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Thursday, September 21, 2006

Chair

Mr. Rob Merrifield

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● (1535)

[*English*]

The Chair (Mr. Rob Merrifield (Yellowhead, CPC)): Seeing that we have a quorum and that it's just past the time to start the meeting, we will call the meeting to order at 3:35 instead of 3:30.

I want to welcome our witnesses and the department for coming out and starting us on this very important study on childhood obesity. Just to let the committee members know, we're into a study on obesity.

I notice on the side we usually bring in snacks, and we have fresh fruit and cookies. I'm not so sure the cookies should stay. I know, Mr. Batters, that will bite a little, but maybe we should lead by example. We'll be watching to see how many cookies disappear at these meetings.

At any rate, we have a very important issue that has impacted many Canadians, and we're very intrigued with what our witnesses have to say as we move on to this study.

To let everyone know, committee members as well, we have with us Dr. Finegood from the Canadian Institutes of Health Research.

It's good to have you back. I understand we heard from you last spring and you're to answer any questions.

We'll move right to our presenters and start with the Public Health Agency of Canada, Gregory Taylor.

Maybe I'll introduce all of the presenters first and then we'll start with the presentations.

We have, from the Department of Health, Mary Bush, Kathy Langlois, and Janet Beauvais; and Debra Bryanton from the Canadian Food Inspection Agency. That's our panel for this afternoon.

We'll start with the Public Health Agency.

Gregory Taylor, the floor is yours.

Dr. Gregory Taylor (Acting Director General, Centre For Chronic Disease Prevention and Control, Public Health Agency of Canada): Thank you, Mr. Chair.

I'm pleased to be here today to discuss childhood obesity. Let me start by passing on the regrets of our Chief Public Health Officer, Dr. David Butler-Jones, who could not be here today due to illness. This is an important issue to him personally. I'll be representing the Chief Public Health Officer today in my capacity as director general of the Public Health Agency's Centre for Chronic Disease Prevention and Control.

I know that during your meeting last June, committee members identified childhood obesity as a key issue that required long-term study this fall. This is important work. The World Health Organization has declared obesity to be a global epidemic. In Canada, childhood obesity rates have almost tripled over the past 25 years. The health portfolio recognizes that answers to these increasing rates lie beyond the scope of individual Canadians, any one level of government, or any one sector of society. Changes can only come through collaboration with partners in such diverse areas as built environment and targeted prevention activities, in addition to providing increased access to healthy eating options and physical activity.

It will be important for governments and society to reflect on all the tools and mechanisms we posses to determine our direction forward. Today's session is an important step toward strengthening, understanding, and moving ahead in this area. This will involve taking stock of what the evidence tells us about childhood obesity, what work we have under way and can build on, and then developing recommendations on our next steps.

I want to provide you with some broad considerations to reflect on in these areas. This may help launch your discussions and provide a starting point for focusing on questions you plan to probe in greater depth.

I have mentioned that obesity is increasingly prevalent in Canada, with the most dramatic increases reported in children. This increase during recent years is likely a result of both an upward shift in energy intake—people are eating more—and a downward shift in energy expenditure; in other words, people are moving less. Obesity that begins in childhood is particularly troublesome, since the longer a person is obese, the greater the health risk.

There have also been a number of environmental changes over the past years that are considered key influences on childhood obesity—for example, dramatic increases in the availability of fast foods, which are often poor in nutrition and energy dense, or high caloric; larger portion sizes; environments that do not support physical activity; and the increase in leisure and passive leisure activities such as television, Internet, and video games.

Today there are a number of social and cultural factors that impact our own lives and those of our children. Many things that we now accept as a normal way of life, such as driving instead of walking, and eating take-out food instead of a home-cooked meal, may be contributing to growing levels of the early onset of childhood obesity.

Children are also particularly vulnerable to environmental conditions, such as reductions in school physical activity programs, food and video computer game advertising that now targets kids specifically, and choices within the home environment. We also know that ethnic racial groups vary in the prevalence of obesity. Some of Canada's most profound challenges in obesity lie within our aboriginal communities. The obesity rates for adults and children in Canada is estimated to be the highest among aboriginal peoples, followed by Caucasian, black, and Latin American populations.

Given the evidence we have accumulated to date, what have we done to address childhood obesity? Over the past few years the health portfolio, including the Public Health Agency of Canada, Health Canada, the Canadian Institutes of Health Research, and other federal departments such as the Canadian Food Inspection Agency, have developed a number of initiatives in partnership with provincial and territorial governments; other federal departments; first nations, Inuit, and Métis communities; and non-government organizations.

I want to highlight some of these initiatives for you. First there is the pan-Canadian healthy living strategy that was approved by the federal-provincial-territorial governments in October 2005. As part of the strategy, governments agreed to important targets to help support Canadians in achieving healthy weights through physical activity and healthy eating. There is also the work of the joint consortium for school health, which was created in a partnership with federal-provincial-territorial ministers of health and education to provide a coordinated approach to school health. The joint consortium develops tools to assist in the development of programs, policies, and best practices that will improve the overall health of young people and address specific issues and risk factors such as healthy eating and physical activity.

The health portfolio has been active on the research front as well. Through the Canadian Institutes of Health Research, specifically the Institute of Nutrition, Metabolism and Diabetes, the Institute of Human Development, Child and Youth Health, and the Institute of Aboriginal Peoples' Health, approximately $63 million has been invested in obesity research. In fact, the Institute of Nutrition, Metabolism and Diabetes has made obesity its single strategic priority. Of the $63 million, $9 million has been specifically directed toward new projects to address the problem of childhood obesity and $4.1 million to research obesity in aboriginal populations. The knowledge generated by these projects will help to assess and identify the most effective interventions and prevention strategy for obesity and provide evidence for sound policy decisions.

● (1540)

Some of the studies specific to youth have focused on understanding the challenges that children believe make it difficult to manage their weight in school, out of school, and in the family home and on developing improved methods for assessing obesity in children and adolescents. Health portfolio members have also developed and promoted national guidelines for physical activity and healthy eating to assist Canadians in their efforts to be physically active and to make healthy food choices.

The Public Health Agency published “Canada's Physical Activity Guide to Healthy Active Living”, which targets both adults and children. The guide explains how to achieve better health by making physical activity an important part of daily living. For example, it provides strength, flexibility, and endurance activities that can help Canadians have more energy, move more easily, and get stronger.

Health Canada has developed guidelines for healthy eating, including “Canada's Food Guide to Healthy Eating”. These guidelines underpin nutrition and health policies, standards, programs, services, and other nutrition initiatives across the country. “Canada's Food Guide to Healthy Eating” is currently under revision, and the release of the updated food guide is planned for late 2006 or early 2007.

We have also undertaken work to address this issue through program development and implementation, research initiatives, and public education. Likewise, provincial and territorial governments are putting into place policies and programs to address this concern. But since childhood obesity rates continue to rise, there is a growing consensus across Canadian society that more needs to be done.

As Canada is one of the member states that have adopted the World Health Organization's global strategy on diet, physical activity and health, we remain committed to improving public health through healthy eating and physical activity. The health portfolio remains committed in particular to addressing childhood obesity and to working in partnership with all sectors to develop effective and appropriate actions and interventions.

We look forward to the results of your study and to your recommendations for actions. These will become focal points for future work in this important area.

Thank you.

● (1545)

The Chair: Thank you very much.

We'll now go to the Department of Health.

Mary Bush.

Ms. Mary Bush (Director General, Health Products and Food Branch, Office of Nutrition Policy and Promotion, Department of Health): Thank you.

I'm here in my capacity as the director general of the Office of Nutrition Policy and Promotion.

As you know, healthy eating and physical activity play a very important role in promoting healthy weights and reducing the risk of obesity and overweight.

[*Translation*]

The issues related to obesity are an important consideration in the work that we do, including, of course, the revision of Canada's Food Guide.

[*English*]

The new food guide will in fact provide much more precise guidance about the amount of food from each food group that is appropriate for Canadians two years old and over. The guidance will be age and sex specific so that there will be no guessing, if you're of a particular age or sex, about how much food you need to consume.

More specific guidance will be given on the types of foods to choose and limit. For the first time, Health Canada is developing, with its partners, a tailored version of the food guide specific to first nations, Métis, and Inuit. In order for the guide to be an effective tool for aboriginal people, it's being tailored to specific audiences. Key messages in this tailored guide will promote eating that recognizes the importance of traditional and non-traditional foods in the diets of first nations, Inuit, and Métis consumers today.

The dietary pattern in the food guide is designed to encourage food choices that are relatively low in calories. While the food guide contains an important policy—it defines healthy eating—it is only one element within a broader comprehensive strategy needed to improve nutritional health and well-being.

Dr. Taylor referred to some national and international strategies such as the WHO's global strategy on diet, physical activity and health, the pan-Canadian healthy living strategy, and some of the initiatives that have evolved, such as the joint consortium for school health. We work very closely to ensure that nutrition and healthy eating components are being looked at. Comprehensive action by all sectors and at all levels is needed. We need policy, evidence, leadership, capacity, and information.

A comprehensive review of the literature published in the supplement to the *Canadian Journal of Public Health* last year on the determinants of healthy eating has confirmed the need to understand the broad factors that influence eating. It is clear that Canadians are eating too many calories for their current inadequate levels of activity. Food is everywhere. Time pressures faced by families have changed the way Canadians are eating. For the first time in 35 years, we now have national data on what Canadians are eating.

We're working closely with Statistics Canada and the Canadian Institutes of Health Research to build capacity and research opportunities using these new data. Research from these data will provide valuable insights not only into what Canadian adults and children are eating, but also into the underlying factors, such as income, that influence eating patterns.

