House of Commons
CANADA

Standing Committee on Health

HESA • NUMBER 024 • 1st SESSION • 39th PARLIAMENT

EVIDENCE

Tuesday, October 31, 2006

Chair

Mr. Rob Merrifield

Also available on the Parliament of Canada Web Site at the following address:

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● (1535)

[*English*]

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

This is a bit of an interruption, but also a continuation to some degree of the study we're doing on childhood obesity. We have with us people from the type 1 juvenile diabetes group who are here on the Hill today visiting members of Parliament. I understand you also had an opportunity to visit the Prime Minister for a short time this afternoon.

We are very pleased and feel honoured that you are able to come to speak to the committee and present your case. We look forward to your presentation and to asking you some questions on it.

Before we get into that I want to introduce a new member, who is actually a past old member. Hedy Fry is with us on the committee as a member.

Hon. Hedy Fry (Vancouver Centre, Lib.): Just say "past member", not a "past old member".

The Chair: Yes. My eyes are getting bad, so forgive me for that.

I'd like to introduce to the committee Robert Hindle. I'll have you introduce the rest of your group and start the presentations.

Mr. Robert Hindle (Member of the Board of Directors, JDRF Canada and JDRF International, Juvenile Diabetes Research Foundation): Thank you, Mr. Chair.

[*Translation*]

Good afternoon, members of the committee. We thank you sincerely for giving us the opportunity to talk to you today.

[*English*]

As you know, we are holding our kids' day on the Hill today. We call it Mission Possible.

I would like to first introduce two of our special agents, Mitchell Burke from Winnipeg, and Chloe Rudichuk from Regina.

[*Translation*]

I would like to introduce Josée Goulet, who has been our president and chief executive officer for two months now. She is from Montreal and has been working part time in Toronto for the past two months.

[*English*]

I have been around for a long time with JDRF.

I'll now ask Chloe to start off our briefing.

Ms. Chloe Rudichuk (Cure Special Agent, Juvenile Diabetes Research Foundation): My name is Chloe Rudichuk. I am 11 years old and from Regina.

Five years, ago on Canada Day 2001, my life changed forever. On that day I was diagnosed with juvenile diabetes. Today I want to tell you about what it's like to have this disease. I've told this story many times, but I'm happy to do it today because you actually have the ability to do something about it.

My family and I really didn't know anything about juvenile diabetes. I had never even heard of it before. I didn't realize that I would have to prick my finger six to ten times a day. I didn't realize that I would need to have three to four needles every single day to keep me alive. I didn't realize that the long-term complications from juvenile diabetes include blindness, kidney disease, heart disease, and amputation.

In the beginning it was hard to adjust. I had to learn to test my blood sugar by pricking my finger. My parents had to learn how to give me insulin with a needle. We all had to learn about counting carbohydrates, what I could eat, how much, and when. It was hard for people to understand why this was so important. I look healthy enough.

I feel left out when kids bring treats for the class, because a lot of times my blood sugar is too high and I can't join in and have the snack. I have to watch while the rest of my class enjoys their treats. Because I'm a dancer, I have to be careful about getting blisters on my feet. They take a long time to heal, and as I grow older they can cause serious health complications.

When my blood sugar drops too low I feel really sick. I'm dizzy and weak and need sugar fast. I've been lucky because I have always recognized when my blood sugar was too low and have been able to treat it. People with juvenile diabetes often lose consciousness and may even have seizures if they don't treat their low blood sugar quickly.

When my blood sugar is too high I usually end up with a headache. My parents worry a lot about my high blood sugars because they're hard on my body and lead to serious long-term complications. Since I was first diagnosed I have pricked my finger almost 16,000 times. I have had almost 6,000 needles. I'd like the needles to stop.

I now want to introduce Madam Josée Goulet, president and CEO of the Juvenile Diabetes Research Foundation Canada.

Ms. Josée Goulet (President and Chief Executive Officer, JDRF Canada, Juvenile Diabetes Research Foundation): Thank you, Chloe.

Health committee members, I want to begin by thanking you very much for giving children like Chloe and Mitchell the opportunity to address your committee formally today. I'm sure it is something they will remember for a long time—as well as the whole day.

Please allow me, as president and CEO of JDRF Canada for the last two months, to also thank you for the important work you do studying and debating health issues of importance to Canadians. We all hope you will see the unique opportunity that is before us to find a cure here in Canada, and soon.

● (1540)

[*Translation*]

I would like to say a few words by way of familiarizing members of the committee with our organization. The Juvenile Diabetes Research Foundation was founded in 1970 by parents of children with juvenile diabetes, or type 1 diabetes. The foundation is the leading non-profit, non-governmental organization in this area and the leading advocate of diabetes research worldwide. We have 12 branches across Canada, from coast to coast, headquartered in Toronto. Our organization's success depends in large part on the hard work and determination of the children, whom many of you have heard from today, as well as on the generous support of our donors and the tireless energy and financial support of the parents, many of whom are also here today.

[*English*]

In the course of your work as parliamentarians you will receive compelling submissions from many groups, all of whom have great reasons for you to support causes like ours. I would only point out to committee members that no chronic disease has ever been cured, but many experts consider that of all the chronic diseases, we are closest to curing juvenile type 1 diabetes. We're this close.

For everyone, particularly children who are primary victims of type 1 diabetes, a cure will be nothing less than a fresh chance at life. For millions of adults it will mean the end of costly, painful, and life-threatening complications.

On behalf of JDRF I want to thank you, members, for your continued support of our efforts.

I would like to introduce Bob Hindle, who will explain more about the great research being done in Canada and what JDRF is currently asking from the federal government.

Bob.

[*Translation*]

Mr. Robert Hindle: Thank you, Josée.

[*English*]

We are asking for something that is probably unique, and we readily admit we are trying to distinguish our cause of funding for diabetes type 1 research because of what JDRF has already produced.

[*Translation*]

In my conversations with some of the committee members and other members of Parliament, I did not have the opportunity to mention what I am about to say.

[*English*]

It has been suggested that perhaps apart from the previous history I have as a volunteer with JDRF that I discuss an issue that relates to what you have heard from Chloe and what you're going to hear from Mitchell. I say this in the context of Canada and of being a Canadian who is familiar with Canadian research results already on the books.

I too was diagnosed with type 1 diabetes as a young child. Chloe gave you a list of the complications that can arise. After 37 years, I suffered kidney failure and was on dialysis. I have first-hand knowledge of what happens to you no matter how well you control your blood sugars, how regularly you take your exercise, and how attentive you can be. I spent four hours a day, three days a week hooked up to a machine to stay alive. I won't dwell on the bad news. I had, among other members in my family, one particular brother who tested positive and was accepted to donate a kidney to me. The day before that transplant surgery was scheduled, a compatible pancreas became available within the Montreal region, where I live. On April 13, 1999, I became the first Canadian to successfully receive a double transplant of a kidney from a living donor and a pancreas at the same time. So for seven and a half years, I have had personal knowledge of living on the other side of the line without the need for constant finger pricks, blood sugar monitoring, and insulin injections.

