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Chair

Mr. Rob Merrifield

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● (1105)

[*English*]

The Chair (Mr. Rob Merrifield (Yellowhead, CPC)): I call this meeting to order.

I want to thank the witnesses for coming forward. This is a very important issue, and we may want to make a more significant study of childhood obesity. The committee is trying to be teased into a potential study on this, drugs, or perhaps wait times.

I'm pleased that you could all be here to share this with us and maybe tease us along in that venture. I want to thank you for coming. It's important for us to be able to hear what you have to say on this important subject.

We'll just fix the translation before we get going.

She says it's working, Réal. Is it your birthday, or is your birthday coming soon? It was in April; it's passed.

This is a standing joke. Réal Ménard was a member of our committee for many years, and he made quite a display about his birthday all the time. He made sure we never missed it. So when he asked to speak, that was the first thing that came to mind. He's 102 and he's looking no more than 29.

Let's start with our witnesses. I want to thank you all for coming. We're going to start with Diane Finegood from the Institute of Nutrition, Metabolism and Diabetes. Please start. Then we will change our schedule and go next to Statistics Canada and Ms. Shields.

Dr. Diane T. Finegood (Scientific Director, Institute of Nutrition, Metabolism and Diabetes): Thank you very much for the invitation to be here. I'm quite pleased to have the opportunity to help the committee in its investigation and to tell you about what I've learned over the last five or six years as scientific director of the Institute of Nutrition, Metabolism and Diabetes.

I'm sure this committee is well aware of CIHR and its roles and responsibilities as the Government of Canada's health research funding agency. Our mandate is to excel, according to internationally accepted standards of scientific excellence, in the creation of new knowledge and its translation into improved health.

As you know, there are 13 institutes. When CIHR was established in 2000, we undertook an environmental scan across the mandate of the Institute of Nutrition, Metabolism and Diabetes, which includes research to enhance health in relation to diet, digestion, excretion, and metabolism. So the institute's mandate includes nutrition, metabolism, diabetes, kidney, GI, liver, and endocrinology.

So we undertook that environmental scan, and it was very clear from talking to not only researchers but policy-makers and stakeholders, such as the Heart and Stroke Foundation and many others, that the priority for this institute really should be the area of obesity and the maintenance of a healthy body weight.

Toward the end of 2001, we launched our strategic initiative and our strategic priority on obesity. I'll show you in slide 4 a little bit about the funding that has gone out the door for CIHR. But this has afforded me—originally a basic scientist in diabetes—the opportunity to learn about all of the many aspects of obesity that we need to consider. So I brought some of these lessons learned to you today.

As you can see, CIHR has accelerated funding for obesity. That figure illustrates the research funding that CIHR puts out that's relevant to obesity, and you can see that we've increased it four- to fivefold since 2000-01. We've also illustrated for you that a portion of those funds is relevant to childhood obesity. I think we would like it to be more. We've increased this through specific strategic initiatives on childhood obesity, but I think we also have a capacity development issue for researchers, who need to learn how to work with children and do studies with children. So we're working to try to build that capacity as well.

The fifth slide illustrates some random titles of projects we've funded over the last four or five years that are relevant to childhood obesity. You can see that they range from things like genetic and environmental influences on body weight, to the issue and challenge of being overweight in aboriginal communities, to trying to understand the socio-cultural environment and factors that play a role in contributing to childhood obesity. This is just a sample of the many studies that are now currently under way focused on childhood obesity.

I'll give you a few statistics in the sixth slide, because I know my colleagues from Statistics Canada and Dr. Katzmarzyk will give you considerably more data on the problem of childhood obesity. But roughly one in three children in Canada is overweight or obese. Obesity in childhood is correlated with adult obesity, and as the child gets older, if they remain obese or overweight, their prospect of being overweight as an adult increases.

Obesity in children is associated with other metabolic abnormalities, usually classified in a grouping called metabolic syndrome. That constitutes things like hypertension and high lipid levels, which are things we normally associate with adults but are increasingly being seen in children. About 30% of obese children have metabolic syndrome, which is in essence a precursor to diabetes and cardiovascular disease.

It's estimated that one in three children born in 2000 will at some point in their life develop diabetes, and we're certainly seeing younger and younger individuals developing the disease. It's very apparent in the aboriginal population that they get diabetes 10 to 20 years, on average, before the Caucasian population. Other immigrant populations are starting to experience childhood obesity as well. The impact of that is significant. If you have diabetes early in life, the quality of life associated with the complication of diabetes is certainly likely to go down.

● (1110)

I bring you only one set of statistics in the seventh slide about quality of life of children who live with obesity. This slide represents impaired quality of life. If you read across the first line under "physical health, impaired physical health", when you compare obese children to healthy children, they're five times as likely to have impaired physical health, nearly six times as likely to have impaired psychosocial health, etc. That's comparing obese children with healthy children.

Even more stunning is when you compare obese children with children who have cancer and are undergoing chemotherapy. You see that even obese children are twice as likely to have impaired psychosocial health in comparison with children who are undergoing chemotherapy for cancer. It's really quite shocking, I think, how much obesity affects the lives of children.

The challenge is complex. My usual sound bite is that obesity is not rocket science; it's more complex. I don't say it's so hard and such a challenge that we shouldn't do anything about it, but to remind us that simple solutions will not really solve this problem. We need multiple levels of solutions. Really, the whole society needs to be engaged in one way or another in tackling physical inactivity and healthy eating. I know that sounds overwhelming sometimes when I say it, but I think it's part of what we need to do. And we can learn from the fact that we understand its complexity, if we embrace that complexity and think about solutions that arise out of thinking about complex systems.

The ninth slide is to remind me to illustrate to you or to make the point to you that it's not only complex from a socio-cultural environmental component or aspect but also from a biological aspect. There are more than 600 genes or locations on the human genome that in fact are associated with the human obesity phenotype. What does that mean? It means that we have quite complex biological mechanisms for regulating body weight. In fact, if you think about how much of an imbalance in calories it takes to lead to increases in body weight, only in the order of 50 to 100 calories a day imbalance between what you take in and what you expend can lead to weight gain over the course of a year. Unfortunately, like a mortgage, you compound it on a daily basis.

Actually, we have exquisitely good regulating systems for our bodies and they're regulated by a whole host of biological factors. But fat cells themselves secrete a whole host of molecules that play a role in regulating body weight. So it is complex biologically. I'm not arguing that it's biology that's causing the problem, but our biology may predispose us to the obesogenic environment that we actually live in. That's now being revealed, as our environment becomes increasingly obesogenic, with many forces that play a role in decreasing physical activity and increasing food intake.

The tenth slide is there to illustrate what some of these factors are in our socio-cultural environment that play a role. On the right, you see energy expenditure and food intake. Yes, it's really true that for the individual it's as simple, in some respects, as taking in too many calories for the number you expend on a daily basis. That's what determines whether you will be overweight or not. And it's not what you do on occasion, it's about what you do everyday and the habits we have on a daily basis. Our biology plays a role in driving how we eat and whether we're physically active. It may be surprising to think about it, but there are genes that have already been identified that actually play a role in our food-related behaviours that drive us to eat or not eat.

There are many, many factors, some of which are very proximal to us, like work, school, and home environments. Some are a little more distant to us, like our community environment, public safety, the agricultural environments we live in, even our access to public transit, that play a role in whether or not we have certain food and physical activity-related behaviours. That really goes all the way up to international factors that play a role, such as globalization of markets and media advertising.

Simply to illustrate some data around one of those areas that I know the committee is interested in, food marketing to children and youth, work was done by the Institute of Medicine in the U.S., recently published, that illustrates that food and beverage marketing to children in the ages 2 to 11 years really does influence things like food preferences, purchase requests, and beliefs about food. Unfortunately, the evidence in older children and adolescents is somewhat less clear, so they didn't conclude that this was necessarily important.

● (1115)

Content analysis indicates that most of the television food and beverage advertising that's relevant to children and youth really does promote high calorie, low nutrient products, and exposure to television advertising is associated with increased overweight in children 2 to 11 years and in adolescents from 12 to 18 years. It is very clear that media advertising, food advertising, does play a role in childhood obesity.

What are the common responses when we recognize the complexity of a problem, one that has many biological factors, one that has many social and cultural factors? When we think about complex problems we often go through a range of emotions about it. As an individual who was formerly obese, as I like to call myself, I've been through these emotions many times myself. We tend to think the problem is beyond hope. We sometimes despair or retreat from it. These are common across all kinds of complex problems, but what excites me is that we're now in a phase in this country, and really worldwide, where we're ready to galvanize our collective efforts and to invest significantly in trying to tackle this challenge.

We can learn from the discipline of complex systems science, and I'm not going to impart lots of academic information here, but we can learn how to deal with complex problems like obesity when we turn to that science.

I will just bring two points to you. One is that when things are this complex, individuals really matter. If you have a really complex system, you can't just necessarily, from a top-down approach, solve all the problems that exist. All of the people who live and work in different environments who are involved in the transportation sector or the agriculture sector, and even the individual who may have a weight challenge, are all important when we think about how we can solve this problem.