Information and public education are components of a comprehensive strategy. Education on the use of nutritional labelling, and information on what healthy eating is, contained in such tools as the food guide, are key examples.

Action to improve nutrition is a shared responsibility, so collaboration with partners in all sectors and at all levels, including provinces, territories, health, agriculture, education, and social services are all fundamental. Canada is making important strides. It's gratifying to witness the growing prevalence of healthy offerings in schools, on restaurant menus, on grocery shelves, and at breaks in meetings such as this.

Canadians live in an environment that poses unprecedented challenges to the goal of healthy eating. We need to create the social, physical, and economic environments that will support healthy eating and make it possible.

We look forward to the outcomes of your study and the contribution it will make to future actions that are aimed at childhood obesity. Your work is critical.

Thank you.

● (1550)

The Chair: Thank you very much.

I don't know if it's a sobering thought or a good thought that government now knows exactly what I'm eating. I'll think about that a little while as we take our next witness. Kathy, I think you're up.

[*Translation*]

Ms. Kathy Langlois (Director General, Community Programs Directorate, First Nations and Inuit Health Branch, Department of Health): Mr. Chairman and honourable members, my name is Kathy Langlois. I am the Director General of Community Programs, in Health Canada's First Nations and Inuit Health Branch.

Thank you for inviting me today to highlight some of the issues related to overweight and obesity among Canadian First Nations and Inuit children, and to answer your questions.

[*English*]

There are good data on the extent of overweight and obesity among the Canadian population. However, it is difficult to be exact on the scope of the problem of overweight and obesity among first nations and Inuit children because we do not have the type of population-wide representative data for these children that we have for other Canadian children.

What we do know from the first nations regional health survey, and from other studies that have taken place, is that approximately 22% of first nations children living on reserve are overweight, while a further 36% are estimated to be obese.

At the same time, while we suspect that rates of overweight and obesity among Inuit children are rising, we have even less information on this population. Inuit have indicated that the current body mass index or BMI does not accurately measure overweight or obesity among their people because of their different body types.

Inuit leaders have proposed the development of an index established on Inuit norms. Until we have this information, it is difficult to provide an accurate picture of overweight or obesity among Inuit children.

In summary, however, indications are that rates of obesity among first nations are two to three times higher than the Canadian average. This is consistent with the rate of diabetes, which is three to five times higher than the Canadian average.

[*Translation*]

The causes of obesity and overall poor health among First Nations and the Inuit are complex—the results of a combination of historical, economic, and social factors. Understanding these determinants of health enables a more effective approach to the issues and needed interventions.

[*English*]

Poverty, income, and food insecurity—meaning access to healthy food—can present obstacles to achieving health, including healthy weights, and very real day-to-day problems for first nations and Inuit.

Low income, high cost, and lack of availability of fresh and healthy foods, especially in remote and isolated communities, contribute to the growing trend of overweight and obesity.

Awareness skills and behaviours are important tools by which individuals can impact their health, and in particular their weight. Awareness of healthy eating habits and food preparation are necessary to promoting overall nutrition and healthy weights. Understanding and adhering to nutritional guidelines and recommendations described on food labels and other educational materials are also important.

Supportive environments that encourage healthy lifestyle choices and make healthy choices the easy choices are ones in which there are healthy food choices in schools; where smoking rates are significantly decreased; and where there is strong mental wellness, including healing from the legacy of residential schools, addictions, and substance abuse.

Families living in remote or isolated communities also have limited recreational opportunities. For many communities there are basic gaps in infrastructure, such as sidewalks, which means motorized vehicles are used exclusively.

First nations and Inuit children are also not immune to the current reality faced by other Canadian children, such as reductions in school physical activity programs, easy access to junk food, video computer games, and sedentary lifestyle habits within the home environment.

There has been a loss of culture, traditional knowledge, and practices. For example, traditional harvesting, such as hunting and fishing, which is a source of physical activity, a source of cultural wellness, as well as a source of nutritious food, is diminished. The causes of this are complex, but the outcome has contributed greatly to the rates of overweight and obesity among first nations and Inuit today.

Traditional indigenous diets were nutritious and health-promoting. In general, they were low in fat, rich in protein and in complex carbohydrates. Today the diet of indigenous populations is often not adequate for good health, and the diet is typically high in fat and in simple carbohydrates, sugars, and salt.

It's also important to note that there are concerns about environmental contamination and its impact in revitalizing traditional food sources.

We also know that the issue of overweight and obesity among first nations and Inuit children is not just an issue in Canada. Lifestyle and dietary changes have occurred among indigenous populations around the world.

These factors are all direct contributors to the growing problem of childhood obesity among first nations and Inuit. The health system has one of the key levers for success; however, there are other levers, including the food industry, regulatory bodies, and the education, economic development, housing, and environment sectors. A lasting solution, therefore, requires the engagement of multiple groups, governments, and individuals.

● (1555)

While increased education and employment opportunities, as well as improved infrastructure within communities, are very important, Health Canada is also taking a more active role in preventing childhood obesity in several key areas. These include culturally appropriate strategies to promote healthy choices around physical activity and food, and supporting policies that result in the availability of healthy foods at a reasonable cost.

The Department of Indian and Northern Affairs plays a key role in providing social and other services for first nations and Inuit children. These services are key to the determinants of health. The committee may find that it would be of benefit to hear from a departmental representative on their activities.

It is important to note that First Nations and Inuit Health Branch works in close partnership with the Assembly of First Nations and the Inuit Tapiriit Kanatami to promote and protect the health of first nations and Inuit. Issues around childhood obesity and food security specifically are of shared interest. It may also be of interest to the committee to hear from these organizations.

[*Translation*]

Before I conclude, I will briefly outline the federal responsibilities in current programs for First Nations and Inuit children.

The federal government provides some health services to status “Indians” and Inuit on the basis of policy and historical practices, and supports the provincial and territorial governments to provide health services to all Canadians including aboriginal peoples.

The federal policy is based on a recognition that the Canadian health system has been and continues to be an interdependent system of responsibilities shared by the federal government, provincial and territorial governments, communities and health practitioners.

The current role of the federal government in providing health services to First Nations and Inuit is based on the 1979 Indian Health Policy which established the policy framework for subsequent federal programs and expenditures.

[*English*]

The First Nations and Inuit Health Branch supports community-based health promotion and health protection services on first nations reserves and in Inuit communities, as well as primary health care in remote and isolated first nations communities. These programs and services are delivered at the national, regional, and community levels and are managed in collaboration with first nations and Inuit.

The branch funds a number of programs that contribute to the prevention of childhood obesity. In brief there's the aboriginal diabetes initiative, which funds obesity prevention projects for children, including healthy school policies that emphasize healthy snacks, and children's camps that focus on preventing obesity through promotion of healthy lifestyles. Many of the diabetes prevention projects in communities target youth, and funding has been provided for research on lifestyle interventions that specifically reach children.

The aboriginal head start on reserve program promotes healthy physical activity and nutrition with children ages 0 to 6, while strengthening connections with first nations culture and language. The goal is to support early childhood development strategies that are designed and controlled by first nations communities. These include a focus on healthy diet and physical activity.

We also have the Canada prenatal nutrition program and our new maternal child health program. They aim to prevent childhood obesity by providing parents with the information, resources, and support they need to care for their children and themselves.

A number of activities to improve food security in first nations and Inuit communities are taking place. We're working together with the Assembly of First Nations and the Inuit Tapiriit Kanatami to develop a framework for implementing effective food security interventions. We're also working on a joint venture with retailers in the north that will increase the availability and accessibility of healthy store foods.

As well, as Mary has mentioned, we are involved in tailoring Canada's food guide to the needs and considerations of first nations, Inuit, and Métis. We know this resource will recognize the cultural, spiritual, and physical importance of traditional foods, while recognizing the role of non-traditional foods and contemporary diets.

● (1600)

[*Translation*]

I believe that the work this committee is undertaking will be of great value to First Nations and Inuit, and to Health Canada in terms of informing future program and policy development.

Thank you.

[*English*]

The Chair: Thank you very much.

We'll now move on to Janet.

Ms. Janet Beauvais (Director General, Health Products and Food Branch, Food Directorate, Department of Health): Thank you, Mr. Chairman.

My name is Janet Beauvais, and I'm the director general of the food directorate at Health Canada.

I'm very pleased to be here today as you begin your study of childhood obesity.

Let me begin by saying that the food directorate, as part of the Health Products and Food Branch, plays an important role in maintaining the safety and nutritional quality of Canada's food supply. We are responsible for establishing policies and standards relating to the safety and nutritional quality of food, as well as health and safety-related labelling and advertising of food sold in Canada. The CFIA is responsible for enforcing these policies and standards.

One of the key activities highlighted by the World Health Organization's global health strategy on diet, physical activity and health was nutrition labelling. According to the strategy, national governments should provide accurate, standardized, and comprehensible information to allow consumers to make healthy choices. Mr. Chair, I'm pleased to say that Health Canada published nutrition labelling regulations in 2003, after an extensive five-year consultation period. These regulations, which require that calories and the content of 13 core nutrients be listed on labels for most pre-packaged foods, came into effect on December 12, 2005.

The regulations require that this information about the caloric value and the nutrient content of a food be conveyed in a standardized format known as the nutritions facts table, which is easy to find and read on a label. The caloric value is the first item listed in this table. It was envisioned that the provision of information would not only help consumers make healthier food choices but would also act as an incentive for the food industry to produce healthier products. Evidence is mounting that this intended effect is taking place. For example, since the requirement to list trans fat became mandatory under the new regulation, a number of food companies have reformulated their products to remove trans fat.

