regular and ongoing skills enhancement in health hazard investigation and management. Training for Public
Health staff focuses on emerging issues and new evidence, which allows them to provide continued support and best practice solutions in health hazard prevention and management to our partners and the community. For new, emerging or more complex issues where internal experience is limited, Region of Waterloo Public Health has a contract with GlobalTox for the provision of ad-hoc expertise and consultation (Report: PH-11-039).

**Proactive Activities**

While Public Health undertakes a number of response-type activities, effective programming also requires a balance with proactive activities aimed at ensuring priority health hazards are identified and addressing the prevention of priority hazards or the mitigation of their effects. To this end, Region of Waterloo Public Health has been focusing on two areas of program development: understanding our community’s priority health hazards and strengthening our relationships with our partner agencies to enhance our ability to effectively respond to, mitigate and prevent health hazards in Waterloo Region in partnership with these agencies.

**Prioritization of Health Hazards for Program Planning**

In 2012, Public Health conducted a local threats assessment to identify, evaluate, and prioritize health hazard issues in Waterloo Region in order to inform program planning and response. GlobalTox was contracted to provide a list of potential environmental health hazards relevant to Waterloo Region. Using the list of 54 health hazards provided by GlobalTox and removing those covered in other program areas, Public Health prioritized the list based on criteria such as the estimated frequency and severity of possible adverse effects, the feasibility and effectiveness of potential interventions, and the mandates and activities of Public Health and its partner agencies.

The priority hazards identified were: outdoor air quality, indoor air radon, contaminated sites, extreme weather, and health hazard emergencies. Program planning for the above mentioned priorities is currently underway (see Table 2).

**Table 2: Description of priority health hazard initiatives as of July 2013**

<table>
<thead>
<tr>
<th>Health Hazard Program Priority Areas</th>
<th>Activities Underway</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outdoor Air Quality</td>
<td>Public Health is working on an outdoor air quality strategy that aims to support existing partners working on interventions that improve local air quality.</td>
</tr>
<tr>
<td>Indoor Air Radon</td>
<td>A radon health promotion initiative was launched in January 2013 with plans to repeat it in the Fall of 2013, in collaboration with 17 other Health Units across the Province.</td>
</tr>
<tr>
<td>Contaminated Sites</td>
<td>Public Health has also established regular meetings with the regional District Office of the Ministry of the Environment to enhance communications and information-sharing regarding local MOE-led projects. This will strengthen our ability to collaboratively respond in the event Public Health support is required, such as for a contaminated site of public health concern (e.g. Bishop Street Community, Chemtura).</td>
</tr>
<tr>
<td>Extreme Weather</td>
<td>Public Health’s extreme heat and cold weather protocols have been revised and updated in consultation with relevant partners (e.g. Social Services, Area Municipalities, etc.)</td>
</tr>
<tr>
<td>Health Hazard Emergencies</td>
<td>Development of a Public Health Hazardous Materials Emergency Plan is underway, in support of a potential public health response to hazardous material emergencies in partnership with Fire (lead agency), the Ministry of the Environment and others.</td>
</tr>
</tbody>
</table>
Partnerships

In order to identify, investigate and respond effectively to health hazards, a clear, mutual understanding with partner agencies of respective roles and responsibilities is essential. These agencies may have primary responsibility for dealing with a reported health hazard in the environment, in which case Public Health provides support (such as through the provision of health-related information and advice to the public). As a result, over the past two years, Public Health has been reaching out to a number of these agencies to clarify roles and responsibilities in order to enhance our ability to prevent or manage local environmental health hazards. In 2011, Public Health surveyed nine agencies about our respective roles for health hazard prevention and management. In 2012 we summarized the responses, disseminated the results to partners, and invited partners for one-on-one, follow-up meetings. In 2012 we met with six agencies (Ministry of Labour, Ministry of the Environment, Region of Waterloo Water Services, and City/Township By-law Departments) to discuss roles and identify opportunities for collaboration. Further to this, the Health Unit planned a knowledge exchange forum between tri-city/township By-Law Officers and Public Health Inspectors. Public Health has also established regular meetings with the regional Guelph District Office of the Ministry of the Environment to enhance communications and information-sharing regarding local MOE-led projects. This will strengthen our ability to collaboratively respond in the event Public Health support is required, such as for a contaminated site of public health concern (e.g. Bishop Street Community, Chemtura).

Public Health is also a co-lead with Wellington-Dufferin-Guelph Public Health for the Central West Health Hazard Prevention and Management Community of Practice, which consists of seven health units. The goals of this group are to work together on common areas of program development, reduce duplication of work, provide knowledge exchange opportunities, and enhance consistency between health regions in responding to health hazards.

In conclusion, the Health Hazard program plays an essential role in promoting and protecting the public’s health. Public Health continues to identify ways to improve how it prevents and manages health hazards, as well as balance response-based activities with proactive, planned work focused on the prevention and/or mitigation of priority health hazards in collaboration with its partner agencies.

ONTARIO PUBLIC HEALTH STANDARDS:

Under the Health Protection and Promotion Act, Region of Waterloo Council serves as Waterloo Region’s Board of Health. Boards of Health are expected to adhere to the Ontario Public Health Standards, which outline the expectations for providing public health programs and services. This report informs the Board of activities undertaken by Region of Waterloo Public Health to meet the Health Hazards Prevention and Management Program Standard of the Ontario Public Health Standards.

CORPORATE STRATEGIC PLAN:

4. Healthy and Inclusive Communities: Foster healthy, safe, inclusive and caring communities
5. Service Excellence: Deliver excellent and responsive services that inspire public trust

FINANCIAL IMPLICATIONS:

Health Hazard Prevention and Management Program activities are carried out within existing resources.
OTHER DEPARTMENT CONSULTATIONS/CONCURRENCE:
NIL

ATTACHMENTS:
NIL

PREPARED BY:  Paige Schell, Public Health Planner, Health Protection & Investigation
               Marla Rocca, Public Health Inspector, Health Protection & Investigation
               Dr. Hsiu-Li Wang, Associate Medical Officer of Health

APPROVED BY:  Dr. Liana Nolan, Commissioner/Medical Officer of Health
TO: Chair Sean Strickland and Members of the Community Services Committee

DATE: August 13, 2013

FILE CODE: P10-80

SUBJECT: QUARTERLY CHARGED/CLOSED FOOD PREMISES REPORT

RECOMMENDATION:

For information

SUMMARY:

This report is a summary of food premises enforcement activities conducted by Public Health Inspectors in the Health Protection and Investigation Division for the second quarter of 2013.

REPORT:

During the second quarter of 2013 one establishment was charged under the Health Protection and Promotion Act, Ontario Food Premises Regulation 562 (See Table 1: Food Safety Enforcement Activity).

Food premises charges and closures can be viewed on the Food Premises Inspection Reports website Enforcement Actions Page for a period up to 6 months from the date of the charge or closure. Every food premises charged has the right to a trial and every food premises ordered closed, under the Health Protection and Promotion Act, has the right to an appeal to the Health Services Appeal and Review Board.

CORPORATE STRATEGIC PLAN:

Health and Safe Communities: Support safe and caring communities that enhance all aspects of health.

FINANCIAL IMPLICATIONS:

NIL

OTHER DEPARTMENT CONSULTATIONS/CONCURRENCE:

NIL

ATTACHMENTS

Table 1: Food Safety Enforcement Activity

PREPARED BY: Chris Komorowski, Manager, Food Safety, Recreational Water Programs and Cambridge & Area Team

APPROVED BY: Dr. Liana Nolan, Commissioner/Medical Officer of Health
Table 1: Food Safety Enforcement Activity

<table>
<thead>
<tr>
<th>Name of Establishment</th>
<th>Date of Charges or Closure</th>
<th>Charges or Closure</th>
<th>Total Charge</th>
</tr>
</thead>
<tbody>
<tr>
<td>King Tin Restaurant</td>
<td>Six Provincial Offences Notices issued for infractions observed on May 21, 2013</td>
<td>Fail to protect food from contamination or adulteration ($300) Use dirty cloth for cleaning tables ($120) Mechanical equipment not maintained to provide sufficient chemical solution rinse ($120) Operator fail to ensure floor of food-handling room kept clean ($60) Operator fail to ensure walls of food-handling room kept clean ($60) Operator fail to ensure ceiling of food-handling room kept clean ($60)</td>
<td>$720</td>
</tr>
</tbody>
</table>
TO: Chair Sean Strickland and Members of the Community Services Committee

DATE: August 13, 2013

FILE CODE: P20-80

SUBJECT: INCOME GAP REPORT

RECOMMENDATION:
For Information.

SUMMARY:
Income is well-known as a significant determinant of health. More recently, research has been focusing on income inequality and its impacts at both the individual and population level. The Income Gap report is the latest in a series that began in 2000 and provides a snapshot of the issue of income inequality, at the local level, using data from Statistics Canada that was released in October 2012.

REPORT:
Background
Income equality or inequality describes the distribution of wealth in a given community. Globally, income inequality has increased in many developed countries since the 1990s due to changes in the structure of the population, unequal earnings, and changes in employment. In Canada, this increase is largely due to changes in the age and household structure of our population, for instance, a shift towards more single-parent and non-family households which typically have lower incomes. Additionally, increases in employment income have typically benefited households that already make over $100,000, while employment rates have fallen among less-educated people.

Income Gap Report
After-tax average household income is often used as an indicator of the well-being of a community's residents by determining a family’s ability to purchase necessary goods and services. In 2010, the average after-tax household income, in Waterloo Region, was $74,628 up from $46,481 in 1995. When the region is divided into five (5) income quintiles, it becomes clear that while all quintiles have experienced an increase in income, the largest gains were realized in the highest income quintile. See Figure 1.

Figure 2 shows that the trend, for income distribution, is similar for Ontario as a whole. However, it is important to note that the change in income from 1995 to 2010 is a much smoother gradient than observed in Waterloo Region meaning that the provincial increases have been occurring more steadily compared to the sharp increase in Waterloo beginning in 2000.
Figure 1: Average after-tax household income by quintiles, Waterloo Region, 1995, 2000, 2005, 2010.

![Figure 1: Average after-tax household income by quintiles, Waterloo Region, 1995, 2000, 2005, 2010.](image)

<table>
<thead>
<tr>
<th>Quintile</th>
<th>1995</th>
<th>2000</th>
<th>2005</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Highest Quintile</td>
<td>$91,603</td>
<td>$94,582</td>
<td>$122,737</td>
<td>$158,990</td>
</tr>
<tr>
<td>Mid-high Quintile</td>
<td>$53,494</td>
<td>$63,090</td>
<td>$73,363</td>
<td>$86,338</td>
</tr>
<tr>
<td>Middle Quintile</td>
<td>$42,444</td>
<td>$45,646</td>
<td>$51,281</td>
<td>$62,785</td>
</tr>
<tr>
<td>Low-mid Quintile</td>
<td>$29,302</td>
<td>$30,137</td>
<td>$33,328</td>
<td>$42,760</td>
</tr>
<tr>
<td>Lowest Quintile</td>
<td>$15,564</td>
<td>$8,348</td>
<td>$16,412</td>
<td>$22,266</td>
</tr>
</tbody>
</table>


Figure 2: Average after-tax household income by quintiles, Ontario, 1995, 2000, 2005 & 2010.

![Figure 2: Average after-tax household income by quintiles, Ontario, 1995, 2000, 2005 & 2010.](image)

<table>
<thead>
<tr>
<th>Quintile</th>
<th>1995</th>
<th>2000</th>
<th>2005</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Highest Quintile</td>
<td>$81,801</td>
<td>$106,089</td>
<td>$129,788</td>
<td>$148,086</td>
</tr>
<tr>
<td>Mid-high Quintile</td>
<td>$50,600</td>
<td>$62,236</td>
<td>$73,888</td>
<td>$84,879</td>
</tr>
<tr>
<td>Middle Quintile</td>
<td>$37,034</td>
<td>$44,712</td>
<td>$52,666</td>
<td>$60,372</td>
</tr>
<tr>
<td>Low-mid Quintile</td>
<td>$25,130</td>
<td>$29,856</td>
<td>$35,406</td>
<td>$41,388</td>
</tr>
<tr>
<td>Lowest Quintile</td>
<td>$12,385</td>
<td>$13,719</td>
<td>$17,079</td>
<td>$20,485</td>
</tr>
</tbody>
</table>

The Gini coefficient is the most commonly used measure of income inequality. It measures the extent to which the distribution of income among households in a society deviates from a perfectly equal distribution (World Bank, 2013). The coefficient can range from 0, which reflects complete equality (that is, everyone shares equally), to 1, indicating complete inequality (one person has all the income while all others have none). Seemingly small changes in the Gini coefficient indicate larger-scale changes in earnings over time because the Gini indicator is difficult to move (World Bank, 1998). Since 1995, there has been an increase in average household inequality of 13 per cent in Waterloo Region, compared to only 6 per cent in Ontario.

As seen in Table 1, there was a significant increase from 1995 to 2000 (from 0.30 to 0.34), but the Gini coefficient has remained stable since then. Compared to other similarly-sized Canadian cities, this increase of 0.04 points is relatively large. For instance, in the same time period (1995-2000) inequality in Vancouver increased by 0.008 points and Quebec City increased by 0 points (Chen, Myles, & Picot, 2011). The national average has remained around 0.32 since 2000 (The Conference Board of Canada, 2012).


<table>
<thead>
<tr>
<th></th>
<th>Gini Coefficient</th>
<th>Per cent Change from 1995-2010</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1995</td>
<td>2000</td>
</tr>
<tr>
<td>Waterloo Region</td>
<td>0.30</td>
<td>0.34</td>
</tr>
<tr>
<td>Ontario</td>
<td>0.32</td>
<td>0.34</td>
</tr>
</tbody>
</table>


The Income Gap full report looks at the results of these various indicators to describe the growing trend of income inequality in Waterloo Region. The report provides some insight into why the gap is growing and the potential impact that a widening income gap may have on the health of a community. There are several key messages from the report grouped into four main themes: Trends; Health Impacts; Vulnerable Groups; and Impacts on Poverty.

Trends
The Income Gap Report has examined the trend of a widening income gap in Waterloo Region and discussed the potential implications for population health. The statistics show that the income gap has been growing between the highest and lowest income quintiles since 1995. Additionally, more shares of the income distribution are being held by the highest income quintiles, at the expense of middle-income groups. There have been imbalanced increases in earnings across groups. While the wealthiest households have seen their earnings grow significantly, the middle and lowest-income households have only seen their earnings increase marginally over the last 15 years, suggesting a trend of rising income polarisation.

Health Impacts
Research has shown that the links between income inequality and population health are numerous, particularly through psychosocial pathways such as lower levels of social cohesion, decreased public participation, greater mistrust, social comparisons between groups, and an overall reduction in the quality of social relations. These effects tend to heighten the experience of deprivation and stress, which can result in maladaptive coping responses and behaviour (e.g., increased violence, smoking, poor eating habits, high-risk behaviours). Less equal societies are at higher risk for poorer self-reported health, lower life expectancy, increased infant mortality, and higher all-cause mortality. Moreover, the impacts on communities may be even more significant as societies with greater economic disparity tend to experience decreased social cohesion and citizen commitment, which has impacts on violence, mistrust, and high-risk behaviours. The evidence indicates that Gini
values greater than 0.3 have a more consistent association with adverse health effects. It should be noted that Waterloo Region’s Gini coefficient has been stable at 0.34 since 2000. If the income gap continues to widen, this would be expected to have implications for the social distance between individuals and families, and accordingly indices of population health.