We need to match the complexity of the environment the person works in to the complexity of the problem. If we take that to the individual who is overweight or obese, if we live in a very complex environment and there are so many different forces that affect our food and physical activity behaviour, then it's very hard to tackle the problem. So what we really need to do is think about how we can change our socio-cultural environment to make the healthy choice, the easy choice.

A good example is if we look at the relationship between the cost of food and the energy density of that food. The cheapest foods are the most energy-dense, least nutritious foods. For people who live in any socio-economic environment, but particularly for those who live in poverty, it's easier to make the choice to buy the cheaper food, isn't it? We need to really think about some of those price structures as we try to tackle the problem.

Lots of people like to make the comparison to the problem of tobacco. I'll make that comparison and make some points about where the comparison is valuable and where it is maybe not so valuable.

On slide 14 you see a plot of cigarette consumption in the U.S. over the years since 1900. I want to make a couple of points about this picture. You see that cigarette consumption increased steadily from 1900 until about 1960, 1970. There are many forces that play roles in that, including our knowledge that meant smoking is linked to cancer. It had a small impact on the consumption of cigarettes. Even the Surgeon General's report in the U.S. had a small impact, but it wasn't really noticeable.

When did we really start to see a significant decline in cigarette smoking? It occurred when non-smokers' rights started to really take hold as a public movement. When people who didn't smoke said, “You shouldn't smoke in my environment, it's not right, I don't want you affecting my health”, it made smoking that used to be quite desirable and part of the social environment.... You'd sit around after a meal and that was the desirable thing to do. Now if you're a smoker you have to go outside; you have to go out of your way to smoke a cigarette. When our normative behaviour went from smoking as the right thing to do to smoking as the wrong thing to do, that's when you see very significant declines in smoking, not in all populations but in general.

How do we translate that to obesity? I'm not trying to suggest, as the *Toronto Star* quoted me as saying, that we make obesity uncool, because clearly, children and adults who are obese and overweight are already living with significant stress just because of their condition. That's not what I'm saying. What I am saying is we need to change the normative environment around food and physical activity. When we come to meetings we should have that plate of fresh fruit, not the plate of cookies. I like to refer to the plate of cookies as second-hand junk food to make the point that somebody else has made the decision about what my food environment actually is, if they offer me cookies instead of fruit.

● (1120)

We have to replicate that notion a hundredfold in all the things around us. There are many things, like food advertising to children, that affect what we think about food and what children think about food. Food is linked to fun for children. Why isn't physical activity the thing that's linked to fun? Why don't we get rid of that relationship? I think that's something we're thinking about.

I'm also not arguing that public education campaigns and talking about the benefits of physical activity are a bad idea in association, while maybe you won't see big drops in obesity as a result of that, but it is important to recognize that we need to change how we think about food and physical activity.

I've listed for you—and I won't spend time going over it—some of the ways to think about complex problems and complex systems, but there are many lessons we can learn, and we can talk about that if there's time after my colleagues have spoken.

One that I do want to highlight is just the notion that we need to measure effectiveness in the field. It's not worthwhile to spend public dollars on health promotion activities unless we find out what the impact of those activities are, in part because we not only need to know which ones are effective, but which ones may have unintended consequences, where in fact they might lead to a decrease in the appropriate or healthy behaviour.

We've learned through CIHR that there are ways to do this, to drive not only health promotion but data collection, through a project run out of my institute called “Canada on the Move”. It wasn't really a health promotion project. It was a project set up to try to facilitate four organizations that are doing health promotion. We need to engage, in doing this kind of work, a mechanism for them to learn about the effectiveness of their program.

Lastly, slide 17, gives you some of the lessons we learned through this project, which were recently published in the *Canadian Journal of Public Health*. We learned that you do need to distribute messages consistently and through multiple channels, and that health promotion and disease prevention can create innovative partnerships between industry, government, and the health charity sector.

So I think we have evidence to suggest that there are ways to tackle the problem and to get the evidence we need.

Thank you.

The Chair: We're trying to tighten it into 10 minutes. I let you go a significant amount over, only because you pricked my conscience with the plate of cookies that was over here. I was going to go and I decided not to.

Margot Shields, from Statistics Canada, would you please continue?

Mrs. Margot Shields (Senior Analyst, Health Statistics Division, Statistics Canada): I'm going to present the stats of childhood obesity over the past 25 years. I've used three data sources.

The first is the 2004 Canadian community health survey. In the past several years, when Statistics Canada produced overweight and obesity estimates, for the most part, they've been based on self-reported data. It meant that interviewers went out and asked people about their height and weight. We took them at face value when we produced our estimates. In 2004 we equipped interviewers with scales and tape measures, and they actually went out and measured the height and weight of Canadians.

When you base obesity on measured numbers, a different story emerges. Self-reported data for the most part result in lower estimates of weight, particularly for women, and higher estimates of height, particularly for men. When you put that together, you get higher estimates of obesity when you use measured data.

When you make comparisons across time and internationally, you have to make sure you have the same methodology. I made comparisons to the 1978-79 Canada health survey, which was also based on measured data. The national health and nutrition examination survey in the United States is again based on measured data.

The estimates I'm producing are all based on the body mass index. Obviously, people who are taller weigh more, so this is basically a weight measurement adjusted for height. It's calculated by dividing the weight in kilograms by the height in metres squared.

The obesity and overweight cut-off points for adults are well established. We have Canadian guidelines that are in line with the World Health Organization. Adults who have a BMI of 25 or higher are classified as overweight and 30 or higher as obese, and that's associated with increased health risks.

Things are less clear for children, but the International Obesity Taskforce recently recommended the cut-off points for classifying children as being overweight and obese. They basically took the cut-offs for adults and extrapolated them backwards based on the growth curves of kids. We now have cut-offs for age, sex, and specific years of age for children. I'm going to be producing estimates for kids aged 2 to 17 years.

In 2004 we found that 8% of Canadian children were obese. A further 18% were overweight, for a combined overweight and obesity estimate of 26%. It was up substantially from 1978-79, when only 3% were obese and 15% were either overweight or obese. A similar pattern emerged for both boys and girls, but it's still been quite a substantial increase over the past 25 years.

On chart 2, looking at it by age, as boys get older, going from 2 to 5, 6 to 11, and 12 to 17 years, the estimates increase. It's more stable for girls up to age 17, but then there's quite a large increase. Males and females again become more similar. It basically peaks at about ages 45 to 64. For adults, the obesity rates for men and women are about the same, at 23%.

Over the past 25 years, the increase among youth has been largest for the group aged 12 to 17 years. On chart 3, I have the distribution of BMIs and the percentage of kids with those various BMIs. Back in 1978-79, there were far more kids with lower BMIs, but then things changed. When you look after the cut-off point of 25, there are far more youth with those heavier weights, and these are the cut-off points for adults. It's very rare in a population to see a distribution shift of this magnitude. In fact, among 12- to 17-year-olds, the obesity rate has tripled from 3% to 9% between 1978-79 and 2000.

On chart 4, on the overweight and obesity rates by province, rates to tend to be higher in the Atlantic provinces, particularly in Newfoundland and New Brunswick. Lower estimates were observed in 2004 in Quebec and Alberta.

● (1125)

Chart 5 does a Canadian/American comparison. Generally speaking, estimates are quite similar between the two countries. American girls tend to have a higher obesity prevalence than Canadian girls do, but then if you compare just the white population to the white population, that difference disappears.

Chart 6 is back to Canada. It looks at obesity and overweight rates by ethnicity. The black population in Canada is basically no different from the white. The black bar looks a bit strange because the sample size was too low for me to produce an estimate. However, children of Southeast and East Asian descent are less likely to be obese, whereas aboriginal children living off reserve are significantly more likely to be obese. The obesity rate is 20% and the combined rate 41%, far higher than the overall Canadian rate of 26%.

In terms of some of the things that obesity is associated with, chart 7 looks at obese and overweight rates vis-à-vis fruit and vegetable consumption. The bar on the right-hand side indicates the youth who eat fruits and vegetables five or more times a day. They are far less likely to be overweight or obese than are those children and youth who consume fruits and vegetables less often.

Part of the 2004 community health survey is the nutrition component, in which we asked people to indicate everything they had eaten over the past 24 hours. Those data are just going to become available next month. In the future, we'll be able to look at obesity rates in relation to a whole host of nutritional factors, such as fat content of foods consumed, frequency of eating at fast food restaurants, and things like that. That will be researched down the road.

Chart 8 looks at obesity and overweight by what I call screen time. That refers to the number of hours that kids spend each day either watching TV, playing video games, or sitting in front of the computer. This slide shows measurements taken daily for 6- to 11-year-olds. You can see that kids who are in front of the screen for more than two hours a day are far more likely to be overweight and obese than kids who spend an hour a day or less in front of the screen.

Chart 9 shows the same thing for 12- to 17-year-olds. We measured screen time on a weekly basis for this group, but again you can see the same association.