The regulations also contain requirements for the use of over 40 nutrient content claims. These claims indicate, for example, that a food is calorie reduced; it must have 25% fewer calories than a comparable food. These claims are another tool that help Canadians choose a healthier diet and in turn encourage the food industry to innovate and develop products that, for example, are lower in calories, sodium, saturated fat, and trans fat.

Mr. Chair, I would also like to mention that Health Canada has been encouraging the Canadian restaurant industry, which is not subject to these requirements, to provide nutrition information to consumers. In February of last year, the Canadian Restaurant and Foodservices Association launched a voluntary nutrition information program that will see participating restaurants provide consumers with nutrient values that are consistent with the core nutrient label information currently required for packaged goods. Since the launch of the nutrition information program, more than 25 restaurant chains, representing about 40% of all chain establishments, have signed on to this program.

Let me conclude by saying that the mandatory nutritions fact table, in addition to nutrient content claims and the nutrition information provided in major restaurant chains, combined with education on their use, offers a significant public health opportunity to improve the nutritional health and well-being of Canadians. This information helps consumers make healthy food choices to reduce their risk of developing chronic diseases and conditions such as obesity by enabling them to compare products more easily, determine the nutritional value of foods, and better manage special diets related to chronic disease.

We look forward to the results of your study and any recommendations for action that will assist us in creating an environment that supports all Canadians in achieving healthy body weights.

Thank you.

● (1605)

The Chair: Thank you.

We'll move on to our last presenter, the Canadian Food Inspection Agency, Debra Bryanton.

The floor is yours.

Ms. Debra Bryanton (Executive Director, Food Safety, Canadian Food Inspection Agency): Thank you, Mr. Chair.

Thank you for the opportunity to appear before the committee in its examination of childhood obesity. The committee is certainly to be commended for taking on such an important topic.

My name is Debra Bryanton and I'm the executive director of the food safety directorate with the Canadian Food Inspection Agency.

As the committee is aware, the CFIA is mandated to safeguard Canada's food supply and the animals and plants upon which safe, high-quality food depends. The CFIA verifies compliance with some 13 federal acts and their respective regulations, including the Food and Drugs Act. The agency works in partnership with other stakeholders to carry out this mandate. Our more important partners are, of course, Health Canada and its portfolio organizations.

The CFIA is committed to serving Canadians by providing protection from preventable health risks, delivery of a fair and effective regulatory regime, sustaining the animal and plant resource base, and promoting the security of Canada's food supply.

With the growing public awareness about the relationship between food choice and health and access to a wide range of information, Canadian consumers are becoming more sophisticated in their food nutrition choices. Information on labels can assist consumers in making healthier choices, adapting their diet to specific needs, and in handling their food safely. Collectively, this contributes to the overall health of the Canadian public.

As noted by Janet Beauvais, the food and drug regulations were amended on January 1, 2003, to require a nutrition facts table on the label of most pre-packaged foods. The new nutrition labelling regulations became mandatory for large companies as of December 12, 2005, and will be mandatory for small companies by December 12, 2007. I must also note that due to the fact that many small companies do supply larger companies, many have already moved ahead with their nutrition information on their labels. The CFIA is responsible for enforcing the implementation of these regulations, and as we approach the end of the first year since the regulations came into effect for large companies, we are happy to report that industry has responded well to the regulatory requirements.

CFIA has taken a staged approach to the implementation of the regulations. In partnership with Health Canada, an industry education program was undertaken providing tools and educational material to assist industry in their efforts to comply with the new regulations.

The CFIA has also developed tools for stakeholders to help facilitate compliance and assist in applying the regulations. This includes, for example, the publication of a guide for food labelling and advertising. This provides policy advice and basic ground rules with respect to labelling and claims. There is also the publication of a nutrition labelling toolkit that provides guidance on the interpretation of nutrition labelling requirements under the food and drug regulations. We will continue to work with stakeholders through responding to their inquiries and providing presentations at industry meetings and seminars at their request, again to promote understanding and compliance.

Childhood obesity is one of the many health issues directly affected by consumer choice in food and nutrition. Public awareness on this issue is growing. No doubt consumers will make choices based in part on the information highlighted on product labels.

CFIA's role relating to the issue of childhood obesity is complementary to the ones of our federal health partners, Health Canada, the Canadian Institutes of Health Research, and the Public Health Agency of Canada. We support and will continue to support our health partners in tackling this issue and other public health concerns.

Thank you.

The Chair: Thank you very much for your testimony before the committee.

We'll start our questioning now. I'll start with Ms. Keeper.

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

I would like to thank everybody for their presentations, and please excuse me for being a bit late.

I'll start off with a question, and I'm not sure who wants to take it.

This is a significant issue and it is the reason the committee has decided to undertake this study. Although we've received a lot of information about how problematic this is, the impacts it will have on our children and why it may have happened, I don't get a sense of how long this seems to have been an issue. I looked at the revision of the Canada health guide and the food guide was last revised in 1992. In 1992, was this a significant issue? How recent is the issue of childhood obesity at this crisis level in Canada?

● (1610)

Dr. Gregory Taylor: I can start that response.

It's been on the horizon and on the radar for quite some time, but we haven't had really good, accurate data until recently. Part of the data that tells us what's going on has been self-reported data, until just 2004, when the Canadian community health survey, which was done by Stats Canada, actually measured people's height and weight.

We were quite complacent in thinking that the Americans were way more obese than us because it was based on self-reported data. What we found out was that men consistently overestimate their height and women consistently underestimate their weight.

Ms. Tina Keeper: I always say that—they overestimate their height.

Dr. Gregory Taylor: Well, we have proof of that now.

So when you actually measured people and measured children, the rates were much higher. That doesn't mean it wasn't on the radar scope, but it really does mean that the problems were worse than we anticipated.

As well, it's been particularly difficult in the aboriginal communities to get good, solid data.

Did you want to speak to that, Kathy?

Ms. Kathy Langlois: I think I commented on that in my opening remarks, that we don't have the kind of population-level representative data that we would need. We are aware that first nations are looking at a public health surveillance approach, and we're interested in working with them on that.

Ms. Tina Keeper: And specifically the regional health surveys, then, gave you some data?

Ms. Kathy Langlois: Yes, they did.

Ms. Tina Keeper: And you did mention that from that you gathered there was an issue that actually is an even greater crisis than Canadian children.

Ms. Kathy Langlois: That's correct.

Ms. Tina Keeper: Your sense was that it was about two to three times....

Can I also quickly ask...you mentioned it's approximately 22%, but overweight and obesity rates might be at about 36%. So the obesity rate includes that 22%. We're not talking about half or over 50% here, are we?

Ms. Kathy Langlois: My understanding is that they're additive, that's correct. So it's 22% overweight and 36% obese.

Ms. Tina Keeper: So we're talking about over 50% of aboriginals...and this would be first nations, right, in the regional health—

Ms. Kathy Langlois: This is the first nations, yes.

Ms. Tina Keeper: So over 50% are dealing with a weight issue, 36% with obesity.

Ms. Kathy Langlois: Correct.

Ms. Tina Keeper: I want to ask you one more question. You said you received this data in 2004 and that there had been the thought that in Canada we weren't at the levels of our counterparts in North America with a similar lifestyle.

A couple of you mentioned the World Health Organization, that it had a strategy on diet. Is there extensive research in other countries, western nations or developed countries, that we're looking to in terms of what will have a significant impact on obesity rates in children?

Dr. Gregory Taylor: Yes.

I think if you're looking to compare us to other countries, we're quite comparable to other developed countries, which is actually quite worrisome, as developing countries are actually acquiring the same problem. So it's now being thought of as a double burden, meaning that developing countries not only have infectious disease problems, they also have obesity and chronic disease problems at the same time.

We're clearly looking at research in other countries.

Perhaps Dr. Finegood could comment.

Dr. Diane T. Finegood (Scientific Director, Institute of Nutrition, Metabolism and Diabetes): Sure, I'd be happy to comment.

I think your question was more directed toward how to solve the problem—did I understand correctly?—or how big the problem is.

Ms. Tina Keeper: Well, yes. Is there research that can point to really effective strategies?

Dr. Diane T. Finegood: Yes, there are a number of efforts around the world. One I can point to specifically is called the community guide, which is organized by the Centers for Disease Control in the U.S., whose sole purpose is to take the whole bulk of literature that's out there and ask what we can actually learn from that literature about how to intervene.

Particularly on the physical activity side, there's enough data now to know that a number of different kinds of interventions around physical activity actually have an impact on people's behaviour—and this is generically, beyond childhood obesity—for example, things like comprehensive programs; quality daily physical education; point-of-decision prompt, so that when you're at an elevator it says if you take the stairs, you'll actually burn this many more calories.

On the nutrition side, unfortunately, the database is really much weaker, and although there are some good studies that show there are ways to intervene in nutrition in schools and things like that, there isn't enough data yet for that body to actually make strong recommendations about how to intervene. It really speaks to a gap in our understanding about intervention.

So while we know something and we know enough to know that we need to act, one of the really important things is that when we do act we make sure we also learn from those actions in order to be able to feed our understanding in an ongoing way.

● (1615)

Ms. Tina Keeper: Do we have enough data to project where we'll be in five years or ten years if we don't have any effective strategies in place or if we don't take action quickly?