**Vulnerable Groups**
We must pay particular attention to those vulnerable groups who are at higher risk for poverty, as they will also experience the effects of a widening income gap more intensely. Those individuals who are newer to Canada are over-represented in the lowest income quintiles and under-represented in the highest income quintiles. They have also seen their earnings decline in recent years compared to Canadian-born workers. Children are also particularly vulnerable and are implicitly affected by the earnings of their caregivers. As incomes have become more polarized over time, child poverty has also increased. Individuals who experience childhood poverty generally have greater challenges throughout their lifespan and may be at a disadvantage for life. Seniors are now also increasingly at risk for poverty, particularly elderly women, racialized seniors and those living alone. It is probable that these groups will carry a disparate burden if the income gap continues to widen.

**Impacts on Poverty**
Finally, small changes in income distribution can have a large effect on poverty, particularly the experience of poverty – its depth and severity. Just like the experience of living in poverty, the experience of social deprivation that results from income inequality can prevent people, communities, and whole societies from reaching their full potential. Accordingly, there should be more emphasis on relative poverty measures, such as the Gini coefficient. Such measures illustrate shifts in income and can also be used as indicators for population health.

**ONTARIO PUBLIC HEALTH STANDARDS:**
The Income Gap Report was prepared as part of our work under the Foundational Standards Requirement 5: The board of health shall provide population health information including determinants of health and health inequities to the public, community partners, and health care providers, in accordance with the Population Health Assessment and Surveillance Protocol, 2008.

**CORPORATE STRATEGIC PLAN:**
The Income Gap Report provides information that may be utilized by a variety of service areas in our efforts to:
Create Healthy and Inclusive Communities--4.2 Foster healthy living through information, education, policy development and health promotion and
Improve Service Excellence-- 5.1 Improve the accessibility of Regional programs and services to support our diverse community.

**FINANCIAL IMPLICATIONS:**
NIL

**OTHER DEPARTMENT CONSULTATIONS/CONCURRENCE:**
NIL

**ATTACHMENTS**
Attachment A: Income Gap Report Executive Summary

Income Gap Report Full Report
APPENDIX A: Income Gap Report Executive Summary

I. Executive Summary

In the last year, several reports have been released which discuss the issue of income inequality, both nationally and internationally. We know that the conditions in which individuals are born, grow, live, work, and age have significant impact on their health and that income is a major determinant of health. Recent developments in research also suggest that income inequality has impacts for population health as individuals may become stressed by social comparisons with others. Current measures of income can be used to derive income distribution, that is, which groups carry greater shares of the income 'pie' and whether these trends are changing over time. Despite some mention of how Canada is faring on this issue in the literature, income distribution has yet to be considered at the local level. This report aims to compare measures of income for Waterloo Region to Ontario data to determine whether income inequality is something of concern in our region.

Region of Waterloo Public Health has previously looked at the impact of income on health through reports in 2000, 2008, 2009, and 2010. This latest report provides a snapshot of the issue of income inequality utilizing data extracted from Statistics Canada in October 2012. While not an exhaustive review of the literature, and with new data/reports emerging regularly, it does provide useful insight into the growing income gap in Waterloo Region. It is intended that this report be used as a resource when considering programming options to address the health of residents living in Waterloo Region.

What is happening in Waterloo Region with regard to income distribution?

Analysis of income measures in Waterloo Region show that the average after-tax household income has increased from $46,481 in 1995 to $74,628 in 2010. However, when this data is analyzed in terms of income groups, or quintiles, we can see that the largest gains during those years have been concentrated in the highest income groups. Other measures point to increasing shares of income held by the wealthiest fifth of Waterloo Region households, while middle-income households are losing shares. Currently, the wealthiest group in our community has roughly seven times the income of the poorest, a figure which has been rising since 1995 (from 5.9 to 7.1 times). All the evidence points to an increasing income gap in Waterloo Region, in some cases at a faster rate than the provincial average.

What contributes to growing inequality?

Globally, income inequality has increased in many developed countries since the 1990s due to changes in the structure of the population, unequal earnings, and changes in employment. In Canada, this increase is largely due to changes in the age and household structure of our population, for instance, a shift towards more single-parent and non-family households which typically have lower incomes. Additionally, increases in employment income have typically benefited households that already make over $100,000, while employment rates have fallen among less-educated people. In 2010, nearly one-third of employed people in Waterloo Region were earning less than a living wage (determined as $14 per hour and under).

Implications of income inequality on population health

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3 Ibid.

While it is apparent that income has considerable impacts on health and wellbeing, differences in income between population groups are also now being linked to health status. The income inequality hypothesis suggests that when individuals compare their social position against others (which is a by-product of their economic status), their health can suffer through feelings of shame and low-self esteem. Less economically-equal societies thus are at greater risk for poorer self-reported health, lower life expectancy, increased infant mortality, and higher all-cause mortality. These effects are not limited to just those at the lower end of the income scale – economic inequality can have a negative impact on the health of everyone. In a society of high inequality, individuals at all levels of income tend to have decreased overall life satisfaction, low levels of social cohesion, decreased public participation, greater mistrust and an overall reduction in the quality of social relations. Resultant maladaptive coping mechanisms such as higher teenage pregnancy rates, increased violence, and poor habits such as smoking, poor eating, and high-risk behaviours have been linked to increasing inequality.

Who does income inequality affect most?
Just as vulnerable groups are more at risk for poverty, these same groups may also carry the burden of an unequal society more heavily. When shifts in income distribution occur, some groups may experience more difficulty making sufficient earnings due to increasingly precarious employment, fewer job opportunities, and lower-paying jobs. Recent immigrants, refugees, and racialized groups (also known as ‘visible minorities’) typically are disproportionately affected, although there is considerable variation among groups. Children are another vulnerable group, particularly those from female lone-parent families, racialized families, and children of recent immigrants. At the other end of the age-spectrum, seniors are increasingly vulnerable due to their limited and fixed incomes. Canada’s elderly poverty rate has been steadily rising since the 1990s.

What are we doing and what can be done?
As there are many elements that contribute to a widening income gap, any actions taken to address the underlying issues will require a multisectoral approach. In particular, a strong social infrastructure is key to moderating the effects of growing inequality. Public health is in a unique position to play a role through its function as a municipal service that provides accessible programs and services to all members of the community. Public health can contribute to reducing the impact of an income gap by providing services that contribute to the physical, mental, and emotional health and wellbeing of all. When individuals are capable of achieving and improving their health, this impacts their ability to provide for themselves and their families, and contributes to the wellbeing of the community-at-large. Public health currently works with several community organizations and members to promote health, and to reduce health inequalities. Public Health will continue to work across sectors with an equity lens to ensure vulnerable populations do not get left behind.

Income Gap Report
What Rising Disparities Mean for Population Health in Waterloo Region

Region of Waterloo Public Health | July 2013
Acknowledgements

This report was written by Torshie Sai, Public Health Planner with Region of Waterloo Public Health. Support from the Epidemiology and Health Analytics team (ROWPH), specifically Jessica Deming and Kathryn Bocking, was used to compile the relevant data. Mary MacKeigan from Opportunities Waterloo, Cheryl Grove and Heather Froome from Region of Waterloo Social Services provided assistance as well.
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I. Executive Summary

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**Implications of income inequality on population health**

While it is apparent that income has considerable impacts on health and wellbeing, differences in income between population groups are also now being linked to health status. The income inequality hypothesis suggests that when individuals compare their social position against others (which is a by-product of their economic status), their health can suffer through feelings of shame and low-self esteem\(^4\). Less economically-equal societies thus are at greater risk for poorer self-reported health, lower life expectancy, increased infant mortality, and higher all-cause mortality. These effects are not limited to just those at the lower end of the income scale – economic inequality can have a negative impact on the health of everyone. In a society of high inequality, individuals at all levels of income tend to have decreased overall life satisfaction, low levels of social cohesion, decreased public participation, greater mistrust and an overall reduction in the quality of social relations. Resultant maladaptive coping mechanisms such as higher teenage pregnancy rates, increased violence, and poor habits such as smoking, poor eating, and high-risk behaviours have been linked to increasing inequality\(^5\).

**Who does income inequality affect most?**

Just as vulnerable groups are more at risk for poverty, these same groups may also carry the burden of an unequal society more heavily. When shifts in income distribution occur, some groups may experience more difficulty making sufficient earnings due to increasingly precarious employment, fewer job opportunities, and lower-paying jobs. Recent immigrants, refugees, and racialized groups (also known as ‘visible minorities’) typically are disproportionately affected, although there is considerable variation among groups. Children are another vulnerable group, particularly those from female lone-parent families, racialized families, and children of recent immigrants. At the other end of the age-spectrum, seniors are increasingly vulnerable due to their limited and fixed incomes. Canada’s elderly poverty rate has been steadily rising since the 1990s.

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What are we doing and what can be done?

As there are many elements that contribute to a widening income gap, any actions taken to address the underlying issues will require a multisectoral approach. In particular, a strong social infrastructure is key to moderating the effects of growing inequality. Public health is in a unique position to play a role through its function as a municipal service that provides accessible programs and services to all members of the community. Public health can contribute to reducing the impact of an income gap by providing services that contribute to the physical, mental, and emotional health and wellbeing of all. When individuals are capable of achieving and improving their health, this impacts their ability to provide for themselves and their families, and contributes to the wellbeing of the community-at-large. Public health currently works with several community organizations and members to promote health, and to reduce health inequalities. Public Health will continue to work across sectors with an equity lens to ensure vulnerable populations do not get left behind.
II. Key Messages

Trends. This paper has examined the trend of a widening income gap in Waterloo Region and discussed the potential implications for population health. The statistics show that the income gap has been growing between the highest and lowest income quintiles since 1995. Additionally, more shares of the income distribution are being held by the highest income quintiles, at the expense of middle-income groups. There have been imbalanced increases in earnings across groups. While the wealthiest households have seen their earnings grow significantly, the middle and lowest-income households have only seen their earnings increase marginally over the last 15 years, suggesting a trend of rising income polarisation.

Health Impacts. Research has shown that the links between income inequality and population health are numerous, particularly through psychosocial pathways such as lower levels of social cohesion, decreased public participation, greater mistrust, social comparisons between groups, and an overall reduction in the quality of social relations. These effects tend to heighten the experience of deprivation and stress, which can result in maladaptive coping responses and behaviour (e.g., increased violence, smoking, poor eating habits, high-risk behaviours). Less equal societies are at higher risk for poorer self-reported health, lower life expectancy, increased infant mortality, and higher all-cause mortality. Moreover, the impacts on communities may be even more significant as societies with greater economic disparity tend to experience decreased social cohesion and citizen commitment, which has impacts on violence, mistrust, and high-risk behaviours. The evidence indicates that Gini values greater than 0.3 have a more consistent association with adverse health effects. It should be noted that Waterloo Region’s Gini coefficient has been stable at 0.34 since 2000. If the income gap continues to widen, this would be expected to have implications for the social distance between individuals and families, and accordingly indices of population health.

Vulnerable Groups. We must pay particular attention to those vulnerable groups who are at higher risk for poverty, as they will also experience the effects of a widening income gap more intensely. Those individuals who are newer to Canada are over-represented in the lowest income quintiles and under-represented in the highest income quintiles. They have also seen their earnings decline in recent years compared to Canadian-born workers. Children are also particularly vulnerable and are implicitly
affected by the earnings of their caregivers. As incomes have become more polarized over time, child poverty has also increased. Individuals who experience childhood poverty generally have greater challenges throughout their lifespan and may be at a disadvantage for life. Seniors are now also increasingly at risk for poverty, particularly elderly women, racialized seniors and those living alone. It is probable that these groups will carry a disparate burden if the income gap continues to widen.

**Impacts on Poverty.** Finally, small changes in income distribution can have a large effect on poverty, particularly the experience of poverty – its depth and severity. Just like the experience of living in poverty, the experience of social deprivation that results from income inequality can prevent people, communities, and whole societies from reaching their full potential. Accordingly, there should be more emphasis on relative poverty measures, such as the Gini coefficient. Such measures illustrate shifts in income and can also be used as indicators for population health.

The Region of Waterloo’s Strategic Focus for 2011-2014 and the Region’s Comprehensive Approach to Poverty Reduction call for action to work collaboratively to reduce poverty. Efforts to address the increasing income gap should be undertaken broadly across sectors.
Glossary

**Average after-tax income** is total income, which includes government transfers, less income tax.

**Gini Coefficient**\(^1\) is the most commonly used measure of income inequality. It measures the extent to which the distribution of income among households in a society deviates from a perfectly equal distribution. The coefficient can range from 0, which reflects complete equality (everyone shares equally), to 1, which indicates complete inequality (one person has all the income while all others have none).

**Income Inequality Hypothesis**\(^2\) posits that income inequality affects social status differences, such that greater income inequality heightens status competition and status insecurities across both low- and high-income groups. If the socioeconomic gradient is also related to social status differences, then bigger income differences may worsen health across society by increasing insecurities and competition. Thus, income inequality is harmful to all persons, regardless of their absolute income level.

**Income Quintile Share Ratio (S80/S20 ratio)**\(^3\) is a measure of the inequality of income distribution. It is calculated as the ratio of total income received by the wealthiest quintile (highest 20 per cent) of the population compared to the total income received by the lowest quintile (20 per cent).

**Income segregation** is the spatial expression of income inequality. Because poverty and affluence can be spatially concentrated, this may lead to health consequences, especially in highly segregated urban areas. A by-product of this is residential segregation, where poorer families are increasingly concentrated in certain areas; this can lead to increasing geographic isolation & polarization, “high density, low-income ghetto pockets”\(^4\), and ultimately less opportunity for interaction between groups in geographic areas of the city.

**Living Wage**: A living wage is not the same as the minimum wage, which is the legal minimum all employers must pay. A living wage reflects earnings would support a family of three in a specific community\(^5\). It also includes benefits that supplement financial income such as access to paid time-off and benefits from social insurance programs.

**Low Income Cut Off (LICO)**\(^6\) is an income threshold below which a family will likely devote a larger share of its income on the necessities of food, shelter and clothing than the average family. It estimates an income threshold at which families are expected to spend 20 percentage points more than the average family on food, shelter and clothing.

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Pollution model/effect: within this model, inequality is described as “socially corrosive”, and there is a relationship between inequality and levels of trust, violence, and social capital. The model suggests that the effects of greater inequality are not confined to the poor, but extend “like a pollutant” far up the income distribution ladder.

Quintile: A quintile is where a sample or population is divided into fifths.

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III. **What is Income Inequality and Why Does it Matter?**

Recent evidence suggests that what matters most in determining health in a society is not the overall wealth of the society, but instead how that wealth is distributed. For example, having a few people with most of the wealth is an indication of inequality. The more evenly wealth is shared among members of a society, the better the health of that society (Wilkinson, 1999). The conditions in which individuals are born, grow, live, work, and age have enormous impact on their health and are shaped by the way economic resources are distributed. One of the key ways to reduce inequalities in health is to address the issue of income and wealth inequality.

A 2008 report by the OECD (Organization for Economic Co-operation and Development, 2008) ranked Canada 12th out of 30 OECD member countries (i.e., high-income countries) on levels of income inequality; first-place is given to the country with the least income inequality, so Canada’s ranking indicates it is not doing as well as many of its peers in ensuring income equity. Moreover, after 20 years of continuous decline, both inequality and poverty rates in Canada have grown in recent years, to a level now higher than the OECD average. Although average income for Canadians has increased in the past three decades (from $51,100 in 1976 to $59,700 in 2009, adjusted for inflation to 2009 dollars) this wealth has mostly gone into the hands of the richest 20 per cent of the population (The Conference Board of Canada, 2012). Rising inequality is no longer just about the rich and poor. Incomes are becoming more polarized, such that more middle-income families are taking home smaller shares of income than previously. Lower-income individuals are also not making significant financial gains in order to improve their situations.