My point in telling the story is that today, this year, the Royal Victoria Hospital, where that surgery was done, has now done 16 pancreas and kidney transplants. They expect to do 25. That is as a result of Canadian research and Canadian medical expertise. When I was the first in Canada, I was the third in the world, so let's keep in mind that Canada has always proven to be a leader in medical and health research related particularly to type 1 diabetes and its complications.

I think that we must keep that in mind, because we will also unabashedly wrap ourselves in the Canadian flag, not because it's a wonderful emotional argument to our federal government, but because there are provable successes out there.

I would ask you, please, to ask your staff to double-check what we are saying to you, from what the *Globe and Mail* pointed out in their list of Canada's ten best things, Banting and Best's discovery of insulin, to, since then, Canadian research into type 1 diabetes. I have had the occasion to meet people from other countries through JDRF, many of whom have trouble speaking English or French. While perhaps I can't understand what they say most of the time, they can pronounce very well two words - “Edmonton protocol”. Dr. James Shapiro and his medical team have made fantastic advances and continue to do so in islet transplants. Since then almost every year in Canada, Dr. Leo Behie, Dr. Lawrence Rosenberg, Dr. Derek van der Kooy.... There must be a reason why Canada on a pro rata basis is head and shoulders above the world in type 1 diabetes research.

That is why we are proposing something that is unique as we address the health committee to discuss funding for an organization like ours with the federal government in Canada. We're not simply asking for a handout of $125 million. We're asking for a partnership. Please come to the table and sit down, and let's look at what a research path could look like for type 1 diabetes. We are far beyond basic research.

● (1545)

One of the new tag lines of JDRF is “fund the gaps”—in other words, how we continue to make these quantum leaps. The business strategy of JDRF International—and I emphasize international, because we fund research in at least 37 countries around the world—is based on getting tangible results within five years.

JDRF goes where the best research is. We continue to strive to increase our fundraising efforts every year—and we have done very well at it, I may add. We have always been net importers of research dollars. The international research analysis and allocation has resulted in this recognition of Canadian talent, of proven Canadian success, and of the potential for what we call a “made in Canada cure”, which started back in the 1920s with Drs. Banting and Best.

Those are the two points I would ask you to take from our presentation and our requests of you.

With that, it is my pleasure to introduce to you Mitchell Burke, who has a few words of his own.

Mr. Mitchell Burke (Cure Special Agent, Juvenile Diabetes Research Foundation): Thank you, Mr. Hindle.

My name is Mitchell Burke, and I am from Winnipeg. I am 11 years old. I was diagnosed with type 1 diabetes on May 14, 2004. My life took a big turn that day, one that I will never forget, nor will my parents.

The hopes and dreams of living a normal childhood and adulthood are gone. I had to grow up very quickly. I used to think that diabetes was just part of my life, but looking at it more closely, I realize it is my life. I wouldn't be here today if it wasn't for insulin, needles, finger pokes, counting carbohydrates, and watching my daily activities. Even with all this work, I am constantly worrying about the highs and lows of my blood sugar and the life-threatening complications associated with this disease.

When people ask me what the cure would mean, it would mean freedom to live my life free of complications, and freedom to be a normal person without the worry of what I am eating or what activity I would like to do. It would mean the freedom to grow old and follow my dreams.

Without JDRF, we wouldn't be this close to a cure. We are here today to spread our message to all parliamentarians that a cure is close. With your help, you can make it happen. The fact that you are all here today supporting and encouraging us gives us hope that our lives can change. A made-in-Canada cure for juvenile diabetes is a mission possible, but only if people like yourself make it your mission to ensure that the federal government increases research funding for this disease.

Thank you for giving us the opportunity to appear before you today. Your support and dedication to our cause is greatly appreciated. Accept the mission to help us find the cure for type 1 diabetes.

Thank you.

● (1550)

The Chair: Okay. Thank you very much.

We'll open the floor to the committee for questions. We will question back and forth and try to learn a little bit more about juvenile diabetes and your work and your requests.

We'll start by opening the floor to Ms. Dhalla. You have ten minutes, unless you're splitting your time.

Ms. Ruby Dhalla (Brampton—Springdale, Lib.): Thank you very much.

I want to really thank Mitchell and Chloe for telling your stories and taking the time to share your stories with us.

I had a couple of young students, as well, who have been affected with diabetes and who came to speak at my office. I was really touched to hear what they go through on a day-to-day basis.

I think there's a responsibility with all of our members at this table to ensure that there is the funding and the investments and the resources for research, and to ensure that we, as I believe Robert said, can work collectively in a partnership to come up with a cure to help children throughout Canada and the world.

I have a couple of questions. First of all, where does the funding for the association come from? Are there any research projects under way right now with the Canadian Institute of Health Research that are related to some of the issues you want to pursue?

Ms. Josée Goulet: We will both speak, I guess.

Most of the funding we have is through fundraising activities or events. We've raised several million dollars per year. At the same time, this is money that is pooled world-wide, because we belong to the Juvenile Diabetes Research Foundation International. As Bob pointed out, there is a group of decision-makers or researchers who allocate that money for different projects, depending on the submissions and so on.

Bob can correct me if I'm wrong, because it's been two months and a lot longer for Bob, but I believe we in Canada received more than $10 million and we raised about $7 million, so we're net importers, in that they find that the research expertise is there. What's good about JDRF International is the way it functions: it's not territorial, and they will put the money where they believe there's the most potential to find a cure world-wide. If there is more in Canada, the U.S., or Israel, and so on, they will do that. There's a committee, and we have Canadian representation on these committees. They determine allocations every year, five-year grants and so on. I believe that's how the process works.

Bob, I don't know if you want to add anything.

Mr. Robert Hindle: That's a fairly accurate description for the first question.

Maybe I'll move on to the second question about working with CIHR. We receive no funds from CIHR. In the past year, CIHR has funded $6.6 million in research for type 1 diabetes. JDF is currently working on a first potential partnership with CIHR, but the answer to your question is none.

● (1555)

Ms. Ruby Dhalla: There was an announcement recently made by the minister of $348 million into CIHR, I believe. Will any of that money be allocated to research for type 1 diabetes, that you know of?

Mr. Robert Hindle: To be honest with you, I don't think we received any details on what will happen. The honest answer is that it's premature for us to try to answer that.

Ms. Ruby Dhalla: To the kids, either Chloe or Mitchell, you mentioned that you must have your sugar levels monitored throughout the day. Perhaps you could share with the committee your experience of what that's like, and also, if you know of some of the costs that are associated with you having to buy the type of equipment to do so.