Dr. Diane T. Finegood: Absolutely, and the projections, of course, are always a bit challenging because the world changes over that time. But I think the most striking statistic I've heard is that one in three children born in the year 2000 will develop diabetes in their lifetime, and that's as a consequence of, obviously, growing obesity rates. So that's a very frightening statistic. It doesn't mean that they'll necessarily develop the diabetes as children, but if they develop obesity as children, then it leads to the consequences of that.

Ms. Tina Keeper: And you're specifically talking about type 2 diabetes?

Dr. Diane T. Finegood: Yes, because that's what it's linked to.

Ms. Tina Keeper: Can I also ask about type 2 diabetes amongst children? I know that within the first nations community this is occurring. Do we see that across the board in Canada with children?

Dr. Diane T. Finegood: Yes, but when you look at it from a statistical point of view it doesn't sound very frightening because the numbers are down at 1% or 2%, or something like that. I think it's about 1% across Canada in children. The problem, of course, is that is really the tip of an iceberg, and it's a disease that you shouldn't get, if you're going to get it, until you are 50 or 60 or 70. That is very frightening, because most people with type 2 diabetes, even if they work hard to control their disease, within 15 years or so usually develop the complications of diabetes. So if you have children developing diabetes at age 10 and developing the complications of diabetes at age 25, it's a very frightening prospect for the health system.

There's an excellent researcher in Manitoba who has had a pediatric obesity and diabetes clinic for a number of years. When she went to follow up those children to find out what happened to them after they left her clinic—because she's a pediatrician—many of them were on dialysis and some of them had already died of their disease. It's a very frightening prospect.

Ms. Tina Keeper: Thank you.

Dr. Gregory Taylor: If I may, I believe Mary Bush wanted to comment in answer to your question.

Ms. Mary Bush: I think your question about whether we had some indication of this is a very important one. And I think it's important to flip back not many years, to 2001, when the Institute of Nutrition, Metabolism and Diabetes, Obesity Care Canada, and ourselves held a meeting for two days called “National Dialogue on Healthy Body Weights”. Part of that was to try to peel back and say: What is it that we know? What data do we have? Is it an issue of energy and food being consumed? Is it physical activity? Where are we?

We were truly at an exploration stage.

Data you will hear over and over again has been an issue, but equally an issue is not just having the data, but having a system that someone is analyzing, looking at, reflecting on, and using in an ongoing way. I know Dr. Taylor mentioned that in his opening remarks. That kind of system is part and parcel of what's absolutely essential.

Ms. Tina Keeper: Am I out of time already?

The Chair: You actually are, yes.

Perhaps you can pick it up in the second round.

Christiane Gagnon.

[*Translation*]

Ms. Christiane Gagnon (Québec, BQ): Thank you.

Over the past few days, we have been trying to better understand why there has been an increase in obesity in both the aboriginal and non-aboriginal populations.

I referred to a longitudinal inquiry into the health of the First Nations in the Quebec region. I was struck by certain factors and lifestyles pertaining to the population as a whole, in this case the aboriginal people. Geographical remoteness is a big factor in determining whether one can obtain good information and certain services. The problem of obesity is greater since they are located in regions that are very far away from centres where services and information are available and there is a greater awareness about healthy eating habits.

We have a Food Guide which we are encouraged to consult and we have food labelling, but these things will not result in young people being more physically fit or eating better.

What solutions could we suggest to people who live in remote areas, and here I refer more specifically to the aboriginal people?

● (1620)

Ms. Kathy Langlois: I will refer specifically to aboriginal people in remote regions. I will ask my colleagues to discuss isolated communities in general.

Let me give you an example. We have information about the Nunavik region, which is an Inuit region in northern Quebec. We've set up projects where the indicators are more positive. This relates to the notion of food security/insecurity.

Nunavik has set up programs that apparently help with nutrition. For example, the Fédération des coopératives du Nouveau-Québec operates stores in northern Quebec. Their price policy favours healthy nutrition. Moreover, these communities have a support program for Inuit hunters. That program is part of the land claims. The communities also have community freezers to store the food brought back by the hunters.

[*English*]

The community has access to food in these freezers, and we believe that is a good practice.

[*Translation*]

In this region, pregnant women can obtain Arctic char through our prenatal nutrition program.

[*English*]

Dr. Gregory Taylor: I want to pick up on your comment about labelling not being enough. I think it is very clear that this is one of the many things that must be done. It's not sufficient on its own.

The best comparison that we like to use is tobacco. Canada is a global leader in tobacco reduction, but that's been over many years of sustained investment and multiple interventions. As you've pointed out, no one thing is going to fix it or attack it, but there are multiple interventions. We've tried to give you a flavour here of what we're actually engaging in to try to deal with the problem.

But your point is so right on; no one intervention is actually going to do it.

[*Translation*]

Ms. Christiane Gagnon: There is another aspect that seems to be troublesome. In low income families, it is more difficult to pay for groceries, and these people often pay less for their food. You just have to look at the food in shopping baskets when you go to the grocery store. People who seem less privileged will buy products that cost less and are often on sale.

What steps could we be taking? I know there are incentives, we referred to accounting-related measures. It was mentioned that, for example, we could give a tax credit for healthier food. I don't really like the punitive approach, such as imposing a tax or increasing the price of food that is less healthy.

Could this type of initiative help the less fortunate populations to have access to better nutrition?

[*English*]

The Chair: Your time is done, but I'll allow a quick response.

Dr. Gregory Taylor: Just very quickly, if you're talking about the taxation of junk food, there's been some controversy—that may be a bad word to use—or some evidence that in some situations it does work very well, but it's not as easy as some of the taxation that has existed, such as with tobacco.

I think Mary's area has done a fair bit of work in that area, and I'd like her to comment, if possible.

Ms. Mary Bush: I took your question as being focused very much on those who have limited income and who have difficulty purchasing food that's adequate. You are absolutely right. Our statistics suggest that 6.8% of our population, some 2 million Canadians, live in households with insecure food access due to limited financial resources.

We actually have a tool, called the Nutritious Food Basket, that is used right across Canada by other jurisdictions to cost a basket for healthy eating. It's used as one of the inputs into social service decision points right across the country.

So the issue you touch on is important, and it's important also in terms of what it leads to. You touched on the fact that calories can be cheap when they're high in fat and not always the most nutritious choices, and you're very right.

● (1625)

The Chair: Mr. Fletcher, go ahead, please.

Mr. Steven Fletcher (Charleswood—St. James—Assiniboia, CPC): Thank you, Mr. Chairman.

I found all the presentations excellent. I found particularly interesting Dr. Taylor's comments about people's estimation of themselves. You may be interested to know, Dr. Taylor, if I wasn't always sitting down, that I'd be 10 feet tall.

Voices: Oh, oh!

Mr. Steven Fletcher: This is obviously a very important issue, and this is why we're studying it. I think it would be helpful for us as a committee, as we enter this study, to frame it a little bit more concisely around the areas of financial cost and life expectancy. Those are two quantitative things. There is also the qualitative measurement, or however you would like to describe it, of quality of life for children who are obese versus children who are not obese as they go through life.

So who would like to answer that?

Dr. Gregory Taylor: I could begin.

In the material we provided there's a recent study showing an annual cost of about $4 billion, but I think that's an underestimate. Part of what we're worried about—and where I work our lens is a chronic disease lens—is the kind of disease that obesity is going to lead to, such as diabetes, heart disease, high blood pressure, arthritis, etc. So it's difficult to capture that actual real cost because it needs to be measured over a lifetime of exposure. So from a cost-benefit perspective, I think more work needs to be done. Someone suggested that it is very cost effective to prevent disease before it comes on.

In terms of reduced life expectancy, as you've alluded to, people with diabetes don't live as long. I'm not sure what the case is from an obesity perspective. I don't think the reduced life expectancy applies to people with obesity generally; it's the diseases they get from it that put them at higher risk of that.

Dr. Diane T. Finegood: What I would add to that—and I didn't come with the exact numbers about life expectancy—is that we believe the generation of children being born now and over the recent past are not expected to live as long as their parents. It's the first generation that will come to that.

Mr. Steven Fletcher: What about quality of life of children who are obese versus that of children who are not obese?

Dr. Diane T. Finegood: There's little doubt that there is a lower quality of life. I brought you the statistic last time that illustrated the point with studies that compared the quality of life for children who are obese with that for children who have cancer and who are undergoing chemotherapy. They were about the same.

Mr. Steven Fletcher: Wow!

Those were all my questions.

The Chair: Thank you, Mr. Fletcher.

Omar, you've got five minutes.

Mr. Omar Alghabra (Mississauga—Erindale, Lib.): Thank you, Mr. Chair, and thank you all for coming here today. The committee has accepted this very important task, and your testimony here today and your evidence are going to be very important in shaping the outcome.

My first question is to Dr. Taylor. If you don't mind, since I only have five minutes, I'd like a concise answer because I have a question to follow that is for everybody.

As I mentioned, I want to clarify one of your statements because it might have an impact on the outcome of the study. You alluded to the fact that ethnic and racial groups have a prevalence towards obesity. I'm just curious, is this for cultural or genetic reasons, or is it because of some socio-economic conditions leading some of these ethnic groups to be disproportionately represented?

Dr. Gregory Taylor: I think it's a combination of all those factors. The aboriginal groups are the ones we talked about specifically, but there is a combination of genetic predisposition, ethnocultural types of food they eat, and socio-economic status. There are multiple factors. Is that concise enough?

● (1630)

Mr. Omar Alghabra: It's very concise. I was also hoping we could have some evidence about the socio-economic conditions that have an impact.