The ‘income inequality hypothesis’ suggests that shifting distribution of income towards higher-income groups creates the *perception* of deprivation. This sense of inequality adversely affects health through the resulting social comparisons among groups. An individual’s heightened sense of relative deprivation could result in frustration, shame, stress, and maladaptive coping responses such as smoking, poor eating habits, and alcohol abuse (Wagstaff & van Doorslaer, 2000). It has already been proven that social and economic conditions influence individual and population differences in health status, but what is now becoming more apparent is the role that wealth distribution plays. Income is not only a determinant for material standard of living, but it also impacts psychosocial factors such as
sense of control, security, status, prestige, social distance, and cohesion. Thus, rising inequality has implications for individual and community health, crime, education, political stability, governance, and social structure.

It is therefore important to get a sense of how Waterloo Region is faring with regard to income inequality. Indicators of income inequality can be an important complement to income per capita statistics in that the latter measures how much income a geographic region has, while the former shows how it is distributed. Changes in relative income (i.e., how one is doing in relation to others) have been shown to have a larger impact on wellbeing than changes in absolute income (Ball & Chernova, 2007). The benefit of relative measures of income is that they take into account issues of social exclusion. In order to participate fully in society, one needs a level of resources that is not too far below the norm. Falling below this norm equates to exclusion from societal life. Townsend (1979) described it thus:

“Individuals, families and groups in the population can be said to be in poverty when they lack the resources to obtain the types of diet, participate in the activities and have the living conditions and amenities which are customary, or at least widely encouraged, or approved, in the societies to which they belong. Their resources are so seriously below those commanded by the average individual or family that they are, in effect, excluded from ordinary living patterns, customs and activities”.

These effects are particularly evident in urban settings given the diversity found there. Urban poverty is typically concentrated among vulnerable groups such as single-parent families, Aboriginal people, recent immigrants, visible minorities, elderly women, and those with disabilities. Drawing a picture of income distribution in Waterloo Region will give us the opportunity to assess trends and tailor services to meet the needs of local priority populations.
IV. Recent Trends in Income Disparity: Where do we stand?
Alongside conventional measures of poverty such as the Low Income Cut-Off (LICO, there is a need to measure the distribution of income within a society. These measures give an indication of whether income inequality has changed over time and who has gained or lost in the process. Various reports have shown an increase in income inequality over the last two or three decades throughout developed countries, but what may be surprising is the rate at which this increase has occurred, particularly in Canada (Organization for Economic Co-operation and Development, 2008). This section will describe indicators for income inequality in Waterloo Region, such as average household income and share of household income held by particular income groups, compared to the province of Ontario in order to assess whether there have been shifts in income distribution.

(a) Average After-tax Household Income
Household income is a measure of the combined incomes of all people sharing a household or residence. The level of after-tax average household income is often used as an indicator of the monetary wellbeing of a region’s residents by determining whether families have sufficient resources to purchase necessary goods and services. The average after-tax household income in Waterloo Region was $74,628 in 2010 across all income groups, up from $46,481 in 1995. This increase in earnings has not been spread equally across income groups, as subsequent figures will demonstrate. Figure 1 shows the change in average after-tax household income by quintiles, that is, the population split into 5 equal groups from 1995 to 2010.
Figure 1: Average after-tax household income by quintiles, Waterloo Region, 1995, 2000, 2005, 2010.


Table 1 illustrates the percentage increase for each quintile based on average household income in 1995. Note that while incomes have increased overall, the largest gains have been concentrated in the highest income groups. Table 1 also shows a general gradient effect from lowest to highest quintile, where the largest per cent increases are found in the mid-high and highest income groups.

Table 1: Per cent change based on 1995 average after-tax household income, Waterloo Region, 2000, 2005 & 2010.

<table>
<thead>
<tr>
<th>Per cent Change from 1995 , Waterloo Region</th>
<th>2000</th>
<th>2005</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Highest Quintile</td>
<td>3.3%</td>
<td>34.0%</td>
<td>73.6%</td>
</tr>
<tr>
<td>Mid-high Quintile</td>
<td>17.9%</td>
<td>37.1%</td>
<td>61.4%</td>
</tr>
<tr>
<td>Middle Quintile</td>
<td>7.5%</td>
<td>20.8%</td>
<td>47.9%</td>
</tr>
<tr>
<td>Low-mid Quintile</td>
<td>2.8%</td>
<td>13.7%</td>
<td>45.9%</td>
</tr>
<tr>
<td>Lowest Quintile</td>
<td>-46.4%</td>
<td>5.4%</td>
<td>43.1%</td>
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</table>

Figure 1 also illustrates a significant gap between the quintiles, most notably between the highest and mid-high quintiles. Average after-tax household income in Ontario shows similar trends (see Figure 2), with similar average incomes by 2010. However, Waterloo Region’s highest income quintile has had a sharp upturn from 2000 onward, while incomes have been increasing more steadily in the province. Another notable trend in Figure 1 is that, between 1995 and 2000, average household income in the lowest income quintile in Waterloo Region dropped significantly. This was likely due to the implementation of Ontario Works in 1995/96 (see Interpretation section, page 19 for a more detailed explanation).

![Figure 2: Average after-tax household income by quintiles, Ontario, 1995, 2000, 2005 & 2010.](chart)


Table 2 shows the percentage change in income from 1995 in Ontario, and shows a smoother gradient from lowest to highest income groups than observed in Waterloo Region. Again, the highest per cent increases were in the highest quintile.
Table 2: Percentage change based on 1995 average after-tax household income, Ontario, 2000, 2005 & 2010

<table>
<thead>
<tr>
<th>Per cent Change from 1995, Ontario</th>
<th>2000</th>
<th>2005</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Highest Quintile</td>
<td>29.7%</td>
<td>58.7%</td>
<td>81.0%</td>
</tr>
<tr>
<td>Mid-high Quintile</td>
<td>23.0%</td>
<td>46.0%</td>
<td>67.7%</td>
</tr>
<tr>
<td>Middle Quintile</td>
<td>20.7%</td>
<td>42.2%</td>
<td>63.0%</td>
</tr>
<tr>
<td>Low-mid Quintile</td>
<td>18.8%</td>
<td>40.9%</td>
<td>64.7%</td>
</tr>
<tr>
<td>Lowest Quintile</td>
<td>10.8%</td>
<td>37.9%</td>
<td>65.4%</td>
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</table>


(b) Share of Income

Another measure of income inequality is the proportion of income held by each quintile, or the share of income each population subgroup holds. As Figure 3 shows, the share of after-tax income that the wealthiest fifth of Waterloo Region households receive has been rising, particularly since 2000. In 2000, the middle three quintiles lost shares and have continued to do so, while the highest quintile and lowest quintile have gained shares. This suggests that the highest and lowest quintiles are gaining at the expense of the middle-income households. This follows the national trend where Canada’s middle class shrank during the 1990s, while incomes were becoming more polarized in both directions towards lower-income and higher-income families (Heisz, 2007).
The most recent data shows that the highest income quintile accounts for approximately 43 per cent of the total income distribution in Waterloo Region (Figure 4). These proportions are nearly identical to the Ontario average for each quintile (data not shown) and show that significant income growth has been concentrated at the top of the income scale in recent years.
Figure 4: Proportion of population total after-tax income held by each quintile, Waterloo Region.


(c) Income Quintile Share Ratio

The income quintile share ratio or the S80/S20 ratio is another measure of the inequality of income distribution. It is calculated as the ratio of total income received by the wealthiest quintile (highest 20 per cent) of the population compared to the total income received by the lowest quintile or 20 per cent (Eurostat, 2013). The ratio of average after-tax household income has been increasing in both Waterloo Region and Ontario since 1995 (see Table 3). In 1995, the wealthiest fifth of the population in Waterloo Region had 5.9 times the average income than did the lowest fifth. By 2010, this figure had grown to 7.1 times.


<table>
<thead>
<tr>
<th>Year</th>
<th>Waterloo Region</th>
<th>Ontario</th>
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<tbody>
<tr>
<td>1995</td>
<td>5.9</td>
<td>6.6</td>
</tr>
<tr>
<td>2000</td>
<td>11.3</td>
<td>7.7</td>
</tr>
<tr>
<td>2005</td>
<td>7.5</td>
<td>7.6</td>
</tr>
<tr>
<td>2010</td>
<td>7.1</td>
<td>7.2</td>
</tr>
</tbody>
</table>

(d) **Gini Coefficient**

The Gini coefficient is the most commonly used measure of income inequality. It measures the extent to which the distribution of income among households in a society deviates from a perfectly equal distribution (World Bank, 2013). The coefficient can range from 0, which reflects complete equality (that is, everyone shares equally), to 1, indicating complete inequality (one person has all the income while all others have none). Seemingly small changes in the Gini coefficient indicate larger-scale changes in earnings over time because the Gini indicator is difficult to move (World Bank, 1998). Since 1995, there has been an increase in average household inequality of 13 per cent in Waterloo Region, compared to only 6 per cent in Ontario. As seen in Table 4, there was a big jump from 1995 to 2000 (from 0.30 to 0.34), but the Gini coefficient has remained stable since then. Compared to other similarly-sized Canadian cities, this increase of 0.04 points is relatively large. For instance, in the same time period (1995-2000) inequality in Vancouver increased by 0.008 points and Quebec City increased by 0 points (Chen, Myles, & Picot, 2011). The national average has remained around 0.32 since 2000 (The Conference Board of Canada, 2012).

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<tbody>
<tr>
<td></td>
<td>1995</td>
<td>2000</td>
<td>2005</td>
<td>2010</td>
</tr>
<tr>
<td><strong>Waterloo Region</strong></td>
<td>0.30</td>
<td>0.34</td>
<td>0.34</td>
<td>0.34</td>
</tr>
<tr>
<td><strong>Ontario</strong></td>
<td>0.32</td>
<td>0.34</td>
<td>0.34</td>
<td>0.34</td>
</tr>
</tbody>
</table>


(e) **Interpretation**

There is not a consistent method of interpreting income inequality. Most sources suggest using indicators such as increasing earnings in the top income group compared to stagnant or declining earnings in the middle and bottom income groups, as well as measures of the Gini coefficient. These indices suggest a growing gap between the richest and poorest groups. Given the indicators listed above, there is evidence that the income gap is increasing in Waterloo Region.

Even though absolute income levels are rising, the highest quintile has grown at a faster rate than all others, resulting in a larger proportion of income being held by the richest income group. This is
evidenced by the per cent changes in income against 1995 levels as well as the difference between income groups over time. For instance, in 1995 the difference between the highest and lowest quintiles was $76,039 in Waterloo Region; by 2010, this difference had grown to $136,724. Figure 1 shows a dip in average income in the lowest quintile in Waterloo Region between 1995 and 2000, which could be a product of the implementation of Ontario Works in 1995/96 which reduced social assistance rates by 21.6 per cent (Association of Local Public Health Agencies, 2005). Waterloo Region also experienced a large loss of manufacturing jobs during this period that could account for this change (Social Planning, Policy and Program Administration, 2012). While this trend is not apparent in provincial figures, the Ontario data represents a greater diversity of low-income households not necessarily on social assistance. In the years following the mid-1990s recession, modest gains were made in employment income provincially, such that the social assistance and Employment Insurance reductions may have had less impact in Ontario overall (Canadian Council on Social Development, 2001).

The Gini coefficient for Waterloo Region has not increased since 2000 and remains at 0.34 points. Although this is consistent with provincial and national trends, the Gini coefficient does not show income polarisation; rather, it indicates the spread of income distribution from the mean, not where the income is being shifted (Region of Waterloo Public Health, 2009). The data that shows changes in share of household income (Figure 3) offers a more nuanced explanation as we can see that the highest income quintile has increased shares in income distribution over time while middle-income shares have been eroded.

The data comparing Waterloo Region to Ontario through measures such as average household income, share of income, income quintile share ratio, and Gini coefficient indicate that wealth disparity may be increasing more in Waterloo Region than in the province as a whole. While it is possible that these trends are partly a product of a smaller population size in Waterloo Region, there is evidence of a shifting distribution of income. This should be of concern. The literature supports the conclusion that “more equal cities within more equal countries have better summary measures of population health than do their counterparts” (Ross, 2004). Though Waterloo Region may not have a high degree of
income inequality at present, the gap may continue to grow over time if the underlying issues are not explored.

V. What Contributes to Growing Inequality?
Globally, income inequality has increased since the mid-1990s in many developed countries, including Canada. Some of the factors that have driven these changes over time include:

(a) Changes in the structure of the population

(b) Unequal earnings

(c) Changes in employment

The Organization for Economic Co-operation and Development (2008) has found that one-fifth of the increase in income inequality in Canada is linked to changes in the age and household structure of the Canadian population. Some of these changes in living arrangements tend to exacerbate differences in household incomes. For instance, divorces, separations, and older age at first marriage have led to a shift towards more single-parent and non-family households. These groups typically have lower incomes in America (U.S. Bureau of the Census, 1996), and this phenomenon is likely to occur in Canada as well. Moreover, there has been an increased tendency for high and low earners to live with partners of similar earning potential. This has contributed to a widening gap between high-income and low-income households (Chen, Myles, & Picot, 2011).

Another significant factor has been an increasing gap in earnings between already high-earners and low-earners. In recent years wealthier households have done particularly well in comparison to middle-income households and those at the lower-end of the income distribution. For example, employment income in Ontario grew by $62 billion between 2001 and 2009, while the majority of growth has been for those households who make over $100,000 (Yalnizyan, 2012). Many studies have suggested that the largest contributor to this growth is the 35 - 44 year old group of high-income families (Federation of Canadian Municipalities, 2003).

Among full-time workers, high earners are earning even more compared to others. Part of this is due to market shifts towards more highly-skilled, trained and educated workers who have experienced real
wage gains, while there is less need for lower-skilled workers. While higher employment rates typically dampen the effect of wider wage disparities, employment rates among less-educated people have fallen. Even among individuals with employment, jobs are increasingly unstable, lower-paying, have fewer benefits/protection and less mobility in a climate where there has also been a decline in the value of minimum wage (Federation of Canadian Municipalities, 2003). For instance, in 2010, almost one-third of the employed population in Waterloo Region was earning less than a living wage (determined as $14 per hour and under) (Opportunities Waterloo Region, 2010). A living wage is not the same as the minimum wage. Typically, a ‘living wage’ reflects what individuals need to bring home, based on the actual costs of living in a specific community (Vibrant Communities Canada, 2013). It also includes benefits that supplement financial income such as access to paid time-off and benefits from social insurance programs (Opportunities Waterloo Region, 2003).