Ms. Chloe Rudichuk: During the day today my blood sugar level was pretty good. I had it recently tested before the meeting and I was high, at a level of 16.4, I believe. The normal range for me would probably be between five and nine, so....

Mr. Mitchell Burke: My readings weren't that good today. I was mostly high and I had a low. My normal reading should be between four and seven.

Ms. Ruby Dhalla: How much does your equipment cost that you have to buy to get tested? Could you share that with the committee?

Ms. Chloe Rudichuk: I think for a couple of boxes of 100 strips it costs about $25. I'm not sure about the syringes or the lancets, but I think that's around what the strips cost.

Mr. Mitchell Burke: The meters can cost a lot, but they usually don't because you can get free things. For example, if you buy a box of 200 strips you can get a free meter and that kind of thing.

Ms. Ruby Dhalla: Thank you.

The Chair: Thank you.

Ms. Keeper, you have about four minutes.

Ms. Tina Keeper (Churchill, Lib.): I would like to also thank everybody who has participated in the lobbying efforts today and for your presentation. I as well had a presentation from some of the young people and family members here today. It was very educational. I applaud you young people for the professionalism and the level at which you made your presentations in the office. It was fantastic and very educational. The courage it must take to do this is outstanding, so I thank you.

Mr. Hindle talked about a clear research path, or made reference to a direct research path. Might I ask you about that, because it was in the presentations that the youth made today. They referenced a direction in which JDRF is moving.

Mr. Robert Hindle: Two years ago JDRF moved from the concept of a cure to identifying what are called six cure therapies, or therapeutic cures—it works either way—because of the fact that research has shown that there will not be a single eureka moment. There will be steps along the way to achieving what we called a cure when we were back in the black hole of basic research.

Also, for people in different stages of diabetes, there will be different cures. They include the restoration of normal blood sugar that could come, for example, through islet transplants, which currently have other issues and are not the simple answer to that. For people who have islet transplants or for people like me who have a new pancreas, they don't eliminate the process of attack by our autoimmune system, the T cells. Therefore, recurrence is an issue.

That leads to prevention, which is a third area.

I'm just giving this as background to what you asked, which was the research path. There is nothing clear in terms of what the end result will look like, because it's hard to get scientists to ever talk about things like that, even behind closed doors.

But there is very definitely a direction. It's somewhat like knowing what you're looking for and seeing it behind the glass but having to figure out how you break the glass to get there. The steps that will allow us to proceed to the next stage have to be identified, and then the stages to the end have to be identified.

● (1600)

Ms. Tina Keeper: Could I ask you about one of those six targets you're talking about? It is the islet transplant—is that right?

Mr. Robert Hindle: Yes.

Ms. Tina Keeper: There are problems with that for youth. They mentioned in their presentation to me that islet transplant is not an option at this point for children. Could you explain that a little bit?

Mr. Robert Hindle: Islet transplants were first attempted back in the 1970s. Dr. Alex Rabinovitch, also from the University of Alberta, took them on as a serious research project in 1987 or 1988, and never achieved a success rate that reached 10%.

What Dr. James Shapiro, Dr. Ray Rajotte, and Dr. Jonathan Lakey did was bring that up to a level of 80% by changing the immunosuppressing mixture, and that has resulted in a higher than 80% success rate after one year. What happens is that the success rate declines drastically over five years—so of course it took until 2005 before there were reviewable numbers—and therefore more work is required on that.

Is it because the T cells are coming back to attack the new islet cells? We don't know. Because it's a transplant, it also requires exposure to immunosuppressants, which is a risk not worth putting on the heads of young children and otherwise healthy diabetics. Those are the issues that are currently being dealt with through JDRF-funded research.

And I may add that because of the success of the researchers at the University of Alberta, 12 different protocols, around the world, copying Edmonton, which will be slightly different, have been tried or put in place. So we're trying to advance the timeline by having different researchers try different protocols and share information.

The Chair: Thank you.

Madame Gagnon, you have five minutes.

[*Translation*]

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

I would like to thank the children and the parents. I know that being here today has meant a lot of time and energy, as well as a willingness to tell us the story of your lives. When children have a disease, it affects the whole family. We know that day-to-day living is not easy for these families, as we heard this morning. They chose a good way to reach us, describe their everyday experiences and explain how they live with this illness and the diagnosis.

You have raised this issue with several governments—not just the federal government for research, but also other governments for school protocols. This morning, one girl told us that it is not easy for her to do her tests and take her medicine at school and she talked about her teachers' understanding of the disease. Although I realize that this matter falls within the purview of the provinces, including Quebec, I would like the children to tell us what kind of standard protocol they would like to see to provide guidelines for supporting children in terms of their treatment.

I have a second question. Earlier, I asked Ms. Goulet what she thought the best question to ask would be. I think she answered in part or perhaps in whole: What would you do with more money, and what would it enable you to accomplish?

I am not sure I understood your remarks, but it seems to me you said you would like to see legislation on research. Did I understand correctly, or did I misinterpret because people around here are always talking about legislation? I may have misunderstood your remarks, but I think you said something about research legislation or spending more money on research. I think you were saying we need to spend more money on research.

Ms. Josée Goulet: I said that we need to spend more money on research.

Ms. Christiane Gagnon: Okay. I misunderstood and I apologize.

Ms. Josée Goulet: If legislation would give us more money for research, maybe that is what we need, but—

Ms. Christiane Gagnon: I think you were very clear about how important it is to act now. You are sure that with enough funding, a cure will be found within five years. Can you tell us a bit more about your short-term objectives? It is not easy to find cures for degenerative diseases within five or ten years. I know because my daughter has multiple sclerosis. Research in these areas is very difficult. I would be very happy if a cure for type 1 diabetes could be found.

● (1605)

Ms. Josée Goulet: I will answer both of your questions.

You mentioned a protocol for schools. Awareness programs for schools happen more on a local level. When children are diagnosed with type 1 diabetes, juvenile diabetes, their parents need to be educated of course, but when the children go to school, as Chloe said earlier, everyone around them needs to be aware of what is going on, of what could happen, and so on. I would call this a school program, because in some schools, there is more than one child with type 1 diabetes. We have to work with local boards. We really have to do this on a local level. I would not call it a protocol; rather, it is a way of working with school boards and individual schools to educate them about the child's illness. We have to tell them that it is not contagious, and we have to educate classmates, teachers and parents of the other children so that everyone knows what is going on. I would even go so far as to say that in some places, schools take this so seriously they hold fundraisers to help these children. That is how I see school programs.