Dr. Gregory Taylor: There is evidence. The CCHS, the Canadian community health survey, had very good evidence because they looked at socio-economic status at the same time. Interestingly enough, men in higher income levels actually have higher rates of obesity, which is quite surprising. Women in the middle-income area tend to have the highest rates of obesity. But if you look overall, folks with less than a high school education have higher rates of obesity than folks with more than high school education.

Mr. Omar Alghabra: Thank you.

This is a question for all of you. In order to help us come up with recommendations, I would like each of you to give me three recommendations you would like us to come up with if you were sitting in our seats, because you've shared with us a lot of the work you have been doing—and a lot of it is excellent work—but we want to know what we have to do to move forward.

The Chair: I can see they're all really eager to answer that. We'll just take one at a time.

Dr. Diane T. Finegood: I guess I'll give you the recommendation that I got when I asked the world's authority on pediatric and child obesity, who also works for the U.S. federal government, that exact question: what's the role of a federal government in dealing with this problem?

His response was that the role is to seed the work that needs to go on in local, provincial environments. That's really where the work has to happen, because populations vary by where they live and what their circumstances are. So we need to seed that, but we also need to ensure that as we do that seeding of that activity, we do it in a way such that we learn from it and then we disseminate appropriately that information. That was his recommendation for the role of a federal government, and I think it's completely appropriate.

We don't know enough to blanketly say, “Here are the actions we should take.” So let's take the ones that are the most promising and learn from those actions so that we can do it even better as we continue to go forward.

The Chair: Are there any further responses?

Mr. Omar Alghabra: I hope so.

The Chair: Janet.

Ms. Janet Beauvais: From the perspective of the food directorate, we set standards, policies, and regulations concerning food safety and nutritional quality. We certainly would like to continue monitoring the effectiveness of nutrition labelling regulations. It's a fairly new regulation, not fully implemented, and I think we would like to understand the real impact it's having on helping Canadians make better choices, or are they actually changing their eating patterns in relation to this information? Certainly we'd be interested in understanding evidence to support the development of any other policies or regulations that can support action on childhood obesity.

Ms. Mary Bush: I guess what I would want more than anything else is a recognition that this is a very complex issue. It doesn't ascribe to simple solutions. It needs to be comprehensive in the way you come back. I think there needs to be a very clear indication that this is serious, that this is about resources, this is about resource reallocation within a health system delivery, this is about making sure you have capacity to do what we all talk about, that you have resources to implement things that we've already created in terms of strategies, and that there is a real need to move forward.

I'm always struck that it's very true, when I build on what Diane Finegood said, that you really want to make sure that whatever you do the role of a government is to seed and then make sure we learn from that. We've learned a great deal. I think we could learn a lot from some of the examples that are out there now, such as has happened in Nova Scotia—comprehensive school intervention, robust research. Out of that comes reallocation of resources. There are wonderful examples of things going on, but as a country we need to take it seriously and start the resource reallocation process.

The Chair: Thank you very much.

I have to apologize to Penny Priddy for missing her in the order.

Ms. Priddy, you have the floor.

● (1635)

Ms. Penny Priddy (Surrey North, NDP): Thank you, and thank you to the witnesses for your presentations.

Janet, I'm interested in the fact that you say you want to do follow-up around the labelling. That was part of what one of my questions was about—and I'll do this quickly.

We can label as much as we like, but I'm interested in whether you have any sense as yet of the percentage of the population, and I realize you'd be just guessing, who do not at this stage have enough education—and by the way, it could be any of us in the room, so it's not necessarily about education level—about what those nutrients mean, or secondly, the percentage of people who are not literate and for whom labelling will make no difference, and whether you've thought about how we'd get at that one. That would be the first question I would ask—and we'll just get through as many of these questions as we can.

My next question is, what would we do for better data? I think, Kathy, you, or somebody, said we didn't have as much data as we would like. What do we need to do to get better data?

Lastly, because what we're looking at is federal responsibility, are there any direct resources on reserve for people in regard to diet counselling, diet assistance, etc.?

As many of these questions as we get through, we get through.

Ms. Janet Beauvais: Maybe I'll start on the question around nutrition labelling—what impact it is having, whether people have the ability to understand the label. It's a fairly new regulation, and when we developed it we did a significant amount of focus testing with real Canadians to develop a label that was as easy to read and understand as it could be.

Based on our analysis to date, we know that 60% to 80% of Canadians are reading the nutrition facts panel. That's fairly significant this early in the process of having the new regulation. But as time goes on, we certainly will want to go back to Canadians to learn more about the impact these labels are having. Are they reading them? Are they helpful? Do they understand what they mean? Are some of the educational toolkits we're putting into place reaching Canadians? We have an educator's toolkit, but Mary's team has also developed an interactive website to help Canadians learn how to read a label. These are all activities we can do as time unfolds.

Ms. Penny Priddy: And the literacy one?

Ms. Janet Beauvais: On the literacy issue, we know 60% to 80% of Canadians are reading them, but as to whether they understand them or not, I don't have data. In our focus group testing, we did the best we could to get them at the right reading level.

Maybe, Mary, you can speak more to literacy.

Ms. Mary Bush: Yes. When that policy was being developed, part of the reason it was a standardized presentation was that the literacy community said there's enough complexity to the terminology and the numbers; put it in a standardized presentation and we will be able to build on that. And it becomes a tool that's in the environment, that is integrated into the nutrition education programs of provinces and communities across the country. It's not just about "here is labelling and here is how you use it"; it becomes a tool that's referred to as people are educating across the country.

Dr. Diane T. Finegood: Can I offer a quick response on the better data question? I think that's an important one, certainly.

There are two areas around data that are important. One is surveillance. We don't have very good surveillance in this country. Not only is this the first national nutrition survey in 35 years, but we don't even measure heights and weights very often. I think that's really important. It isn't even just about body weight; it's also about surveillance of food and physical activity behaviours, and it's about surveillance of policies that have an effect. That's important.

The other aspect of data collection that I think is important is to support more community-based research and even community alliances for research, where you have researchers working with communities for which this is an issue and the communities play a significant role in the whole process of articulating what their needs for information are, the researchers working with them to get that information in a coherent way and feeding it directly back to those communities, as well as to the greater pool. Those are the kinds of key things we need to do and the kinds of things we have done, albeit in a limited way, through the Canadian Institutes of Health Research.

● (1640)

Ms. Penny Priddy: Thank you; that's helpful.

Dr. Gregory Taylor: Let me add, on surveillance with respect to weights, that we try to make it more comprehensive for all our disease collection things and risk factors.

The other thing to think of is that surveillance is a mechanism to actually evaluate what you've done. Surveillance isn't sophisticated enough yet. If you go into a community or a province or a region and have an intervention, how do you measure whether or not it's made a difference? That's the kind of surveillance that's necessary.

A voice: It's more longitudinal now.

Dr. Diane T. Finegood: We're supporting researchers to do that kind of work, although not enough.

Dr. Gregory Taylor: So on your third question....

Ms. Kathy Langlois: All right.

I would just say on the labeling that we have—I'll follow on from Mary—an approach in terms of the first nations and Inuit as well in labelling for literacy purposes.

In terms of direct resources on reserve, there are a number of programs that are aimed at this at different ages and life stages. The aboriginal Head Start program working with children 0 to 6, the prenatal nutrition program, and the aboriginal diabetes initiative are all aiming at building these skills across different life stages.

Ms. Penny Priddy: And those are real people. Head Start is, but....

I'm done?

The Chair: Yes, your time is actually quite a bit over, but I allowed them to finish answering that first question. I did it out of grace because—

Ms. Penny Priddy: Kindness and grace. Thank you so much, Mr. Chair. It's very kind.

The Chair: We'll move on to Ms. Davidson, for five minutes.

Mrs. Patricia Davidson (Sarnia—Lambton, CPC): Thank you, Mr. Chair.

I'd like to say thanks to all the presenters. Certainly I enjoyed each of them, and we've heard some very good information here this afternoon.

I have one question and I'm going to put it to all of you. I'm not sure if anyone has any ideas.

We talk about the increased incidence of obesity, and we're all well aware that that is the case. We've got huge numbers; whether it's native, non-native, it's right across the country.

But I've also been involved in politics at the municipal level for a long time and I know that at the lower levels of government there have been increased programs—healthy children's programs and things set up through public health agencies and units, and cooperation and partnerships with education people and institutions. We've had all these initiatives. We've had fitness incentives at the federal level; we've seen that. Certainly some of those are quite recent, and we probably have not had time to see any results. We've seen better labelling, much more information being supplied; this is an ongoing thing, and I agree that consumers are really starting to pay attention to that. I know probably ten years ago most people never read a label and now they do, and I think the standardized form is extremely beneficial. Whether or not people understand what it all means, they can at least compare this product to this product because it is in a standardized form. I think that's good.

I know there are education programs for smarter shopping; they do supermarket tours and teach lower-income families how to shop smart. Those things have been going on for a long time. There are healthy breakfast programs in schools.

You've talked about redesigning Canada's Food Guide again. It was done a few years ago; it's going to be done again.

But where are we going wrong? We've been taking several initiatives, but the incidents still keep increasing by leaps and bounds. So what are we doing wrong, and what direction should we be taking?

We talk about sports, and a lot of people are involved in sports. Certainly at the municipal level people are getting more involved with hiking trails and biking trails and all of those types of things. A lot of initiatives are happening, but we don't seem to be touching the problem.

Dr. Gregory Taylor: I'll begin to try to address that.

I'm not sure we can say this is where we're going wrong. I come back to the tobacco analogy—multiple interventions over a sustained period of time. Forty years ago tobacco began the work that led us to where we are now.