VI. How Does Income Inequality Affect the Health of Society?
It is well-recognized that personal circumstances and environment affect the health of individuals and communities. Factors such as income have considerable impacts on wellbeing. Higher income and corresponding social status are linked to better health. Research now links disparities in income to the health of populations because improvements in health status are not strictly linked to making more money. This is why the richest countries in the world don’t necessarily have the highest life expectancy. The prevailing argument suggests that there are psychosocial processes at play that produce feelings of shame, low self-esteem, and eventually compromised health among those individuals who compare their social position against others (Wilkinson & Pickett, 2008). Subramanian & Kawachi (2004) have shown that more egalitarian societies generally have better health and longevity. In addition, several studies have shown that cities with more equal distributions of income have lower mortality rates, longer life expectancies, fewer homicides and less crime, stronger patterns of civic engagement, and more robust economic vitality (Federation of Canadian Municipalities, 2003). While no studies have found significant association between any specific health condition (chronic, mental, or otherwise) and income distribution, the literature does show that less economically-equal societies are at higher risk for the following health outcomes:
• Poorer self-reported health (Kondo, 2012); (Xi, McDowell, Nair, & Spasoff, 2005); (Sturm & Gresenz, 2002)

• Lower life expectancy (Xi, McDowell, Nair, & Spasoff, 2005); (Ross, 2004)

• Increased infant mortality (Wilkinson & Pickett, 2008)

• Higher all-cause mortality (Wilkinson & Pickett, 2008)

What is most intriguing about the income inequality hypothesis and what distinguishes it from traditional thoughts about poverty is that economic inequality has a negative impact on the health of everyone in society. The evidence shows that well-off people in highly unequal societies also experience deteriorating health, such that in 1996 the British Medical Journal wrote: “What matters in determining mortality and health in a society is the overall wealth of that society and how evenly wealth is distributed. The more equally wealth is distributed, the better the health of that society.” Researchers believe that societies with greater economic inequality experience “disintegration”. In essence, through the deterioration of social capital (i.e., the degree of social cohesion or citizen commitment to society), individuals tend to have decreased overall life satisfaction. Thus, in a society of high inequality, the well-off may be growing wealthier, but they are subject to the same threats as the less well-off such as increased crime and violence due to general feelings of lack of personal control (Kawachi & Kennedy, 1997). This is known as the “pollution model” where inequality is described as “socially corrosive”, extending throughout the income distribution (Wilkinson & Pickett, 2008).

No matter what their socioeconomic status, age, or gender, people living in regions with high income inequality are at risk for premature mortality. Through a meta-analysis of international cohort studies, this estimated excess mortality risk has been calculated as 8 per cent per each 0.05 increase in Gini coefficient (Kondo, et al., 2009). Furthermore, Gini values greater than 0.3 show a more consistent association with adverse health effects such as poorer self-rated health and higher overall mortality. Generally societies which have larger shares of income received by the least well-off 70 per cent of the population (for instance, countries like Switzerland, Sweden, Norway, and Netherlands) have the highest life expectancy among their OECD peers (Wilkinson, 1992).
In addition to the direct health effects of income inequality, inequality also has “cascading effects” on society-at-large, especially through psychosocial and behavioural effects (Wilkinson, 2004). Societies with the highest degree of income inequality are also those with the lowest levels of social cohesion. Several studies have shown that greater inequality leads to decreased public participation, greater mistrust, and an overall reduction in the quality of social relations. For instance, higher teenage pregnancy rates, as well as increased violence have been linked to income inequality (Pickett, Mookerjee, & Wilson, 2005); (Gold, et al., 2004). Additionally, increasing inequality tends to increase an individual’s sense of relative deprivation, resulting in frustration, shame, stress, and maladaptive coping responses – such as smoking, poor eating habits, and high-risk behaviours (Kondo, 2012). These psychosocial factors, many of which are associated with low social status, affect health partly through the physiological effects of chronic stress and partly through their influence on health-related behaviour.

Shifts in income distribution also have the potential to impact how neighbourhoods develop. In cities with high levels of segregation, for example Calgary and Saskatoon, poorer families are increasingly concentrated in certain areas, thereby increasing geographic isolation and reducing the opportunity for interaction between groups (Federation of Canadian Municipalities, 2003). This is known as “income segregation” (Ross, 2004). A growing tendency of “niche neighbourhoods” occurs as higher-income individuals are increasingly able to dictate where they want to live, impacting housing prices and creating more homogenous neighbourhoods (Chen, Myles, & Picot, 2011); (Canadian Centre for Policy Alternatives – Manitoba Office, 2008). These phenomena have the potential to impact health because of the greater social distance between individuals (Wilkinson & Pickett, 2006). Both the poor as well as the better-off can be affected by the psychosocial stress which often results from social comparisons.

VII. Who Does Income Inequality Affect Most?

As stated earlier, the pollution effect suggests that individuals (regardless of their individual incomes) tend to have worse health in societies that are unequal (Wilkinson & Pickett, 2006). There is little evidence to suggest that income inequality mainly affects the health of the poor, however the literature does suggest that just as vulnerable groups are more at risk for poverty, these same groups may carry the burden of an unequal society more heavily. Parallel to patterns for poverty, income
inequality affects population subgroups and contributes to inequities within groups, for instance, income disparities between age-groups as well as those between recent and longer-term immigrants.

Those groups that are at increased risk for health inequities are particularly vulnerable to large-scale shifts in income distribution, particularly when they experience difficulty making sufficient earnings. For example, immigrants and refugees are over-represented in the lowest income quintile and under-represented in the highest income quintile in all Canadian geographic regions, suggesting a “racialization” or “ethnicization” of poverty (Federation of Canadian Municipalities, 2003). These groups have also seen their earnings decline in recent years compared to Canadian-born workers, but there is a divide between recent and longer-term immigrants as the longer they stay in Canada, the higher their income. Nevertheless, recent immigrants and racialized groups (also known as ‘visible minorities’) are more likely to live in urban areas where income segregation is more visible.

Because children are implicitly affected by the earnings of their caregivers, as incomes have become more polarized over time, child poverty has also increased. From 1981 to 2009, the percentage of children living below the Low-Income Measure in Ontario jumped from 11.4 per cent to 14.6 per cent (Ontario Common Front, 2012). At increased risk are children from female lone-parent families as well as children in racialized families and children of recent immigrants. There is mounting evidence that child wellbeing is a key determinant of how well someone will do as an adult (how much they will earn, how healthy they will be, etc.). Those individuals who endure childhood poverty generally experience greater health challenges throughout their lifespan (Organization for Economic Co-operation and Development, 2008). Societies with high income inequality tend to have fewer opportunities for social mobility, such that individuals brought up in a situation of disadvantage are less likely to be able to improve their social status.

Another major group that may be particularly affected by a society’s level of income inequality is seniors. While many people around retirement age (i.e., 55 to 75 years of age) have seen large increases in their income over the past 20 years, pensioner poverty is on the rise (Organization for Economic Co-operation and Development, 2008). Canada’s elderly poverty rate has been rising since the mid-1990s with women even more vulnerable (The Conference Board of Canada, 2012). Seniors are now considered an at-risk low-income group that has been falling further behind due to their
limited and fixed incomes (Federation of Canadian Municipalities, 2003). The incidence of poverty among seniors has been rising steadily, especially among seniors living alone, women, and racialized seniors, particularly in Ontario, where the senior poverty rate has been rising faster than the national average since 2007 (Ontario Common Front, 2012).

Overall, the health of the population-at-large is improved by greater societal and income equality, but those individuals who experience the highest levels of economic instability will benefit most. When income distribution is not so imbalanced, the situation of marginalized groups will be improved.

VIII. What Can Be Done to Address the Income Gap?

There are many elements that contribute to the widening income gap in a society. Accordingly, the solution will require a multi-pronged and multisectoral approach. Many sources suggest economic policies that address the growing disparity in wages and income, for instance, policies that help people get into work, stay in work, and enable good job prospects. Others suggest a reform of government taxes and transfers to help reduce inequality, suggesting that social assistance, employment insurance, child benefits, and old-age security are the answer (The Conference Board of Canada, 2012). Regardless of the particular approach, it is clear that a strong social infrastructure is important to moderating the effects of growing inequality.

Accessible public programs and services play an important role in that they act as “equalizing instruments” that are available to all members of the community (Federation of Canadian Municipalities, 2003). These services are most often provided by municipalities and their range, scope of services, and policies regarding use and fees greatly affect access to these services. Services such as public health, recreation, and the library provide opportunities for education and training, ensure equitable access to social and primary health services, and provide affordable recreation and sport opportunities for all. Additionally, because of the structure of municipalities, these services tend to address regional and geographic inequalities.

As a municipal service, public health has a role to play. Public health can ensure their services are equitable and accessible, which can help to mediate the effects of a growing income gap, especially in cities. Region of Waterloo Public Health initiates and supports targeted actions for specific high-need
or at-risk populations, often collaborating with multiple stakeholders who represent a range of interests. As mandated by the Ontario Public Health Standards, public health units are tasked with addressing the determinants of health and reducing health inequities. Public health can contribute to reducing the impact of the income gap by providing services, within the public health mandate, that contribute to the physical, mental, and emotional health and wellbeing of all. This enables individuals and communities to maintain a level of health conducive to obtaining and sustaining employment. Furthermore, public health can monitor trends, research issues and correlate to health outcomes, and then disseminate information and data to stakeholders. Successful approaches to tackling income inequality include a willingness to span institutional boundaries, working with stakeholders at different levels and in different sectors. These approaches are summarized as the 3 P’s: Participation, Policy, and Political action (Raphael, 1998). Raphael suggests that we should broaden the parameters of the health policy debate to include economic and social issues; he argues that to date, public health discourse has focused on the health impacts of poverty, especially on the needs of “risk groups”, but that health inequalities exist across the socioeconomic gradient and not just between rich and poor. As such, efforts that address the main effects of economic inequality (such as decreasing social cohesion, increasing polarization and alienation) will be most effective.

Typically, public health responses take three forms:

1. the medical approach, where the emphasis is on high-risk groups, screening, and healthcare delivery;

2. the behavioural approach, where the focus is on high-risk attitudes and behaviours, and result in programs to change behaviours; and

3. the socio-environmental approach which integrates the other two approaches within a focus on high-risk conditions.

Under the third approach, public health could work to “support community development and participation by working closely with community organizations and members to promote health”. Additional responsibilities could include developing and advocating for public policies that promote health and reduce health inequalities, in collaboration with community partners. These responsibilities are supported by The Ottawa Charter for Health Promotion, which recognizes shelter, education, food, and income as prerequisites for health (World Health Organization, 1986).
Works Cited


Ross, N. (2004). *What have we learned studying income inequality and population health?* McGill University, Department of Geography. Ottawa: Canadian Institute for Health Information.


TO: Chair Sean Strickland and Members of the Community Services Committee  
DATE: August 13, 2013  
FILE CODE: P19-80  
SUBJECT: ONTARIO’S PUBLIC HEALTH SECTOR STRATEGIC PLAN

RECOMMENDATION:

THAT the Regional Municipality of Waterloo, as the Board of Health, send a copy of Report PH-13-032 to Dr. Arlene King, Chief Medical Officer of Health of Ontario, for her information.

SUMMARY:

This report provides information on Ontario’s Public Health Sector Strategic Plan recently unveiled by Ontario’s Chief Medical Officer of Health, Dr. Arlene King. This is the first strategic plan developed for the Public Health Sector in Ontario. The Public Health Sector is defined as the Provincial Government, the Chief Medical Officer of Health, Public Health Ontario and Ontario’s 36 local public health units. The Public Health Sector is also a cross section and bridge between the health sector and all other sectors that influence health (See Figure 1).

While Ontario’s Public Health Sector Strategic Plan does not represent new requirements for Health Units, its goal is to help the sector as a whole achieve greater impact through focused alignment, collaboration and collective action. It aims to achieve this by setting out key strategic goals and collective areas of focus for the Sector for the next 3-5 years (See Figure 2). Since many of the factors that contribute to poor health are outside the control of the health sector, it is recognized that success will depend on our collective ability to build relationships and work across sectors to create communities and environments that promote health.

With the high-level framework of strategic goals and collective areas of focus having been established, the next step is to develop actions to support the Plan. This work will be led by the Office of the Chief Medical Officer of Health and, over the next few months, the Ministry will hold consultations across the Province to develop potential actions and implementation plans.

In addition, recognizing the importance of outcomes and indicators, the Public Health Sector Strategic Plan concludes by noting that, over the next year, work will be done to define desired population outcomes and metrics that align with the strategic goals and collective areas of focus.

REPORT:

Plan Development - Despite the significant gains made in the overall health and longevity of Ontarians in the last several decades, there remain population health challenges to address. Many Ontarians are continuing to develop preventable chronic and life-limiting conditions, such as heart disease and cancer, and childhood and adult obesity rates are on the rise. There is also the issue of health disparity, as some Ontarians - particularly those who are poor, less educated and socially marginalized or disadvantaged - are at greater risk of poor health outcomes. In addition, the health...
system is facing an aging population. With the goal of strengthening the impact of the Public Health Sector through focused, collective action, the Plan was developed by the Office of the Chief Medical Officer of Health of Ontario, in consultation with various health and non-health sector partners, including the Council of Medical Officers of Health of Ontario.

**Public Health Sector** - The Public Health Sector Strategic Plan is intended as a roadmap to achieve improved health outcomes for all Ontarians. The Plan looks at how the Public Health Sector can collaborate to conduct its core business, create greater consistency across the Province and make effective use of all public health skills, expertise and resources. Since many of the factors that contribute to poor health are outside the control of the Health Sector, it is recognized that success will depend on the Public Health Sector’s ability to build relationships and work across sectors to create communities and environments that promote health. The Public Health Sector, which includes the Provincial Government, the Chief Medical Officer of Health, Public Health Ontario and the Ontario’s 36 local public health units, is uniquely positioned to create the bridge between the health sector and all other sectors that influence health.

**Figure 1: Cross Section of Health and Non-Health Sectors**

**Overview of the Public Health Sector Strategic Plan** - The Plan lays out core values, a 15 to 20 year vision and mission, and eight collective areas of focus, organized under five strategic goals, for the next three to five years (see Figure 2).
Assessment of Region of Waterloo Public Health Alignment - Within Region of Waterloo Public Health, combining both current initiatives as well as projected future developmental areas within the Department, we are well positioned with respect to the Plan. Following the release of the Plan, discussions with Leadership and staff led to a number of detailed examples of current alignment (See Appendix A). One focus area where it is believed that local public health units could play an increasingly effective role is in the domain of the ‘Built Environment’. The Plan recognizes the developmental aspect of this area and proposes its two initial actions to be: “define the scope and role for the public health sector in addressing and mitigating the health impact of the built environment”; and “enhance provincial capacity to generate evidence to guide provincial and local public health collaboration with municipal planners, transportation planners... and others who influence the built environment.”

Obligations and Next Steps - Currently, the Ontario Public Health Standards provide a framework that Public Health Units must comply with. In addition to our compliance with the Standards, the Region of Waterloo Public Health Department, as expected of all Health Units, has entered into an Accountability Agreement with the Province of Ontario, as outlined in report PH-11-041 Public Health Budget Approval & Accountability Agreement, dated September 27, 2011. The Public Health Sector Strategic Plan does not represent new mandatory obligations for Health Units, but its purpose is to provide a set of common goals and objectives that the entire Public Health Sector (Ministry of Health and Long-Term Care, Public Health Units, and Public Health Ontario) can work towards to strengthen its impact through collaboration, collective action and focused alignment. There will also be importance placed on the development of indicators. In the coming year, work will be lead by the Ministry to define desired population outcomes and metrics that align with the strategic goals and collective areas of focus in the Plan.

Future Actions - Region of Waterloo Public Health is committed to staying abreast of updates related to, and participating in the next steps with respect to the development of Public Health Sector Strategic Plan. The Board of Health will be kept informed of relevant updates and progress through future reports.
ONTARIO PUBLIC HEALTH STANDARDS:

Under the Health Protection and Promotion Act, Region of Waterloo Council serves as Waterloo Region’s Board of Health. Boards of Health are expected to adhere to the Ontario Public Health Standards, which outline the expectations for providing Public Health programs and services. This report is intended to inform the Board about Ontario’s first Public Health Sector Strategic Plan and how Region of Waterloo Public Health is positioned to align with it.

CORPORATE STRATEGIC PLAN:

The Ontario Public Health Sector Strategic Plan has five strategic goals that align with the following sections of the Region of Waterloo Strategic Plan 2011-2014 (which are currently being targeted by Public Health programs):

- Environmental Sustainability: Protect and enhance the environment.
- Growth Management and Prosperity: Manage growth to foster thriving and productive urban and rural communities.
- Healthy and Inclusive Communities: Foster healthy, safe, inclusive and caring communities.
- Service Excellence: Deliver excellent and responsive services that inspire public trust.