We'd like to be able to make historical comparisons of screen time to see if it's going up. It's a bit difficult. Because of the computer, it's not quite the same. From the 1988 Campbell Survey of Fitness and Well-Being, we know that this age group averaged nine hours a week of watching television. In those days, basically, the video games were unknown and so was the computer. When we look at 2004, the TV viewing has just gone up by one hour, to 10 hours a week, but when you add the other components of screen time, it doubles to 20 hours a week. So there really has been quite a rise in screen time and the more sedentary activities.

Chart 10. For the most part, the negative health consequences associated with obesity manifest themselves only in adulthood, but as part of the survey we did ask children 12 to 17 to rate their health as being excellent, very good, good, fair, or poor. You can see there's already an association: normal-weight kids are far more likely to have positive perceptions of their health than are overweight or obese children.

I have just two last thoughts. Even for the 12- to 17-year-olds, the numbers we're seeing, even for the overweight category, are of concern. We don't have Canadian data on longitudinal studies yet, but a recent study that tracked adults over time showed that among overweight adults, the ones who were the most likely to become obese were those in their twenties. So there's concern that these overweight adolescents are going to end up as obese adults, with all the negative health consequences associated with that.

The other point is that once an individual is obese, sustained weight loss back to the normal weight range does not happen very frequently.

● (1130)

One last thing, too, is that increasingly we're seeing obesity happening at younger and younger ages. So in the next generation we're going to be facing people who have been overweight for many more years and with all the complications of the chronic conditions associated with obesity.

Thank you.

The Chair: Thank you very much.

I appreciate your information. It gives us lots to consume and to take a look at—no pun intended.

Now we have, from Queen's University, Peter Katzmarzyk. Thank you for coming.

I understand you've studied this subject in depth. We look forward to your 10 minutes.

Dr. Peter T. Katzmarzyk (Associate Professor, School of Physical and Health Education and Department of Community Health and Epidemiology, Queen's University): Thank you for the invitation to be here.

I'm an obesity researcher. I'm an epidemiologist. I've been working for about 15 years in the area of obesity in Canada doing similar studies to what you've just heard about, in other words, tracking prevalences of obesity over time as well as trying to estimate the burden of obesity on the heath care system in Canada.

Rather than going into any more statistics, in a nutshell, we're in the midst of a worldwide epidemic of childhood obesity right now. We've done a recent international comparison of 34 different countries around the world—mainly North America and Europe—and of these countries, Canada rates fifth in the prevalence of overweight kids right now. The United States is a little bit ahead of us. They're ranked second or third right now. So they're on the podium, but we're catching up to them.

In a nutshell, we're all aware of this dramatic increase in the prevalence of obesity. In adults, it has gone up. But the scary thing really is that it has escalated at a far greater pace in our kids than the adults. This is a major concern of mine as well as other obesity researchers working in the area.

Again, just to touch a bit on the socio-economic and the provincial variation, we do see in the Atlantic provinces higher rates of obesity than in other parts of Canada. Within each region of Canada, we see distinct gradients along socio-economic class; in other words, those in the lower socio-economic strata have higher prevalences of obesity, particularly in the kids—you see nice, clear gradations across the country. Nevertheless, even taking this into account, the lower socio-economic status of the Atlantic provinces does not explain the high prevalence. There's something else going on there that we need to investigate.

With that in mind, we know that there are several health risks of obesity. Dr. Finegood mentioned a few. Higher rates of dyslipidemia, hypertension, and diabetes are now appearing in kids. The big thing we have to keep in mind is that these kids, this generation, are growing up and there is a strong tracking of obesity from childhood into adulthood. Although we have an epidemic of obesity right now, it's just the tip of the iceberg. This next generation, as they move into adulthood, will really put a spike into our health care costs.

Dr. Finegood mentioned the metabolic syndrome. Today among adults we see this clustering of risk factors: heart disease, diabetes, and hypertension. This is becoming more and more evident among kids. In the United States right now, about 50% of boys and about 30% of girls have more than one cardiovascular disease risk factor. We're talking about 12- to 17-year-olds, and many of them have multiple—two, three, or four—risk factors.

We've done some studies in Quebec. The kids who have four or more risk factors, kids 8 to 18 years of age, have between 20 and 40 times the risk of being overweight or obese. So we know the risks. They're substantial. And that's what we're faced with right now, a high prevalence and a high risk.

What does this translate into? We've done some work on the economic cost of obesity and the economic cost of physical inactivity in this country. Most of that work has been done in adults, because although kids are obese, the diseases associated with obesity take several years to develop. Obese kids don't have heart attacks and they don't have strokes until they become adults.

One study in the United States has estimated some economic costs of obesity. They found that in the last 20 years hospital discharges related to obesity have tripled, and the health care costs associated with obesity have also tripled—that's in children and in 20 years.

In terms of the economic toll in Canada, we've done several studies trying to estimate that. Right now we're paying about $4.5 billion a year treating obesity and obesity-related disorders in this country—$4.5 billion. When you factor in the cost, for example, of physical inactivity, which is a separate cost, that's more than $5 billion as well.

● (1135)

These can be broken down into both direct and indirect costs. The direct health care costs associated with obesity are about $1.6 billion a year. These are health care expenditures directly related to doctors, hospitals, nurses, drugs, and research—$1.6 billion a year.

The indirect costs, the things that are harder to measure, are even more substantial. They're about $2.7 billion. These are such things as lost productivity at work and mortality. If somebody dies at the age of 45 or 50 from a stroke from being obese, we've lost productivity from that individual from our society, let alone all the taxes they could have paid. These are the things when you estimate the indirect costs of obesity. It's a burden on our society.

So that's the number we're working with now: $4.3 billion.

It does not take into account the burgeoning child obesity epidemic, which is coming up. Right now, these costs range from between 3% to 5% of our total health care costs—3% to 5%—and as these kids grow up, I can see that going up quite substantially in the coming years.

From the perspective of a researcher working in the area, those are my comments today. I'd like to leave it there.

● (1140)

The Chair: Thank you very much.

Now that we are quite nervous about this subject, we have the Canadian Council of Food and Nutrition. We're going to talk nutrition.

Francy Pillo-Blocka, you have 10 minutes.

Ms. Francy Pillo-Blocka (President and CEO, Canadian Council of Food and Nutrition): Good morning, and thank you for inviting me to the panel.

I'll start off by speaking a little bit about the council to give you some perspective about the organization. It's a multi-sectoral, trusted voice for science-based food and nutrition policy and information in Canada. It was established in August 2004 through a merger of two other organizations: the National Institute of Nutrition, which was in existence for over 25 years, and the Canadian Food Information Council, which was in existence for over five years.

The purpose of CCFN is to be a catalyst in advancing the nutritional health and well-being of Canadians by championing evidence-based solutions to key nutritional issues, and we advocate for evidence-based nutrition policy. So I thank you again for inviting me here.

I'll give you more details about the organization. We have a multi-sectoral membership comprising universities, health organizations, non-governmental organizations, commodity groups, food companies, retailers, pharmaceutical companies, and the like. Our board of trustees is made up of 15 individuals, nine from the private sector and six from the public sector. The chair is a public sector trustee. Our main strategic direction is to ensure that nutrition policy activity is evidence-based and that it supports the health and well-being of Canadians.

At the moment, we have three priority areas, the first being childhood obesity. Trans fats in the diet is the second, and *Canada's Food Guide to Healthy Eating* is the third. Due to the complexity of the problem of childhood obesity, we feel that this issue will be one of our priorities for many years to come.

The purpose of my attending the panel today, and what I was asked to do, is to present CCFN's perspective on childhood obesity as one of our priorities related to policies combating obesity.

Since our inception, we've had three initiatives, which I'm going to report on today. The first was an obesity forum called New Directions in Policy in Canada, which was held in October 2005. Our second initiative was our participation on the trans fats task force in 2005, and although that doesn't apply directly to childhood obesity, the model does apply to how to solve health issues and that sort of thing. Finally, tomorrow we're hosting a think tank on school nutrition and activity, and I'll tell you a little bit about that as well.

A couple of key findings from our forum—I won't reiterate all the great facts and figures that have already been brought up this morning—were that obesity is an epidemic, and childhood obesity is an epidemic. And that's a fact. It's becoming quite worrisome, not only nationally but globally. Obesity policy needs to be multi-level and multi-sectoral in its approach. There are potential solutions; we just need to get started.

Obesity is definitely better prevented in the first place, so the more we can do now, the more we will really help the issue down the road. Again, complex issues require multi-level, multi-sectoral approaches. It's important to be cautious, though, and not compare obesity with other issues, such as tobacco. It's good to use it as a model, but obesity and childhood obesity is not the new tobacco. People don't need to smoke, but people do need to eat.

It's important to note that there are multiple obesity epidemics happening at the same time. It is affecting children and youth, but also poor children and youth and aboriginal children and youth. There are different complexities in the different groups that policies will need to be shaped around if they are to help.

So in terms of tackling the problem from a government perspective, looking at eating, body weight, physical activity, health, and promotion, health-related agencies need to continue that important research, consumer education, and advocacy. In the private sector, we need consumer and professional education, healthy living programs, promotion, and food and product research and development. All that stuff needs to happen simultaneously to create some synergy.