In the last few years what's been very exciting for us is looking at things totally outside health. For example, there's really good evidence looking at urban design. How you build your communities has a profound effect on obesity, believe it or not, because of safe places to walk, the types of stores that are available, etc.

We had some think tanks in Toronto a couple of years ago when we invited urban design people who believe they're acting for good health, and they have evidence to say they are acting for good health and it does promote that.

There's a new community being designed on the top of a mountain in SFU, an ideal community, which is incredible in terms of the open spaces and the ability to walk instead of taking the car, etc.

Certainly in the aboriginal communities, as Kathy alluded to, safety issues are huge; you can't get out and walk like you used to do. I think we're really beginning to recognize it's the environment... it's the determinants that we really need to influence more.

As we mentioned earlier, simple labelling by itself isn't enough. It may not be that we're failing; we're on the right track, and maybe lots of these interventions are working, and maybe if we hadn't done them the problem would be a lot worse than it is now.

● (1645)

Mrs. Patricia Davidson: Is the seed money that we talked about to form partnerships? What would be directly involved with that?

Dr. Diane T. Finegood: Certainly we do need partnerships across all portfolios—across agriculture, transportation, across all sectors. That's really critical because it affects everybody. When I talk about seed money I talk about getting efforts to intervene under way, to have work happen, and then understand it.

I'd like to comment also that the scale of our response is the problem. When you weigh the scale of our response against how much money the food industry that generally markets—we market high-energy-dense, low-nutritious-value food. We just compare those two things? They're out of orders of magnitude different, with the enormous expenditure around that.

There's a significant underlying problem in that our food supply puts the least nutritious, most energy-dense food, and also the cheapest foods.... That goes back to issues of socio-economic status, but it also impacts the degree of marketing we see, because the highest-profit foods are the ones that are the most highly processed, containing the cheapest ingredients. So you end up in a situation where not only are they the cheapest foods, but they're the most marketed and they're the most available food.

We're responding a little, but the scale has to change.

The Chair: I am going to allow Mary to respond.

Ms. Mary Bush: I just love your question, because it's so bang on in the sense that it's not about telling people what to do. This problem is way beyond that. I get this all the time with Canada's Food Guide: it affects obesity. No, we're not. It's not about all these little individuals. It's coming to grips with the profound change that has happened over the last 20 years in terms of a society that is now functioning in a way that it has never before...faced with food. You can't even go to Home Depot without passing food. It's in your face 24/7, 365 days a year.

We're also in a time where we're sitting in rooms like this. I look at the artwork on the wall and see an era when people actually worked and expended energy.

It's a profound challenge, and it's not simply about tinkering at the edges with education. There has to be a much more comprehensive approach to this.

The Chair: As an example of how powerful peer pressure really is, you notice the remarks about cookies and you notice how many cookies were picked up. The tray is still full.

Madame Demers, you have your time.

[*Translation*]

Ms. Nicole Demers (Laval, BQ): Thank you, Mr. Chairman.

Thank you for appearing before the committee. I'm pleased to see representatives of both the Department of Health and the Public Health Agency of Canada. That doesn't happen very often. I will be asking you questions which will certainly be more interesting for you.

Mr. Taylor, you mentioned that there are fewer problems with obesity among the middle class and the affluent than among those struggling with poverty. Personally, I think that all young people have problems with obesity, regardless of their social class. We are seeing that obesity problem among boys but it is also very important not to forget that there is also problem with anorexia among girls, on the one part, as well as extreme thinness among young girls.

We are very familiar with the effects of obesity, but as we've been saying for some time now, we don't understand all its causes. Perhaps we should examine the relevance of informing people on the effects rather than trying to make them understand the causes. The effects are known. For instance, in the case of cigarettes, we have explained that it can cause lung cancer, among other things. That way, people understood much more quickly. We point out that cigarettes can perhaps cause erectile dysfunction and of course that makes people think.

Therefore, I'm wondering whether it wouldn't be preferable to opt for a public awareness campaign, providing information and education and targeting parents first and foremost. Regardless of their budget, they are the ones who are usually responsible for buying food for their children. Has such an initiative been considered? Maybe it could help people understand better the importance of healthy nutrition. Pointing out the number of calories in such and such a food is not sufficient, in my opinion.

● (1650)

[*English*]

Dr. Gregory Taylor: I think you're talking about educating the outcomes and the risks of being obese to families, so that they can make sure they're feeding their children appropriately.

There is evidence that education is important, but as with tobacco it's not sufficient. There's lots of good survey evidence in tobacco, and Canadians know obesity is bad and probably for the most part know that it's related to diabetes. But their actual behavioural changes are very difficult.

So part of the nutrition labelling is an attempt to get there, and part of the work we've been doing is an attempt, specifically in diabetes and obesity, to say that these are some of the bad outcomes—and Dan alluded to this.

But it's not enough by itself because of the terrible environments people live in. They're just not capable, or they're not receptive, or they're not ready to actually make changes. It gets into the stages of change theory, which I'm sure you're aware of, where if you're not aware of this at all, you're not going to hear the messages.

It means that part of what we have to do in our social marketing campaigns is target and direct them better. Regarding some of the ethnic groups, we haven't even begun to get the messages into the right perspective. In Kathy's area, the messaging has to be very culturally specific.

The BMI, the body mass index, that's used for some groups doesn't work at all, so they're probably not even interested in this. We have to tailor our messaging, but at the same time recognize that it's not enough by itself. I think you're right. Just because this is high calorie, then being aware of the bad outcomes.... Again, I keep coming back to tobacco because people were well aware that tobacco was terrible and they were going to get lung cancer, but they still continued to smoke because they were addicted, because they couldn't change—it was a whole myriad of reasons.

So we have to do both at the same time, as well as educate people and parents to be responsible.

Part of the problem you also alluded to was that when the healthy living agenda was developed, it was obesity-driven, where obesity was the concern. The feedback after two years of consultation is moving away from blaming the victim. Instead of calling it obesity and "you're a bad person", it became about healthy living and was given a positive environment and a positive spin, with the thinking that it's much easier for people to adopt positive behaviour than to say to children you're bad, you're fat—and there's so much pressure on children.

Regarding your comment earlier about anorexia, I'm very concerned. I have a 15-year-old daughter who is probably about 30 pounds overweight, and it's very difficult. I don't want to be telling her about that, since the last thing I want to see her do is make herself throw up because she wants to be attractive to the boyfriend she's now getting.

In the general population I don't know if there's good evidence to suggest—and maybe Dan could comment—that we may actually be going too much in that direction if we move too hard...so it's a positive body image and a positive environment that children are exposed to rather than a negative one.

Dr. Diane T. Finegood: Leaders in this field recognize that focusing on the word and the target "obesity" is actually a problem, particularly for children. That's not what we want to do. What we want to move away from is the tremendous linkage in our population between food and fun.

So what the leaders in this field suggest is that we don't want programs to target obesity; we want to target physical activity and fun. In essence they're calling it a stealth intervention. We need to get children more active through the recognition of fun—that being physically active can be fun. The outcomes of the studies in which this has been done have been much stronger than those in which the target was telling children or their parents that they needed to do something about it.

Eighty percent of Canadians want to change their behaviour to improve their eating habits, but they're not able to make those changes either because they live in an environment where they can't or don't.

Certainly parents have a responsibility here because they have control over a large part of their children's environments, but I don't think just telling them that is the solution. I think it's a lot more about going around and making it more about fun.

The Chair: Thank you very much.

Mr. Batters, you have five minutes.

● (1655)

Mr. Dave Batters (Palliser, CPC): Thank you very much, Mr. Chair.

I would like to thank all the witnesses for being here and for their time today on a very important topic as we start our study.

I'm going to pick up on my friend's question and leave you with this thought. If not everyone got their comments on the record, we're going to have this report after eight meetings of this committee. Are there things that maybe haven't been discussed today, or specific things that if we don't have them in our report we will have completely missed the boat and dropped the ball? This is the opportunity for you, the experts in your specific areas, to ensure you've addressed those areas. Just think about that, if you haven't put them on the record. I know the last time Dr. Finegood was here I asked that question and she gave an excellent answer.

Dr. Finegood, you talked about seeding provinces, territories, and communities in order to make the changes we desire to help combat what looks like an epidemic. I'd like you to comment a little bit on what you mean by seeding, in our role as the federal government. Perhaps you'd like to comment on seeding individual Canadians.

I'm very proud to be part of a government that intends to have a $500-a-year physical fitness tax credit, which I believe is for children under the age of 16. I see that as a way of going right down to individual Canadians. On a really simplistic level I see this as being a matter of physical activity in our schools, and education in schools about healthy eating. I think that goes some distance toward accomplishing the goal of physical activity.

Dr. Finegood, perhaps you could talk about seeding.

Dr. Diane T. Finegood: When it comes to Canadians, I think the word I would use is “support” as opposed to “seed”. So when you talk about individuals, the key here is to support them in their environments to be able to make healthy choices.

In some cases they don't have access, as my colleagues have told you, and in some cases it's just not the easy choice. So the more we can make the healthy choice available, possible, and the easy choice—that's clearly critical for Canadians.

On seeding, I would go to the example of what CIHR has done. In the creation of CIHR we created a number of programs that were called community alliances for health research. We gave funding initially to a researcher, who was working directly with communities, to tackle the research component of that problem.

A good example is a program called Saskatoon In Motion: Building Community Capacity through Physical Activity and Health Promotion, which was started by a researcher at the University of Saskatchewan who had an idea that they needed to build the capacity of the community there to undertake more physical activity.