FINANCIAL IMPLICATIONS:

NIL

OTHER DEPARTMENT CONSULTATIONS/CONCURRENCE:

NIL

ATTACHMENTS

Attachment A: Alignment Between Region of Waterloo Public Health and Ontario’s Public Health Sector Strategic Plan.

The full report by Ontario’s Chief Medical Officer of Health, Dr. Arlene King, entitled “Make No Little Plans - Ontario's Public Health Sector Strategic Plan”, can be found at the following link: http://www.health.gov.on.ca/en/common/ministry/publications/reports/make_no_little_plans/

PREPARED BY: Jordan Steffler, Strategic & Quality Improvement Specialist  
Ann Derry, Project Coordinator  
Dr. Hsiu-Li Wang, Associate Medical Officer of Health

APPROVED BY: Dr. Liana Nolan, Commissioner/Medical Officer of Health
APPENDIX A: Alignment Between Region of Waterloo Public Health and Ontario’s Public Health Strategic Plan

The following tables outline select examples of current initiatives and programs at Region of Waterloo Public Health that align with the focus areas and strategic goals laid out in Ontario’s Public Health Sector Strategic Plan.

<table>
<thead>
<tr>
<th>Strategic Goal #1: Optimize healthy human development</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Collective Area of Focus</td>
<td>Select Example(s) of Current Region of Waterloo Public Health Alignment</td>
</tr>
</tbody>
</table>
| 1.1 - Early childhood development, including mental wellness and resiliency | • Implement the Healthy Babies Healthy Children Program according to the new Ministry of Children and Youth Services Protocol and Guidelines for the program, as outlined in report PH-13-024 Healthy Babies Healthy Children Program Changes.  
• Region of Waterloo Public Health is working towards the Baby-Friendly Initiative (BFI) designation by the end of 2014 through supporting, promoting and protecting breastfeeding for residents of Waterloo Region.  
• Maternal mental health is promoted prenatally through Reproductive Health programs and services. |

<table>
<thead>
<tr>
<th>Strategic Goal #2: Improve the prevention and control of infectious diseases</th>
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<tbody>
<tr>
<td>Collective Area of Focus</td>
<td>Select Example(s) of Current Region of Waterloo Public Health Alignment</td>
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</tbody>
</table>
| 2.1 - Immunization | • Director level participation on work groups as part of the provincial Immunization System Review (as highlighted in the plan).  
• Re-engineering the Vaccine Preventable Diseases Program so that it is more flexible and better able to adapt to ongoing changes to Ontario’s immunization programs.  
• Evaluating programs (e.g. travel clinic) and redeploying resources where appropriate. |

<table>
<thead>
<tr>
<th>Strategic Goal #3: Improve health by reducing preventable diseases and injuries</th>
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<tbody>
<tr>
<td>Collective Area of Focus</td>
<td>Select Example(s) of Current Region of Waterloo Public Health Alignment</td>
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</tbody>
</table>
| 3.1 - Physical Activity and Healthy Eating | • Support the development and implementation of initiatives and policies in schools, workplaces and the community to promote healthy eating, physical activity and active transportation.  
• Promote the expansion of community gardens in the Region through membership in the Diggable Communities Collaborative, and staff support to the Waterloo Region Community Garden Council.  
• Establish and co-ordinate a Healthy Communities Partnership in Waterloo Region to take action regarding three community priorities – healthy eating, physical activity and mental health promotion. |
## Strategic Goal #3 (Cont’d): Improve health by reducing preventable diseases and injuries

<table>
<thead>
<tr>
<th>Collective Area of Focus</th>
<th>Select Example(s) of Current Region of Waterloo Public Health Alignment</th>
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</thead>
</table>
| 3.2 - Tobacco and Alcohol | • Enforcement of the Smoke-Free Ontario Act  
• Work with community partners to increase capacity to provide comprehensive tobacco control programs and policies.  
• Currently coordinating a collaborative Municipal Alcohol Policy across 7 municipalities and the Region of Waterloo. |

## Strategic Goal #4: Promote healthy environments – both natural and built

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<tr>
<th>Collective Area of Focus</th>
<th>Select Example(s) of Current Region of Waterloo Public Health Alignment</th>
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</thead>
<tbody>
<tr>
<td>4.1 – Built Environment</td>
<td>• Support NEWPATH knowledge and exchange strategy in consultation with Transportation Demand Management.</td>
</tr>
</tbody>
</table>

## Strategic Goal #5: Strengthen the public health sector’s capacity, infrastructure and emergency preparedness

<table>
<thead>
<tr>
<th>Collective Area of Focus</th>
<th>Select Example(s) of Current Region of Waterloo Public Health Alignment</th>
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</table>
| 5.1 - Information and Knowledge Systems | • Planning for local implementation of Panorama, a provincial information system for the monitoring, surveillance and management of communicable diseases including tracking of immunizations/vaccines.  
• Working with other Ontario Health Units to achieve consistency in inspection information that is disclosed to the public.  
• Development of an over-arching communication strategy for Public Health is in progress, with the inclusion of emergency/crisis communication, as well as social media components. |
| 5.2 - Collaborative Mechanisms | • Working with other Ontario Health Units and the Ministry of Health and Long-Term Care through the ‘Open for Business’ initiative to provide consistent food handler education.  
• Collaborating with community partners to improve harm reduction and prevention programming in Waterloo Region (Corporate Strategic Plan item 4.2.1) and on a Youth Sexual Health Strategy.  
• Participating in the Central West Communicators Network (collection of 19 Health Units in the province) as well as the Region of Waterloo Communicators Group. |
| 5.3 - A Highly Competent Workforce | • Region of Waterloo Public Health is on the Steering Committee of a Public Health Agency of Canada (PHAC) funded project with other public health units to develop a Public Health Core Competencies Framework.  
• A three-year Departmental Nursing Practice Strategic Plan (2014-2016), aimed at identifying areas of focus/priority for nursing practice and supporting action, is under development. |
To: Chair Sean Strickland and Members of the Community Services Committee

From: Margaret Parkin, Manager of Planning Information and Research

Subject: UPDATE ON STATISTICS CANADA’S NATIONAL HOUSEHOLD SURVEY

The National Household Survey (NHS) was undertaken by Statistics Canada from May to August 2011, as a replacement to the "long form" component of the Census of Canada. The data contained in the long form Census have previously been used by Regional staff in many areas including Community Planning, Transportation Planning, Housing, Social Planning, Public Health, Crime Prevention, Community Services and Strategic Planning. Prior to the NHS being undertaken, Regional Council approved a four-part resolution as described in Report No. P-10-067/SS-10-036/PH-10-035, dated August 10, 2010, which included advising the Federal Minister of Industry of concerns with respect to the discontinuation of the mandatory nature of the long form for the 2011 Census. Council indicated that the loss of the highly reliable data that was previously collected through the mandatory Census long form would significantly impact planning, policy development and programs at the Region of Waterloo.

Staff is reviewing data and documentation from the NHS as it is being released by Statistics Canada, and has prepared this memo to apprise Council of findings to date. It is clear that caution will be required in using the NHS data. Further examination of the data and forthcoming technical documentation is necessary to evaluate the NHS for use in policy and program development, as described in further detail in this memo.

Status of data releases from the NHS

Two waves of data have been released from the National Household Survey to date. On May 8, 2013, Statistics Canada released immigration, citizenship, place of birth, language, ethnic origin, visible minorities and religion data, and on June 26, 2013, education, labour, place of work, commuting to work, language of work, mobility and migration data was released. The final release is August 14, 2013 and includes income, earnings, housing, and shelter costs. The released data is for Canada, the provinces and down to the geographic level of each Area Municipality. At the time of writing of this memo, some data had also been made available at finer levels of geography, such as Census Tracts. Statistics Canada is continuing to review the data before releasing it at sub-municipal levels.

Implications of the survey methodology

Response Rate

The NHS was received by approximately 4.5 million households in Canada, representing about 3 in 10 households – a larger sample than the 2 in 10 households for the distribution of the Census long form. It was a voluntary survey, and the Canadian response rate was 68.6% (rather than the near-
100% rate that the Census garnered in previous years). Therefore, about 2 in 10 households (about 21% of the Canadian population) participated in the NHS, which is about the same final rate as the previous Census.

However, there were areas where the non-response rate was high, meaning that many households that received the survey did not respond to it. For Ontario, the Provincial non-response rate was 27.1%, however Statistics Canada has advised that the rate could be 50% or higher at smaller levels of geography, such as Census Tracts and Dissemination Areas. In such cases, Statistics Canada will suppress the data, resulting in missing data for some areas. Concern also remains about the usefulness of data in areas where the non-response rate is high, but not high enough to warrant suppression.

In addition, Statistics Canada has advised that the response rate to the NHS survey questions varied with the question asked. Some questions were less often answered than others. This variation is factored into the Global Non-response Rate (GNR), a quality indicator calculated by Statistics Canada, and included with each dataset released.

Response Bias

Since the NHS was a voluntary survey, there are concerns about non-response bias. This occurs when some segments of the population choose not to complete the survey, and are therefore under-represented in the results. This can occur no matter how large the sample size, but it is most apparent for small populations.

Statistics Canada has attempted to “mitigate” the effects of the response bias both at the time that the NHS survey was being undertaken, as well as in the processing of the results. Through comparison with the 2011 Census, previous Census long form results, as well as other survey and administrative databases such the Labour Force Survey and Citizenship and Immigration Canada's immigration database, Statistics Canada has attempted to adjust for the bias. A full technical report on Statistics Canada's method of sampling and weighting is scheduled for release early in 2014. These methods can mitigate but will not remove the effect of bias.

Survey Method and Content

While the NHS was similar to the previous long-form Census, there were important methodological and content differences. The key methodological change was the voluntary nature of the survey, however, there were additional differences. For example, the reference period for the questions about employment status was slightly later in the year, and the questions about language were asked in new contexts, in both the Census and the NHS survey. Such differences can lead to a variance in interpretation by the respondents and a resulting lack of comparability with previous Census results.

Region’s Approach to Use of NHS Data

According to the NHS User Guide issued by Statistics Canada, “Any significant change in survey method or content can affect the comparability of the data over time, and that applies to the NHS as well. It is impossible to determine with certainty whether, and to what extent, differences in a variable are attributable to an actual change or to non-response bias.” Further, the Guide states, “Caution must be exercised when NHS estimates are compared with estimates produced from the 2006 Census long form, especially when the analysis involves small geographies”.

Caution will be used in interpreting the National Household Survey results. Staff will carefully look at the data, compare the results with other administrative and survey datasets, and review the Statistics Canada technical report which is scheduled for release in the fall of 2013. This approach is similar to the approach of other governments and agencies in Canada such as the City of Toronto. In the meantime, Regional staff will take the following approach:
• use the NHS data with caution, and advise others accordingly, including staff responses to requests from the media;

• not determine trends or change over time by comparing data from the 2011 NHS with data from previous Census periods; and

• not publish data at sub-municipal levels of geography, such as Census Tracts and Dissemination Areas, when made available.

Caution will always be required in using the NHS, as is true in the use of any voluntary survey data, but there may be specific situations under which evaluation shows that it is the best available data for the purpose, and in those cases, the Region may publish NHS results, with appropriate caveats.

Next Steps

The Data Networking Group, an internal staff group that meets regularly to coordinate on data that is acquired from external sources, will have a key role in the evaluation of the NHS data. Next steps for staff include:

• coordinating the Region’s approach to the use and publication of the data;

• creating standard footnote(s) to be used when the data is referenced in Regional publications to concisely explain the caveats around its use; and

• communicating with peer groups in agencies both inside and outside the Region to share best practices.

Following these assessments and consultations, Planning, Housing and Community Services will publish Regional results from the National Household Survey for key data such as employment and income. It may be important to undertake local surveys or acquire data from other sources to complement the NHS data.
Provincial Initiative

Several memoranda spanning September 2011 through October 2012 have been provided to Committee outlining the Provincial project to replace the Service Delivery Model Technology (SDMT) which supports the delivery of social assistance (Ontario Works, Temporary Care Assistance, Ontario Disability Support Program, Assistance for Children with Severe Disabilities) in Ontario. The initiative known as the Social Services Solutions Modernization Project is part of a broader modernization effort by the Province to enhance service delivery and customer service. The project will be implemented in two phases: Online Application for Social Assistance (implemented Spring 2011), full replacement of the SDMT.

Planning Structure

In preparation for the replacement of the Service Delivery Model Technology, Employment and Income Support has initiated a planning structure to guide implementation activities. The Executive Steering Committee is responsible for overall guidance and support of the Project. Members of the Executive Steering Committee are the Employment and Income Support management team and representatives from Corporate Finance, Human Resources and Information and Technology Services. A Business Transformation Team is responsible for planning decisions and implementation recommendations including changes to business processes. Members of the Business Transformation Team include Employment and Income Support Supervisors as well as representatives from Corporate Finance, Human Resources and Information and Technology Services. Staff of Employment and Income Support is contributing to planning and implementation activities through participation in work groups that began in October 2012. In addition, front line staff is participating in an Advisory Committee which develops activities to engage and inform all staff leading to the implementation of the new technology.
Memo to Community Services Committee  
August 13, 2013

Site Readiness Plan

The current Service Delivery Model Technology (SDMT) will be replaced by what has been named the Social Assistance Management System (SAMS) technology. As part of the implementation, service delivery agents, such as the Region of Waterloo, are required to submit a comprehensive Site Readiness Plan as well as a quarterly Update Summary. The objective of these documents is to ensure delivery agents are prepared and supported to successfully implement the Social Assistance Management System technology.

Delay of Implementation

In the Province’s 2013 Budget, commitments were made to transform social assistance programs to work better for individuals in need. These changes are highlighted in a separate report to Committee (Report SS-13-024, August 13, 2013) and include, but are not limited to, a rate increase and changes in asset levels and earning exemptions. While SAMS has the capacity to manage these changes, resources are limited to reconfigure the current technology for these changes as well as complete the remaining activities for the launch of SAMS. For this reason, the Province is no longer planning to implement SAMS in the Fall of 2013. The Province has undertaken a comprehensive exercise to determine a revised implementation date.

The schedule for implementation activities remains largely unchanged. As planned, Region of Waterloo staff participated in early learning sessions in July (to be offered again in September 2013) and will continue to review and revise business processes required for the implementation of SAMS. Council will be kept informed of progress as the project proceeds.

The delivery of social assistance addresses the Region’s Corporate Strategic Plan 2011-2014, Focus Area 4: Healthy and Inclusive Communities; (to) foster healthy, safe, inclusive and caring communities.

For further information, contact Leslie Perry, Project Manager, Social Services Solutions Modernization Project at Phone: 519 883-2317 or lperry@regionofwaterloo.ca or David Dirks, Director, Employment and Income Support at Phone: 519 883-2179 or ddirks@regionofwaterloo.ca.
MEMORANDUM

To: Chair Sean Strickland and Members of the Community Services Committee
From: Christiane Sadeler, Executive Director
Date: August 13, 2013
Subject: JANE’S WALK 2013

The Waterloo Region Crime Prevention Council helped to organize and facilitate the annual Jane’s Walk (www.janeswalk.net) weekend in Cambridge, Kitchener & Waterloo. Jane’s Walk is a celebration of people and cities that is held around the world on the first weekend of May. Through the simple act of walking together and discussing what makes up a neighbourhood, Jane’s Walk helps to connect people into strong and resourceful communities. Created in 2007 by friends of the urban thinker, Jane Jacobs, (www.janeswalk.net/about/jane_jacobs) the annual series of free, volunteer led walks is now held in over 100 cities across the globe.