There is one example, the New Zealand Food Industry Accord, which I was going to speak about today. The membership of the New Zealand Food Industry Accord, developed in 2004, was multi-sectoral in nature—the food industry, NGOs, producers, distributors, and the like. All members of that group acknowledged that obesity is a complex problem and that all parties must take ownership in the solution.

● (1145)

That model perhaps could be used in a similar fashion for the Canadian experience. There have been a number of efforts and initiatives, all simultaneously. There have been numerous collaborative partnerships and initiatives in that regard: in research, labelling, advertising on obesity, and education in schools on diabetes. There's the encouragement of companies to lead initiatives as well: food and beverage composition and recomposition, serving sizes, labelling, sponsorship support, social marketing, and public awareness. So just to look to a solution abroad of initiatives that have been happening from the New Zealand experience would be worthwhile.

The next one is our work with the trans fat task force, which was co-chaired by the Heart and Stroke Foundation and Sally Brown, who is on our panel today. The reason I bring up this initiative is because childhood obesity and trans fat are very different issues in complexities and whatnot, but the model to have all sectors around the table to discuss and come up with some consensus around a complex issue was a very worthwhile process. So I did want to bring that forward today, and I would recommend an open model to address childhood obesity as well. That's recent. That work was just completed.

Finally, there's our think tank on school nutrition and activity, which is happening tomorrow. We have key experts presenting on how children formulate eating behaviours, physical activity in children, what school-age children are eating, childhood obesity and the school environment, and partnerships—international, national, and provincial. Our experts are going to address how strong the evidence is to take action and what are the gaps in evidence. The speakers will focus on prevention, comprehensive treatments, healthy environments in schools around food and activity, evidence-based policy, partnerships, and more research and continued surveillance.

In summary, then, childhood obesity rates are increasing and have many negative consequences. It's strategic to prevent childhood obesity from increasing any further. Childhood obesity is complex, and solutions will also need to be complex, but a multi-sectoral approach will definitely help in that regard.

Thank you.

The Chair: Thanks very much. I appreciate that.

We have one more group of panellists, Sally Brown and Stephen Samis, from the Heart and Stroke Foundation. I'm not sure who's going to speak.

Sally, you have 10 minutes. We appreciate you being here.

Ms. Sally Brown (Chief Executive Officer, Heart and Stroke Foundation of Canada): We appreciate the opportunity to be here. Thank you very much.

The mission of the Heart and Stroke Foundation of Canada is to reduce death and disability from heart disease and stroke.

I will mention that June is our 50th anniversary.

There have been many advances in heart disease and stroke control and alleviation in the last half century. We like to think we've played a role in that; we've invested about $1.2 billion over the last 50 years in research and health education.

A new priority area for us is obesity reduction. Obviously we're coming at it because it's a risk factor for heart disease and stroke. We're very pleased that we've been able to partner with Diane's institute more recently on obesity research, the institute we affectionately call the “Institute of No More Donuts”. We've been working with Diane and her team on capacity-building, identifying research gaps in obesity, and in trying to fill them with some strategic research opportunities.

Again, we want to thank you for inviting us to speak on this critical issue. We addressed it about two weeks ago in a recent release of our document, *Tipping the scales of progress: Heart Disease and Stroke in Canada 2006*, talking about the progress of heart disease and stroke in Canada.

We've distributed in our slide presentation as well a number of data and statistics. I won't go through a lot of them. I may repeat a couple of the messages, though, because I think they bear repeating.

In slide 2 you can see that the burden of CVD is huge. There is good news and bad news. The good news is that mortality and hospitalization rates have been dropping for many years, but the bad news is that there are still almost 74,000 deaths annually from heart disease and stroke, and they are still the leading causes of death in Canada. I was struck by Peter Katzmarzyk's comment that while hospitalizations for CVD are coming down, obesity-related hospitalizations are going up.

There is more bad news. As you've heard, the burden is more prevalent among older age groups—and we're aging, so the burden will get worse, not better.

In slide 4 we've shown you the risk factors for heart disease and stroke. Clearly, poor diet and physical inactivity—two separate risk factors—combine in contributing to obesity as a risk factor.

I will mention, as Francy did, that unhealthy diet for us also constitutes the extremely important issue of trans fat reduction. Trans fats are in and of themselves a big risk factor for heart disease, and, as we all know, Canadians are among the highest consumers of trans fats in the world. So it's not an obesity issue. It's probably seen as an obesity issue because many of the foods that are high in trans fat are junk foods and contribute to the obesity problem.

There is more bad news still: obesity has increased over the past 25 years, if you've heard, across all age groups. So while I said we've made impressive gains in cardiovascular disease, obesity could cause us to start going backwards. Is 60 the new 70? As figure 7 shows, the trend applies to children—and I won't go through some of the incredibly impressive StatsCan data on that. Obviously we've heard obesity worsens with age among children. As Francy indicated, they are then at increased risk of remaining overweight and obese, and that's important to reinforce as adults. So these kids who are now showing signs of obesity are on the fast track to developing heart disease and stroke problems in later life.

We've included in your presentation some projections on obesity rates for men and women by income level. I won't speak to them.

We also know it's very bad news for our health that almost half of Canadians over 12 report being inactive. I was personally quite shocked by that figure. An aging population adds to the problem, since activity decreases with age.

As we also heard from Stats Canada, children who report higher levels of screen time are more likely to be overweight or obese than those who report less screen time. Some studies now have shown that this increase is not solely a result of time displaced from physical activity, but that advertising of food and beverage products during children's TV programming has had a significant impact.

● (1150)

Finally, we want to emphasize that there's still a lack of adequate surveillance data and other data in Canada about Canadian dietary intake and trends, about physical inactivity, and how these variables affect obesity over the course of a person's lifetime.

Stephen Samis will now provide our thoughts on how we believe, based on the evidence, the obesity epidemic in children and adults should be tackled. We're speaking only to the federal government's role. Although clearly it's not just a federal government problem, the federal government has a huge role in this area.

Mr. Stephen Samis (Director, Health Policy, Heart and Stroke Foundation of Canada): Thank you, Sally

I'll be very brief, Mr. Chair.

We know there are lessons to be learned from tobacco control. While we have said at the Heart and Stroke Foundation that fat is the new tobacco, we do not believe the food industry and the tobacco industry are equal. We believe the food industry needs to be a partner in the reduction of obesity in Canada. In fact, we work very closely with the food industry through our Health Check program. So while we're making some analogies between food and tobacco, we want to really clearly differentiate our views of the industries in this case.

We know there are lessons to be learned from tobacco, and I'll just point out a few of them. We know, for example, that education is important, but not enough. As Diane pointed out in her slides, education is important, but it only takes us so far. We need, as others have said, multiple jurisdictions working in a variety of ways to help us control obesity and reduce the rates. We have to take a comprehensive approach. What we really learned from tobacco reduction—and Canada now has the lowest rates of smoking in the world, and of that we should feel very proud—is that when we commit ourselves to addressing an issue and work in a coordinated way, we can make a difference.

We also want to reiterate that our data infrastructure needs to be improved, as Sally said. Canada is one of the few countries in the world without a lifelong cohort study. This is really unacceptable for a developed, first world country like ours. In fact, many Canadian researchers have to resort to using American and British data to be able to track health trends and outcomes over the course of an individual's life. Canada really needs a lifelong cohort study. It will increase our brain-gain, if nothing else.

We've talked before in our report and in other fora about the importance of using tax incentives and disincentives to address obesity. We've done it with tobacco and we can do it with obesity. We've talked about removing sales taxes from restaurant or retail foods that are deemed to be healthy, and perhaps adding some taxes to foods that are less healthy, although we know from the evidence that in the area of food, tax incentives work better than disincentives, so we would recommend them more highly.

We're asking the federal government to remove some of the sales taxes from sports and recreation equipment that would get Canadians moving, and combine it with a promotional campaign that makes it known to Canadians that it has happened and encourages them to get out and be physically active.

Finally, we are encouraged by recent moves, but we encourage the federal government to continue to provide tax credits and breaks for enhancing physical activity, whether those be for fitness classes, gym memberships, registration of kids, or organized sports, etc.

Canada desperately needs an integrated, adequately funded, chronic disease prevention strategy. We're urging the federal government to move on this and to work with the Chronic Disease Prevention Alliance of Canada to help develop and implement this.

I want to note, Mr. Chair, that four years after the federal government announced it was developing a healthy living strategy for Canada, we're still here calling for the implementation of a healthy living strategy. Clearly, the time to act on this is now.

We also want to point out that, like tobacco, this is not an individual issue, and that the environments we live in shape our behaviours and patterns. Diane talked about an obesogenic environment, and that's a very important point. We're asking the federal government to continue to look at how to enhance, through its gas tax transfer program, transportation infrastructure funding to the provinces and the cities that will enhance physical activity. We are asking the federal government to actually allocate 7% of its infrastructure funding dollars to transportation infrastructure that enhances physical activity. The United States federal government currently allocates 10% of such transfers for that kind of active transportation, and Canada doesn't allocate anything.