With respect to research and timelines, Bob can tell you more about that. What I would say is that research is research. When I met Dr. Shapiro to discuss the Edmonton protocol, I asked him right away if we would have a cure in two years, or five, or ten. He did not want to give me an answer because, he said, that would not be very professional. Research is sometimes full of surprises. He did say that he could see the light at the end of the tunnel. I found this very encouraging, and I heard something similar from someone else when I went to New York after that. He said that he could not see that light before now. I think that is very interesting. I met an extraordinary man in New York, Dr. Richard Hansell, who said:

[*English*]

“If there's one disease that is cured in our lifetime, it will be type 1 diabetes.”

[*Translation*]

He has already done something similar for another disease. This is very encouraging. With more money, we can do more research and we can probably reach our goal faster. That is the underlying logic. As Bob said, we have a very strong international team that can identify which horses are likely to get to the finish line faster. That is one way to describe the situation.

[*English*]

The Chair: Thank you very much.

Mr. Fletcher, you have five minutes.

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

Thank you very much to the panellists, especially to the kids, for coming here today. I'd like to thank my colleague Mr. Batters for suggesting that you come to committee. This has been quite a day for everyone, I think.

Everyone, regardless of their party, is very concerned about this issue. As chair of the juvenile diabetes caucus, and Ruby Dhalla is on the committee, I think all of us, including Dr. Bennett, Madam Gagnon, Penny Priddy, Dave Batters, and Pat Davidson, are involved outside this committee on this issue. We are very concerned.

I have two questions, one to Mitchell and the other to Madame Goulet and Robert.

First, at lunch today, Mitchell, who is from the great province of Manitoba, gave me a poem. I'd like to just read it into the record, if that's all right. I think it speaks a lot to the challenges that are faced.

Here is *The Cure*, by Mitchell Burke, special agent:

Happiness, Freedom, no more pokes
Normal like other kids,
And no more stupid jokes

Happiness, Freedom, no more pain
L - shots and N - shots
Washed down the drain

Happiness, Freedom, the silly questions all gone away,
No more frustration,
And treated normally for one whole day

Happiness, Freedom, no more lows
No tablets to chew,
No more silly diabetes woes

Happiness, Freedom, no more testing
No meter to carry,
And a lot more resting

Happiness, Freedom, when there's a cure
Back to normal and happy
And no diabetes stuff to endure.

Mitchell, I was caught by some things you said at the start of your poem, such as “no more pokes”, and “no more stupid jokes”. Can you explain to us the stigma here, or the attitude of your classmates and friends, how they challenge you on this issue, and what we can do as a society to create more understanding about the challenges you face?

I also have a question for the older people around the table. This committee is going to be reviewing the assisted reproduction act regulations that deal with issues around research, specifically around stem cell research. I wonder if you could explain JDRF's position on stem cell research.

Mitchell, and then Madame Goulet.

● (1610)

Mr. Mitchell Burke: What I mean by the joking is that sometimes some of the kids in my class ask questions about why I have to poke every time, and they make fun. They go, “Pokey Fingers”, or “Black Dot Fingers”, and all that.

And what I mean about the pokes is the lancets going into your fingers, and the needles.

Mr. Steven Fletcher: Is there anything we can do to make them understand?

Mr. Mitchell Burke: I don't know.

Mr. Steven Fletcher: And on the stem cell research, Madame Goulet?

Ms. Josée Goulet: Robert is going to take that one. I have the formal answer, but he will be able to give that answer in more detail.

Mr. Robert Hindle: First of all, seeing that we have this unique opportunity that you've granted us, I'd like to be very practical in the answer. JDRF's official position on stem cell research is that we do not want to see any areas of potential research leading to a cure be cut off. We recognize the issue that everybody has with embryonic stem cell research. What we're saying is that adult stem cells have yielded great potential as well. You folks are the parliamentarians who have to make those decisions. We are in agreement, and always have been, with the Canadian position. We made that position clear prior to the passage of the current legislation.

I'd like to add one further point, if I may. Without the concept—the word is “concept”—of cell regeneration, which came from this huge time-bomb of an issue called stem cell research, our researchers did not have the ability to think of the body regenerating its own ability to take care of itself, if I can put it that way. What was not known before the area of stem cell research was first delved into is that the pancreas in fact still produces islet cells, and those very few islet cells, which are not sufficient to take away type 1 diabetes from any of us who have to take insulin, may be capable of regenerating themselves.

In fact, at our JDRF research centre in Canada there is currently research going on in Montreal on a very specifically identified portion of the islet that seems to be the button you push to make islets replicate. The goal of that research is to make someone's own islets reproduce within their own bodies. That is a step beyond what you've referred to, Mr. Fletcher, which is stem cell research. I would just like to point out already what tangible research progress has resulted simply from the idea that stem cell research has been carried out.

● (1615)

The Chair: Okay, thank you.

Ms. Priddy, you have five minutes.

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

Thank you to all of the panellists.

I'd like to ask Mitchell and Chloe both, what is the hardest part for you of walking every day with this disease, including getting wakened up in the night? That's one thing I didn't realize, that you have to get tested during the night, which would be pretty sleep disruptive if you have to get up for school in the morning. The kids I talked to today said yes, they all wake up; they don't sleep through it.

What's the hardest part? And a bit like Mr. Fletcher's question, what is it you would like your classmates to either do or understand about you?

Ms. Chloe Rudichuk: I'd say the hardest part is when kids bring treats to school, and testing and having my blood sugar too high to actually enjoy the treat with the rest of them—just for them to understand that I can't have this some of the time, and for them to take into consideration to call the night before or let me know so that I can raise or lower my insulin accordingly so that I can have the treat along with the rest of the class.

Ms. Penny Priddy: Okay. Does the teacher ask for sugar-free snacks or treats for everybody when you do treat day?

Ms. Chloe Rudichuk: No.

Ms. Penny Priddy: Okay. One of the young people talked about that today.

Mitchell.

Mr. Mitchell Burke: The stuff that I find hardest is when I'm in the middle of a sports game or something, having to stop and do the test—the needles and all that.

Back to what Chloe said about the snacks, they should try to use less sugar, sweeten them without real sugars, use Splenda and all that. They should do that—and call, too.

Ms. Penny Priddy: Yes, because we do it with peanuts. People don't put peanuts in snacks for school any more at all, right? Thank you for answering that.

I have another question. I know you're here talking about type 1 diabetes. Do you know the difference between the research dollars for type 1 and type 2 diabetes? I know you do, but....

Mr. Robert Hindle: Last year's figures from CIHR themselves are $6.6 million for type 1 and $11.5 million for type 2.

The Chair: Thank you very much.

Mr. Batters, for five minutes.

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

This is a very big pleasure for me to welcome everyone from JDRF to this committee. This is something we have been trying to accomplish for a while. I thank all committee members for agreeing to have this hour dedicated to this very important topic.

I'd like to start by giving you a little background for 30 seconds.