Waterloo Region hosted 17 walks across Cambridge (1), Kitchener (11) & Waterloo (5). Topics covered on the walks included: sustainable transportation, local economies & urban agriculture, inclusive communities, urban development, park redevelopment, and neighbourhood design. Other walks looked at development and change, “old & new”, in specific neighbourhoods (Downtown Galt, Mount Hope Breithaupt Park, Williamsburg, Northdale, Uptown Waterloo, Uptown West, St. Mary’s, Lower Doon). The Waterloo Region Rainbow Coalition hosted a walk in Uptown Waterloo from the perspective of the LGBTQ community. A walk in Kitchener’s Mount Hope Cemetery and another in Victoria Park were among the most well attended. “Made in Kitchener”, a walk exploring personal stories from our industrial past, used smartphones to access digital media stories along the walk route.

Walk attendance ranged from 7 to 60 people, with approximately 400 people participating in 17 walks over two days. Some people attended multiple walks in one weekend.

“I wish EVERY weekend was a Jane’s Walk weekend. So much choice...so little time!”
~ S. Ross, Avid Jane’s Walk Participant, Kitchener
Walks were led by neighbourhood associations, several municipal Councilors, various residents, one local MPP, local historians, activists, members of the Kitchener Safe & Healthy Community Advisory and the Waterloo Region Crime Prevention Council.

Participants had a chance to learn something new, discover a new area of their city; meet new (or existing!) neighbours and get in touch with the environment.

Jane's Walk helps residents to connect to their neighbourhood and community. The Waterloo Region Crime Prevention Council believes that a more connected community is a safer community and Jane's Walk is an effective way to engage citizens in conversations about what makes a vibrant, dynamic, safe and healthy neighbourhood and community.

Jane's Walk is another tool and activity that help our Community Engagement program to emphasize the role that placemaking (http://www.pps.org/reference/reference-categories/placemaking-tools/) can play in creating safe & healthy neighbourhoods and public space. The WRCPC will likely be involved again next year with a goal of 25 walks across the Region. Residents and community leaders will be encouraged to start thinking about a walk they might want to lead in their neighbourhood on May 3 & 4, 2014 in the fall of 2013.

The events are entirely volunteer resourced in addition to the commitment from the office of the WRCPC.
TO: Chair Sean Strickland and Members of the Community Services Committee

DATE: August 13, 2013

FILE CODE: S07-80

SUBJECT: SUNNYSIDE HOME PROVINCIAL FUNDING UPDATE

RECOMMENDATION:

THAT the Regional Municipality of Waterloo approve an increase to the 2013 Operating Budget for the Seniors’ Services Division in the amount of $225,768 gross and $0 net;

AND THAT the 2013 Operating Budget for the Seniors’ Services Division be increased by $51,000 gross and $0 net on a one-time basis for the purchase of equipment and training costs;

AND FURTHER THAT an increase of 4.45 full-time equivalents (FTE) be approved for the Seniors’ Services Division as of September 1, 2013 to increase the hours of direct care services and behavioural support staffing for the residents of Sunnyside Home as outlined in report SS-13-013, dated August 13, 2013.

SUMMARY:

This report outlines a number of provincial announcements and funding policy changes announced by the Ministry of Health and Long-Term Care over the past several months. Sunnyside Home has received revenue increases from the Province that exceed the increases assumed in the 2013 operating budget by $363,495. The report outlines the announcements and seeks approval to expend $225,768 of the funds to mitigate the risk of serious injury to residents and staff.

There is concern related to the risk of increased resident injuries and resident-to-resident adverse events due to the escalating number of residents with dementias, mental health issues and complex diagnoses. It is critical that the resident-to-staff ratio be reduced to allow for the closer observation, monitoring, enhanced care support and documentation that are required for the resident population now residing at Sunnyside Home.

Approval is requested to increase direct care hours by Personal Support Workers in the Home by 4.24 FTEs for care and an additional 0.21FTE for specialized behavioural support staffing, effective September 1, 2013; and for on-going high-intensity needs costs, previously funded on a cost-recovery basis. In addition, approval is sought to expend the one-time funds of $51,000 announced by the Province for high-intensity needs equipment and staff training to support the care of residents with complex physical and/or mental health needs.

REPORT:

The Ministry of Health and Long-Term Care (MOHLTC) has made several funding announcements in 2013 impacting Sunnyside Home. The per diem has been increased based on the Case Mix Index (CMI), a measure of resident acuity, following a freeze on acuity-based funding last year. While Sunnyside Home’s resident acuity level increased last year, the unprecedented freezing of...
the acuity funding increased the risk of resident and staff adverse events. Improved annualized funding has also been provided for incontinence products and medical director fees. In addition, a new funding mechanism was introduced to fund high-intensity needs, which includes both base and one-time funding. A one-time funding allocation was also announced for staff training.

1.1 Medical Director’s Fee

Effective January 1, 2013, the MOHLTC announced an increase $0.06/resident/day for the medical director fee. The medical director’s fee has been increased to reflect ministry funding, consistent with the terms of the contract.

1.2 Incontinence Products

Effective January 1, 2013, the MOHLTC announced an increase in the long-term care home per diem of $0.22 per resident/day for incontinence products. The 2013 Budget includes sufficient provision for incontinence products at Sunnyside. As a result, it is proposed that this funding be reallocated within the Home’s budget.

1.3 Case Mix Index Funding Revenue Adjustment

Last year, for the first time in over a decade, the MOHLTC capped funding related to the level of care of residents. The MOHLTC advised that the cap was due to data quality issues related to a category in the funding formula called special rehabilitation. This unanticipated cap resulted in a funding shortfall in the 2012 operating budget. The financial impact and a mitigation plan was outlined in SS-12-009 (February 28, 2012) and updated in SS-12-039 (September 11, 2012).

Earlier this year, the Ministry advised that while data issues remain, it had reached consensus with the long-term care associations and Local Health Integration Network (LHIN) representatives on a calculation to mitigate the effects of the data quality issue. The methodology sets a 5% home level maximum (cap) on special rehabilitation days for the 2013/14 budget year. Given the increase of resident acuity of residents at Sunnyside Home and the number of residents included in the special rehabilitation category, the Home is subject to the 5% cap.

As noted in the financial section of this report, the incremental revenue relating to the per diem and CMI adjustments totals $363,495 ($521,897 annualized).

1.4 Allocation of 2013 Funding

It is recommended that $92,815 ($278,446 annualized) be utilized to increase the Personal Support Worker (PSW) hours at Sunnyside Home by 4.24 FTE, effective September 1, 2013. It is noted that 1.4 FTE is required to provide one day, evening or night shift, 7 days a week. This allocation represents the provincial increase that was specifically identified for nursing and personal care, based on the increased acuity of residents in the Home.

PSWs, under the supervision of registered nursing staff, provide the majority of personal care for 263 residents, including dressing, feeding assistance, bathing, and transferring. Equally as important, these staff members monitor resident behaviours and activities, intervening and redirecting those with challenging behaviours.

Unfortunately more residents are being admitted that suffer from dementia, often in addition to other diagnoses, including complex physical conditions. Due to their dementia and/or other mental health issues, many of these individuals present with challenging responsive behaviours such as agitation, territorial behaviour and verbal and/or physical aggression. In addition, because more residents
require two staff in the room to provide personal care, fewer staff members are available to circulate in the common areas, preventing and/or de-escalating resident-to-resident altercations. Direct care staff members are very challenged to provide client-centred care, given their shift assignment of 9-15 residents, with the majority of residents requiring significant physical and psychosocial support. The 5% cap continues to limit the provincial funding and does not adequately support the care requirements of Sunnyside Home residents. It is important to mitigate the risk of resident and staff injuries by increasing the number of PSW hours. Currently, on average, staffing ratios allow for 2.8 hours of nursing and personal care/resident/24 hours. As funding permits, the provision of 3.0 to 3.5 hours of care/resident/24 hours would provide a safer environment, enhance the ability to meet legislated requirements and enable the provision of care and support required by residents and their family members. From a cost perspective, according to the 2011 Ontario Municipal Benchmarking Initiative (OMBI), the daily cost to provide one long-term care bed at Sunnyside Home has been slightly below the median of the upper-tier municipalities and on par with single-tier municipalities for the past three years.

1.5 High Intensity Needs Fund

For over a decade, the MOHLTC has offered a claims-based program called the High Intensity Needs Fund (HINF). This fund was available to long-term care homes (LTCHs) to prevent unnecessary admissions to hospitals from LTCH and to enable the discharge of patients from hospitals to long-term care homes. The aim of the HINF Program was to meet the care requirements of high-needs residents in LTCH in an effective, sustainable, accountable and integrated manner. The funding was used to offset extraordinary treatment costs of residents with acute or intensive service needs. Sunnyside Home has utilized the High Intensity Needs Fund to offset the cost of the following eligible expenses:

- Enteral nutrition support (tube-feeds)
- Wound care products/supplies
- Equipment and supplies to support vital processes for pain management
- Treatment/transfer equipment and supplies
- Transportation for dialysis
- Preferred accommodation
- Training
- Supplementary staffing
- Ostomy supplies
- Oxygen supplies and equipment
- Assessments

Items covered by the home’s Levels of Care per diem funding were not covered by the HINF, nor was this funding available for residents in Convalescent Care.

As of January 1, 2013, significant funding policy changes were announced by the MOHLTC with regard to the HINF. The Fund will now be administered largely through per diem funding to reduce administrative burden and improve focus on wound prevention rather than treating wounds that already exist. To support the shift to an outcome-oriented system, the Ministry will be focusing on indicators to support accountability within the sector, which may include enhancements to the audit process.

In keeping with this shift in policy, all LTCH in Ontario have received additional envelope funding of $0.63 per diem for the Nursing and Personal Care (NPC) envelope and $0.12 per diem for the Raw Food Envelope. The NPC envelope is intended to cover all costs for wound care, vital pain management, treatment and transfer, staff training, ostomy supplies, oxygen supplies and
assessments, previously covered by the HINF. The Raw Food Envelope is intended to cover the costs of oral feeds and total parenteral nutrition.

The HINF claims-based structure will be retained for the four remaining categories:

- supplementary staffing (1:1 staffing) usually required as a result of mental health and/or severe behavioural response issues causing significant risk of harming themselves or others
- preferred accommodation (private room) for residents with severe behavioural response issues who may be at significant risk of harming themselves or others or where there is a need for isolation related to infectious diseases
- transportation for dialysis
- exceptional wound care for specific types of residents with chronic and intractable wounds and will require signed verification by a doctor or nurse practitioner

The Ministry will cost-share these claims-based categories with LTCHs, paying 95% of the costs; LTCHs will pay 5% of the costs as an incentive for Homes to seek cost efficient purchases to meet resident needs in order to stretch finite dollars.

Based on the funding available, an annual provision of $113,769 is recommended for those expenditures formerly funded by the HINF. It is important to note that the usage of the HINF varies annually based upon the needs of high acuity residents within the home. A preliminary analysis has been conducted based on the past two fiscal years to estimate the impact of this policy change. A comparison of historical costs submitted for HINF and the information available with respect to the new funding process indicates that there could be a funding shortfall, depending upon the demand for HINF and the Home’s experience under the new funding rules.

### 1.6 Behavioural Support Ontario Funding

Behavioural Support Ontario (BSO) is an initiative implemented in 2011 by the Province to enhance services for elderly people with complex responsive behaviours associated with cognitive impairments due to complex mental health and addictions, dementia, or other neurological conditions. The local funding is administered by St. Joseph’s Health Care Centre in Guelph on behalf of the Waterloo Wellington Local Health Integration Network (WWLHIN).

Every LTCH in the WWLHIN receives funding based upon their number of beds. Effective April 1, 2013, additional funding was provided for the program in the amount of $13,625. This funding must be specifically allocated to Behavioural Support staff hours. Sunnyside Home is recommending an increase to the PSW behaviour support of 0.21 FTE, increasing the total BSO staff to 1.50 FTE (0.54 FTE RNs and 0.96 FTE PSWs). BSO team members have received enhanced education and work with residents with complex behaviours, developing care plans and providing support to the multi-disciplinary care team.

### 1.7 One-time Funding

a) High Intensity Needs Funding:

To assist with the transition of the HINF from claims-based to per diem based funding, and for continuing to provide safe care for high acuity residents the Province has invested $10,052,700 provincially in one-time funding for fiscal year 2012/13. Sunnyside Home’s allocation is $16,800. Staff will closely monitor 2013 expenditures under the new program and any shortfall will be managed within the approved operating budget. Reporting for the HINF per-diem categories will be captured in the annual reporting to the Ministry and the new HINF claims process.
The one-time allocation of $16,800 had to be expended by March 31, 2013. As such the Home has purchased therapeutic mattresses which support the prevention and treatment of pressure sores.

b) Staff Training and Development
In late December 2012, the Ministry advised that one-time funding for long-term care homes would be made available to ensure that staff has the knowledge and skills to provide safe and quality care that meets the changing and specialized needs of residents. The communication identifies a number of areas where they feel training and development funding would result in such a benefit. Areas include:

- Quality Improvement
- Abuse/Neglect Prevention
- Complex/Responsive Behaviours
- Specialized/Complex Care, including palliative care

The Province has provided a one-time investment of $10,052,700; Sunnyside Home received an allocation of $34,200. These monies had to be expended by March 31, 2013. As such, the Home has utilized the one-time funds to purchase educational resources and to provide staff education in the areas of nurse leadership and the Montessori, Hush No Rush, and Gentle Persuasion models of care. The most significant expense related to staff education is the cost to backfill staff members so they can participate in the programs.

CORPORATE STRATEGIC PLAN:

This report supports strategic action 5: Deliver excellent and responsive services that inspire public trust, specifically objective 5.3: Ensure Regional programs and services are efficient and effective and demonstrate accountability to the public.

FINANCIAL IMPlications:

The projected 2013 revenue for Long Term Care, based on announcements received to date and the recommended allocation of these funds is summarized in the following table:

<table>
<thead>
<tr>
<th>Sources of Revenue:</th>
<th>2013</th>
<th>Annualized</th>
</tr>
</thead>
<tbody>
<tr>
<td>Operating 2013 Per Diem &amp; CMI</td>
<td>$ 369,983</td>
<td>$ 528,367</td>
</tr>
<tr>
<td>High Intensity Needs Fund</td>
<td>113,769</td>
<td>113,769</td>
</tr>
<tr>
<td>Behavioural Supports Ontario (BSO)</td>
<td>13,625</td>
<td>13,625</td>
</tr>
<tr>
<td></td>
<td>$ 497,377</td>
<td>$ 655,761</td>
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<tr>
<td>LESS: 2013 Budget Increase</td>
<td>133,882</td>
<td>133,882</td>
</tr>
<tr>
<td>Funding in excess of Budget</td>
<td>$ 363,495</td>
<td>$ 521,879</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Recommended Expenditures:</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Directors Fees</td>
<td>$ 5,559</td>
<td>$ 5,559</td>
</tr>
<tr>
<td>PSW Staff - effective Sept 1/13 - 4.24 FTEs</td>
<td>92,815</td>
<td>278,446</td>
</tr>
<tr>
<td>PSW Staff (BSO) - 0.21 FTE</td>
<td>13,625</td>
<td>13,625</td>
</tr>
<tr>
<td>High Intensity Needs Expenditures</td>
<td>113,769</td>
<td>113,769</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>$ 225,768</td>
<td>$ 411,399</td>
</tr>
</tbody>
</table>
In 2013, it is projected that there will be a net positive variance of $137,727 relating to the additional funding and proposed expenditure. Unless otherwise approved by Regional Council, this will form part of the overall year end Seniors’ Services position. The annualized amount of $110,480 will be incorporated into the 2014 Operating Budget.