An investment from CIHR of $1 million per year for five years was leveraged tenfold by this researcher. So once we put the money on the table and said this was a good thing to do, their city and province came to the table with additional funds for the intervention activity that was under way. So when I talk about seeding, from my perspective it's doing that kind of activity.

On your first question about what the evidence tells us we should do, we should ban advertising of junk food to children. I recognize that's a very difficult task to undertake and may not be something we want to do, but there is good, strong evidence that it would have a huge impact on our environment.

Mr. Dave Batters: Does anyone else have any recommendations for our study that we'll have just missed the boat if we don't include?

Ms. Mary Bush: Diane has used the word “seeding” down to the individual; I would use “empower”. I'm not sure you should think there's just a huge capacity at the local level to have change happen.

You went through a number of programs, and you need to know that as we looked at this seriously from the federal level, we were trying to figure out how we could enhance capacity at the local level. At the same time, cities were amalgamating, including our own city of Ottawa-Carleton. I got a call from someone who was trying to bring in physical activity and healthy eating and influence the environment. They were being asked by their council what the impact would be if their budget was cut by 50%, 70%, and 90%. I don't think you should think there's capacity.

Diane raised the issue of the Saskatoon in Motion program. One of the biggest issues is that when you go outside of some of these centres, there's no capacity. So the whole seeding down to individuals and empowering individuals is important, but I think you need to appreciate that to do this and do it well it's going to be....

I'm trying to imagine an example for you that would be an analogy to your physical activity....

● (1700)

Mr. Dave Batters: One last little point—

The Chair: Your time is actually gone. It's actually a little over, but that's okay.

Mr. Dykstra, five minutes.

Mr. Rick Dykstra (St. Catharines, CPC): Following up on that, Mary, could you expand a bit on the reference you made to capacity? Driving down and trying to figure out how each person is going to think about that seems, at the end of the day, to be what's important here. It's not big programs that we can speak about from a federal perspective, or provincial or municipal; it's about how does an individual.... I think Kathy or Diane mentioned the whole elevator theory—seeing that note on the elevator—is a personal way of kind of reaching it and maybe relating capacity in an individual.

Ms. Mary Bush: Thank you.

I think there are some exciting potentials on the horizon. Dr. Taylor mentioned this joint consortium on school health and the interface between where the environments are that children use and what we can do. The reality is for things to happen at that level. You need somebody who cares about health, who interfaces with education and is making some changes within the system. In fact, I can tell you, three children later, that over the lifetime of having three children, there isn't even an interface between those two systems that's operative right now. Those are some of the early steps that are being taken out of the new joint consortium on school health. But there's so much more that needs to be done. So if you meet Canadians where they're living, you need them to be supported so that they have environments.

Dr. Taylor mentioned the environments that can encourage physical activity. Those built-in environments are equally important for healthy eating. You need to be able to support Canadians. When they get on an airplane—you people travel; have you tried to eat? Let me tell you, it's a huge challenge in the area of what you're given, how you even access foods that are going to meet your nutrient needs and do it at a reasonable calorie level and allow you to get on.

I guess I'm simply trying to say that when you're doing this, the capacity for me is that I think we've decimated public health systems in this country to a level where even when you're at our levels, trying to figure out how you are going to do this, you become a country of demonstration projects. Monique Bégin said that to us not long ago, and that's what we've become. We've got to move past that. We have to get down to making sure that there are systems in place at the local level that can support people.

Mr. Rick Dykstra: That kind of fits into the—

The Chair: Was there any more to that question? Do other witnesses want to answer that?

Ms. Kathy Langlois: Yes, Mr. Chair, I had hoped to add something to the list of requests. If you didn't study this, would you have missed the boat?

If I may, from a first nations and Inuit perspective, I think the committee really needs to look at the issue of food insecurity, particularly for first nations and Inuit. We know that high rates of overweight and obesity are linked when there are food-insecure situations. I think the committee could add tremendously to the efforts we need to take in this country around that issue for first nations and Inuit.

Mr. Rick Dykstra: The point kind of leads to my next. As a younger individual in grade school, I recall that one of the punishments we received was...you know, in class, if you do something wrong, you won't be allowed to go to phys. ed. I remember that to this day, only because—and I recall it now and I remember it on a regular basis—how upset our phys. ed. teacher got, because he obviously questioned what kind of punishment that was. It was all about physical activity. I wonder about that in terms of my next question, which we all struggle with. And I think I hear from you as well that you're struggling with the aspect of whether it is about what you eat or whether it is about physical activity, and which one takes priority. I wonder about that.

Greg, if you could, advise us a bit on where we as a group and as a committee focus in terms of recommendations. Does physical education for young people become that first priority, or is it what we eat? I know you're going to say both, but I think one needs to take precedence over the other.

Dr. Gregory Taylor: You can't have one take precedence; it has to be both. The approach can be independent, and some of the approaches to get physical activity are different from some of the approaches for nutrition, but it's pretty tough to pick and choose which one. They're so interrelated, and I think that's what the evidence has shown us. That gets into the interventions you do. You can't pick one particular intervention or magic bullet; you've got to do a myriad of interventions.

I want to follow up on Mary's comment earlier. My wish list—I think this is what you're getting at—is going to take a long time. This is going to take a large investment of a long period of time. We're all in this for the long haul because what this is reflecting is the fabric of our society. Little interventions aren't going to do the trick. It's going to take societal change; it's going to take differences in terms of how we build, how we structure, how we school, rewards and punishments. Your example is quite interesting. Daily physical activity used to be in schools and it's gone. Now it's starting to come back, and we're realizing we've gone backwards there. But that daily physical activity can't be isolated without having some of the junk food taken out of schools, etc. So it really has to be both. I'm sorry, I can't answer one or the other.

Mary is dying to say something.

● (1705)

Ms. Mary Bush: I'm absolutely dying, because I really think it would be a huge error to do one over the other. I'd urge you to go to the Annapolis Valley example, because in fact they had both a food nutrition policy, a comprehensive school health initiative, and rigorous evaluation. Those schools that were participating in this comprehensive health program were less than half as likely to have children who were overweight and obese; the students ate more fruits and vegetables and had a higher overall diet quality than students without the program, and it was the comprehensive health nature of the program.

The Chair: Thank you very much.

We're going into the second round. Ms. Keeper.

Ms. Tina Keeper: Great. Thank you.

Do I only have five minutes?

The Chair: Yes, at the very most.

Ms. Tina Keeper: Okay, very quickly, I would like to thank Ms. Langlois for mentioning food security because it was one of the questions I had wanted to ask you. The food mail program, which used to operate in some of the fly-in communities in my riding, where a four-litre jug of milk can often cost $16, $19—it's just unbelievable, the cost of healthy food—has been eliminated over the last number of years. I'm wondering whether FNIB has a relationship with INAC, because primarily INAC has been in charge of that, and whether it's a direction you think is really important.

Ms. Kathy Langlois: Yes, Health Canada FNIB does have a relationship with the food mail program, and I'm not aware that it was removed from any communities, so that is something I'll have to check on.

The role we play there is to provide guidance on nutrition and, for example, which foods to include in the subsidy. That is the role we play, plus we have since 2001 been involved in three pilot projects to look at nutritious perishable food, where we've actually further increased the subsidy rate or reduced the cost of transportation, and we've done some other interventions to see if we're able to have an impact on healthy food consumption.

Ms. Tina Keeper: Has there been an analysis of the pilot projects yet, and have you decided how you're going to move forward?

Ms. Kathy Langlois: Yes, there has been. We are in the process of finalizing the evaluations of those projects. One of the major lessons from them is the work we need to do at the retail site in the store with the public coming in to buy the foods in terms of education, reading labels, and giving ideas and showing how to prepare, perhaps, different foods.

Ms. Tina Keeper: In my riding it's definitely a matter of access. We don't have the food mail program anywhere in my riding, and I have 19 fly-in communities.

I would like to ask one more question of the panel. One of the things, Mary Bush, you mentioned is the overhaul of how we think about our lifestyle in terms of the impact. Could I ask, is one of the...?

You said you can't go anywhere without passing food, and it seems to me that because we have so much fast food, and not only in the franchise stores but also in terms of what we're buying, putting in our homes for ourselves and our children.... I don't know who this is for, Janet or Mary, but is what we're thinking of as food maybe part of the problem too? I'm thinking of all the frozen foods we feed ourselves, our children, as you said, on planes....

Ms. Mary Bush: I'll start and then pass to Janet, because that is a very important issue. The reality is you can stop by on your way home and slug back a frappuccino, a cappuccino, and have as many calories as you would have if you sat down to, say, a plateful of vegetables, fish—a dinner. People need to reacquaint themselves with the energy content of food, absolutely. That's why the program of food labels in the grocery stores is so important.

● (1710)

Ms. Tina Keeper: Right. I'm just thinking that often things we consider food are not even really food a lot of the time.

Ms. Janet Beauvais: Do you have an example?

Ms. Tina Keeper: Like a pizza pop or something—do you know what I mean? Or you think of corn dogs, these types of things, the hot dog stands that are on the busy streets, outside people's businesses. I'm thinking about how the overhaul you're talking about is not just in terms of physical activity but what we look at as food. There might be a label on the hot dog, but is it really food?

Ms. Janet Beauvais: It's all considered food. I think it's just a changing pattern of what's available in the food supply and our familiarity with what those products may have in terms of calories, fat, nutrients, or lack of nutrients. That's where nutrition labelling may help Canadians, as Mary said, to better acquaint themselves with the nutritional value of these foods and better compare.