We also are asking the federal government to ensure that some social infrastructure that supports physical activity is included in the gas tax transfer program, so that it's not just roads and sewers, but also things such as recreation centres, community centres, pools, etc., that can be funded through the program. We're asking the federal government to continue enhancing transfers that would enhance public transit and other such physical activity-enhancing measures.

We've also noted the importance of the marketing and advertising of foods to children. The research on this is overwhelming and the evidence is clear that the marketing of unhealthy foods to kids leads to increased consumption of unhealthy foods. Young children do not understand when the programming ends and when the commercials start, and that influences their food choices.

● (1155)

The Chronic Disease Prevention Alliance of Canada, a coalition of public health organizations of which we are the chair, has been examining this issue, and we look forward to bringing recommendations on this issue back to the committee in the near future.

We're asking the federal government to explore options to reduce the marketing of particularly fatty foods to kids. We do have a world precedent-setting model here in Canada, in Quebec. Quebec instituted a TV ban on advertising to children in 1980 that applies to kids under the age of 13 years. It applies to commercial advertising, not to public service announcements.

What are the outcomes of the Quebec ban? Well, interestingly, Quebec has instituted such a ban and has among the lowest soft drink consumption rates in Canada, among the highest fruit and vegetable consumption rates in Canada, and among the lowest obesity rates in Canada. We want to be clear that we're not making a causal link here between that ban and these behaviours, but there's definitely an association and it's something worth exploring. You can see on slide 22 that the percentage of kids 6 to 11 who are overweight and obese in Quebec are amongst the lowest in the country.

● (1200)

Ms. Sally Brown: In conclusion, Mr. Chair, we believe we can and must apply a number of the lessons learned from tobacco control. You've heard that from all of us. We did a good job on tobacco control. We can do a good job again. We need to be comprehensive in our approach. We have to use many levers. We must apply public policy instruments at all levels. You've heard that the solutions are complex, but we need to start now and we can do it in a step-by-step way.

Without wanting to make light of this heavy subject, I'll leave you this final slide, which shows.... This was a picture taken two weeks ago by a parent of one of our staff members, so it wasn't set up. It was in a store in France, and it shows four sizes of French fries, *petit, moyen, grand, et American*, and the *American* is four times as large as anybody else's. This shows we have a particular problem in North America. We have to deal with it. We can start with the easy scenes, like serving sizes; other things are going to be as complex as rocket science. But it doesn't excuse us from moving forward.

The Chair: Thank you very much to all the panellists. It's been very informative. We're going to have the committee actually question you on this. I'm looking forward to that.

Before we do that, I'll relay a comment that somebody said to me the other day: it's not that children are not interested in sports any more; it's simply that they're more apt to go home from school and turn on the computer and play basketball on the computer instead of going into their backyard to play it. It's probably true.

Ms. Dhalla, we'll start with ten minutes.

Ms. Ruby Dhalla (Brampton—Springdale, Lib.): Thank you very much. I found your presentation extremely informative. I think many of you have a tremendous amount of expertise and have put in a lot of work and time to address what I think Peter called an epidemic that is facing not only North America but the global society at large.

Before I start, I was going to put a motion forward that I thought my colleague, Mr. Batters, might support. It was to ban all cookies at all health committee meetings.

Some voices: Oh, oh!

Mr. Dave Batters (Palliser, CPC): I can't support that, Mr. Chair. What would I eat?

Ms. Ruby Dhalla: If he lifts his sign, we'll find out exactly how many cookies he has on his plate.

Mr. Dave Batters: Thank you, Ms. Dhalla.

Ms. Ruby Dhalla: You're welcome.

One of the issues I was quite interested in, and I think it has been mentioned in the media as of late, was a report done by Heart and Stroke and I think an initiative that has been carried out provincially in Ontario in regard to the removal of vending machines in schools. In taking a look at your report, I realize that you have also made that recommendation. Have you worked with other provinces and perhaps other schools throughout the country to promote that particular recommendation? I know when Ontario brought it in, there was quite a bit of controversy in regard to it by some of the children and teachers in schools as to government interfering and trying to dictate to children as to the type of food they should be provided with.

Would you please comment on that and what type of integrated strategy has taken place at a national level to ensure that children in schools do get the proper type of healthy foods?

Mr. Stephen Samis: Thank you. That's a good question.

We have worked at this across the country, both at the Heart and Stroke Foundation as well as through the Chronic Disease Prevention Alliance of Canada. There are a number of initiatives going on across the country. Ontario is one jurisdiction. British Columbia is in a similar situation, at this point addressing that issue. Quebec is looking at the issue. Alberta has been looking at the issue. This is increasingly a movement across the country. It comes to the realization that kids spend about seven or so hours a day in the school environment and are, to a certain extent, constrained in that environment. It's very difficult to come and go at leisure, especially for younger kids, so the food environment in those schools really does restrict their choices. Therefore, it's important for us to ensure that the food in the school system is food that's going to make kids healthy and able to learn, rather than contribute to this problem.

So we have been working at this. All of our provincial foundations and alliances at the provincial level are actively focusing on this issue.

● (1205)

Ms. Ruby Dhalla: Has the institute done any work that you've been involved with, Diane?

Dr. Diane T. Finegood: We have done work specifically with schools to talk about that. But the challenge, in terms of research, is that when you isolate one factor like vending machines and you try to study whether taking vending machines out of schools or changing the content of vending machines has an impact, what you often see is a very small effect, because it's one of, as we say, 50 or 100 different factors. That doesn't mean we shouldn't try to make that school environment healthier, but it is challenging to have the evidence around that.

At this point in time I'm not aware of sufficient evidence to say just doing that is going to have a big impact on kids.

Ms. Ruby Dhalla: The other question I had was in regard to the chart that was forwarded to us by Ms. Shields, from Stats Canada. I believe in your presentation you spoke about some of the statistics from different cultural communities relating to obesity and children being overweight.

Has there been a pan-Canadian strategy to reach out to the different demographics in the different ethnic communities in Canada?

In a riding like my own, Brampton—Springdale, there are individuals from many different cultural backgrounds. I know some of those individuals unfortunately don't read the *Globe and Mail* or the *Toronto Star*; they're reading their own ethnic newspapers, whether in the Chinese community or the Indian community.

What type of outreach has been done with some of these ethnocultural communities to ensure that we reduce obesity—children who are overweight—within the ethnic groups?

Mrs. Margot Shields: As a StatsCan employee, my job is to get the numbers out. I think another panel member would be better able to address that question.

Ms. Francy Pillo-Blocka: I could answer that question.

I have done clinical work for 10 years, and I know that public health departments have used *Canada's Food Guide to Healthy Eating* and have translated it in many languages. That tool is available for all the various cultures.

Ms. Ruby Dhalla: If we could perhaps get copies of that, I would appreciate it.

Ms. Francy Pillo-Blocka: Sure.

The Chair: Thank you.

Ms. Keeper, five minutes.

Ms. Tina Keeper (Churchill, Lib.): Thank you.

I would like to commend the panel. It was a very interesting presentation.

I also have a question to StatsCan, for Margot, going back to the same page in terms of the cultural communities. I would like to address this question to Diane as well.

The population in my riding is 60% to 70% aboriginal. In fact, I have many first nations. I notice the brief refers to off-reserve aboriginals. I'm just wondering whether there is a working relationship between the first nations and Inuit health branch and Stats Canada in terms of this issue.

Mrs. Margot Shields: Diane, you'd probably be better able to address that.

Dr. Diane T. Finegood: What I can say is that, first, as you may be aware, we do have an Institute of Aboriginal Peoples' Health at CIHR. We've worked closely with my colleague, Dr. Jeff Reading, on issues around aboriginal peoples' health and diabetes. We've co-funded a number of projects. We illustrated one there.

So we are trying to work with communities that are at greater risk of obesity and developing subsequent chronic diseases. We are also working with the first nations and Inuit health branch and other components of the Public Health Agency at the level of trying to ensure that we can bring researchers and individuals who are working on health promotion to the same table.

Actually, one of the slides I didn't use, the very last slide in my presentation, illustrates the knowledge cycle. One of the things we've become really clear about in this country—and this is true around the world—is that when we put money out the door for health promotion, often the money stops at the point in time when you ask about evaluation of the impact of that particular activity. So we've been working hard behind the scenes with colleagues who are doing health promotion to ensure the systems and mechanisms that are in place to actually get the evaluation and research done on those health promotion programs actually are used. That's really a critical systemic problem that needs to be fixed in order for us to actually know what the impact of different interventions is.

We certainly know that as you move from culture to culture, the way you approach, say, encouraging physical activity is not going to work the same way for one culture as it might for another. It's really important to have people on the ground level working with different communities and for us to understand what the impact of those efforts actually is.

● (1210)

Ms. Tina Keeper: I'm going to take this back to Margot again. I want to explore this issue a little bit.

Margot, are you telling me that when Stats Canada does this type of work, they do not work with the first nations and Inuit health branch in terms of these statistics? Are these off-reserve numbers you're looking at only in the aboriginal community?