I met Chloe Rudichuk, obviously a very well-spoken young girl of 11, who is an excellent—as you are, Mitchell, as well—spokesperson for this very important cause. I was able to meet Chloe's parents, Jeff and Carla. We had a good discussion and this is what has come out of that. I'm very proud of you, Chloe, for persevering and coming to committee today.

I have two questions for you, Chloe, and then I'd like to ask Bob two questions. I only have five minutes.

Chloe, this is my first question. I wonder if you could tell me a little bit about the difference between type 1 and type 2 diabetes, because not everyone understands that. Type 2 diabetes can be the result later in life of poor eating habits or not enough exercise, but that's not the case with type 1 diabetes, is it?

Ms. Chloe Rudichuk: No. Type 1 diabetes is an autoimmune disorder than cannot be prevented by eating right or proper exercise. Type 2 diabetes can be prevented by proper exercise and eating habits.

With type 1 diabetes, after someone has been diagnosed they are then insulin-dependent for life and will have to take several different injections every day to keep them alive. With type 2 diabetes, you can control the disease more with proper exercise and eating habits.

● (1620)

Mr. Dave Batters: Right. Thank you very much for that.

I spoke to your parents a little while ago. I understand that the cost for managing your type 1 or juvenile diabetes is about $400 a month. Does that sound about right?

Ms. Chloe Rudichuk: Yes.

Mr. Dave Batters: Wow.

I'm going to focus on Chloe because I know Mr. Fletcher's focus is on you, Mitchell, as his constituent.

Chloe, what is the important message you'd like to leave with us, as parliamentarians, today?

Ms. Chloe Rudichuk: Just that it's hard to live with this disease, and with you helping us it'll help us a great deal to make that extra leap to finding a cure.

Mr. Dave Batters: Thank you so much again.

I'm going to focus on Bob in a second, but I want to thank you so much for coming to this committee. You're a very gutsy little girl.

Mitchell, thank you very much as well, and the other 44 individuals who came. You've made a strong case here today, and we hope to have a cure for you.

Bob, we've met before.

Hello, Josée.

Bob, I'd like to commend you as well. You have a little bit different message, but you're also a very gutsy individual, a transplant patient. This has been a very important cause for you for an awfully long time.

Bob, if JDRF were to get into a partnership with the Government of Canada, where would the $125 million go? What would the government and Canadians get for that investment? Simply, will it make a difference and will it make the cure for juvenile diabetes a mission possible?

Mr. Robert Hindle: The quick answer is yes.

Before I start, we'd like to thank the committee members. I would particularly like to thank Mr. Batters, publicly, for having arranged this opportunity.

What will happen with the $125 million? What will we get? Part of the answer is we don't know what we'll do with it. What we are asking for is a partnership that requires input from the federal government. We are asking the federal government to commit $125 million. JDRF does not intend to take that money and run away for five years and say “Give us a call and we'll tell you what we've got”. We would expect that JDRF will put JDRF research money into this. Together we will look at the next steps possible in Canada, resulting from the six, seven, or eight key research projects.

JDRF will fund the research to get to a cure for type 1 diabetes, whatever that has to be. We're saying, why not Canada? We will wrap ourselves in the flag, but for very good reasons. Our researchers have been leading the world for 85 years in type 1 research. There is every valid reason to believe that our researchers, with the appropriate funding in Canada, can complete this job. We can't do it alone in Canada. Don't forget the islet transplant results from Dr. Shapiro's Edmonton protocol. This will always be known as a key component of the cure for diabetes, no matter where it is finally found.

I repeat, why not in Canada? We have the track record. We have the research going on right now. Why not take advantage of what we have, the talent we have in Canada? Rather than simply handing us money to go into a black hole of research, why not adopt the JDRF plan? If I may use a quick analogy, we know that businesses have business plans—a three-year business plan, a five-year business plan. We have one for our fundraising; we have a five-year fundraiser plan. We also have a research business plan for where we go in response to various conditions. We would like to sit down and take the input of the Canadian government and analyze what's possible in Canada. We would like to add other research money to what JDRF is providing. This would allow us to put together the entire answer to what will result from the $125 million. To go one step past that, whatever costs it takes, JDRF will be a key component in finding a cure. And a cure will be found.

The Chair: Madame Demers.

[*Translation*]

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

Good afternoon, Mr. Hindle and Ms. Goulet. Good afternoon, Chloe and Mitchell. Thank you very much for being here today. You are very courageous, and I find that very moving. Every time children come to the Hill, I am very moved. This is the second time children have come here, and your presence encourages us, your members of Parliament, to do the work you want us to do.

I know that unless and until research finds a cure for type 1 diabetes, there will have to be advances in treatment, and that is what is happening now. In Quebec, we have the Lantus, which is approved for patients and is on the list of covered drugs. I know that this is not the case elsewhere. Are you working to ensure that more effective treatments for children are made available in other provinces? I know that on some reserves, aboriginals do not have the right to this treatment, yet I was told this morning that if a child takes this medication, he does not have to get up in the middle of the night to test his blood sugar. It is healthier not to have to get up at night.

Chloe said that the strips cost $25 for 100, but I was told they cost a dollar each. I am not sure I understand. I know that it is very costly for parents of children with juvenile diabetes. I would like to know whether something else can be done while we wait for research to come up with a cure for this disease.

● (1625)

Mr. Robert Hindle: I hope I have time to answer all three parts of your question.

First of all, provincial governments are new territory for us. Alberta's health care system covers islet transplants and the Government of Ontario covers insulin pumps. That tells us we have more work to do at the provincial level. I cannot give a specific answer to your question, but we will be starting to give presentations at that level.

Second, to ensure that all aspects are covered, we will be focusing on private insurance companies. I am not an insurance expert, but I know that in general, when a federal or provincial system approves something new, private companies have a tendency to follow close behind.

Third, I have been hearing for a long time that by the time researchers make it 99% of the way to a cure, they have spent only 10% of the money needed because clinical trials are the most expensive part of the research. This is very frustrating. As I said at the beginning, it is like looking at something on the other side of a window and not knowing how to break that window to get it.

Ms. Nicole Demers: Mitchell said that type 1 diabetes has robbed him of his dreams. I think that by coming here today, Mitchell and Chloe, you are giving us back our dreams. I am sure that with the courage you have shown, you will find a way to achieve your dreams.

I really hope you do. Thank you.

[*English*]

The Chair: Thank you very much, Madam Demers. Those are very kind words, indeed.

We have one more questioner, and then we'll call this part of the meeting over.

Mrs. Davidson, you have five minutes.

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

I'd also like to say thank you very much to all of you for appearing before us today.

I was privileged this morning to have a meeting in my office with one of my constituents who is suffering from juvenile diabetes. Along with her were some other members of your group, one of them as young as two years old. It's not something that only affects those who are seven, eight, or nine; it can affect at any age, from what I'm being told.