Prior to 2013, the HINF was a claims based program that was fully funded by the Province of Ontario. As the needs of the residents could not be reasonably forecast, and because all costs were covered by the Province, the operating budget did not include a provision for these costs. With the change in the program’s funding to a per diem basis, costs and revenues will be estimated and included in future budgets.

The increase to the BSO program of $13,625 is funded by the WWLHIN. This funding is dedicated to PSW staffing and therefore the funds will be used to increase PSW staffing by 0.21 FTE.

In addition to the ongoing funding announcements, the Province has provided one time funding in the amount of $51,000; $16,800 for the purchase of equipment to assist with the transition to the new High Intensity Needs funding; and $34,200 for staff training. The sources and uses of these funds are as follows:

<table>
<thead>
<tr>
<th>Sources of Revenue</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equipment Fund (HINF) Training Fund</td>
<td>$16,800</td>
</tr>
<tr>
<td>Staff Training</td>
<td>34,200</td>
</tr>
<tr>
<td>Total Provincial Subsidy</td>
<td>$51,000</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Recommended Expenditures</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Training</td>
<td>$34,200</td>
</tr>
<tr>
<td>Equipment (therapeutic mattresses)</td>
<td>16,800</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$51,000</strong></td>
</tr>
</tbody>
</table>

OTHER DEPARTMENT CONSULTATIONS/CONCURRENCE:

Finance has been consulted in the development of this report.

ATTACHMENTS

None

PREPARED BY:  Gail Kaufman Carlin, Director, Seniors’ Services

APPROVED BY:  Douglas Bartholomew-Saunders, Commissioner, Social Services
TO: Chair Sean Strickland and Members of the Community Services Committee

DATE: August 13, 2013

FILE CODE: S04-20

SUBJECT: AMENDMENTS TO PURCHASE OF SERVICE AGREEMENTS FOR CHILDREN’S SERVICES

RECOMMENDATION:

THAT the Regional Municipality of Waterloo amend current service agreements with the Waterloo Region District School Board and the Waterloo Catholic District School Board to incorporate all school sites offering extended day programs, as outlined in report SS-13-022, effective September 1, 2013.

AND further that the Regional Municipality of Waterloo amend current service agreements with Conestoga College Institute of Technology and Advanced Learning, 299 Doon Valley Drive, Kitchener, ON N2G 4M4; Jacob Hespeler Child Care Services, 640 New Hampshire Street, Waterloo, ON N2K 0A5; Young Women’s Christian Association, Kitchener-Waterloo, 153 Frederick Street, Kitchener, ON N2H 2M2; and Kitchener Waterloo Young Men’s Christian Association, 161 Roger Street, Waterloo, ON N2J 1B1, for the purposes of offering youth development programs, as outlined in report SS-13-022, effective September 1, 2013.

SUMMARY:

This report provides background and context to amend existing agreements for the provision of before and after school programs for children, 4-12 years of age in local schools. These programs are administered by the local school boards either directly or through third party agreements. The numbers of school sites has steadily grown over the past three years in conjunction with the implementation of full day kindergarten. Availability of before and after school programs is a welcome addition to support families in Waterloo Region. Further background and descriptions of the services provided are outlined in this report.

REPORT:

1.0 Background

The implementation of full day kindergarten in the Province of Ontario has created significant changes to licensed early learning and child care. Starting in 2010 in a five year phased approach, all school boards in Ontario were mandated to deliver a full day kindergarten program for all four and five year old children and where demand exists also offer before and after school care. In Waterloo Region the local School Boards have been working closely with staff to plan for and implement before and after school programs.

2.0 Before and After School Programs
Before and after school programs have historically been provided by licensed early learning and child care centres either in a community setting or co-located within a school. With the implementation of full day kindergarten changes to the Education Act directed school boards to offer before and after school programs for 4 & 5 year olds and could be provided for children up to the age of 12 years. These programs operated by the school boards are called extended day programs.

2.1 Extended Day Programs

During the 2010-11 school year, Waterloo Region District School Board (WRDSB) provided extended day programs for children aged 4-7 in four schools. During the 2011-12 school year, the Waterloo Catholic District School Board (WCDSB) also began to implement extended day programs for 4-12 year olds in a format similar to their coterminous board. Since that time the number of extended day programs offered by both boards has steadily grown. This September, the WRDSB will be offering extended day programs at 17 new schools for a total of 42 schools. The WCDSB will be offering extended day programs at 9 additional schools for a total of 21 schools. In total, board run extended day programs will be available in 63 public and catholic schools this September. When demand exists school boards have the ability to expand the extended day program to offer space to families, meaning families enrolled in these programs do not have to wait for service. The numbers of children enrolled in these programs has grown from approximately 200 in the first year to over 1600 by September 2013.

In addition to the board operated extended day program, there are seven school sites that had child care operators co-located in purpose built space within schools prior to implementation of full day kindergarten. Through a third party agreement these operators are providing before and after school care on behalf of the WRDSB at these sites. These programs operate under Day Nurseries Act and are licensed child care settings.

The report for consideration today recommends amending the current service agreements with both Boards of Education to ensure subsidy eligible families have timely access to extended day programs. As of this September there will be 42 public schools and 21 catholic schools providing extended day programs.

WRDSB Extended Day Schools for September 2013

<table>
<thead>
<tr>
<th>Abraham Erb Public School</th>
<th>Empire Public School</th>
<th>Howard Robertson Public School</th>
<th>Moffat Creek Public School</th>
<th>Southridge Public School</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ayr Public School</td>
<td>Forest Hill Public School</td>
<td>Jean Steckle Public School</td>
<td>New Dundee Public School</td>
<td>Stewart Ave. Public School</td>
</tr>
<tr>
<td>Blair Road Public School</td>
<td>Franklin Public School</td>
<td>JF Carmichael Public School</td>
<td>Northlake Woods Public School</td>
<td>Suddaby Public School</td>
</tr>
<tr>
<td>Bridgeport Public School</td>
<td>Glencairn Public School</td>
<td>John Mahood Public School</td>
<td>Preston Public School</td>
<td>Trillium Public School</td>
</tr>
<tr>
<td>Cedar Creek Public School</td>
<td>Grand View Public School (C)</td>
<td>King Edward Public School</td>
<td>Riverside Public School</td>
<td>Wilson Ave. Public School</td>
</tr>
<tr>
<td>---------------------------</td>
<td>-----------------------------</td>
<td>---------------------------</td>
<td>-------------------------</td>
<td>--------------------------</td>
</tr>
<tr>
<td>Central Public School</td>
<td>Pioneer Park Public School</td>
<td>Lester B. Pearson Public School</td>
<td>Rockway Public School</td>
<td>Winston Churchill Public School</td>
</tr>
<tr>
<td>Chalmers Public School</td>
<td>Hespeler Public School</td>
<td>Lexington Public School</td>
<td>Sandowne Public School</td>
<td></td>
</tr>
<tr>
<td>Driftwood Public School</td>
<td>Highland Public School</td>
<td>Lincoln Heights Public School</td>
<td>Silverheights Public School</td>
<td></td>
</tr>
<tr>
<td>Elizabeth Ziegler Public School</td>
<td>Hillcrest Public School</td>
<td>Mary Johnston Public School</td>
<td>Smithson Public School</td>
<td></td>
</tr>
</tbody>
</table>

Bolded schools are the new locations for September 2013

### WCDSB Extended Day Schools for September 2013

<table>
<thead>
<tr>
<th>Blessed Mother Theresa</th>
<th>Our Lady of Fatima</th>
<th>St Brigid</th>
<th>St. Aloysius</th>
<th>St Paul</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blessed John Paul II</td>
<td>Our Lady of Lourdes</td>
<td>St John</td>
<td>St. Daniel</td>
<td></td>
</tr>
<tr>
<td>Canadian Martyrs</td>
<td>Sir Edgar Bauer</td>
<td>St Teresa of Avila</td>
<td>St. Dominic Savio</td>
<td></td>
</tr>
<tr>
<td>Holy Family</td>
<td>St Ambrose</td>
<td>St Teresa(K)</td>
<td>St. Elizabeth</td>
<td></td>
</tr>
<tr>
<td>John Sweeney</td>
<td>St Anne</td>
<td>St. Agnes</td>
<td>St. Nicholas</td>
<td></td>
</tr>
</tbody>
</table>

2.2 Youth Development Programs

In 2012 the availability of before and after school programs was further expanded to 8 – 12 year old children by WRDSB. The WRDSB in consultation with Children’s Services and licensed Early Learning and Child Care operators developed a delivery model for before and after school programs for children aged 8 – 12 years of age using a recreation focus. This fall the WRDSB will be offering Youth Development Programs for children between the ages of 8-12 years at schools, based on demand. Parents pay a fee for their child to participate in the program. The programs will be operated through third party agreements with existing local service providers. Using a Request For Proposal (RFP) process, WRDSB has entered into a service delivery agreement with seven organizations for the delivery of the Youth Development Programs.

The Youth Development Programs will be operated under the legislative authority of the Day Nurseries Act and be available to subsidy eligible families. The Youth Development Programs developed by the WRDSB is the first of its kind for Waterloo Region and is being followed with interest by other areas of the Province. The Youth Development Program created by WRDSB
provides a new option for families of school aged children for before and after school activities on a fee for service basis and meets a significant need in our community.

The following table provides a listing of the organizations and the school locations that Youth Development Programs will run this September. All of the organizations listed have current purchase of service agreements with the Region of Waterloo and require an amendment to the current contracts.

<table>
<thead>
<tr>
<th>Operator</th>
<th>School Name</th>
<th>Rates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conestoga College</td>
<td>J.F. Carmichael Public School</td>
<td>Before School: $8.00</td>
</tr>
<tr>
<td></td>
<td></td>
<td>After School: $14.00</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Non-Instructional Day: $39.00</td>
</tr>
<tr>
<td>Jacob Hespeler Child Care Centre</td>
<td>Lexington Public School</td>
<td>Before School: $9.00</td>
</tr>
<tr>
<td></td>
<td></td>
<td>After School: $13.00</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Non-Instructional Day: $35.00</td>
</tr>
<tr>
<td>KW YMCA</td>
<td>John Mahood Public School</td>
<td>Before School: $9.00</td>
</tr>
<tr>
<td></td>
<td></td>
<td>After School: $14.00</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Non-Instructional Day: $40.00</td>
</tr>
<tr>
<td>YWCA KW</td>
<td>Elizabeth Ziegler, Northlake Woods, and Winston Churchill Public Schools</td>
<td>Before School: $8.00</td>
</tr>
<tr>
<td></td>
<td></td>
<td>After School: $14.00</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Non-Instructional Day: $39.50</td>
</tr>
</tbody>
</table>

There is one additional Youth Development Program, run by the Blair Road Neighbourhood Association, which does not currently meet all of the criteria required to be a licensed child care program and as such is not eligible for a purchase of service agreement at this time. WRDSB and Children’s Services staff will work with this program to formalize their structure in preparation for entry into a purchase of service agreement in 2014.

3.0 Child Care Fee Subsidy

The Education Act allows for subsidy eligible children to be placed in extended day programs which are operated under the Education Act. Parents/guardians using the extended day program are charged a fee for service using a cost recovery model. Service agreements are in place with both the WRDSB and WCDSB for placement of subsidy eligible children in the extended day programs. As outlined in this report the current contract will be amended to include the new sites added in 2013-14 school year.

Extended day programs will continue to increase as full day kindergarten is phased in. September 2014 will mark the final year for implementation, at that time all schools in Waterloo Region will offer a full day kindergarten program for 4 & 5 year olds. Where demand exists extended day programs will also be provided right at the school site. Amending the current
service agreements allows greater choice for families when selecting before and after school care and significantly reduces the number of transitions for children in their day.

4.0 Summary

The availability of extended day and youth development programs is a welcome addition to licensed early learning and child care spaces for children from 4-12 years of age. Limited availability of spaces through licensed child care has meant that many families have not been able to access regulated programs for their children. Families often report resorting to informal arrangements due to lack of options. Under the Education Act, extended day and youth development programs do not accrue waiting lists, this means that whenever families need the program they have access to it. Availability of fee subsidy will ensure that families who require assistance with the fees will be able to access these programs for their children. The seven third party operators delivering the programs also deliver other child care services, expansion to this new service provides an additional source of revenue for these operators. The numbers of children enrolled in both programs has steadily increased over the past three years. This fall enrollment for the two programs exceeds 3,000 children.

CORPORATE STRATEGIC PLAN:

This report addresses the Region’s Corporate Strategic Plan, Focus Area 4: Healthy and Inclusive Communities; Strategic Objective 4.6: Collaborate with the community to support the development of services for children.

FINANCIAL IMPLICATIONS:

The 2013 Purchase of Service budget totals $16.8M. Costs associated with placing subsidy eligible families in the expanded before and after school programs will be funded through the fee subsidy budget. In 2012-13 school year approximately $950,000 was utilized from the fee subsidy budget to support placement of subsidy eligible children in extended day and youth development programs. The expansion of these programs does place pressure on the fee subsidy budget, however the benefits of increasing availability of school aged care programs benefits many fee paying families as well by increasing the number of spaces in Waterloo Region.

OTHER DEPARTMENT CONSULTATIONS/CONCURRENCE:

The assistance of Legal services and Finance are required to establish agreements and monitor expenditures.

ATTACHMENTS

NIL

PREPARED BY:  
Candace Goudy, Manager, Child Care Administration  
Judi Neufeld, Manager, Early Learning Program  
Nancy Dickieson, Director, Children’s Services

APPROVED BY:  
Douglas Bartholomew Saunders, Commissioner, Social Services
TO: Chair Sean Strickland and Members of the Community Services Committee

DATE: August 13, 2013

FILE CODE: S15-80

SUBJECT: PURCHASE OF SERVICE AGREEMENT YWCA - KW

RECOMMENDATION:

THAT the Regional Municipality of Waterloo amend the current Service Contract with the YWCA Kitchener-Waterloo Incorporated, 153 Frederick Street, Kitchener, Ontario, to include the new Jean Steckle Child Care Centre as outlined in report SS-13-0X, dated August 13, 2013, effective August 22, 2013.

SUMMARY:

NIL

REPORT:

The Region currently has service agreements with 133 licensed early learning and child care programs. These service agreements allow the Region of Waterloo to purchase child care space on behalf of subsidy eligible families in a licensed early learning and child care program. These agreements support choice for subsidy eligible families with a wide range of requirements including special needs placements. In addition, the service agreement is a requirement for a licensed early learning and child care program to receive additional funding such as wage subsidy, transition operating, play-based materials and equipment, repairs and maintenance and minor capital retrofits.

The Region of Waterloo currently has a service contract with The Kitchener-Waterloo Young Women’s Christian Association (KW-YWCA), for all of its licensed child care centres. The KW-YWCA will be providing licensed child care in the newly constructed Jean Steckle Elementary school as of September 2013. The newly licensed program will provide child care for 10 infants, 15 toddlers, and 32 preschool aged children. The KW-YWCA Jean Steckle Child Care Centre will be located at 130 Woodbine Avenue, in Kitchener. The following table outlines the 2013 rate structure for the new centre.

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Hours of Care</th>
<th>Per Diem Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infant</td>
<td>6 or more hours</td>
<td>$66.70</td>
</tr>
<tr>
<td>Toddler</td>
<td>6 or more hours</td>
<td>$50.00</td>
</tr>
<tr>
<td>Preschool</td>
<td>6 or more hours</td>
<td>$42.86</td>
</tr>
</tbody>
</table>
CORPORATE STRATEGIC PLAN:

This report supports the Region’s Strategic Focus Area 4: Healthy and Inclusive Communities: Foster healthy, safe, inclusive and caring communities; and Focus Area 4.6: Collaborate with the community to support the development of services for children.