Mrs. Margot Shields: Yes. The Inuit community health survey does not interview on reserve.

Ms. Tina Keeper: Okay. Thank you.

Mrs. Margot Shields: The aboriginal people's survey goes on reserve, but not the Canadian community health survey.

Ms. Tina Keeper: Back to Diane.

Diane, one of the numbers on page 7 talks about the cycle of social health. This is one of the impacts of the issue. As we look at off-reserve numbers in the aboriginal community where we know obesity is an issue, we know type-2 diabetes has become a huge and critical issue among aboriginal children, and it's growing very rapidly. This is going to have an impact in that sense as well.

As the panel has said, the obesity issue is an epidemic and it's growing rapidly in the Canadian population, among Canadian children. When you look at the first nations aboriginal population, the impact is even greater, and the health issues are very critical.

How do you see the pan-Canadian approach working more closely with the research institutes for aboriginal health?

Dr. Diane T. Finegood: Let me draw your attention to the list of solutions to complex problems on page 15, because when the problem is this complex, you need to recognize that what you do in one community may not work in another. You need to support individual initiatives, not just those of the individual but of individual communities. We need mechanisms supporting individual communities to make their own decisions about what will work within their community. We then need to understand how that works if we're ever really going to tackle the problem.

Ms. Tina Keeper: I agree with that. I understand that.

My concern is that the first nations health issues are left off the map.

Dr. Diane T. Finegood: They're certainly not off our map. As I said, not only do I, but I know my colleague, Jeff Reading, works closely with the first nations and Inuit health branch in attempting to solve the problem.

The Chair: Thank you very much.

Réal.

[*Translation*]

Mr. Réal Ménard (Hochelaga, BQ): Thank you, Mr. Chairman. I am pleased to be part of this committee again.

I would like to get your views on a legislative proposal that was made by one of our colleagues in the 38th Parliament. A Liberal Party member, Tom Wappel, had tabled a bill requiring restaurant owners and particularly the owners of big restaurant chains serving fast food like McDonald's to divulge the calorie counts or the absence of nutritive value of all foods sold in their restaurants. He wanted this information to be posted on menu boards and menus.

Do you think that it would be an educationally interesting way of fighting the obesity issue? This is my first question.

Then I would like to question Peter about obesity in low-income neighbourhoods. It was not part of the host of solutions that you proposed. I do not know if my colleague has reintroduced this bill. I didn't see it. Do you think that it would be a good solution?

● (1215)

[*English*]

Ms. Sally Brown: The Heart and Stroke Foundation of Canada spoke in favour of that bill at this committee last year. We recognize some logistical problems for certain restaurants, but it became clear that those calorie counts are known. They're often on the back of a tray liner in some restaurants. They could be more visible and up on the menu boards. While that would not be a comprehensive solution, it would be helpful to consumers. We all know a huge percentage of our families now consume their food outside the home.

Mr. Stephen Samis: Just to add a comment to that and to follow up on your second point, there is emerging research in Canada that also shows a preponderance of fast food and, I would say, higher-fat food choice establishments in lower-income neighbourhoods than there are in middle- and upper-income neighbourhoods. So I think the more information we give Canadians in those neighbourhoods, the better.

[*Translation*]

Mr. Réal Ménard: It is interesting and it brings me to ask…

[*English*]

Ms. Francy Pillo-Blocka: I'd like to concur. We've done studies tracking nutrition trends. Consumers really do look at this sort of information on a package label, and knowledge is power. So from a fast food perspective, people need to know that, and they may change their choices when they know that information.

[*Translation*]

Mr. Réal Ménard: Let me say something parenthetically before I ask a question to Peter. Here on Parliament Hill, there are two gymnasiums one of which is for parliamentarians. I am somehow responsible for the acquisition of equipment. It is very important in all professional fields to encourage people to engage in physical activity. More and more parliamentarians are engaging in physical fitness in the gymnasium. I have not lost hope that someday we will see our Chairman there, even if he is very thin.

Some voices: Ha, ha!

Mr. Réal Ménard: So there is a correlation between the availability of physical fitness equipment at work and the likelihood of engaging in physical activity.

In fact, I would like to know if we have scientific data on the following issue. What is the variable that encourages people to engage in physical activities, for instance in low-income groups? For an inactive person who watches a lot of television and likes all interactive games like Nintendo and similar types of games that my generation didn't have, even if I am in my early forties, what variable would trigger a desire to take up physical activities? Is there a scientific answer to that question? Is it the parents' behaviour? The proximity to sports equipment in the community? A tax incentive? Do we have scientific data on the variable that makes someone go from sedentarity to physical activity?

As usual, it was a short question, Mr. Chairman. I haven't changed.

[*English*]

Dr. Peter T. Katzmarzyk: I could try that.

It's such a complex issue. There are stages of change theory and what makes people want to take up physical activity. Where they are in the cycle will depend on how you approach that person to engage them in physical activity.

Now, this is the area of health psychology. We have a number of excellent health psychologists in Canada right now being funded by CIHR and the Heart and Stroke Foundation of Canada, trying to get at these exact issues. We don't know how to engage people in physical activity and get them to maintain it. We just don't know.

The Chair: I'll allow a short answer.

Dr. Diane T. Finegood: We know most people walk as their form of physical activity. We also know there are good relationships between lower body mass index and the use of public transit and walking, having destinations to walk to.

If you live in the suburbs, having nice trails to walk to will lead to an increase in physical activity, and if you live in a city, having access to all kinds of stores and things like that is what makes people walk. So when we construct suburbs with no destinations to walk to, people don't walk.

● (1220)

The Chair: Thank you very much.

Just before I let Mr. Fletcher on for five minutes, I'll say this to Mr. Ménard. You know, I've never met him in the gym. I've also never met him in the stairwell of our building.

[*Translation*]

Mr. Réal Ménard: I go there three or four times a week. I have no fat.

[*English*]

Mr. Steven Fletcher: Actually, come to think of it, I use the elevator a lot, and I see both of you guys in the elevators. I have an excuse. What's your excuse?

An hon. member: There goes two minutes.

Mr. Steven Fletcher: My, time flies when you're having fun.

First of all, I found the presentations very excellent, from each of the presenters. I think the distinction between obesity and trans fats is helpful. I also found the feedback on the trans fat task force helpful, because in fact this is something the NDP has worked on, and when I was health critic, I was able to assist the NDP in coming up with the wording of that to include an all-stakeholder panel. So I'm glad to hear that it worked out well.

The issue of active living is talked about a lot, and I just want to assure the panel that the government is committed to an active living program. You have seen that in the budget with specific tax credits, and I think you'll see a lot more progress in that area, particularly with input from stakeholders like yourselves. So we look forward to working with you on that.

One thing I would like to see this committee do, if the committee is open to it, is an extensive study on obesity, and come back with an all-party report, because I think this is a non-partisan issue and we can deal with prevention and education and include stakeholders. I would be interested in hearing the opposition's point of view on that.

But if we do decide to do that, I wonder if the committee could comment on whether there would be value in having an economist type of person deal with not only the costs and so on of what chronic disease does...but to follow up on Ms. Keeper's point, in northern communities, it's ironic perhaps that the cost of an apple or a carton of milk is many, many more times that in the city. I know in Manitoba, for example, even for alcohol, if you're in Churchill, it costs the same amount to get a bottle of beer as it does in the city, due to the way the liquor commission works.

So I wonder if there's any thought on the economics of making healthy food affordable in the north—and that would obviously affect the aboriginal community as well as the non-aboriginal community.

Also you mentioned that lower-income families tend to eat out more, which is maybe counter-intuitive, because that's often more expensive overall. I wonder if there are ways to make it economically attractive for lower-income people and other demographics to eat healthy?

Dr. Diane T. Finegood: As Stephen alluded to, the evidence that we do have so far about economic incentives and disincentives suggests that economic incentive is a much better driver for making healthy choices. So lowering the price of healthy food or subsidizing nutritious, healthy food—low energy-dense food—tends to have a greater impact on people's purchases and food-related behaviours.

That may be in part because we haven't made the disincentive great enough to really affect people's behaviour. That's difficult to do, because the more energy-dense foods are much cheaper, so the amount you would have to increase the taxes by, as with gasoline or tobacco, would have to be quite severe.

So yes, economics are clearly an important component of this, and understanding that and collecting the information about how to drive healthy eating and active living is extremely important.

● (1225)

Mr. Steven Fletcher: Do you think it would be helpful if the health committee were to study obesity?

Ms. Sally Brown: Yes.

May I just add two short comments?

I think this just shows what we mean by a comprehensive approach. With smoking, nobody would have guessed it was municipal bylaws that would have the most effect.

For obesity in the north, it's transportation policy. It's not just health policy. I think it's very important, if this committee looks at it, that you get the other departments that are relevant around the table.

The other point I would make is that I had the pleasure of being in Australia a short while ago. Jeff Reading from the Institute of Aboriginal Peoples' Health was a guest speaker. This is an identical problem in Australia. They have the distances; they have the aboriginal issues. They're going to start focusing on it. I know our Prime Minister met with the Australian Prime Minister. This is something we can look at together.