I wanted to ask Chloe and Mitchell a question. Two of the girls who were in my office this morning were able to wear an insulin pump, and I think they felt this gave them a bit more mobility and freedom. Have either one of you thought about that? Is it an option for everybody, or just for some people? I know they're horribly expensive. And along that line, do either of you know whether any of these devices are covered under health insurance in any of the provinces?

● (1630)

Ms. Chloe Rudichuk: I have the option of using the pump. I've chosen not to because I tried doing an insulin needle through my stomach and it didn't go very well. That's how you get it through the pump. I've just chosen not to use it.

Mr. Mitchell Burke: It's the same over here, yes; it hurts too much in the stomach for me.

Mrs. Patricia Davidson: Okay. So for some people it works better than for others. Is that what you're saying?

Ms. Chloe Rudichuk: Yes, I think so.

Mr. Mitchell Burke: Yes.

Mrs. Patricia Davidson: What about the cost of the pump?

Mr. Robert Hindle: I understand that generally it's about $7,000 to $8,000. I do apologize, because I did not have the opportunity to benefit from that technology, given my advanced age.

As for coverage for the cost of the pump, there is only Ontario, which this year admitted the cost of pumps for children under 18.

Ms. Josée Goulet: The supplies are quite expensive too.

Mr. Robert Hindle: Yes, the ongoing supplies are a burden no matter which treatment method you use.

Mrs. Patricia Davidson: I have a minute left, and I'd like to ask Bob a question.

You talked about the research and the CIHR. I think you said that CIHR had $6.6 million for research for juvenile diabetes and $11 million for type 2.

If the federal government were to go ahead with your request, and knowing that most of our health research funds flow through the CIHR, would you be working with them? Is that how you see the $25 million, or $125 million total, flowing?

Mr. Robert Hindle: This isn't an evasive answer, but as part of our partnership discussions, we would like to discuss a method to see that the money goes to JDRF-identified research priorities. Does that preclude the current methods of funding allocation that are structurally in place at CIHR? If I were to venture a guess, I would say yes, currently. We'd just like to work with you; we want to find a solution to a problem.

We don't think the current CIHR method—and I have said before that I believe this is a structural issue, not a CIHR issue—is particularly suitable for where we want to go as JDRF. We are well past the basic research stage, which means you have to target very carefully who you want to fund, and for how much and how long.

The Chair: Thank you.

We've had one more request. Ms. Bennett would like to ask one quick question, and I'll allow it.

Hon. Carolyn Bennett (St. Paul's, Lib.): On the topic of CIHR, sometimes in medicine and in health research somebody who's going down a path trying to find a cure for something quite different can accidentally stumble on something that could be applied in another area. You said there are some structural issues, but would you agree that the funding for CIHR should be increased as well?

Mr. Robert Hindle: In principle, certainly.

I'll give you one example back, so you may want to tie some numbers to it. There's a specific funding model that exists in both the U.S. and Australia. The U.S. government allocated $750 million four years ago, at $150 million a year, specifically for type 1 research. They did that through the National Institutes of Health, mandating a very specific funding structure for this.

After an announcement late last year, Australia put $30 million for type 1 diabetes in place this year, which was the first time the Australian government specifically funded type 1 diabetes. They have their own medical research council, which is what we used to call CIHR. Instead they are giving $30 million to JDRF.

● (1635)

Hon. Carolyn Bennett: I also want to say that when we set up CIHR, part of it was to keep the politics out of it. In the 28 institutes in the U.S., with their lobbying and "my disease is more important than your disease", it can get you into trouble. I guess I'm saying that I have a bit of trouble having politicians make decisions about where the money goes.

Mr. Robert Hindle: And I am trying desperately to give straight answers without getting involved in that political process.

The Chair: We appreciate that very much.

Our time has gone. Before things turn to politics more than they have already, I want to thank you very much for coming in and sharing your experiences with the committee. It's very much appreciated.

Thank you.

Voices: Hear, hear!

The Chair: We'll now have a quick break while those who would like to leave the room do so. Then we will get on with our motions.

●

(Pause)

●

● (1640)

The Chair: Madame Demers has asked me to switch the order and to have hers on the breast implants first. I have no problem with that. If I don't see any dissenting hands on that, that's the way we will proceed.

Madame Demers, if you want to introduce it, the floor is yours.

[*Translation*]

Ms. Nicole Demers: Thank you, Mr. Chair.

You know how disappointed I was to hear that Health Canada had approved putting silicone gel-filled breast implants back on the market without ensuring that they are completely safe. Mr. Chair, I am tabling this motion to obtain the documents Health Canada considered in making its decision.

Last week, my colleague Christiane Gagnon and I asked the Minister of Health to give us the names of the independent researchers who were consulted as part of the decision-making process. The minister could not give us a single name. I think it is very important for us to see all of the studies that were used, as well as the list of all the researchers who were consulted or whose studies were taken into consideration during the decision-making process. We are also asking Health Canada officials to appear before the committee to explain their decision.

[*English*]

The Chair: We have a motion on the floor, asking for this documentation. Is there any discussion on the motion?

Mr. Fletcher.

Mr. Steven Fletcher: I'd like to thank Madame Demers for raising this important issue. We can provide as many documents as we can legally provide. We'd be happy to do that. I think the minister did answer one of the Bloc's questions along those lines in question period.

Within the legal precedents that we have to deal with, I think the intent of the motion is in good nature. We'll be able to support it, with the caveat that there are some privacy issues and so on, especially with the consultation with Canadians. But the intent is good, and I'd be happy to support it in that spirit.

● (1645)

The Chair: Is there any other discussion?

Ms. Ruby Dhalla: I just want to commend our parliamentary secretary for taking that initiative.

The Chair: I'll get to the question.

(Motion agreed to) [See *Minutes of Proceedings*]

[*Translation*]

Ms. Nicole Demers: Mr. Chair, [*ed. note: inaudible*]

[*English*]

The Chair: Thank you.

We'll move on to the other motion that was actually already on the floor. I think it's Ms. Dhalla's. We had some considerable discussion on that.

Is it a point of order? What would you like?

[*Translation*]

Ms. Christiane Gagnon: Could we discuss my motion first? It will be difficult for the committee to adopt both my motion and Ms. Dhalla's motion, but mine will be the more difficult of the two. I would like us to look at more than just the 2007 guide. I would like them to give us the draft so that we can see how the recommendations changed from the first to the final draft.

[*English*]

The Chair: What you're saying is that you'd like to do yours first.

[*Translation*]

Ms. Christiane Gagnon: Yes, and I am asking the committee's consent because my motion also asks for the 2006 draft.

[*English*]

The Chair: I'm not going to take a lot of discussion on this. Is there opposition to that?

Ms. Dhalla, you could speak to that.