Ms. Tina Keeper: Gregory mentioned there's a correlation between the increase in chronic disease as well. We're seeing a pattern that goes across the board.

The Chair: Madam Gagnon.

[*Translation*]

Ms. Christiane Gagnon: It is true that we are constantly being encouraged to consume food which, in many cases, contains many calories but no nutritional value.

I have been asking myself a few questions. When we are on holiday we are less stressed. Earlier we were talking about physical environment, but the psychological environment in which we are working is also important. Children also experience stressful situations, for example, when they go home and are alone in the house.

Is this something you have considered in your studies on obesity?

[*English*]

Dr. Gregory Taylor: Stress and mental health I guess is what you're alluding to, and how it relates to that clearly is an indicator that's related.

Did you want to speak from a scientific perspective, Diane?

Dr. Diane T. Finegood: Certainly there are correlations between stress and obesity, and the stress hormones contribute to the problem. I think underlying that, again, is this issue around access and exposure and advertising and things like that. We have to keep in mind that our least nutritious foods, our most energy-dense foods, are the ones that are most available. It's that relationship between cost and energy density, cost and nutrition, that is the underlying driving force of why the exposure is so great and why the access to that kind of food is much greater than the access to healthy food.

A recent effort has been to not just rate the energy density of food, but to rate the nutritional quality of food by coming up with a simple index that actually gives the consumer an idea about how nutritious and how energy-dense the food is. It goes back to Ms. Keeper's comments about what's food. Well, healthy food has both nutrient content and low-energy density. We have to get people to understand that, but even understanding it won't solve the problem of access and exposure to advertising.

Ms. Mary Bush: I would make one more comment.

As we're evolving the food guide, we're trying to put together a pattern of eating that has a conservative level of energy for each age and sex group. In order to eat and stay within that energy level, you're eating very basic foods. We're urging people to make sure they're making choices with little or no added fat, sugar, energy. We have to drive the message at every food group level or we end up having a pattern that delivers more energy than is appropriate for Canadians.

It's a huge challenge. Looking around at the food environment, and a couple of examples have been used, whether you call them real foods or not, they're foods that are just ubiquitous right now. It's not a case of people thinking of food as, oh, I'm going to go and get carrots, lettuce, and start into my preparation. It's pick a package. Not that you can't pick a package. One of the largest fast foods is bagged salads—yay! There are some good examples out there, but there are also real efforts that need to be made. The food supply that we're all accessing because of the way we conduct our lives has changed profoundly.

● (1715)

The Chair: To follow up on that, when will the updated food guide be done?

Ms. Mary Bush: Late this year or early next. I say it that way because it will come out in 2006 or probably January 2007.

The Chair: We'll finish our questioning with Mr. Batters. I think he has a short announcement after a very short questioning.

Mr. Dave Batters: Perfect.

How long for questioning, Mr. Chair—a couple of minutes?

The Chair: Yes.

Mr. Dave Batters: I'm sitting here realizing my own ignorance in terms of food, nutrition, and density. I think this is something this committee has to address. I'm happy to hear there's going to be a new guide, and I hope it's the simplest document known to man because that's what we need. We need something that is one or two pages, really user friendly.

I have no doubt that for Canadians who want to proactively seek out good eating habits by asking their physician or doing research, the information is there and easily attainable. It's the fact that no one bothers to take the time to do this. How can we make sure it's ingrained in people? It starts with educating our kids, and we're here talking about childhood obesity.

I'd like to know from each of you your opinions. Do you believe this is taught pretty much uniformly in schools? If not, that's something we definitely need to look at. Do we have material that is easy to use and user friendly for our kids as well? Heck, some of this stuff is complicated enough for adults, let alone teaching our children.

That's my question to each of you. Is this taught in our school system—how to eat healthily, what the major food groups are, and examples of healthy meals? I just don't believe the education is there.

Dr. Gregory Taylor: Sorry, I'm not an educator and I can't give you the details, but that's the purpose of setting up the Joint Consortium for School Health, with education and health at the same table.

Ms. Mary Bush: Just at the time that there was a national plan of action called Nutrition for Health: An Agenda for Action in which key things were identified to try to improve the nutritional health of Canadians, one of which was to teach food preparation skills—kids today don't even know how to cook—what did we do across the country? What was termed "home economics" is no more. There isn't that in the educational system right now. It's absolutely gone. Do we even teach appropriately how to eat? It's all melded in different ways across the country. There has been a lot of effort put in, in different provinces, to try to have curriculum that goes to health. It's a very significant issue you touch on.

Mr. Dave Batters: I have no doubt there are all kinds of materials, a wealth of materials, developed by the federal government. It's a matter of getting them into people's hands. If you don't proactively go down to your local Service Canada office and pick up the pamphlet, then no one sees this good material.

I'd suggest as well that the GP's office, the family doctor, would be an ideal place to mass distribute this stuff. Put this information into the hands of parents early in the going, the first time a parent comes in. Maybe this is covered in parenting classes or something. We have to get this into the schools. Maybe we could have a massive public education campaign, with continual advertising with examples of meals. I think there's so much ignorance out there. I'm speaking from experience.

Dr. Diane T. Finegood: I'm not sure the evidence supports that people are as ignorant as you're articulating. I certainly agree that public education is important, but we know the evidence tells us that public education alone is insufficient.

I'll just give you one anecdote. I'm just back from the International Congress on Obesity in Sydney and a very interesting study was presented in which they looked at school-aged children. They asked them in this case about advertising and whether they thought advertising was actually information, and they tried to understand whether kids thought advertising was real. Of the kids, 100% understood that this advertising was propaganda and that it was not real information, but 75% of those kids still asked their parents to buy the items that were being pushed on them as junk food.

While attitudes and awareness are important, the environment that those individuals live in is also critical.

● (1720)

The Chair: All of these good questions, and good answers, by the way, have promoted more questions.

Madam Demers, you have a short one. Then we have Omar with a very short one, and then we'll do a quick announcement.

[*Translation*]

Ms. Nicole Demers: I don't think it is acceptable to put our heads in the sand simply to spare people's feelings, for example, by speaking about healthy living—a term you used earlier—rather than obesity. I myself am obese. I am not plump, as some would have me believe. When people tell me that I am simply plump, then I forget the problems I have because of obesity.

I think we have to stop acting in this manner. Education, information, and awareness-raising are very important. We have to acknowledge these problems for what they are. Otherwise, we end up avoiding them and avoiding calling them by their name, because we are afraid of hurting people's feelings. Once we start telling the truth we may start getting results.

[*English*]

The Chair: Thank you for the comment. That's very well taken.

Omar.

Mr. Omar Alghabra: Thank you, Mr. Chair.

Just as a comment, I'm one of those people who are really benefiting from the labelling that started a couple of years ago.

One of the things that I think my colleague Mr. Batters has also brought up is the fact that some of the food information that's available is quite complicated.

May I propose something like where you have an awareness campaign, where you have some illustrations, 10 dots per day, and each pre-packaged food, whether it's prepared at a restaurant or sold at a store, has a number of squares on it associated with the number of calories or the fat content? If everybody is aware that they should only have 10 squares a day, it becomes easier to keep track of that calorie content.

I hope the committee might consider something like that. Thank you.

Dr. Diane T. Finegood: There is evidence to support programs such as what's called the “red light, green light diet”, where there are red light and green light labels.

If you label food in relatively simple ways, where people can understand what's a healthy food that you can probably eat almost as much as you want of, what's an okay food to eat occasionally, and what's a food that you should only select on rare occasions, that really does help consumers make choices. So that kind of work has been done.

The Chair: Thank you very much.

I'm nervous about this, but nonetheless, Mr. Batters has asked to make a quick announcement. Let's let him do that, and then we'll call the meeting.

Go ahead, David.

Mr. Dave Batters: There's nothing at all to be nervous about, Mr. Chair. Just give me five seconds for what I have to say.

I do not use the labeling. I find it immensely complicated. I have no idea of what's going on there. So I hope the powers that be develop a nice, simple labeling scheme for people like me.

I would like to respectfully make a suggestion to this committee. We are already scheduled to meet on Tuesday, October 31. That day, the Juvenile Diabetes Research Foundation will have a bunch of kids in Ottawa. I guess we'd call it their lobby day. They call it Kids for a Cure.

I've been told that a number of kids from a number of our ridings—46 kids from across the country—will be here. This is an issue that we identified in the spring as being an important one. I would suggest that, being as we have the 46 kids here, we dedicate that meeting to the issues surrounding juvenile diabetes research.

I don't know how many other members have been visited by kids in their riding, but they tell a very compelling story about what it's like to live with juvenile diabetes, and it could be very enlightening for this committee.

The reason I propose this is because this happens only once a year, and it happens to coincide with one of our meetings. By my count, it may be at the end of the eight meetings. We may not even have an interruption. I think we would have just completed the study on childhood obesity.

I don't know if I have to make a motion or just put that on the table.

● (1725)

The Chair: In fairness, why don't we just leave it and discuss it at the next meeting? We have it as information for now. Is that fair enough? Okay.

I want to thank the witnesses for coming in. I thank the committee for their excellent questioning, because I think it was a very good dialogue today. We have a tremendous task ahead of us as a committee and as a country.

If you remember, just a few short years ago it was seat belts. They used to go underneath the seat instead of around our lap and over our shoulders. Now, a six-year-old getting into a car with his or her father will say, “Daddy, buckle up.” So we've come a long way on that, and we have to do the same on this one.

I appreciate you coming in and vaulting us into a very exciting opportunity ahead for us, and the country, hopefully. Thank you.

The meeting is adjourned.

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