Mr. Steven Fletcher: The Australian Prime Minister, by the way, is a great guy.

The Chair: Ms. Priddy, you have five minutes.

Ms. Penny Priddy (Surrey North, NDP): Thank you.

By the way, here is my pedometer, just so you know I'm....

A voice: How many steps?

Ms. Penny Priddy: So far today it's about 3,000.

A voice: It should be 12,000.

Ms. Penny Priddy: Yes, I know, but it is only 12:30 p.m. It's usually 12,000 by the end of the day—truly.

There are several points I'd like to make. I'm sure you've thought of what action you might be taking. I know that *Canada's Food Guide* has been translated. I missed the last part, though. Has it been translated in ways that also recognize the food used culturally by people from different countries?

It's one thing to translate it into Punjabi—okay, fine—but you have to talk about what that means if you're cooking dahl or if you're cooking whatever. Has it taken that into account?

Ms. Francy Pillo-Blocka: There are two things. First of all, yes, absolutely, the translated versions of the current guide take into account the culture, the different foods, and that sort of thing. But keep in mind that *Canada's Food Guide to Healthy Eating*, the new one, is coming out and we'll need to do the same sort of thing for the new version.

Ms. Penny Priddy: Yes, because we're getting so much more.... Thank you.

I'm wondering, on any of the committees that people are involved in, whether there are representatives from anti-poverty groups. Maybe there are lots, but for many people, aside from what we know about other predisposing causes, it is about cost. If my children are really hungry and I give them a piece of melon but I can buy Kraft Dinner for about the same cost, the melon won't keep them full and the Kraft Dinner will.

People have worked very hard in the anti-poverty movement to find ways to offer those suggestions, so I'm just trying to ensure that they indeed are involved in the work that people are doing in terms of how that information gets out to people. Yes?

A voice: Yes.

Ms. Penny Priddy: Okay, thank you.

Thirdly, I'm wondering if you're involved with city managers at all. I come from a city that issues more building permits than any other city in Canada. God forbid that we should leave a piece of free land rather than put six more houses on it. In many ways it is the municipal area that ensures there is enough space, that the leisure activities are close enough together.

If you looked in my community you'd find skateboarding and rock climbing, because they're free and because people can get to them. Even if you get a tax credit for enrolling your child in hockey, I haven't got $500 or $600 to put up front. So municipal governments have a really important role to play in this one as well, and I've never heard them talk about being involved in this. They also deal with transportation as well.

I'll just say one more thing and then I'll leave it.

Can I say one more thing?

The Chair: You can. They want to respond, but go ahead.

Ms. Penny Priddy: Yes, I know.

The other is seniors. If you go into McDonald's at mealtime, often half the people you see will be seniors, because it's a really inexpensive meal. We didn't talk about that sort of further-on age group, but they have those same kinds of risks.

Thank you. Okay, go ahead and talk now.

● (1230)

Mr. Stephen Samis: I can speak to a couple of things you mentioned. The alliances that are at the provincial level—the chronic disease and other healthy living alliances—definitely have groups concerned with poverty involved in them. The recommendations that they tend to bring forward tend to be very conscious of those kinds of issues and concerns. And the Heart and Stroke Foundations across the country participate in those alliances. Through a variety of other fora, I think we tend to find ourselves in meetings with people looking at the issue from a number of perspectives, including that one.

Specifically with respect to the municipal level and a built environment, we're doing a number of things at the Heart and Stroke Foundation to try to increase awareness of this linkage. We have an annual healthy public policy award that we award to a policy-maker in the country who is really seen to make a difference in heart health. This year's award winner was Mr. Larry Beasley, who is the head of planning for the City of Vancouver. We gave him that award in terms of highlighting the ways in which Vancouver has worked very hard to develop a city that encourages physical activity and a more active population.

We're also in discussions right now with the Canadian Institute of Planners to develop a joint award between the Heart and Stroke Foundation and the Canadian Institute of Planners that would go every year to a municipality of whatever size in the country that has done something to get at this issue and to help Canadians live more active lives.

We are also coming out—and we're going to be working with Diane's institute to do it, as well as with a number of other institutes, including the Institute of Aging—with a request for proposals this fall that will really try to build the evidence base on the link between how we design our communities and the food and activity choices available to Canadians in communities and obesity.

The Chair: Mr. Batters, you have five minutes.

Mr. Dave Batters: Thank you very much, Mr. Chair.

I appreciate all of you coming before this committee on this very important subject. Certainly we all recognize in this room, and Canadians recognize, that healthy, active kids equal healthier, happier adults. I think you've explained to us very well today the tremendous human cost associated with childhood obesity. We've talked about the fact that it's associated with diseases such as diabetes and heart disease.

Clearly, the human cost is most devastating, but there's also the tremendous financial cost, as Dr. Katzmarzyk has pointed out, and the costs for drugs and hospital procedures we will incur as a result of childhood obesity are staggering and must be addressed by parliamentarians.

The government certainly feels this is a very important subject. I think the parliamentary secretary said it best: this would be a good issue to study. I hope that members opposite feel the same way and that we'd perhaps issue a report on this very important subject. I'm very proud to be part of a government that provides tax credits, a $500-a-year credit per child, for registration fees in activities that involve physical fitness. Clearly, the government feels this is a priority.

I'm going to give you a heads-up. I'm going to talk for another minute and a half, Mr. Chair, and then I'd like the panellists to answer a quick question. I'll give them a few minutes to prepare their answers, and then perhaps in the rest of this meeting the rest of you would have a chance to respond.

At some point you can get to paralysis by analysis—we have all these reports—but I'd like to ask each of you as experts in this field, what are the two biggest changes that can be made to address this important issue of the increasing trend of childhood obesity? I leave you with that to think on. What are we doing in Canada for prevention, and how do we break this cycle? We can either spend some money now or we can spend a heck of a lot of money later on this problem.

Clearly, we need to do more in terms of physical activity and healthy eating. I believe we need more public education, things like ParticipACTION. We have all seen the ParticipACTION ads. I personally don't see as much of that on television as I used to, or I don't notice it as much, and I think there could be room for a lot more of that. We need the education of parents, as well as children; more programs in our primary schools; changes in school curriculum, perhaps changes in physical education curriculum; education from doctors.... Perhaps we can produce kits that physicians can give to patients, although from talking to many physicians, I know they are less than optimistic about a patient's ability to make dietary and lifestyle changes. The figures are that about 10% to 15% actually work. I know in adults that's certainly the case, and then they come looking for their dyslipidemia medication.

My God, 20 hours of screen time a week, and I'm guilty of perhaps almost as much. What can we do to turn off that television or video game and get the kids outside to play?

I leave you the remaining time. What are the two biggest things that we can do to reverse this very worrisome trend?

● (1235)

The Chair: I think you have the picture. You have a minute and a half.

Dr. Diane T. Finegood: I would say the two biggest things are to have both a top-down and a bottom-up approach. On the top-down approach, the kinds of actions we could take that would have a huge impact would be related to regulating advertising to children on television. I think there are good estimates to show that could have a huge impact on behaviour.

And the bottom-up approach needs to be where we seed communities to undertake their own actions that are going to work within those communities, and we provide them the tools to measure the effectiveness of those activities so that they know and can do it better as they move along in the future.

Mr. Dave Batters: Does anybody else wish to comment?

Ms. Sally Brown: We agree with those.

Probably at the top of our list we would have put school policies as an immediate hit, and that includes food available at the schools, physical activity in the schools and after the schools, and education and incentives around a healthier lifestyle. So we would say school policies would be the best place to start.

Mr. Dave Batters: Do I have more time, Mr. Chair?

The Chair: Not for another question, but if there are more responses we'll hear them.

Ms. Francy Pillo-Blocka: I agree with what's been said already, but keep in mind two things. The equation has to do with food and it has to do with activity, and not just with one of these. Whatever we're doing has to keep those things in mind, because they're parts of the energy balance.

The Chair: Peter.

Dr. Peter T. Katzmarzyk: I'd like to add to those comments and say, regarding a healthy school environment, that it's just criminal that we're sitting around debating the merits of physical activity or healthy diets in the schools and there are people up in arms about the government getting in their faces. The amount of physical activity that's going on in the schools is just criminal.

A voice: Or that's not going on.

The Chair: Thank you very much.

Stephen.

Mr. Stephen Samis: One thing the federal government can do—it's the sole jurisdiction of the federal government—is to improve our data infrastructure and invest the money we need for a lifelong cohort study, so that we can understand health outcomes and factors that influence us over a lifetime for different kinds of communities.

The Chair: Ms. Davidson, you have five minutes.

Mrs. Patricia Davidson (Sarnia—Lambton, CPC): Thanks, Mr. Chairman, and my thanks to all of the presenters today. It has certainly been extremely interesting, and we've received a tremendous amount of good data, I think.

I have a couple of comments to make, and I go back to Dr. Finegood's presentation. In slide 4 we see that the funding has increased four to five times over the years, but obesity is still increasing by leaps and bounds. So even though we are funding at an increased rate, we don't see results from it.