Ms. Ruby Dhalla: In terms of my motion, I had recommended that we obtain a draft copy of the food guide that is going to be released; a list of all the stakeholders, organizations, and individuals that were consulted, along with their suggestions that they did put forward; and a list of questions that were also put forward for consultation.

I thought that within those three things it was very thorough. However, in regard to Ms. Gagnon's motion, which also states to obtain the 2006 draft—which, I believe, is a pre-consultation draft you're speaking about—could we just do a friendly amendment to my motion in order to have that included?

The Chair: Okay. There are two requests, then: one, to make it a friendly amendment to Ms. Dhalla's, and the other to have yours go first. If I don't see a direction fairly quickly, I'll make a decision on this.

[*Translation*]

Ms. Christiane Gagnon: I do not think that is a good idea because if we add the point at issue, your motion will not be passed. I do not think that is a good strategy.

[*English*]

The Chair: Okay, fair enough. There's no consent for its being an amendment. This is my rationale: we have a motion on the floor left over from the last meeting. It was Ms. Dhalla's. If there's something further to that, I think Ms. Gagnon can add that as part of her motion, and we'll deal with it that way.

We had a considerable amount of debate on Ms. Dhalla's motion. It was introduced. There were two individuals who had their hands up when I called the meeting over. We will start with those two. One was Mr. Fletcher, and the other was Ms. Davidson.

Mr. Steven Fletcher: Ms. Davidson can go first.

The Chair: Ms. Davidson, go ahead, please.

Mrs. Patricia Davidson: Thank you, Mr. Chairman.

If I can remember correctly from our last meeting, I think my questions were going along the line of asking Ms. Dhalla what the intent of this was. I wasn't sure where this was going. What were we going to do with it—just table it with the committee and leave it at that? We didn't have any time slotted in.

We also have a notice of motion before us today for different times of meetings and so on. Certainly we have nothing in our timeframe or our meeting schedule to do anything with this motion. So I was wondering what the intent of the motion was. Was it just to bring it and put it on the table before the committee, or was it to try to deal with it and scrutinize the three years of work that has gone into this?

● (1650)

The Chair: So the question is whether you want this paper document or you want to get some decisions and have witnesses. Is that the intent?

Mrs. Patricia Davidson: Yes.

The Chair: Okay.

Ms. Dhalla, go ahead, please.

Ms. Ruby Dhalla: Once again, the intent behind the motion came to light from hearing numerous individuals and stakeholders who presented to us at committee, and who all stated one of two things: either they were consulted or they were not consulted. The ones who were consulted stated that they were consulted on what the diagram should look like and where the pictures should go on the draft food guide.

When Mary Bush came in and spoke so passionately about the issue, she stated that they had done over 6,000 consultations. Considering this process has been in review for over three years, I think we owe it to Canadians to ensure that we bring forward a list of the people who were actually consulted and the types of questions they were asked, and to be sure that we look at where those suggestions ended up and whether or not they were incorporated into the food guide.

I know that the clerk has also handed us copies of e-mails, which I referred to last time, from Dr. Freedhoff, who also mentioned, further what to Mary Bush said, that there is a discrepancy between what Health Canada is saying and what these witnesses had stated. So I think this is really a non-partisan issue.

Regarding Ms. Davidson's concern about the fate of the documentation that comes forward, I think we collectively, as a committee, are going to have to decide what we do with that evidence. It may be that they have incorporated some, but not all, of those suggestions. It may be that they have taken a look and have done extensive consultations, and perhaps we as a committee will not need to proceed further. I think it is imperative that members of our committee receive the information, do an assessment, and decide collectively.

In terms of the work plan that was put forward, I've just spoken to the chair, and I believe there is a meeting of the steering committee on Thursday morning at which there will be discussion of how we move forward as a committee and what issues will be discussed. We can take a look at the second motion at that particular point.

I think it's imperative that we receive this food guide. There are four million copies going to print, and I think we owe it to Canadians.

The Chair: We're just debating the motion itself.

Mrs. Patricia Davidson: Can I have one follow-up question just for clarification?

I understand why you brought this motion forward. I think we debated that very fully at the last meeting. So I'm still not quite clear, then. Your intent, I gather, from what you have just said, is to dedicate at least one meeting, and perhaps more, to reviewing this. Is that the intent?

The Chair: Depending on what we see.... Is that fair enough?

Ms. Ruby Dhalla: To be honest, yes, depending upon what we see, we may need more. We may need fewer. We may not need any. I think we have to make that decision once we receive the information.

The Chair: Okay, Ms. Dhalla, we got that.

Mr. Fletcher, did you have a comment?

Mr. Steven Fletcher: There are three points to Ms. Dhalla's motion. One is the draft copy of the food guide. In the explanation, what the intent was still doesn't come across. I really hope there isn't an intention to start rewriting the food guide by committee, but that's the only logical outcome of the request. If you're going to ask for the draft copy of what is going to be released before it's released, you must have an intent to change it. That causes a lot of problems, in the sense that a lot of time and effort has already gone into it. Yes, Dr. Fry and Dr. Bennett are doctors and may be able to provide some additional insight, but many other people have been consulted.

Also, in regard to the list of stakeholders, there are privacy concerns, and so on. I'm sure most of them would have no problem in granting permission, but there is a whole bureaucratic exercise that we have to go through anyway to ask, and I'm just not sure it's practical or a good use of resources.

There are other ways of addressing some concerns. I think perhaps having the officials come forward again and asking some more questions is fine, but the actual motion is not practical. Therefore, regrettably, I can't support it.

● (1655)

The Chair: Okay.

Madame Gagnon.

[*Translation*]

Ms. Christiane Gagnon: I do not understand why the members cannot see the importance of having more information about the Canada Food Guide that is about to be published. A lot of money has been spent on this. It took 14 years to rewrite the Food Guide. Will this take another 14 years? We all know how much influence a food guide can have, and we know that obesity causes a lot of deaths. The Food Guide seems inappropriate. There are obesity specialists here in Ottawa and even in the United States who have expressed major concerns about the Food Guide.

I recently received some information and the release of the Food Guide adds to my concern. I think that we have a responsibility as a committee. We are studying obesity, yet we are allowing the publication of a guide that might not be realistic given the current situation and given everything the supermarkets are selling.

Take the consumption of dairy products, for example. Mr. Chair, I do not know if you considered what Dr. Freedhoff sent us. I questioned Mary Bush, the director general, several times, and I was surprised at her answers. She seemed to dodge the tough questions. She was very good at it. I realize this is her baby, but I think that baby will get a bit too big if it follows the Food Guide she is recommending.

[*English*]

The Chair: Did that come through in English the same as it was said in French?