FINANCIAL IMPLICATIONS:

The 2013 fee subsidy budget totals $16.8M this new agreement and rates will be accommodated from within the current budget allocation for fee subsidy.

OTHER DEPARTMENT CONSULTATIONS/CONCURRENCE:

The implementation of service agreements requires the assistance of Finance and Legal Services staff.

ATTACHMENTS

NIL

PREPARED BY: Candace Goudy, Manager, Child Care Administration
Nancy Dickieson, Director, Children’s Services

APPROVED BY: Douglas Bartholomew-Saunders, Commissioner, Social Services
TO: Chair Sean Strickland and Members of the Community Services Committee
DATE: August 13, 2013
FILE CODE: S02-20
SUBJECT: DEVELOPMENTAL EVALUATION PROJECT

RECOMMENDATION:

THAT the Regional Municipality of Waterloo approve entering into an agreement with the J.W. McConnell Family Foundation and Social Innovation Generation dated August 2013, in a form satisfactory to the Commissioner of Social Services and the Regional Solicitor;

AND THAT the 2013 Operating Budget for Social Planning, Policy and Program Administration be increased by $20,000 and $0 net Regional Levy, as outlined in report SS-13-026, dated August 13, 2013.

SUMMARY:

In May 2013, Innoweave (an initiative of the J.W. McConnell Family Foundation in collaboration with Social Innovation Generation) issued a targeted solicitation of applications for developmental evaluation projects. The Region submitted a proposal in July 2013. On July 16, 2013, Region Staff were informed that the proposal was successful and that Innoweave would be providing the Region $20,000 between September 2013 and December 31, 2014 to complete developmental evaluations on the Region of Waterloo’s Comprehensive Approach to Poverty Reduction and the Children’s Planning Table.

REPORT:

1.0 Developmental Evaluation

Governments and communities across Canada are working to reduce poverty and address social issues in order to create more sustainable, healthy and resilient communities. The Region of Waterloo is just one of many partners including all orders of government, citizens, community groups, businesses and not-for-profit organizations that has an important role to play in reducing poverty and addressing social issues in Waterloo Region. It is beginning to be understood that it requires the collective effort of all of these partners to make substantial social change. Many collaborative efforts have emerged to address these complex social issues.

Developmental evaluation has emerged as an evaluation methodology that supports adaptive learning in complex and emergent initiatives. Its focus is on “real-time” feedback that allows for evaluation rigour, flexibility and innovation. Traditional evaluation works well for situations where an initiative has been developed and needs refinement. Developmental evaluation is used in situations where innovative initiatives are developing and feedback is required about the creation of the initiative.

2.0 Evaluation Project
The proposed evaluation project is reflective of the innovation and collaboration that exists within the Region to build resilient communities. The Region submitted a proposal to support the evaluation of two new complex initiatives; one which is internally focused and one which is externally focused. The Region’s Comprehensive Approach to Poverty Reduction (Comprehensive Approach) is internally focused and provides the perspective of working across a large corporation. The Children’s Planning Table is externally focused and is an emergent, community-based initiative. Both projects are focused on aligning and coordinating resources in order to avoid duplication, find efficiencies and maximize impact so that individuals and families are better served. Given the complexity of the issues that both of the projects are addressing, evaluation frameworks have been developed that include developmental evaluation methodology.

The Comprehensive Approach and the Children’s Planning Table each have unique needs for evaluative feedback. The project plan involves using one internal evaluator (creating internal capacity) and one external evaluator to support both projects. That is, one staff from the Region will work as the internal evaluator for both projects and one external evaluator will be used to support both projects. The grant funding will be used to hire the external evaluator (subject expert). The benefit of this approach is that the resources of the internal and external evaluator are being maximized as they support both projects. Additionally, each project has dedicated staff resources which will help with the implementation of each evaluation. The information from the evaluation will help to ensure that each initiative is on track and that through departments and community organizations working better together individuals and families will have access to services that are better coordinated and easier to navigate. It is anticipated that there will be significant learning that will occur for each project but also learning that will occur from doing two developmental evaluations within a large regional municipal government.

2.1 Comprehensive Approach to Poverty Reduction

In December 2012, Regional Council approved the Region of Waterloo’s Comprehensive Approach to Poverty Reduction. The Comprehensive Approach is designed to enhance the corporation’s impact on poverty reduction by addressing the issue in a coordinated and comprehensive way across all department and program areas to find sensible, innovative and lasting solutions for poverty reduction.

For the Comprehensive Approach developmental evaluation, the Leadership Team, Planning Team and Regional Council are the anticipated users of the evaluation and have questions such as:

Long Term
- Can a corporate-wide comprehensive approach enhance the Region’s impact on poverty in Waterloo Region?

Short Term
- Is the Comprehensive Approach building organizational will and capacity to align work, collaborate and co-create?
- Are there improvements in information flow, changes in service delivery, and social policy as a result of the Comprehensive Approach? If so, where is this happening and why?

The information gathered through the evaluation to address these questions will allow for a rapid response and will provide opportunities to re-think the way the Region structures its systems and services pertaining to poverty reduction. Additionally, it will enable the evaluation users to adjust, if necessary, how the planning team organizes its work and supports innovation and co-creation.
2.2 The Children’s Planning Table

The Children’s Planning Table began in 2011 in order to build on previous planning initiatives and take a systems level approach to addressing the needs of children aged pre-birth to twelve in Waterloo region. The vision of the Children’s Planning Table is that “all children in Waterloo Region live in a community that supports their developmental health through a system of coordinated and effective services”. The Children’s Planning Table is an inclusive and open planning body which has 300 members; approximately 60 – 80 of these members participate on a regular basis.

Members of the Children’s Planning Table, its Working Groups, the Early Years Strategy Group and funders such as the Ministry of Children and Youth Services and the Hallman Foundation are the anticipated users of the developmental evaluation for the Children’s Planning Table. Anticipated questions for the evaluation will focus on the contribution of the Children’s Planning Table to the development of a community-driven early years system plan and whether the level of collaboration between partners has increased as a result of the Children’s Planning Table. Ultimately with the goal of creating a family-centered system of services that is as efficient and accessible as possible.

The evaluation information from these questions will allow the evaluation users to adjust, if necessary, how the Children’s Planning Table organizes its work and makes change and to help with decisions about strategic investment.

3.0 Next Steps

The Leadership team for the Comprehensive Approach and the Early Years Strategy Group for the Children’s Planning Table meet on a bi-monthly basis and it is anticipated that evaluation information will be brought to each meeting for sense-making discussions. Evaluation feedback will be provided to the Children’s Planning Table at quarterly meetings for further sense-making and analysis. It is expected that refinements and changes to processes, activities and the theory of change will occur as a result of these discussions so that the impact to individuals and families can be maximized. Additionally, available Children’s Planning Table evaluation information will be included in reports that are due to funders in December 2013 and March 2014. It is anticipated that summary reports will be completed for each initiative in the fall of 2014.

CORPORATE STRATEGIC PLAN:

Each project supported by the proposed developmental evaluation is aligned with the Region’s Corporate Strategic Plan (2011 – 2014), Focus Area 4: Healthy and Inclusive Communities. Strategic Objective 4.1 identifies the need to “work collaboratively to reduce poverty” and Strategic Objective 4.6 identifies the need to “collaborate with the community to support the development of services for children”.

FINANCIAL IMPLICATIONS:

The Innoweave grant provides a one time allocation of $20,000 in funding to be expended by December 31, 2014. The funding allocation will be used to hire an external consultant to support the developmental evaluation project. The in-kind contribution of staffing support is a requirement for the funding allocation and will be accommodated within current staffing resources.

OTHER DEPARTMENT CONSULTATIONS/CONCURRENCE:

Legal will support the Agreement process and Finance will assist with claims under the Agreement.
ATTACHMENTS

NIL

PREPARED BY: Arran Rowles, Manager, Social Planning
Heather Froome, Administrator Social Development Programs, Social Planning

APPROVED BY: Douglas Bartholomew-Saunders, Commissioner, Social Services
REGION OF WATERLOO
PUBLIC HEALTH
Healthy Living Division

TO: Chair Sean Strickland and Members of the Community Services Committee
DATE: August 13, 2013
FILE CODE: P13-80
SUBJECT: SHARING THE ROAD

RECOMMENDATION:
THAT the Regional Municipality of Waterloo, as the Board of Health, endorse the draft recommendations of the Ontario Public Health Association (OPHA) Health and the Built Environment working group report, “Beginner Driver Education (BDE) Curriculum Study”, as follows:

1. Advocate for mandatory cycling content in the Ministry of Transportation (MTO)’s Beginner Driver Education Curriculum Standards

2. Advocate for all MTO-approved Beginner Driver Education educators to receive regular consistent professional development training

3. Encourage MTO to identify accurate and consistent Share the Road with Cyclists resources for Beginner Driver Education educators to use as additional teaching tools.

And that a copy of Report PH-13-033 and the resolution be sent to the President of the Ontario Public Health Association and the Minister of Transportation.

SUMMARY:
Bicycle use on roadways has been the focus of a great deal of media attention in recent weeks. At the heart of the issue is the need for both motorized vehicle drivers and cyclists to recognize that a bicycle is a vehicle and to follow the rules of the road, respecting one another when they encounter each other on the road.

The likelihood of a collision is reduced when all vehicles follow the rules of the road and drive or ride in a predictable fashion. Cars drivers and cyclists are all human beings and members of the community. Car drivers and cyclists both make mistakes. The consequences of a collision between a car and a cyclist can be fatal for the cyclist. By respecting one another on the road (i.e. follow the rules of the road, slow down and give a wide berth when passing) the likelihood of a collision and serious consequences are reduced, especially in situations that involve driver or cyclist error.


While the OPHA working group’s recommendations may take some time to be approved and implemented, the Share the Road advocacy group’s website (http://www.sharetheroad.ca) has a number of reminders for cyclists and drivers. Two of these reminders are:

“For cyclists, follow the law — it’s the safest way to ride. Bicyclists have the same rights and duties as other drivers and need to follow the same traffic laws” and,
“For drivers, respect bicyclists as legal road users with the same rights and responsibilities as motorists. Drive courteously and with tolerance. That cyclist is your neighbor and you are sharing the same road.”

REPORT:

The Role of Public Health

Promotion of safe sharing of the road:

The Share the Road advocacy group’s website (http://www.sharetheroad.ca) has a number of reminders for cyclists and drivers. Two of these reminders are:

“For cyclists, follow the law — it’s the safest way to ride. Bicyclists have the same rights and duties as other drivers and need to follow the same traffic laws” and,

“For drivers, respect bicyclists as legal road users with the same rights and responsibilities as motorists. Drive courteously and with tolerance. That cyclist is your neighbor and you are sharing the same road.”

Education for Cyclists:

Public Health partners with CAN-BIKE to facilitate the delivery of cycling training programs. Locally, CAN-BIKE training is delivered by certified instructors at host organizations such as schools and municipalities. All CAN-BIKE courses include helmet, bicycle and gear checks, parking lot skill development and actual on-road riding. The goal is to increase rider skill and confidence to successfully share the road with motorized vehicles. In 2012, 4 new instructors were trained and certified. Two schools offered CAN-BIKE training sessions for all their grade 5 students. Adult courses were offered through workplaces and community centres. For more information about CAN-BIKE, please contact: Colleen Cooper, PHN at ccooper@regionofwaterloo.ca.

Education for Drivers:

Public Health staff have been working with the Ontario Public Health Association (OPHA) working group for Health and the Built Environment to understand the training currently being provided to new drivers in Ontario and ways in which training around sharing the road with cyclists might be improved. The working group determined that in order to make suggestions to improve Beginner Driver Education (BDE) they needed to survey staff of driving schools, to understand their needs and attitudes towards sharing the road with cyclists (STRC) content in their teaching curricula.

Four hundred and six Beginner Driver Education organizations from across Ontario were contacted and 242 agreed to participate in the OPHA survey. A total of 75 respondents completed the survey resulting in a 31 per cent response rate. Major findings from this report are listed below:

1. 95% of BDE schools surveyed agreed that all BDE curricula should include teaching how to share the road with cyclists.
2. 65% of BDE schools did not know of any professional development opportunities for BDE instructors where education about sharing the road with cyclists could be offered.
3. 97% of BDE respondents said their school would be willing to include additional cycling content into their curriculum.

1 http://www.sharetheroad.ca/improving-road-safety-s15933
2 http://www.sharetheroad.ca/improving-road-safety-s15933
Once the survey results were analyzed, the working group came up with three recommendations for consideration by the Ministry of Transportation. The recommendations include:

- Advocate for mandatory cycling content in the Ministry of Transportation (MTO)’s Beginner Driver Education Curriculum Standards
- Advocate for all MTO-approved Beginner Driver Education educators to receive regular consistent professional development training
- Encourage MTO to identify accurate and consistent Share the Road with Cyclists resources for Beginner Driver Education educators to use as additional teaching tools.

It is intended that the recommendations, if endorsed by the Ministry of Transportation, will ensure that all new drivers will have a better understanding of their responsibility to share the road with cyclists.

**Background**

Under the Highway Traffic Act (HTA), a bicycle is considered a vehicle. And while the Highway Traffic Act does not state specifically where a bicycle should drive, it does state:

**Slow Vehicles to Travel on Right Side**

147 (1): Any vehicle travelling upon a roadway at less than the normal speed of traffic at that time and place shall, where practicable, be driven in the right-hand lane then available for traffic or as close as practicable to the right hand curb or edge of the roadway.

**Overtaking and Passing Rules**

**Passing meeting vehicles**

148. (1) Every person in charge of a vehicle on a highway meeting another vehicle shall turn out to the right from the centre of the roadway, allowing the other vehicle one-half of the roadway free.

**Vehicles or equestrians overtaken**

(2) Every person in charge of a vehicle or on horseback on a highway who is overtaken by a vehicle or equestrian travelling at a greater speed shall turn out to the right and allow the overtaking vehicle or equestrian to pass.

**Vehicles meeting bicycles**

(4) Every person in charge of a vehicle on a highway meeting a person travelling on a bicycle shall allow the cyclist sufficient room on the roadway to pass.

As a vehicle, bicycles have the same rights and responsibilities on the road as a motorized vehicle and as such both cyclists and operators of motorized vehicles must follow the same rules of the road.

**ONTARIO PUBLIC HEALTH STANDARDS:**

Prevention of Injury and Substance Misuse Requirement #2:

The board of health shall work with community partners, using a comprehensive health promotion approach, to influence the development and implementation of healthy policies and programs, and the creation or enhancement of safe and supportive environments including road and off-road

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3 These draft recommendations are currently under review by the OPHA and expected to be approved by 9 August 2013.
4 R.S.O. 1990, c. H.8, s 147(1).
5 R.S.O. 1990, c. H.8, s. 148 (1).
6 R.S.O. 1990, c. H.8, s. 148 (2).
7 R.S.O. 1990, c. H.8, s. 148 (4).
safety.

CORPORATE STRATEGIC PLAN:
Foster Healthy and Supportive Communities (4.2):
Foster healthy living through information, education, policy development and health promotion.

FINANCIAL IMPLICATIONS:
NIL

OTHER DEPARTMENT CONSULTATIONS/CONCURRENCE:

PREPARED BY:  Shartene Sedgwick Walsh, Director Healthy Living
Kevan Marshall, Public Health Planner

APPROVED BY:  Dr. Liana Nolan, Commissioner/Medical Officer of Health
<table>
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<tr>
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<td>S. Strickland</td>
<td>That the matter of mandatory CPR and AED training for all Regional employees be referred to staff to report back with options for a Health &amp; Safety staff training policy.</td>
<td>Public Health/Human Resources</td>
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