Then on slide 15 you say we need to be measuring effectiveness in the field. I look at those two things. Then, when Peter was speaking he said, if I heard him correctly, he'd been working for 15 years on this issue of obesity. I think we're all starting to recognize that childhood obesity is a worldwide epidemic, and you said, I believe, that Canada was the fifth-worst in the world for the numbers, and that even though adult numbers are rising for obesity, we're seeing huge leaps and bounds in childhood obesity, that it's increasing far more rapidly in children.

You've pointed out the anomalies from eastern Canada and said we need to do a study on those, and you spoke of the $1.6 billion in costs directly to the health care system and the $2.3 billion indirectly —huge, phenomenal amounts of dollars that are going towards this for health costs.

I guess my question, to whoever wants to address it, is, do we not have any measurements in place? You're saying on one hand that things need to be measured, but we're hearing from everybody that although funding has increased, the results are not there to reflect the increase in funding. So are we using any measurements, are they incorrect measurements, or do we just not have measurements at this point?

● (1240)

Dr. Diane T. Finegood: It's a big question. Let me make a few comments in response. One is that the funding you saw on page 4 is for all obesity research, everything from trying to understand the genes that play a role in determining obesity to working with communities in ways that will help communities to find approaches that work for them and to understand whether the approaches work. So it's the sum total, and it's far too little, given the size of the problem.

There's a long delay between when one starts research and when you get the results and then when their impact actually happens. One of the biggest issues, really, is to close the gap between knowledge development and knowledge transfer. That's something I go back to; that when you work with communities that are trying to develop programs, you are really communicating and transferring knowledge. In those bar graphs, there are even grants that Dr. Katzmarzyk has gotten from us to help us understand the magnitude of the problem. His work isn't necessarily going to solve the problem; it's going to bring it to your attention first, and then we have to work with communities and community groups and in partnership with our other health portfolio partners to ensure that when we seed communities with health promotion funding they actually are understanding the impact of their activities.

Does that address your question adequately?

Mrs. Patricia Davidson: Yes, thank you.

Ms. Sally Brown: As Dr. Finegood said, there are various types of research. One area in which we don't do a lot of it and should be doing more is what I'll call intervention research, so that when we make a change in a community, we research it. A lot of the research is telling us why we should be doing things, what the basis of the actions is. We're not doing enough research in Canada on what works. When you implement a change in a community, the requirement should be almost, if it's government-funded, that money be set aside to research the success of that intervention, so that if it succeeds it can be applied and if it doesn't we won't waste our money applying that intervention in other communities when there's no evidence it works. We can do more of that kind of research in Canada.

The Chair: Stephen.

Mr. Stephen Samis: I would also add that much of the research that has been funded is still relatively recent research, which Diane pointed out, and the huge spike in research is still relatively new. Some of the research is ongoing.

I think many of the things that we've talked about here today in terms of the environmental issues around obesity and the school situation, with soft drinks in schools, etc., have been brought to our attention through some of the research that's been funded. It is starting to have an impact on policy. As Sally said, we now have to really measure the interventions of those policies that take place.

A lot of the research that has come forward has started to describe the problem. Policy makers are starting to act. Our data infrastructure in the country is such that we are only really able to do descriptive research. It's very difficult for us to get at a lot of the processes under way, given the limited data sources we have.

Mrs. Patricia Davidson: Thank you.

The Chair: Mr. Dykstra.

Mr. Rick Dykstra (St. Catharines, CPC): Thank you, Mr. Chair.

I have a couple of things.

It's actually been fascinating to listen. Thank you very much for your presentations. It certainly helps.

From one of the things you mentioned, Peter, I get the impression that we're making progress from an adult perspective with respect to the issue, but not with our children. I don't know how you can explain it, but it seems to me to be a dichotomy.

I know that if we're eating healthy food in our household, our children are eating healthy food. I'm trying to understand why there isn't a positive relationship among adults eating healthier and children not doing so. Maybe it has to do with physical activity, but I'd appreciate a clarification.

Dr. Peter T. Katzmarzyk: No, there is certainly a strong relationship. There's a strong family resemblance in diet and physical activity, not only genetically but in the shared household environment. We really have to start at home for that type of thing. There's definitely a high degree of correlation, but we don't know about the health care costs for kids.

● (1245)

Mr. Rick Dykstra: Right, the impact of it.

Stephen, you mentioned the fact that you've been coming to the committee for about four years and asking for an implementation of the strategy. I thought it was a pretty fair and bold statement. Could you follow up on why you think that's the case?

Mr. Stephen Samis: Why I think that's the case?

Mr. Rick Dykstra: Yes.

Mr. Stephen Samis: That's a good question; it's a very good question.

Sometimes the wheels of government turn slowly and sometimes they can turn very quickly. It really depends on the issue.

This should be given a high priority by the government. I know we've had a commitment to it for four years now. I think the government has had some difficulty trying to figure out how best to do it, partly because of the complexity of the issues. One of the things Diane mentioned about complexity is that it can create paralysis.

How do you tackle this thing? Our response would be that we have some ideas, work with us, and let's do it.

Mr. Rick Dykstra: Okay. I have one other question.

You've all touched on the fact that if children are going to eat more healthily and eat healthier food, the potential of subsidizing that or finding a way to subsidize it makes the cost of junk food more expensive than the cost of good food.

From a government perspective, one of the issues we face within the ministry of agriculture is on the difficulties we have in terms of subsidization and what that means from an international perspective and maybe from a more global perspective. I'm not trying to make this into a bigger issue than it is, but it has a significant impact in terms of how we might address that.

One, what have you done in terms of working with the ministry of agriculture to understand that? Two, on the implementation of said strategy, how would it work from a more global perspective without putting us into conflict?

Dr. Diane T. Finegood: I've been thinking about and working on this problem for four or five years. I'd say it's only been within the last six to eight months that agriculture has really got it on their radar. Over the last six months, I've been to quite a few meetings with people in industry, from farm gate to dinner plate, if you will, and in government, both nationally and locally, to discuss this. It's now on their radar.

We're doing whatever we can to help educate them on the issues that we talked to you about today and to work with in close connection with them to ensure that—again, from my point of view, it's the research issue—we bring evidence to the table and that, whatever they do, they do it in a way in which we understand the impact of it.

Ms. Sally Brown: If I might just add to that, both Diane and I were recently involved in an initiative being led by the agri-food institute to bring the four departments—Public Health Agency, Health Canada, Agriculture Canada, and the CFIA—together to talk about how we can change food policy and at the same time benefit our agriculture policy. We need that sort of coming together of the various interests. There are going to be a lot of issues around that table, but if that discussion moves forward, it will have the potential to bring all the players to the table who need to be there.

Mr. Rick Dykstra: Okay, thank you.

The Chair: Thank you very much. We have one more questioner.

Ms. Keeper, do you have a short question?

Ms. Tina Keeper: Thank you.

I'd like to pick up on what Rick was asking about, regarding the impact on our children over this period of time. We look at the numbers from the 1970s until now and how drastic a change there has been in them. I'm just wondering, Diane or Peter, whether you have worked with sociologists to track trends of how our culture is changing, and the impacts of globalization and marketing, which you've talked about a lot.

On the other side of the equation are the anorexia and bulimia eating disorders, which have also drastically risen, I'm sure, since the 1970s. Are these trends, which have an impact on our health, marked by a shift in our culture over the last 25 years? I'm just wondering if you could comment on that a little bit.

Dr. Diane T. Finegood: What I would say is that the creation of CIHR was a great vehicle to allow us to engage a much broader range of researchers. As a result of that, some of the funds that you see in that bar chart are going to people who come from sociology departments, who are interested in behavioural aspects. There are people who come from economic departments and business schools, and places like that. So by shifting the playing field to one in which we're engaging all people who are relevant to health research, we're going down the road, but I will say that it's going to take some time to engage more players, and also to build the capacity for that kind of work. That's a good first step, but it's really just a first step.

● (1250)

Ms. Tina Keeper: I was thinking as Rick was talking—and I think Dave talked about the amount of television or screen time—that when I was a kid, we had one channel. Just the level of availability of everything requires sort of a push back. And you were talking in terms of policy development. I think the Quebec model is a really excellent example of that.

Dr. Diane T. Finegood: Unfortunately, we don't actually know the impact of Quebec's decision to do that 15 or 20 years ago in any really serious way. There's no real causal linkage, because the research wasn't done when that policy change was implemented. So when we implement policy, we absolutely must have our systems in place so that researchers can come to the table and understand the impact of it.

The Chair: Thank you very much. Ms. Keeper certainly doesn't look to be of an age that would remember a time when there was only one television station.

Our questioning is over. I just have one short comment to make. I like the Quebec model. I see that, but I also notice that Alberta has the least amount of obesity of the provinces. That actually surprises me a little bit, but nonetheless, it's something to take note of.

I want to thank you all for being here. You've given the committee a tremendous amount to consider as far as whether or not to proceed with something significant on this issue. My suspicion is that this is something we would want to pursue. Thank you very much.

The meeting is adjourned.

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