[*Translation*]

Ms. Christiane Gagnon: Yes, I think it is the same thing. I wanted to lighten up the conversation, but this is a weighty issue. Let us be serious. Why should they not give us their last version and the one before? Why should we not hold our own consultations? What is the rush to publish the Food Guide? The publication date is a few months away, but how many millions have been spent so far? We have a responsibility. The committee was told—

[*English*]

The Chair: Okay, we got your point, and we made those the last time as well.

[*Translation*]

Ms. Christiane Gagnon: Yes, but I would like to shake you up a little.

[*English*]

The Chair: I'm shaking. I'm vibrating over here.

[*Translation*]

Ms. Christiane Gagnon: Mr. Chair, some members of the committee, especially the government members, do not seem to think the Food Guide issue is very important, and we are trying to raise some points that will change their minds.

[*English*]

The Chair: You'll have to ask him later, but not here now.

Ms. Priddy, you have a quick comment. Keep it to the motion and keep it tight and we'll move to a vote on this. I think it's fairly simple to see where everybody's sitting on it anyway, but go ahead.

Ms. Penny Priddy: You thought the need to say that just before I spoke, right?

● (1700)

The Chair: No, not at all.

Ms. Penny Priddy: Well, as a member of the committee, I am not suggesting that having this information means we're going to start rewriting the food guide from square one. But it is clear that there have been some questions that have been raised by a number of people along the way. This will either reassure some people that some areas they're concerned about were covered, or if there's something absolutely glaring for people and there are enough people who think that there's a glaring piece missing that's been raised by witnesses and is also of concern to committee members, it can be flagged.

Perhaps people can have that part of the discussion, or see if indeed the piece about aboriginal people, or whatever, is reflected in the kind of respectful way that people would like, or includes that.

I don't think anybody is suggesting we should try to rewrite the food guide, because we're a bunch of folks who couldn't do that. But we are politicians, we do listen to people in our communities, and for all I know it may reassure people and they may never raise it again.

The Chair: Okay, fine. I think we have exhausted this. We went around a considerable amount.... Okay, Ms. Fry, very quickly.

Hon. Hedy Fry: Sorry, I don't think you've exhausted it, because I really want to—

The Chair: Oh, we exhausted it before this meeting, actually.

Hon. Hedy Fry: I think it's important. I don't think we're trying to rewrite the food guide, but having been on the other end of this divide many years ago when I was very involved with the British Columbia Medical Association on health promotion and disease prevention, I will tell you now that the process of consultation through Health Canada has always been wanting.

One would get something sent to you two weeks before it was supposed be distributed, and two weeks before it was supposed to be the final draft, and one would never have the opportunity to give really good input. I think 14 years is a long time. To rewrite a food guide, which may not be changed for the next 14 years, and to take it only from the point of view that we take into consideration a lot of the points made in these other pieces of information that we get, I think we need to be assured, as parliamentarians, that appropriate consultation was given, that all of the new information about dietary factors is taken into consideration in the food guide.

It's not that we want to rewrite the food guide, but basically to upgrade on the old ways of doing things. When we know things about fibre and saturated fats and dairy produce that we didn't know a long time ago, we need to really be assured that we are writing a food guide that is appropriate for preventing disease.

We talked here today about type 1 diabetes, but there's also type 2 diabetes. We talk about childhood obesity. We talk about sugar and pop and those kinds of things. None of those are discussed in the food guide. So we need to be assured, as parliamentarians, not that we rewrite the guide ourselves but that the appropriate consultation was given, that what is going to eventually be the map for Canadians to eat in the future is one that is done according to today's scientific information and knowledge.

We only want to make sure that the process was followed, and if it wasn't done to our understanding, we make sure we update it. I think that's what we're talking about.

The Chair: That's fine. This is the way I see what has happened here, from the chair's position. We have a motion on the floor, and I think there are two bullets on which I don't see dissent anywhere, and that is who was consulted, how were they consulted, was it done thoroughly enough. For that part of it, I see consensus.

The part that I see no consensus on is about issuing a draft piece of the food guide, which has been worked on for the last three years, to this committee rather than exposing it to all Canadians. I think that's where there's a problem. That's the way I see it. The motion includes that.

I think we're ready for a vote on the motion.

Mr. Steven Fletcher: I was going to say, Mr. Chair, that we should go to a vote, even though it doesn't look good for the good guys.

The Chair: Okay. We'll strike that from the record.

Let's call a vote on this.

(Motion agreed to: yeas 7; nays 3) [See *Minutes of Proceedings*]

The Chair: Now we'll go to the second motion. Madame Gagnon, you can introduce it.

[*Translation*]

Ms. Christiane Gagnon: In addition to the new version, which is probably being printed right now, I would like to see the draft version of the new Canada Food Guide—the version that was used in the consultations. I would like someone to convince me that the people who put this together did so in good faith. Ms. Bush told us that she took many recommendations into consideration. I would like to know what changed.

[*English*]

The Chair: Maybe I'll stop you there.

The preliminary version is the one that she had given to the consultants.

Ms. Christiane Gagnon: I think so.

The Chair: Is that the one you're talking about?

[*Translation*]

Mme Christiane Gagnon: Yes.

[*English*]

The Chair: I don't think that would be a problem. And there's the current version. That's what you're asking for: the current version and the one that was placed in front of the consultation a year from now.

The clerk is asking if you want to take out the second bullet, because the first bullet was in the first motion.

[*Translation*]

Ms. Christiane Gagnon: I have no problem with that.

[*English*]

Mr. Steven Fletcher: You can do that if you get unanimous consent.

The Chair: Yes, and then we could probably agree with this one.

[*Translation*]

Ms. Christiane Gagnon: Could we pass it as is?

[*English*]

The Chair: We certainly could. The second bullet was already passed in the previous motion. If you eliminated that and just dealt with the first bullet, then we likely would get unanimous consent on that.

● (1705)

Ms. Christiane Gagnon: We could do that.

The Chair: Okay.

Very quickly, we're going to vote on the first bullet only, and the second bullet is eliminated from this.

(Motion agreed to) [See *Minutes of Proceedings*]

The Chair: Just for the committee's information, every time we sit around and try to discuss future business, it seems like we deteriorate and it becomes dysfunctional. I have therefore asked for a steering committee to be able to bring before committee a plan for future business. We'll have that meeting on Thursday morning, I believe, and then we'll hopefully be able to bring it to committee, in order to be able to address plans for future business.

Mr. Fletcher.

Mr. Steven Fletcher: Just by way of procedure, on Ms. Dhalla's motion, can I ask for a dissenting report on that?

The Chair: It's not a report, it's just a motion we're dealing with right now.

Mr. Steven Fletcher: Okay.

The Chair: There we go. I think we're done. That's the information you need, so thank you very much.

The meeting is adjourned.

Published under the authority of the Speaker of the House of Commons

Publié en conformité de l'autorité du Président de la Chambre des communes

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